

U.S. Department of Homeland Security
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Washington, D.C. 20536



U.S. Immigration
and Customs
Enforcement

February 12, 2021

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

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

Dear Mr. Evers:

This letter is the fourth 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 505 pages of records were reviewed for this interim production. The 505 pages of records were located pursuant to a search of the ICE, Office of Professional Responsibilities (OPR). Of those 505 pages, 1 page was determined to be non-responsive. The remaining 504 pages of records have been marked 2020-ICLI-00057-1080 through 2020-ICLI-00057-1583. Upon review, ICE has determined that portions of the 504 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 are not 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

Sincerely,

ROLANDO
VELASCO JR

Digitally signed by
ROLANDO VELASCO
JR
Date: 2021.02.12
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Senior Paralegal, ICE FOIA for

Fernando Pineiro Jr.
(A)FOIA Officer

Enclosure(s): 504 page(s)

cc:

Michael A. Tilghman II
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U.S. Immigration
and Customs
Enforcement

MAY 15 2019

MEMORANDUM FOR: Nathalie Asher
Executive Associate Director
Enforcement and Removal Operations

THROUGH:

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

FROM:

Acting Assistant Director

SUBJECT:

Findings – Death of ICE detainee
Ronald Francisco ROMERO (JICMS)

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

The U.S. Immigration and Customs Enforcement (ICE) Office of Professional Responsibility, External Reviews and Analysis Unit (ERAU), has completed its review of the facts and circumstances regarding the death of ICE detainee Ronald Francisco ROMERO who died on May 16, 2018, at the Valley Baptist Medical Center (VBMC), in Harlingen, Texas (TX), while in the custody of ICE. The State of Texas Certificate of Death documented ROMERO's cause of death as meningitis,¹ clinical history of diabetic ketoacidosis (DKA),² and clinical history of sepsis.³

On May 9, 2018, U.S. Customs and Border Protection (CBP) encountered and apprehended ROMERO near Rio Grande City, TX. On May 14, 2018, CBP transferred the detainee into ICE's custody, and ICE transported ROMERO to the Port Isabel Detention Center (PIDC), in Los Fresnos, TX.

At 4:21 p.m., ROMERO arrived to the PIDC staging area and received a timely medical evaluation. A Licensed Vocational Nurse (LVN) completed ROMERO's medical and mental health screening in Spanish and found his vital signs were within normal limits, and he denied any pain, medical problems, or medications. ROMERO's mental health screening was normal, his chest x-ray was negative for tuberculosis, and medical staff cleared him for housing in general population.

¹ Meningitis is an inflammation of brain and spinal cord membranes caused by an infection.

² Diabetic ketoacidosis is a diabetes complication in which the body produces excess acids in the blood through rapid breakdown of fat.

³ Sepsis is a potentially life-threatening complication of an infection that occurs when chemicals released into the bloodstream to fight the infection trigger inflammatory responses throughout the body.

On May 15, 2018 at 3:35 a.m., PIDC officers moved ROMERO from the staging area to the processing area and a processing officer inventoried ROMERO's personal property, including unspecified medications, but did not record funds the detainee arrived with.

At 8:50 a.m., an officer in the processing area noticed ROMERO seemed distraught. When he asked ROMERO whether he was ok, ROMERO replied no and asked to sit down. The officer instructed another officer to escort ROMERO to the medical unit where an LVN immediately assessed the detainee and determined ROMERO had a fever.

At 9:05 a.m., the LVN notified the facility's Physician Assistant (PA) of ROMERO's fever and escorted the detainee to an urgent care room by wheelchair. Shortly thereafter, the PA evaluated ROMERO and determined the detainee had the following elevated vital signs: temperature of 102.4 degrees, heart rate at 100 beats per minute (bpm), and blood pressure at 143/78.⁴ ROMERO rated his pain level as 10 on the standardized pain scale⁵ and complained of a fever, headache, left ear pain, sore throat, and body aches. The PA diagnosed ROMERO with a fever, streptococcal pharyngitis,⁶ and abnormal urine findings, and admitted ROMERO to the medical housing unit. The PA ordered acetaminophen and ibuprofen for ROMERO's fever, the antibiotic amoxicillin to treat streptococcal pharyngitis, and a daily intravenous (IV) administration of sodium chloride solution for hydration. Additionally, the PA ordered nurses take ROMERO's vital signs every eight hours and conduct nursing checks on an as needed basis. Medical staff performed checks and administered medications as ordered by the PA.

At 4:28 p.m., a Registered Nurse (RN) conducted a nursing round and found ROMERO had the following elevated vital signs: temperature of 99.5 degrees, heart rate of 106 bpm, blood pressure readings of 170/104 and 180/107. The RN also noted ROMERO's pupils were non-reactive to light, the strength in both his arms had decreased, and he required assistance to move or walk. The RN notified a Nurse Practitioner (NP), and at 4:39 p.m., the NP entered ROMERO's room to evaluate him. The NP observed the detainee's responses were slow, and his pupils were sluggish and hyperactive to light. The NP conducted a neurologic examination on ROMERO and observed he was lethargic and followed limited commands. The NP ordered ROMERO be transported to Harlingen Medical Center (HMC) in Harlingen, TX, via emergency medical services (EMS).

At 4:58 p.m., EMS arrived and moved ROMERO to the ambulance for transport to HMC, but experienced a delay departing the facility while waiting for the escort vehicle. The ambulance departed the facility at 5:25 p.m.

While en route to HMC, EMS staff observed the left side of ROMERO's face drooping and redirected the ambulance to VBMC which has a stroke facility. At approximately 5:47 p.m., the ambulance arrived at VBMC.

⁴ 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; and, normal blood pressure is 120/80, with 90/60 and 139/89 considered within normal range.

⁵ 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.

⁶ Streptococcal pharyngitis, commonly known as strep throat, is a bacterial inflammation of the throat.

Upon arrival to VBMC, a hospital physician assessed ROMERO and noted ROMERO's vital signs were elevated, as well as his white blood count and lactic acid levels. The physician initiated sepsis protocol which included administering IV fluids and antibiotics. The physician also determined ROMERO was in DKA and admitted him to the Intensive Care Unit, where medical staff initiated their DKA protocol to include restoring fluid loss with IV fluids, restoring potassium loss, maintaining acid balance, and treating infections and glucose levels with insulin, as needed.

On May 16, 2018 at approximately 12:45 a.m., ROMERO experienced the first of four cardiac arrests. In response to each cardiac arrest, VBMC staff performed resuscitation efforts in a timely manner. At 6:25 p.m., when ROMERO went into cardiac arrest for the fourth time, VBMC staff tried to resuscitate him but were unsuccessful. At 6:49 p.m., a VBMC physician pronounced ROMERO dead.

ERAU reviewed the medical care ROMERO received while at PIDC, as well as the facility's efforts to ensure that he was safe and secure while detained at the facility. ERAU found PIDC failed to comply with the following requirements of the ICE Performance Based National Detention Standards (PBNDS) 2011 (revised 2016):

1. ICE PBNDS 2011 (revised 2016) Custody Classification System, section (V)(A)(4), which states, "Each detainee's classification shall be reviewed and approved by a first-line supervisor or classification supervisor." A supervisor did not review and approve ROMERO's classification rating.
2. ICE PBNDS 2011 (revised 2016) Emergency Plans, section (V)(D)(18), which states, "The post-emergency part of the plan shall include...: g) debriefing involved staff, and following-up for additional analysis and/or implicated changes in policy or procedures." An officer, assigned to hospital duty and present during hospital staff's emergency resuscitation efforts, was not debriefed or offered employee assistance services following ROMERO's death.
3. ICE PBNDS 2011 (revised 2016) Funds and Personal Property, section (V)(D), which states, "Medical staff shall determine the disposition of all medicine accompanying an arriving detainee." A processing officer inventoried and stored medication that arrived with ROMERO without notifying medical personnel.
4. ICE PBNDS 2011 (revised 2016) 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." A processing officer did not inventory ROMERO's funds when he arrived at the facility.

5. ICE PBNDS 2011 (revised 2016) Funds and Personal Property, section (V)(I), which states, "An itemized inventory of all detainee baggage and personal 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 that the property was previously inventoried by another facility and is contained in a sealed bag." A processing officer did not properly list all of ROMERO's personal property on the Detainee Personal Property Record form.

ERAU noted one area of concern which is discussed in the attached report. If you have any questions, please contact me or have a member of your staff contact (A) Unit Chief

(b)(6); (b)(7)(C) at (202) 71 (b)(6); (b)(7)(C)

Attachment

cc: Derek N. Benner
Claire Trickler-McNulty
Stewart Smith

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

Detainee Death Review: Ronal ROMERO, A078963293
Medical and Security Compliance Analysis
Port Isabel Service Processing Center, Texas

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 Ronal ROMERO, a detainee held at the Port Isabel Detention Center (PIDC). A site visit was conducted June 19-20, 2018 by ERAU personnel (b)(6); (b)(7)(C), Management and Program Analyst and team leader, and (b)(6); (b)(7)(C) Management and Program Analyst; and Creative Corrections contract personnel (b)(6); (b)(7)(C), security subject matter expert, and J. (b)(6); (b)(7)(C) Registered Nurse, healthcare subject matter expert. ERAU requested the participation of subject matter experts to determine compliance with the ICE 2011 Performance Based National Detention Standards (PBNDS), revised 2016, governing medical care and security operations.

This report was prepared collaboratively by (b)(6); (b)(7)(C) and Creative Corrections ERAU contract program manager (b)(6); (b)(7)(C). It includes a case synopsis, description of the facility and its medical services, detention summary, a narrative review of events, and conclusions. The information and findings herein are based on analysis of detainee ROMERO's detention file and medical record; tour of areas of the facility; interviews of staff; review of policies, available incident related documentation, emergency medical services and hospital reports; and analysis of video surveillance footage. The video footage consisted of 47 separate segments edited by PIDC to sequentially show ROMERO's activity and movement during his detention. Because the video was not continuous, description of certain transitions cannot be precise.

The reviewers note that the detainee's medical and detention records reflect his alias name, Ronald Cruz. Per request of ERAU, Ronal ROMERO is used in this report.

SYNOPSIS

Detainee ROMERO was received at PIDC five days after he was taken into custody by U.S. Customs and Border Protection (CBP). He denied current medical conditions, although antibiotic medications prescribed for an ear infection were inventoried and stored with his personal property. Medical personnel had no knowledge of the medications.

Approximately 16 hours after his arrival, ROMERO was taken to the medical clinic when an officer observed he appeared ill. A provider diagnosed strep throat and admitted the detainee to the Medical Housing Unit. Approximately five hours later, ROMERO's temperature, blood pressure and pulse were found severely abnormal and his mental state was severely altered. A provider ordered his transport to the local hospital although in route, the ambulance was diverted to a different hospital when the emergency services responders observed symptoms of a stroke.

ROMERO was admitted to the intensive care unit following evaluation in the emergency room. The detainee coded three times following admission and was not resuscitated following the third. Death was pronounced approximately 25 hours after he arrived at the hospital.

The preliminary autopsy report cites the cause of death was meningitis, with significant contributory factors of diabetes ketoacidosis and sepsis.

HEALTHCARE STAFFING

PIDC earned accreditation by the National Commission on Correctional Healthcare (NCCHC) in June 2016. Healthcare is provided 24 hours a day, seven days per week by 11 commissioned officers of the U.S. Public Health Services assigned to the ICE Health Services Corps (IHSC), a federal General Schedule physician who serves as the Clinical Director, and 56 contract staff employed by InGenesis Medical Staffing. IHSC officers include the Health Services Administrator (HSA), two assistant HSAs, a family nurse practitioner (NP), four registered nurses (RN), a registered pharmacist, a licensed clinical social worker, and a dentist. In-Genesis personnel include two staff physicians, two physician assistants (PA), two NPs, 29 RNs, 16 licensed vocational nurses (LVN), five medical records technicians (MRT), three radiology technicians, two pharmacy technicians, a registered dental assistant, psychiatrist, two licensed clinical social workers, an administrative assistant, and a certified nurse assistant. Vacant positions at the time of the site visit included one staff physician, psychiatrist, and nine RNs. Commander (b)(6) HSA, remarked that the RN vacancies necessitate that he and the Assistant HSAs perform clinical duties in addition to fulfilling their administrative responsibilities.

Review confirmed the credentials of the providers and nurses involved in the care of detainee ROMERO were current and primary source verified.

IHSC's electronic medical record system, e-Clinical Works, is used at PIDC. The times encounters were conducted are not documented in the medical record; therefore, times referenced below are the times vital signs associated with encounters were entered and/or the times nurses and providers electronically signed their encounters.

FACILITY DESCRIPTION

PIDC is owned by ICE and managed by ICE Enforcement and Removal Operations (ERO), San Antonio Field Office. The facility houses male and female ICE detainees. On May 16, 2018, the day of ROMERO's death, the total population was 1004. Security and transportation services are provided by Ahtna Support and Training Services, LLC.

Vehicles arriving at PIDC are searched prior to entering the compound. Vehicle occupants must produce identification and visitor badges are issued to each person. Once inside the facility, visitors pass through a metal detector and personal items are searched by way of an X-ray machine. Video surveillance cameras are used throughout the facility to monitor and record events.

Detainees arriving at PIDC are initially housed in the Staging section of the intake area. There, classification and medical screening are completed to confirm appropriateness for acceptance. From Staging detainees move to the Processing section where they are given the opportunity to make a phone call, personal property is inventoried, and facility clothing and other items are issued. Detainees remain in processing until assigned to a housing unit.

SUMMARY OF EVENTS

May 14, 2018

The Detainee Summary Form documents detainee ROMERO arrived at PIDC at 4:21 p.m. According to ICE Form I-385, he was transferred to ERO from CBP custody this date, having been apprehended and held by CBP starting May 9, 2018. Video surveillance footage shows he entered a holding cell in PIDC's Staging section at 5:04 p.m. As detailed below, over the course of the next ten and a half hours ROMERO was classified and underwent medical screening. He was served two sack meals and except when taken to the medical intake area, sat or laid on a bench in the holding cell.

Form I-216, Record of Persons Transferred, documents ROMERO was classified low by ERO. The same rating was appropriately applied by PIDC personnel using the ICE Detainee Classification System Primary Assessment Form. The level was not reviewed and approved by a supervisor.

Note: (b)(6); (b)(7)(C) stated during interview that initial classification documents are routed to a supervisor for review, but added that it is possible that a detainee could be sent to a housing unit prior to supervisory approval of ratings assigned by officers.

Note: ROMERO's English language proficiency and the language in which the PIDC intake process was completed is not documented in the detention file. The ICE Enforcement Alien Detention Module (EADM) Encounter Summary Report dated May 11, 2018 notes that all forms and rights were explained to the detainee in Spanish prior to his arrival at PIDC.

At 7:00 p.m., InGenesis LVN (b)(6); (b)(7)(C) documented completion of the medical pre-screening. He noted ROMERO was not transferred from another facility and that an interpreter was not used because he is fluent in detainee's native language, Spanish. ROMERO denied

current medical illness, health problems, and medications. Intake screening was categorized as non-priority.

Detainee ROMERO's medical and mental health intake screening was conducted in Spanish by InGenesis LVN (b)(6); (b)(7)(C). Vital signs time-stamped 7:38 p.m. were within normal limits, as follows: temperature 98.1, pulse 87, respirations 18, and blood pressure 122/70. His height was 65 inches and weighed 172 pounds. ROMERO denied any pain and current or past medical problems. He also denied past hospitalizations, surgeries, infectious or communicable diseases, dental issues, and symptoms of tuberculosis, and reported no history of taking medications on a regular basis. The mental health screening was normal. During interview, (b)(6); (b)(7)(C) reported she and one other LVN screened all 63 detainees received at PIDC this evening. She recalled detainee ROMERO wanted to know when he would get a phone call, when he would sleep on a bed and how many meals would he be served daily.

ROMERO signed consent for medical treatment, and a chest x-ray completed at 10:32 p.m. was negative for tuberculosis. He was cleared for general population.

May 15, 2018

According to the Facility Holding Room Log and Processing Logbook, detainee ROMERO and 62 other detainees were moved from Staging to Processing at 3:45 a.m.

Detainee ROMERO's personal property was inventoried by (b)(6); (b)(7)(C). No funds were recorded. His Detainee Personal Property Record lists a phone cord, belt, billfold, sweater, a pair of jeans, tennis shoes, two t-shirts, various hygiene supplies, and "medicine."

As noted, ROMERO denied taking medication during medical screening and nurses wrote that none were received with him; therefore, the review team pursued the handling and disposition of the medicine documented by (b)(6); (b)(7)(C). Reviewers discovered that stored with the detainee's personal property were a bottle of Ciprodex Otic Suspension antibiotic ear drops and a six tablet blister pack with three Azithromycin¹ 250 mg tablets remaining for treatment of an ear infection. The medications were prescribed by (b)(6); (b)(7)(C) of the Mission Medical Center and filled by CVS Pharmacy in Mission, Texas on May 9, 2018, the day ROMERO was apprehended by CBP. The bottle of ear drops and blister pack were in a clear plastic bag labeled with the detainee's name.

Note: HSA Auhl informed the review team that although an estimated 90 percent of detainees processed through PIDC transfer from CBP custody, no medical information, including documentation of care from outside sources, is provided.

¹ Azithromycin is an antibiotic medication.

The Ciprodex prescription directed four drops to the left ear twice daily for seven days. The bottle appeared to be full or nearly full. The Azithromycin prescription was for “two tablets today” then one tablet daily for four days.

Note: As noted, three tablets remained in the blister pack stored with ROMERO’s property. If he had taken the Azithromycin tablets as prescribed, starting May 9, 2018, the full course of antibiotics would have been completed the day before he was transferred to PIDC. Reviewers do not know whether CBP administers prescription medications to persons in their custody, or if ROMERO maintained the medications in his possession and was responsible for self-administration.

PIDC Policy 4.1.3, Reception and Orientation, states, “Medicine the detainee brings into the facility upon arrival will be forwarded to IHSC for disposition.” Because the policy does not delineate procedures, staff were asked how medications arriving with detainees are processed. (b)(6); (b)(7)(C) stated that officers in Staging place medications in a clear plastic bag labeled with the detainee’s name written in marker. The bags are then placed on a table and medical is notified. LVN (b)(6); (b)(7)(C) stated ICE agents or detention officers bring medications to the medical screening area and nurses sort through them, documenting which medications belong to which detainees. There is no record documenting chain of custody for the medications.

Reviewers cannot determine why ROMERO’s medications were not forwarded or brought to the attention of medical personnel during the ten and a half hours he remained in Staging. Officer (b)(6); (b)(7)(C) said that because the medications were sent to Processing, he assumed they were to be inventoried and stored with ROMERO’s property. Asked if he confirms with medical that medications sent to Processing were reviewed (b)(6); (b)(7)(C) said he does not. He said that if he finds medications when inventorying property, he may ask the detainee if everything is alright but typically proceeds to place them in property. As an example, he said that if he were to find eye drops, he would assume medical already saw them and might ask the detainee if he or she needs them. If told no, he would place the eye drops in property. When the medical reviewer pointed out that eye drops may be for a serious eye condition, possibly used to prevent blindness, Officer (b)(6); (b)(7)(C) said they would go in property anyway. According to (b)(6); (b)(7)(C) only medications from Mexico may be authorized for storage in personal property, once reviewed and documented by medical. (b)(6); (b)(7)(C) also reported that she recently was told that an antihypertensive medication not from Mexico was found in a detainee’s property.

Reviewers discussed the discovery of ROMERO’s medications with HSA (b)(6); (b)(7)(C) and Security Chief (b)(6); (b)(7)(C). HSA (b)(6); (b)(7)(C) stated security staff should bring all medications arriving with detainees to medical, remarking that staff “can’t leave it to chance that someone in medical saw it and determined it could be stored.” (b)(6); (b)(7)(C) said this “never should have happened” and emphasized that security does not “destroy medications or store medications.”

Note: Although the Security Chief’s statement was absolute (b)(6); (b)(7)(C) information concerning medications from Mexico suggests that there are, in fact, medications medical

personnel may approve for storage in property. The scope of the ROMERO death review does not allow determination of the extent to which mishandling of intake medications is a systemic problem at PIDC; however, evidence suggests procedures are ill-defined and inconsistently followed. (b)(6); (b)(7)(C) asserted that he will address the issue immediately to ensure that all medications are sent to medical for disposition.

Detainee ROMERO signed the inventory of his personal property and a copy was placed in his detention file. He was issued a towel, blanket, sheets, shower shoes, underwear, socks, two uniforms, handbooks, and spoon and cup. He was offered a free three-minute phone call and given verbal and video orientation. ROMERO also signed a Volunteer Worker Program Agreement form. ROMERO declined to provide an emergency contact during processing.

Note: There was no Prison Rape Elimination Act (PREA) related documentation included in materials provided to reviewers. Because PREA procedures are not relevant to this death review, reviewers did not inquire as to whether documentation of PREA screening and other related processes is maintained.

A 6:38 a.m. entry to the Processing logbook documents that 63 detainees had been processed and were pending cash deposits and issuance of identification cards. Video shows that from 3:35 a.m. until 7:28 a.m., detainee ROMERO mainly slept on a bench, waking occasionally. ROMERO is seen on video attempting to place a call at 7:28 a.m., hanging up within seconds. At 8:41 a.m. he exited the holding cell. The Processing logbook document (b)(6); (b)(7)(C) and another officer escorted new arrivals to housing units at 8:50 a.m.

On interview (b)(6); (b)(7)(C) confirmed he and another officer escorted a group of detainees to their assigned dormitories. He recalled that ROMERO was the last detainee to exit the holding cell and that his shirt was not tucked in. Because detainees are required to tuck in their shirts, (b)(6); (b)(7)(C) instructed ROMERO to do so. He said the detainee did not verbally respond but followed the order. (b)(6); (b)(7)(C) noted that when the detainee turned to face him, he had a blank stare and “seemed distraught.” When (b)(6); (b)(7)(C) asked ROMERO in Spanish if he was alright, the detainee replied no and asked if he could sit down. (b)(6); (b)(7)(C) stated that he is trained to be alert to signs of illness and based on his training, determined “something was not right.” ROMERO was allowed to sit and (b)(6); (b)(7)(C) instructed his fellow escort officer to take the detainee to medical, less than 20 yards away. Once ROMERO was in medical (b)(6); (b)(7)(C) and the other officer resumed their escort duties. Later in his shift (b)(6); (b)(7)(C) stated he called medical to check on ROMERO’s condition and was told he was still in the clinic and that he had a headache.

(b)(6); (b)(7)(C) recalled during interview that an officer asked if he would see ROMERO as he was escorted into medical. (b)(6); (b)(7)(C) agreed and took his vital signs. He recalled the detainee said he had a bad headache and felt tired, but did not mention an ear infection or medications. (b)(6); (b)(7)(C) took the detainee to the urgent care room and contacted a provider.

Note: (b)(6); (b)(7)(C) did not make a medical record entry documenting this encounter; presumably, because it resulted in immediate evaluation by a provider.

Video footage shows (b)(6); (b)(7)(C) wheeled the detainee into the hallway in medical at 9:05 a.m. and waited outside the urgent care room until another detainee was moved out. Detainee ROMERO was seated upright in the wheelchair and spoke briefly to the nurse. At 9:13 a.m. the detainee was wheeled into the now vacant room and was assisted onto the bed by the nurse. He laid down and the nurse lifted his right leg to the bed and moved the guardrail to an upright position.

Physician Assistant (PA) (b)(6); (b)(7)(C) recalled on interview that a nurse reported by telephone that a detainee was coming to sick call with a fever. (b)(6); (b)(7)(C) said that as soon as he received the call, he went to see ROMERO in the urgent care room. The PA's medical record entry includes the vital signs, inexplicably time stamped 8:22 a.m., documenting an elevated temperature of 102.4, pulse at the upper normal limit of 100,² and elevated blood pressure of 143/78. Respirations and pulse oxygen were normal at 18 and 96, respectively. A fingerstick blood glucose test showed an elevated glucose level of 266³, and a dipstick urine test found a glucose level of 500⁴, ketones greater than 160⁵, specific gravity greater than 1.030⁶, protein 100 mg⁷, and a small amount of blood in the urine.

(b)(6); (b)(7)(C) documented the encounter was conducted in Spanish and that ROMERO complained of fever, headache, left ear pain, sore throat and body aches. The detainee rated his pain at level ten on the standardized pain scale.⁸ He reported he was treated with ear drops daily and antibiotics for a left ear infection in the previous detention center. (b)(6); (b)(7)(C) called during interview that although ROMERO mentioned he was treated for ear pain the week before, his main complaint was throat pain.

Note: The PA stated during interview that he did not pursue information on when the antibiotic regimen was started or completed. As noted, it was started the day he entered CBP custody and was not completed.

(b)(6); (b)(7)(C) note documents ROMERO was alert and fully oriented and again denied any chronic medical conditions, but he appeared sleepy and stated he did not sleep well "due to development

² According to Mayo Clinic, the normal pulse rate for an adult is 60 to 100 beats per minute.

³ Normal blood glucose ranges from 70 to 140, depending on whether it is a fasting or non-fasting test.

⁴ Although urine glucose testing is not as accurate as blood testing, normal level in non-pregnant adults is zero.

⁵ A normal urine ketone level is less than 0.6.

⁶ Normal specific gravity compares the density of urine to the density of water. This quick test can help determine healthy kidney functions, dehydration, infections, diabetes, or presence of other diseases. Ideally, urine specific gravity results should fall between 1.002 and 1.030.

⁷ Normal protein ranges from zero to 20.

⁸ 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.

of fever and pain last night (b)(6); (b)(7)(C) noted that the detainee's vital signs were normal during intake, and that the abnormal glucose, protein, and ketone levels may be attributed to dehydration due to the fever and inadequate water intake. General examination findings were that ROMERO was ill appearing with mild erythema⁹ to both ears, enlarged tonsils, erythematous oropharynx¹⁰ with peritonsillar exudate¹¹ to the left tonsil, and left cervical lymphadenopathy¹². Examinations of the skin, heart, lungs, chest, abdomen, extremities, and neurologic functions were normal. (b)(6); (b)(7)(C) Clinical Director, stated during interview that (b)(6); (b)(7)(C) consulted her and collaboratively they determined that testing for diabetes was indicated based on the urine test results. The documented assessment findings and treatment were as follows:

- Unspecified fever: Acetaminophen 325 mg, three tablets as needed four times a day for ten days and ibuprofen 600 mg, as needed three times daily, on an alternating basis with the acetaminophen for breakthrough fever¹³ for ten days. A follow-up urinalysis, comprehensive metabolic panel¹⁴, complete blood count¹⁵, and comprehensive urine culture¹⁶ were ordered for the following day, May 16, 2018. He was instructed to drink two to three liters of water daily to maintain hydration.
- Streptococcal pharyngitis¹⁷: Amoxicillin¹⁸ 500 mg twice daily for ten days, admit to the medical housing unit and treat empirically¹⁹ based on the Centor Criteria²⁰ score of four, positive for cervical lymphadenopathy, presence of fever, absence of cough, and enlargement of tonsils. ROMERO was educated on strep throat and the plan of care.
- Unspecified abnormal findings in urine: Intravenous (IV) administration of sodium chloride solution 0.9 percent, one-liter bolus²¹ daily in the morning with IV flushing to occur every shift to keep the vein open. A dipstick urine test was to be repeated following its completion. Follow-up labs for treatment monitoring included the diabetes test HgbA1c

⁹ Erythema refers to skin redness.

¹⁰ Oropharynx is the cavity that lies between the soft palate and the hypoid bone.

¹¹ Peritonsillar exudate refers to vessel drainage behind the inflamed tonsils.

¹² Cervical lymphadenopathy refers to swollen glands felt on the sides of the neck.

¹³ A breakthrough fever is a fever that recurs prior to the subsequent dosing schedule of the primary medication.

¹⁴ A metabolic panel is a group of tests which measures different chemicals in the blood to determine the health of the kidneys, liver, blood glucose, blood proteins, electrolytes, and acid/base balances.

¹⁵ A complete blood count is a blood test used to evaluate a person's overall health and detect a wide range of disorders, including infection, anemia, or leukemia.

¹⁶ A comprehensive urine culture is a test used to detect bacteria in the urine which may be the cause of a presenting infection.

¹⁷ Streptococcal pharyngitis is a bacterial inflammation of the throat.

¹⁸ Amoxicillin is an antibiotic.

¹⁹ Empirical treatment refers to treatment based on observation or experience rather than theory or pure logic.

²⁰ Centor Criteria is a set of criteria which may be used to identify the likelihood of a bacterial infection in adult patients who are complaining of a sore throat, along with other influenza like symptoms.

²¹ Bolus refers to a single unit of a medication or compound of medication, e.g. a bag of IV solution.

with eAG Estimation²²; TSH and Free T4²³, lipid panel²⁴, and creatine kinase²⁵, all for the following day, May 16, 2018.

The medical record entry was co-signed (b)(6); (b)(7)(C) and according to the medication administration record (MAR), a nurse gave ROMERO doses of amoxicillin and acetaminophen and sodium chloride IV bolus as ordered.

(b)(6); (b)(7)(C) reported that because the clinic does not have a rapid test for strep, he directed ROMERO's placement in the Medical Housing Unit (MHU) and that he be housed alone due to his fever. In his MHU admission note, the PA summarized the assessment and diagnostic findings and directed taking vital signs every eight hours and nursing checks on an as needed basis. PA (b)(6); (b)(7)(C) informed the review team that he expected nurses to check on ROMERO more regularly than the usual eight-hour timeframe to assess his fever and to administer ibuprofen for breakthrough fever as needed. (b)(6); (b)(7)(C) said he left work before the medical emergency and was "very surprised" when he learned ROMERO passed away, commenting that he sees a lot of detainees with fevers.

The video footage shows that at 10:06 a.m., a female medical staff member entered the urgent care room, put the guardrail down and handed ROMERO a cup for urine sample. He grimaced, sat on the side of the bed, then stood and walked unassisted out of the room. At 10:07 a.m., ROMERO entered the holding cell carrying a cup and he went to the toilet behind the curtain at the rear of the cell. At 10:10 a.m. he exited the cell carrying the cup and returned to the urgent care room. The video resumes at 11:17 a.m. when the detainee exited in a wheelchair for placement in the MHU.

An MHU logbook entry documents detainee ROMERO was admitted to isolation room five at 11:30 a.m; video surveillance footage shows he entered at 11:35 a.m. He was wearing a paper mask and was able to move to the bed unassisted. A nurse covered him with a blanket.

The MHU has a capacity of 36. It has rooms with three beds; single bed mental health rooms, including one designated for suicide watch; and single cell isolation rooms. Isolation rooms five and six are side by side and share an anteroom accessed off the main clinic hallway. The anteroom has a sink and viewing windows into both rooms. Isolation room five has a single bed along the back wall with a small window to the outdoors near the foot of the bed. On the right side of the

²² Hgb A1c with eAG estimation is a new term in diabetes management which stands for estimated average glucose and can be calculated using the results of the A1c test. The Hgb A1c is a test which provides an average of blood glucose levels over a two to three-month period.

²³ TSH (thyroid stimulating hormone) and Free T4 are blood tests to determine the level of thyroid functioning.

²⁴ A lipid panel is a group of blood tests that serves as an initial screening tool for abnormalities in lipids, such as cholesterol and triglycerides.

²⁵ Creatinine kinase is an important enzyme in the heart, brain and skeletal muscles. High levels detected in testing can help determine if a heart attack occurred or if there is damage to the muscles.

cell is a stainless steel toilet/sink combination fixture behind a curtain and a television mounted on the ceiling. On the left side is a shower, small table and an intercom call button. The call button triggers a flashing light above the outside of the anteroom and at the nearby nurses' station. The light flashes until the call is answered.

InGenesis (b)(6); (b)(7)(C) completed the first MHU nursing round, documenting the following vital signs time stamped between 12:31 p.m. and 12:47 p.m.: elevated temperature of 100, rapid pulse of 102, and elevated blood pressure of 147/84. ROMERO's respirations and pulse oxygen were normal at 18 and 99 respectively. In his note, electronically signed at 4:25 p.m., (b)(6); (b)(7)(C) described ROMERO's general appearance as alert, ill-appearing, uncomfortable due to level seven pain, cooperative, mildly distressed, well nourished, and well hydrated. Examination of the throat found it red and swollen, with white exudate on the tonsils. ROMERO was alert, oriented, clear in speech, and had intact cognitive function. The assessment finding was "Risk for Infection (spread/reactivation)", and the treatment plan was to continue the current plan of care in the MHU and monitoring per protocol. ROMERO was provided with a water pitcher and instructed to drink three to four liters each day. He was also encouraged to recreate outside and to notify a nurse or security staff if he needed assistance. ROMERO voiced no concerns and verbalized understanding that he would remain in the MHU until discharged by a provider.

The next nursing round was conducted by InGenesis (b)(6); (b)(7)(C). She is seen on video entering ROMERO's cell, taking his vital signs and using a penlight to check his eyes at 4:19 p.m. Abnormal vital signs time stamped 4:28 p.m. include a body temperature of 99.5, two blood pressure readings of 170/104 and 180/107, and rapid pulse of 106. The oxygen saturation was normal at 96, and respirations were normal at 16. He denied pain. In her note, (b)(6); (b)(7)(C) wrote, "39-year-old male detainee housed in MHU for [influenza like infection], Strep and Fever. Detainee is in ISO 5 and lying on the bunk with eyes closed, hard to arouse, oriented to person only. He states he speaks English but stated he does not know where he is or what day it is." The general examination found him ill-appearing, pale, confused, somnolent, lethargic, and requiring assistance with ambulation. His pupils were non-reactive to light, and his strength was decreased in both arms. The nursing assessment was acute confusion. (b)(6); (b)(7)(C) wrote that she stepped into the anteroom while detainee ROMERO was to provide a urine sample. He stood at the toilet and voided, then flushed and returned an empty specimen cup. During interview (b)(6); (b)(7)(C) stated that although she was in the anteroom, she maintained full observation to ensure the detainee's safety. InGenesis (b)(6); (b)(7)(C) as notified of ROMERO's status.

Note: (b)(6); (b)(7)(C) s medical record entry covered her assessment of detainee ROMERO and notification of (b)(6); (b)(7)(C) as well as events after the NP examined the detainee, described below. (b)(6); (b)(7)(C) did not initiate and electronically sign her note until 6:37 p.m., after (b)(6); (b)(7)(C) entered his own. Although not documented as a late entry, the reviewer concludes ensuing events disallowed (b)(6); (b)(7)(C) entry of a note before NP (b)(6); (b)(7)(C) completed his.

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

(b)(6); (b)(7)(C) was seen on video entering ROMERO's room at 4:39 p.m. During interview (b)(6); (b)(7)(C) commented that detainee ROMERO was in a "stupor" and was unable to follow directions. Vital signs associated with the encounter, inexplicably time stamped 3:42 p.m., included a mildly elevated body temperature of 99.5 degrees, an abnormally elevated pulse rate of 106, a very high blood pressure of 170/104, normal respirations at 16, and normal oxygen saturation at 96. The pain level was zero. The general examination findings noted, "in bed, recumbent²⁶ position; stupor²⁷, slow responses." ROMERO's pupils were sluggish and hyporeactive to light and accommodation²⁸, and non-tender cervical lymphadenopathy was noted. Findings were normal for examination of the ears and assessment of his skin, heart, lungs, chest, abdomen, back, musculoskeletal system, and extremities. The neurologic examination noted he was lethargic and followed commands to a limited extent. The assessment conclusion was, "Altered mental status, unspecified."

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

(b)(6); (b)(7)(C) ordered detainee ROMERO's transport to the Harlingen Medical Center via emergency medical services (EMS). Per (b)(6); (b)(7)(C)'s note, medical records personnel were notified and ROMERO was moved to the common area to await the arrival of EMS. (b)(6); (b)(7)(C), InGenesis Medical Records Technician, informed the review team she immediately called EMS after receiving the direction from (b)(6); (b)(7)(C). Consistent with her standing practice, Ms. (b)(6); (b)(7)(C) said she then immediately phoned the transportation lieutenant and the main gate to alert them of the pending emergency transport via ambulance. IHSC form, Medical Transportation Request, states the request for emergency transfer to Harlingen Medical Center was completed at 4:41 p.m.; the Los Fresnos Ambulance Service, Inc. report documents the call was received at 4:39 p.m.

The EMS report documents responders arrived at PIDC at 4:58 p.m. and were at the patient's side at 5:05 p.m. The video provided to reviewers does not show the responders' arriving in medical, but shows ROMERO moving from a wheelchair to the EMS gurney at 5:03 p.m. The gurney was wheeled down the corridor at 5:04 p.m. Video from the external perimeter camera shows the ambulance exited the vehicle sallyport at 5:09 p.m., then immediately pulled over to the side of the perimeter road. The ambulance remained there for nine minutes, moving from camera range at 5:18 p.m.

Officers (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) were assigned to the transportation detail by Lieutenant (b)(6); (b)(7)(C) both in the escort vehicle. (b)(6); (b)(7)(C) stated during interview that he was in Staging when he saw the ambulance arrive and was told he was assigned to the detail. He and Officer (b)(6); (b)(7)(C) reported to Building 9 outside the perimeter to retrieve body armor and equipment, then returned to the facility for requisite paperwork signed by the Captain. (b)(6); (b)(7)(C) said the ambulance was at the main entry gate to the facility compound when he

²⁶ Recumbent mean lying flat, face up.

²⁷ Stupor refers to a state of near-unconsciousness or insensibility.

²⁸ Accommodation refers to the ability of the eye to change its focus from distant to near objects, and vice versa, resulting in difficulty keeping an object in focus.

and (b)(6); (b)(7)(C) were ready to depart (b)(6); (b)(7)(C) estimated 13 minutes elapsed from the time he saw the ambulance arrive to the time he and (b)(6); (b)(7)(C) got to the main gate.

Note: This statement suggests that when the ambulance moved from the side of the perimeter road nine minutes after exiting the vehicle sallyport, it moved on to the main gate where joined by (b)(6); (b)(7)(C). Video of the main gate was not provided; therefore, reviewers cannot determine time elapsed before the escort vehicle joined the ambulance at the main gate. Once at the main gate, exiting vehicles are visually searched and the identity of occupants is checked, a process that may take one to three minutes.

(b)(6); (b)(7)(C) documented in his notebook that the escort vehicle left the facility at 5:25 p.m.; the Official Detail transportation report documents the escort trip began at 5:30 p.m. The EMS report documents the time of departure from the facility was 5:16 p.m. and "Transport delayed while waiting for escort."

Note: Video evidence does not allow substantiation of the time the ambulance and escort vehicle left the PIDC compound. Based on (b)(6); (b)(7)(C) notebook entry, the escort vehicle left the compound seven minutes after the ambulance is seen on video pulling out of camera range on the perimeter road where it was parked for nine minutes. Reviewers presume the ambulance exited the main gate shortly before the escort vehicle, suggesting the total time elapsed between exit of the ambulance from the vehicle sallyport to departure from the compound may have been as much as 15 minutes, nine of which were spent parked on the perimeter road awaiting an escort vehicle.

During interview of Security Chief (b)(6); (b)(7)(C) he stated he was unaware departure of the ambulance was delayed and speculated notification of the transport by medical may not have been timely. (b)(6); (b)(7)(C) was unequivocal in her insistence that she notified security immediately after calling EMS, stating it is her standing practice to do so and, "As soon as I hang up from EMS, I call security." Reviewers were unable to determine what caused the delay.

The EMS report narrative states, "Patient was hypertensive, had a fever, and was showing left sided drooping... Upon the findings we upgraded to Code 3 and transported [patient] to the appropriate stroke facility for further evaluation." According to (b)(6); (b)(7)(C) notes, a lieutenant notified him that the ambulance was being diverted to Valley Baptist Medical Center (VBMC) at 5:39 p.m. Re-routing to VBMC was also documented by (b)(6); (b)(7)(C) in her medical record entry. During interview with (b)(6); (b)(7)(C) he explained that VBMC is recognized for its care of stroke patients.

Note: (b)(6); (b)(7)(C) stated during interview that she had assessed ROMERO for signs and symptoms of stroke due to his high blood pressure readings. The findings were negative,

(b)(6); (b)(7)(C)
including one-side facial drooping. (b)(6); (b)(7)(C) assessment findings were also negative for signs and symptoms of a stroke at the time.

VBMC is in Harlingen, TX, approximately 20 minutes from PIDC. (b)(6); (b)(7)(C) id officers are required to keep sight of the ambulance and follow posted speed limits. He remarked that these requirements conflict at times. He said he tried to follow at a speed that allowed him to keep the ambulance in view, commenting EMS responders activated ambulance lights twice, presumably at intersections. The EMS report documents the ambulance arrived at VBMC at 5:47 p.m. and care was transferred to hospital personnel at 5:55 p.m.

Records from the VBMC-Harlingen Emergency Department (ED) state, "Patient is a 39-year-old male brought to the ED via EMS after being found with altered mental status at the Port Isabel Detention facility. No medical history is available, and patient is severely altered and is not speaking Spanish nor English at time of evaluation. It is confirmed that he is from Honduras. Patient was found to have an elevated temperature of 103.3, heart rate of 112, and a blood pressure 179/92 at time of his presentation. Patient was found to have an elevated white count of 24.6²⁹ and a lactic acid of 2.4³⁰, and sepsis protocol was initiated. Patient has been placed on IV vancomycin³¹ and IV Zosyn³². Patient found to be in DKA³³. During my evaluation patient did stand, lifted his gown, and proceeded to urinate on the emergency room floor. Patient remains severely altered and has been placed on one-to-one sitter and will be admitted to the medical [intensive care unit] under the critical care team."

Note: ROMERO did not report a history of diabetes during intake screening or subsequent assessments. A PIDC provider ordered testing for diabetes based on abnormal urine test results obtained hours before his transfer to the hospital.

The assessment and plan were as follows:

1. DKA – Follow DKA protocol
2. Sepsis – IV fluids, continue with IV antibiotics. Follow lab and culture results.
3. Altered mental status – Pending drug screen liver enzymes and ammonia level. Follow neuro and mental status closely. Avoid psychoactive medication³⁴ as much as possible. Keep patient pain-free and comfortable at all times.

²⁹ Normal white blood count range is 4,500 to 11,000. Elevated levels determine the severity of infection.

³⁰ Normal lactic acid range is an organic acid produced in the muscle tissues during strenuous exercise. Elevated levels can indicate sepsis. The normal level in unstressed patients is 0.5 to 1.

³¹ Vancomycin is a drug which treats infections (antibiotic).

³² Zosyn is a drug which treats infections (antibiotic).

³³ DKA stands for diabetic ketoacidosis, a serious diabetes complication in which the body produces excess acids in the blood through rapid breakdown of fat.

³⁴ Psychoactive medications are drugs which act upon the central nervous system where it alters brain function.

4. Follow electrolyte levels closely and replace per ICU protocol, depending on renal function. Avoid nephrotoxic medications³⁵. Follow GFR³⁶ and adjust medications as needed.
5. Nothing by mouth (NPO) – GI prophylaxis with IV Pepcid³⁷.
6. Monitor closely for any signs of bleeding. Maintain hemoglobin levels³⁸ seven or above unless with active bleeding. Avoid transfusions if benefits do not outweigh risks.
7. DVT prophylaxis³⁹ with SCD⁴⁰, follow INR level⁴¹.

The emergency room record documents, “Unable to discuss treatment plan, advanced directive, length of stay, and disposition with patient due to mental status.”

Transportation officer (b)(6); (b)(7)(C) relieved Office (b)(6); (b)(7)(C) at 11:45 p.m. per their written incident reports. Officer (b)(6); (b)(7)(C) stated that when he arrived at the hospital, the detainee was in emergency room behind a curtain.

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(b)(6); (b)(7)(C) wrote in their incident reports that ROMERO was moved to the intensive care unit (ICU) at 12:25 a.m. Per the EADM summary, detainee ROMERO was admitted to the hospital at 2:53 a.m. The officers documented that a doctor entered the room to check on detainee ROMERO at 12:45 a.m. and said the detainee had no pulse. Per Officer (b)(6); (b)(7)(C) report, at 12:55 a.m. the doctor called Code Blue and hospital staff responded and resuscitated the detainee. (b)(6); (b)(7)(C) stated during interview that when Code Blue was called, he stepped out of the room and notified the shift captain via mobile phone. Per his incident report (b)(6); (b)(7)(C) then handed his phone to the doctor who spoke directly with the captain. Per the officers’ reports, the detainee was “breathing again” at 1:05 a.m. At 1:15 a.m., cardiopulmonary resuscitation (CPR) was again performed.

The officers wrote that at 3:25 a.m., HSA (b)(6); (b)(7)(C) arrived at the hospital. At 4:00 a.m. (b)(6); (b)(7)(C) relieved (b)(6); (b)(7)(C). According to (b)(6); (b)(7)(C), a single officer was assigned to the vigil duty after ROMERO was admitted to the hospital because he was classified low custody. (b)(6); (b)(7)(C) stated on interview that when told he would assume vigil duties, Captain (b)(6); (b)(7)(C) informed him the detainee coded but had been resuscitated and provided him with the policy on detainee deaths. (b)(6); (b)(7)(C) first entry to the hospital logbook was that ROMERO was in ICU and “unresponsive at the moment.”

³⁵ Nephrotoxic medications are drugs which are toxic to the kidneys and can result in the inability for the kidneys to properly function.

³⁶ GFR stands for glomerular filtration rate, a test used to check how well the kidneys are functioning.

³⁷ IV Pepcid is a medication that treats excess stomach acid.

³⁸ Hemoglobin is a red cell protein responsible for transporting oxygen in the blood.

³⁹ DVT prophylaxis involves regular position turning of the patient, performing passive exercises, and ensure adequate hydration.

⁴⁰ SCD stands for sequential compression device, an inflatable sleeve to improve blood flow.

⁴¹ INR level is a measure of the time it takes for blood to clot.

(b)(6); (b)(7)(C) was relieved by (b)(6); (b)(7)(C) at 6:45 a.m. He stated on interview that the detainee's eyes were swollen and he had breathing tubes and numerous intravenous (IV) lines attached. At 8:20 a.m. (b)(6); (b)(7)(C) documented detainee ROMERO "went unresponsive" and a nurse called Code Blue. Per (b)(6); (b)(7)(C) incident report, CPR was stopped and the detainee became stable at 8:34 a.m.

Supervisory Detention and Deportation Officer (SDDO) (b)(6); (b)(7)(C) informed the review team that he was asked by Assistant Officer in Charge (OIC) (b)(6); (b)(7)(C) to report to the hospital. When he arrived at 8:25 a.m., Officer (b)(6); (b)(7)(C) was present and hospital staff were around ROMERO. (b)(6); (b)(7)(C) said he spoke with the doctor and nurses who reported that the detainee had no brain activity. They stated that when the detainee coded, they gave him medications to bring him back but ultimately, the medications would not be effective. (b)(6); (b)(7)(C) estimated that he remained at the hospital for 15 to 20 minutes and said that the detainee was alive when he left. He then reported his observations to Assistant OIC (b)(6); (b)(7)(C).

In an email timed 10:28 a.m. to several ICE personnel, SDDO (b)(6); (b)(7)(C) wrote that ROMERO's brother and sister in Kansas were notified of his condition. In a follow up email timed 2:44 p.m., SDDO (b)(6); (b)(7)(C) wrote that the brother was contacted again and was asked about detainee ROMERO's medical history. His critical condition was re-emphasized.

At 3:00 p.m. Officer (b)(6); (b)(7)(C) relieved (b)(6); (b)(7)(C) and noted in the logbook, "Detainee is unresponsive in bed." Officer (b)(6); (b)(7)(C) stated on interview that ROMERO was unresponsive the entire time he was with him. He said he noted the times of events during his shift in a notebook he carried in his pocket and later transferred the times to the official logbook.

The VBMC record documents that at 4:56 p.m. (b)(6); (b)(7)(C) MD documented his review of diagnostic findings and clinical impression of possible meningitis for which treatment was prescribed. Additional diagnoses were diabetic ketoacidosis, acute kidney injury, hypomagnesemia⁴², malnutrition, respiratory failure, and risk for deep vein thrombosis (DVT)⁴³ and gastrointestinal problems. (b)(6); (b)(7)(C) wrote that he discussed the case with PIDC Clinical Director (b)(6); (b)(7)(C) and based on her conversation with "someone high in the ICE health network infrastructure", the patient was to remain in full code⁴⁴ until family visited. (b)(6); (b)(7)(C) documented he agreed but would reserve his clinical judgment in case care was determined futile.

Officer (b)(6); (b)(7)(C) documented in his incident report that at 6:25 p.m. ROMERO went into cardiac arrest and Code Blue was called. Officer (b)(6); (b)(7)(C) said that when the code was called, he stepped into the hallway to allow hospital staff room to work. They performed CPR until 6:49 p.m. when

⁴² Hypomagnesemia refers to an abnormally low level of magnesium in the blood.

⁴³ DVT is a blood clot in a deep vein, usually in the leg.

⁴⁴ A full code is the opposite of a Do Not Resuscitate order, meaning the patient will be kept alive by artificial means.

(b)(6); (b)(7)(C) pronounced death. Per the hospital logbook, officer (b)(6); (b)(7)(C) notified Lieutenant (b)(6); (b)(7)(C) after death was pronounced.

Subsequent logbook entries by Officer (b)(6); (b)(7)(C) document that at 8:30 p.m. hospital personnel entered the room to clean the body and at 8:45 p.m., the body was moved to the morgue. The review team was not provided with documentation of who moved the body to the morgue. When he returned to PIDC (b)(6); (b)(7)(C) turned in an incident report written while he was at the hospital to Captain (b)(6); (b)(7)(C). Asked if he was offered employee assistance services, he said he was not. He commented it was difficult to watch someone code and then die.

A Cameron County Forensic Pathology report dated May 23, 2018 documents preliminary autopsy findings. The reports states the postmortem examination was performed by (b)(6); (b)(7)(C) MD in order to assist in completing the death certificate. The cause of death was meningitis⁴⁵. Significant conditions contributing to death were a clinical history of diabetic ketoacidosis and sepsis. There was no evidence of trauma.

Following ROMERO's death, Officer (b)(6); (b)(7)(C) documented an inventory of his property listing the following valuables:

- 50 pesos note - one
- 200 pesos note - one
- Lempiras - one
- Ten Lempiras - one
- Cell phone with broken screen - one
- Battery - one
- Black watch - one

Note: None of these items were listed on the original property inventory form or were otherwise documented in the detainee's detention file.

An ICE Chain of Custody form documents inventory of ROMERO's property at 11:00 p.m. The above valuables were listed with the exception of ten Lempiras. The form lists the following items not documented on any PIDC property inventory:

- One pair of underwear
- Bandana
- Ring
- "3 Medication"

⁴⁵ Meningitis is an inflammation of the brain and spinal cord membranes.

The ICE Chain of Custody form documents all property was boxed and stored in the Captain's Office until it was turned over to SDDO (b)(6); (b)(7)(C) 4:22 p.m. on May 17, 2018.

Note: As discussed above, the property was inspected by reviewers during the site visit for the purpose of determining what medications were received with detainee ROMERO. Although three medications were listed on the ICE Chain of Custody form, reviewers found one bottle of Ciprodex Otic Suspension ear drops and three Azithromycin tablets remaining in a six-tablet blister pack. The empty prescription box for the blister pack was also present and may have been counted as a third medication.

Per an email from (b)(6); (b)(7)(C) to ICE personnel, the detainee's brother was notified of his death on May 17, 2018, at 7:56 a.m.

CONCLUSIONS

Medical

Detainee ROMERO was in CBP custody from May 9 to 14, 2018 when admitted to PIDC. No record of a medical condition or treatment accompanied him. His vital signs were normal and he did not report or exhibit any signs of illness. He also did not report any current medications; however, reviewers discovered oral and topical antibiotic medications for treatment of an ear infection were stored in his property. The medications, which were dispensed by a pharmacy on the day he entered CBP custody, were not turned over to medical staff for review. Based on prescription instructions for the oral antibiotic and the number of doses remaining, ROMERO was not given or did not take the full course of the medication as ordered. The topical medication bottle was nearly full suggesting that it, too, was not given or taken as ordered.

Approximately 13 hours after medical intake screening, while security personnel were escorting ROMERO from Processing to his assigned housing unit, an officer observed the detainee appeared to be ill. An officer appropriately took him directly to the clinic rather than proceeding to the housing unit. Once there, ROMERO was seen by a nurse who immediately contacted a provider. The provider promptly evaluated the detainee and based on his findings, diagnosed strep throat and fever and directed placement in the MHU. In addition, the provider ordered IV therapy and laboratory testing based on abnormal urine test results.

During the second of two nursing rounds conducted approximately five hours after ROMERO entered the MHU, an RN found his temperature, blood pressure and pulse had worsened. He was also showing acute confusion. The RN immediately notified a provider who, upon assessment, found the detainee's mental status was altered. Per the provider's direction, EMS was called by a medical records technician and according to the EMS report, an ambulance arrived in 19 minutes after the call was received. ROMERO was moved to the ambulance without delay; however, as

discussed in Security Conclusions, departure of the ambulance from the PIDC compound was delayed waiting for an escort vehicle.

While in route to the hospital, EMS responders identified symptoms of a possible stroke and changed their destination to VBMC. Following evaluation in the VBMC emergency room, ROMERO was admitted to the ICU. His diagnoses were altered mental status, diabetic ketoacidosis, and sepsis.

Code Blue was called three times after ROMERO arrived at the hospital. He did not regain consciousness after the second. Approximately nine hours later, a hospital physician reviewed diagnostic findings and noted his clinical impression of possible meningitis and diagnoses which included diabetic ketoacidosis and sepsis. An hour and a half later, ROMERO went into cardiac arrest and hospital staff performed CPR. Death was pronounced approximately 25 minutes later, at 6:49 p.m.

Compliance Findings

The medical reviewer found no deficiencies in the ICE PBNDS 2011, Medical Care, revised 2016.

Safety and Security

Detainee ROMERO spent more than ten hours in Staging before he was transferred to the Processing area. While he was in Staging, medical intake screening was conducted and he was appropriately classified low; however, a supervisor did not review and approve the rating. In Processing, the officer inventoried one prescription medication and stored it with ROMERO's personal property without review by medical personnel. The officer's inventory did not include items found stored with his property following the detainee's death, including a second prescription medication and foreign currency.

On the morning of May 15, 2018, while escorting ROMERO from Processing to his housing assignment, an alert officer noted the detainee appeared ill and had him escorted to medical. A provider examined ROMERO and admitted him to the MHU. Approximately five hours later, medical staff called EMS after finding the detainee's condition had deteriorated. Although the ambulance arrived quickly, departure of the ambulance was delayed by as much as 15 minutes while a PIDC escort vehicle was awaited.

Death was pronounced approximately 25 hours after detainee ROMERO was admitted to the hospital. Officers maintained logbooks and filed incident reports. Supportive counseling services were not made available to the officer present at the time of the detainee's death.

Compliance Findings

The reviewer identified the following deficiencies in the ICE 2011 PBNDS, revised 2016 governing safety and security.

Custody Classification System, section (V)(A)(4), which states, “Each detainee’s classification shall be reviewed and approved by a first-line supervisor or classification supervisor.”

- A supervisor did not approve the classification rating assigned on May 14, 2018.

Emergency Plans, section (V)(D)(18) which states, “The post-emergency part of the plan shall include the following action items: g. debriefing involved staff, and following-up for additional analysis and/or implicated changes in policy or procedures.”

- Officer (b)(6);
(b)(7)(C) who was present at the time of death, was not debriefed or offered employee assistance resources.

Funds and Personal Property, section (V)(D), which states, “Medical staff shall determine the disposition of all medicine accompanying an arriving detainee.”

- Medications which arrived with ROMERO were not forwarded to medical for disposition. An officer inventoried and stored them in the detainee’s personal property.

This also violates **PIDC Policy 4.1.3, Reception and Orientation**, which states, “Medicine the detainee brings into the facility upon arrival will be forwarded to IHSC for disposition.”

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.”

- Following ROMERO’s death, foreign currency was found in his personal property. The currency was not listed on the property inventory form completed during admission.

Funds and Personal Property, section (V)(I), which states, “An itemized inventory of all detainee baggage and personal 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 that the property was previously inventoried by another facility and is contained in a sealed bag.”

- Property items on the ICE Chain of Custody form completed following ROMERO’s death were not included on the property inventory form completed during admission.

Areas of Concern

The medical and security reviewers cite the following overlapping areas of concern.

- As noted in the above deficiency, detainee ROMERO’s medications were not forwarded to medical for review. Consistent with the standard, facility policy includes this requirement but does not delineate procedures. Staff were unable to clearly and consistently describe procedures followed in practice. Based on available information reviewers conclude the first opportunity to notify or send the medications to healthcare staff was in Staging, where medical intake screening was conducted. Because ROMERO did not report that he was on medications for treatment for an ear infection, receipt of the medications prior to or during the screening would have provided valuable information. The second opportunity to send the medications to medical was in Processing. Despite the fact the policy clearly states medications are to be forwarded to medical, the processing officer inventoried and placed them in ROMERO’s property. At no time were medical personnel made aware medications were received with him. Review of the medications was critical to his care. This is particularly true given the fact that the course of antibiotic treatment was not completed while ROMERO was in CBP custody, and meningitis was the cause of death. Although beyond the scope of this analysis and the medical reviewer’s credentials to identify causal or contributory factors to a death, meningitis is a serious brain injury that can result when bacteria or viruses enter the bloodstream and travel to the brain and spinal cord. It can also occur when bacteria directly invade the meninges⁴⁶, including by way of an ear infection. Reviewers recommend multi-disciplinary design and implementation of procedures for handling of medications received with detainees.

Related to this concern is the fact that according to the HSA, CBP does not provide PIDC with available medical information on transferring detainees. Continuity of care cannot be assured absent known information. Because it is understood that PIDC leadership may not be in a position to address this issue, reviewers recommend that ERO pursue resolution in consultation with CBP.

- Departure of the ambulance from the PIDC compound was delayed while an escort vehicle was awaited. The precise duration of the delay could not be determined based on available information; however, up to 15 minutes elapsed after the ambulance pulled out of the

⁴⁶ The meninges refer to membranous coverings that protect the brain and spinal cord.

vehicle sallyport, nine of which are evidenced on video. One of the primary purposes of transport by EMS is to expedite a patient's arrival at an emergency room; therefore, the unexplained, ostensibly undue delay is significant. Reviewers recommend review of procedures to assure that security escort details are available without delay so as not to impede a detainee's access to a higher level of care.

IMMIGRATION AND CUSTOMS ENFORCEMENT

Detainee Classification System – Primary Assessment Form

Subject ID: (b)(6);

Event # (b)(7)(E)

FINS #: (b)(6); (b)(7)(C)

NAME: **CRUZ, RONALD**

A078 963 293

D.O.B. 01/24/1979

COUNTRY OF CITIZENSHIP:

HONDURAS

CLASSIFIED BY: (b)(6); (b)(7)(C)

(ID #)

DATE: May 14, 2018

LANGUAGE: (ENGLISH Y / N) OTHER:

Field

Location: PORT ISABEL SPC



SECTION I.

INITIAL SECURITY EVALUATION

(b)(7)(E)

A. Severity of Most Recent Charge / Conviction: (Use severity of offenses scale; rate most serious charge / conviction)

LOW.....
MODERATE.....
HIGH.....
HIGHEST.....

B. Serious Offenses History: (Use severity of offense Scale; rate most serious prior conviction)

NONE OR LOW.....
MODERATE.....
HIGH.....
HIGHEST.....

C. Escape History: (Excluding current charges).

SCORE:

NONE (No escapes or attempts).....
WALKAWAY OR ATTEMPTED ESCAPE from minimum security facility or failure to return from authorized absence.....
ESCAPE OR ATTEMPTED ESCAPE FROM SECURE FACILITY.....

MAXIMUM CUSTODY SCORE (Add items A, B, and C)..... TOTAL SCORE:

SCORE OF 7 OR HIGHER ASSIGN TO HIGH CUSTODY

(Always complete remaining items, but **do not** total score if detainee has already been assigned to High custody)

D. Immigration Violations History:

SCORE:

NONE or single entry without inspection (misd).....
Re-Entry after deport or other Immigration charge (Felony).....
3 or more previous immigration violations.....

E. Prior Convictions: (Excluding last conviction)

SCORE:

NONE.....
One to four misdemeanors or One Felony.....
Five or more misdemeanors or Two or More Felonies.....

F. Number of Disciplinary Convictions: (Previous Institution)

SCORE:

NONE.....
ONE.....
TWO.....
THREE.....

G. History / Pattern of Assaults

SCORE:

Assault (Within one year).....
Assault (Over 1 Year/Less than 10).....
Assault (Over 10 years).....

COMPREHENSIVE CUSTODY SCORE (Items A – G)..... TOTAL S

DHS-20-0638-D-000026

Print Date: 05/14/2018

IMMIGRATION AND CUSTOMS ENFORCEMENT

Detainee Classification System - Primary Assessment Form

Subject ID: (b)(6);

Name: CRUZ, RONALD

A #: A078 963 293

SECTION II.

SCALE SUMMARY AND RECOMMENDATIONS

(b)(7)(E)

A. CUSTODY LEVEL (Indicated by scale).....CODE:

HI = High MH = Medium/High ML = Medium/Low LO = Low

CUSTODY CLASSIFICATION

7 or more points on items A through C Section 1 HI (previously 3)
4 or fewer points on items A through G Section 1 with no history of violence LO (previously 1)
5 to 10 points on items A through G Section 1 with no history of violence ML (previously low 2)
10 or fewer points on items A through G Section 1 with a history of violence MH (previously high 2)
11 or higher points on items A through G Section 1 HI (previously 3)

B. SPECIAL MANAGEMENT CONCERNS WHICH APPLY TO THIS DETAINEE: (mark with X)

- | | |
|--|---|
| 1. ☐ Protective Custody | 8. ☐ Known Management Problem |
| 2. ☐ Psychological Impairment | 9. ☐ Suspected Drug/Alien Trafficker |
| 3. ☐ Mental Deficiency | 10. ☐ Suicide Risk |
| 4. ☐ Suicide Risk | 11. ☐ Medical Problem (PHS Form J-794) |
| 5. ☐ Serious Violence Threat | 12. ☐ Physical Impairment (PHS Form J-794) |
| 6. ☐ Known Gang Affiliation | 13. ☐ Other (Specify) |
| 7. ☐ Substance Abuse Program | 14. ☐ Terrorist Threat/Terrorist (Auto. L-3) |

C. OVERRIDE OF SCALE CUSTODY IS RECOMMENDED: ☐ YES ☒ NO

IF YES, GIVE RATIONALE (Required):

D. RECOMMENDED CUSTODY LEVEL:

☐ High ☐ Medium/High ☐ Medium

Classification Agent Signature:

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

Date:

5-14-18

SECTION III.

SUPERVISORY APPROVAL OF OVERRIDE

A. RECOMMENDED CUSTODY LEVEL ☐ APPROVED ☐ DISAPPROVED

B. FINAL CUSTODY LEVEL (If override disapproved).....

☐ High ☐ Medium/High ☐ Medium/Low ☐ Low

Rationale (required if different from recommendation):

SECTION IV.

HOUSING ASSIGNMENT

Final Classification and Housing assignment are:

☐ High ☐ Medium/High ☐ Medium/Low ☐ Low ☐ Admin. Segregation (Memo req.)

SIEA SIGNATURE:

DATE:



U.S. Immigration
and Customs
Enforcement

CRUZ, RONALD

A: 078963293 SubID: (b)(6);

Facility Code: PIC Housing Area: ...
39 Y old Male, DOB: 01/24/1979

Account Number: (b)(7)(F)

27991 BUENA VISTA ROAD, LOS FRESNOS, TX-78566

Appointment Facility: Port Isabel

05/14/2018

Appointment Provider

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

LPN

Current Medications

None

Past Medical History

No Medical History.

Allergies

NKDA

History of Present Illness

Intake:

Initial Assessment

Was the Pre-Screening Progress Note reviewed? Yes

Patient was identified by 2 sources: *Wrist Band, Verbally*

If detainee was transferred from another facility, did a medical transfer summary accompany the detainee? No

What language do you speak? *Spanish*

Interpretation provided? *No, provider fluent in patient's native language*

Chaperone Present? No

Do you have an e-mail address? No

Medical Screening

How do you feel today? *Good*

Are you currently in pain? No

Do you have any current or past medical problems? No

Have you ever had a head injury or head surgery that affected your activities of daily living? No

Have you ever had seizures? No

Are you currently or have you ever taken any medication on a regular basis, including over the counter and herbal? No

Do you have any allergies to include allergies to medication or food? No

Are you now or have you ever been treated by a doctor for a medical condition to include hospitalizations, surgeries, infectious or communicable diseases? No

In the past 2 months, have you experienced any of the following symptoms continuously for more than 2 weeks? No

Cough? No

Coughing up blood? No

Chest pain? No

Fever, chills, or night sweats for no known reason? No

Loss of appetite? No

Unexplained weight loss? No

Do you have previous hx of TB? No

Have you had any recent acute changes with your vision or hearing? No

Do you have any specific dietary needs? No

Are you Transgender? No

Have you ever had Chicken Pox? Yes

Oral Screening

Are you having any significant dental problems? No

Mental Health Screening

Have you ever received counseling for mental health problems? No

Have you ever received medication for mental health problems? No

Have you ever received treatment or hospitalization for mental health problems? No

Have you ever tried to kill yourself? *Denies*

Are you currently thinking about killing yourself? *Denies*

Have you ever tried to harm yourself? *Denies*

Are you currently thinking about harming yourself? *Denies*

Do you have a history of assaulting others? No

Do you ever hear voices that others do not hear? No

Do you ever see things that others do not see? No

Do you believe someone can control your mind? No

Have you been a victim of physical abuse? No

Have you been a victim of sexual abuse? No

Do you feel that you are currently in danger of being physically or sexually assaulted? No

Have you ever sexually assaulted anyone? No

Trauma Screening

Have you ever witnessed, experienced an event that involved actual or threatened death or serious injury? No

Learning/Cultural/Religious Assessment

Is there anything important to know about your religious or cultural beliefs that are of concern to you while in detention? No

Have you ever had difficulties learning? No

Do you have difficulty reading or writing? No

Have you ever had difficulties understanding written information? No

Have you received help for a developmental disability or learning disability? No

Substance Use/Abuse Screening

Do you now or have you ever used tobacco products? No

Do you now or have you ever drank alcohol? No

Have you ever been treated or hospitalized for alcohol problems? No

Have you ever suffered from alcohol withdrawal? No

Do you now or have you ever used drugs? No

Have you ever been treated or hospitalized for drug problems? No

Have you ever suffered from drug withdrawal? No

Vital Signs

Pain scale

DHS-20-0638-D-000028

0 out of 10	05/14/2018 07:38:34 PM	(b)(6); (b)(7)(C)
Temp		
98.1 F	05/14/2018 07:38:34 PM	
HR		
87 /min	05/14/2018 07:38:34 PM	
BP		
122/70 mm Hg	05/14/2018 07:38:34 PM	
RR		
18 /min	05/14/2018 07:38:34 PM	
Wt		
172 lbs	05/14/2018 07:38:34 PM	
Ht		
65 in	05/14/2018 07:38:34 PM	
BMI		
28.62 Index	05/14/2018 07:38:34 PM	

Examination

Intake Screening:

Intake Exam

Patient appears to have normal physical characteristics? Yes
 Patient appears to have normal emotional attributes? Yes
 Patient appears to have no barriers to communication? Yes
 Physical disabilities observed: No
 Is the patient oriented to person, place, time and situation? Yes
 Appears to be responding to auditory or visual hallucinations? No
 Disorganized thoughts or behaviors observed: No
 Agitation observed: No
 Malnourished appearance observed: No
 Low Vision: No
 Hearing difficulty/impairment observed: No
 Difficulty observed with forming speech: No
 Difficulty observed with comprehension: No
 Difficulty observed with focus or concentration: No
 Lack of response observed when asked questions: No
 Mobility/Impairment observed: No
 Skin Broken out in bumps/rash observed: No
 Excessive sweating observed: No
 Abnormal breathing (persistent cough, hyperventilation, etc) observed: No
 Cuts, bruises, jaundice, lesions, scars or tattoos observed: No
 Nits or Active lice observed: No
 Shaking/tremors observed: No
 Needle Tracks observed: No
 Does the patient wear glasses or contacts? No

Assessments

1. Normal Intake Screening - 00.2 (Primary)

Treatment

1. Normal Intake Screening

Notes: Tuberculosis and CXR explained to patient and process completed with appropriate shielding. Physical exam scheduled for patient. Access to medical/dental/mental health care, grievance process explained to patient. Patient given the Medical Orientation and Health Information Brochure and Dealing with Stress Brochure based on the language spoken by the patient. Patient verbalized understanding of any teaching or instruction. Patient was asked if he or she had any additional questions, and any questions were addressed.

Procedure Codes

71010 CHEST X-RAY, Single View

Disposition: Medically cleared for custody

Appointment Provider: (b)(6); (b)(7)(C) LPN

Confirmatory sign off:

(b)(6); (b)(7)(C) 05/15/2018 06:01:54 AM (b)(6); (b)(7)(C) /14/2018
 21:39:04 > INTAKE (b)(6); (b)(7)(C) A 05/15/2018 08:01:54 > Reviewed intake
 screen, concur with findings and disposition

Electronically signed by (b)(6); (b)(7)(C) on 05/14/2018 21:38:53 (Central Daylight Time)
Sign off status: Completed

Port Isabel
27991 BUENA VISTA ROAD
LOS FRESNOS, TX 78566
Tel: 956-504-7282
Fax: 956-504-7284

Patient: CRUZ, RONALD DOB: 01/24/1979 Progress Note (b)(6); (b)(7)(C) 05/14/2018
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Department of Homeland Security
Immigration and Customs Enforcement
Detention and Removal Operations

Detainee Personal Property Record

Detention Location: PORT ISABEL SPC

Subject ID: (b)(6); (b)(7)(C)

Event #: (b)(7)(E) FINS #: (b)(6); (b)(7)(C); (b)(7)(F)

1: Name CRUZ, RONALD		2: A# A078 963 293		3: Nationality HONDU		5: Date May 14, 2018	
6: Date and Time of Action <u>5-15-18 @ 0515</u>		Bin# <u>373/1428</u>		7: Disposition D - Disposed M - Mail S - Storage K - Keep in possession C - Contraband			
I-77# <u>293</u>							

8: Type of Property							
a. Personally Owned Items							
# Article	Disp	# Article	Disp	# Article	Disp	# Article	Disp
1 Belt	S	Photo Album		1 Toothbrush	u	d. Tobacco/ etc	
1 Billfold	S	Photos		1 Toothpaste	u	Canned Tobacco	
Books		Playing Cards		1 Dental Floss		Chewing Tobacco	
- Hard		Purse		Dental Floss		Cigarettes	
- Soft		Religious medal		Dentures		Cigars, snuff	
Boots		Shirt / Blouse		Deodorant	u	Pipe Cleaners	
Brassiere		Shoes		1 Powder		Pipes	
Cap, Hat		Shoes, Shower		Razor			
Coat		Shoes, Tennis	S	Razor Blades	u		
Combs		Shorts		Shampoo			
Dress		Skirts		1 Shaving cream			
Eyeglass case		Slip		Lotion	u		
Eyeglasses		Socks		1 Soap			
Gloves		Stockings		1 Soap Dish			
Hairbrush/Pick		Sunglasses					
Handkerchief		1 Sweater	S				
1 Jeans	S	Sweat Pants		c. Hobby crafts			
Jacket		Sweat Shirt					
Jogging suit		Tie					
Legal Materials		2 T-shirts	S				
Letters		Underwear					
Magazines		1 phone case	S				
Pants / Slacks		1 medicine	S				
Pencils / Pens							
Personal Papers							

Facility Property ☒ 1 Towel K ☒ 2 Sheets K ☒ 1 Blanket K ☒ 2 Uniforms K ☒ 1 Spoon / Cup K ☒ 1 Shower Shoes K ☒ 1 LD & ND Handbook K	Hygiene and Intake ☒ 2 Undergarments K ☒ 2 Socks K ☒ Shower ☒ ☒ Clothes Washed ☒ ☒ Free 3 Min Call / Pin # ☒ ☒ Orientation Video ☒ ☒ Verbally Orientated ☒	Facility Property Returned when Released or Transferred ☐ Officer Int. _____ Call Sign _____
--	---	--

9. RECEIVING: The receiving officer(s) by signing below certifies receipt, review and disposition of the property listed above. The detainee, by signing below certifies the accuracy of the inventory and turns the property over for safekeeping. Any missing or damaged items must be noted in area (8)(e) or on a separate piece of paper.

Receiving Officer/Star#: <u>Urg 208</u>	Date/Time: <u>5-15-18 / 0512</u>
Receiving Officer/Star#: <u>1517</u>	Date/Time: <u>5-15-18 / 0512</u>
Detainees Signature: <u>Ronald F. Cruz</u>	Date/Time: <u>5-15-18 / 0512</u>

10. RELEASING: The detainee, by signing as verified that all of the above listed property was return to them.

Releasing Officer/Star#: _____	Date/Time: _____
Detainee Signature: _____	Date/Time: _____

STATE OF TEXAS

CERTIFICATION OF VITAL RECORD

CITY OF HARLINGEN

STATE OF TEXAS			CERTIFICATE OF DEATH			STATE FILE NUMBER		
1. LEGAL NAME OF DECEASED (Include AKA's, if any) (First, Middle, Last) RONAL FRANCISCO ROMERO						2. DATE OF DEATH - ACTUAL OR PRESUMED (mm-dd-yyyy) MAY 16, 2018		
3. SEX MALE	4. DATE OF BIRTH (mm-dd-yyyy) FEBRUARY 24, 1979	5. AGE-Last Birthday (Years) 39	IF UNDER 1 YR Mo Days		IF UNDER 1 DAY Hours Min		6. BIRTHPLACE (City & State or Foreign Country) HONDURAS	
7. SOCIAL SECURITY NUMBER ?		8. MARITAL STATUS AT TIME OF DEATH ☐ Married ☐ Widowed ☐ Divorced ☒ Never Married ☐ Unknown			9. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage)			
10a. RESIDENCE STREET ADDRESS 27991 BUENA VISTA BLVD.						10b. APT. NO.		10c. CITY OR TOWN LOS FRESNOS
10d. COUNTY CAMERON		10e. STATE TEXAS		10f. ZIP CODE 78566		10g. INSIDE CITY LIMITS? ☐ Yes ☒ No		
11. FATHER'S NAME PRIOR TO FIRST MARRIAGE UNKNOWN UNKNOWN				12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE MARTINA BLASINA ROMERO				
13. PLACE OF DEATH (CHECK ONLY ONE)								
IF DEATH OCCURRED IN A HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DCA								
IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice Facility ☐ Nursing Home ☐ Decedent's Home ☐ Other (Specify)								
14. COUNTY OF DEATH CAMERON			15. CITY/TOWN, ZIP (IF OUTSIDE CITY LIMITS, GIVE PRECINCT NO) HARLINGEN, 78550			16. FACILITY NAME (If not institution, give street address) VALLEY BAPTIST MEDICAL CENTER		
17. INFORMANT'S NAME & RELATIONSHIP TO DECEASED ANDREW FREE - COUNSEL				18. MAILING ADDRESS OF INFORMANT (Street and Number, City, State, Zip Code) C/O LAW OFFICE OF ANDREW FREE P.O. BOX 90568, NASHVILLE, TN 37209				
19. METHOD OF DISPOSITION ☐ Burial ☐ Cremation ☐ Donation ☐ Entombment ☒ Removal from state ☐ Other (Specify)				20. SIGNATURE AND LICENSE NUMBER OF FUNERAL DIRECTOR OR PERSON ACTING AS SUCH (b)(6); (b)(7)(C)				21. ☒ Unknown
22. PLACE OF DISPOSITION (Name of cemetery, crematory, other place) (b)(6); (b)(7)(C)				23. LOCATION (City/Town, and State) SAN DIEGO, HO				
24. DIRECTORS, INC				25. COMPLETE ADDRESS OF FUNERAL FACILITY (Street and Number, City, State, Zip Code) 395 SOUTH SAM HOUSTON, SAN BENITO, TX 78586				
26. CERTIFIER (Check only one) ☐ Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated. ☒ Medical Examiner/Justice of the Peace-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) and manner stated.								
27. SIGNATURE OF CERTIFIER (b)(6); (b)(7)(C)				28. DATE CERTIFIED (mm-dd-yyyy) MAY 29, 2018		29. LICENSE NUMBER		30. TIME OF DEATH (Actual or presumed) 06:49 PM
31. ADDRESS OF CERTIFIER (Street and Number, City, State, Zip Code) W. WILSON ROAD, HARLINGEN, TX 78552				32. TITLE OF CERTIFIER JP				
33. 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. ENTER ONLY ONE CAUSE ON EACH.								
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. MENINGITIS Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated, the events resulting in death) LAST b. CLINICAL HISTORY OF DIABETIC KETOACIDOSIS AND CLINICAL HISTORY OF SEPSIS Due to (or as a consequence of):								
c. NO EVIDENCE OF TRAUMA Due to (or as a consequence of):								
d.								
PART 2. ENTER OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART 1. NATURAL						34. WAS AN AUTOPSY PERFORMED? ☐ Yes ☒ No		
36. MANNER OF DEATH ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined						37. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ No ☐ Probably ☒ Unknown		
38. IF FEMALE: ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to one year before death ☐ Unknown if pregnant within the past year						39. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)		
40a. DATE OF INJURY (mm-dd-yyyy)		40b. TIME OF INJURY		40c. INJURY AT WORK? ☐ Yes ☒ No		40d. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area)		
40e. LOCATION (Street and Number, City, State, Zip Code)						40f. COUNTY OF INJURY		
41. DESCRIBE HOW INJURY OCCURRED								
42a. REGISTRAR FILE NO. 03-0504		42b. DATE RECEIVED BY LOCAL REGISTRAR MAY 29, 2018		42c. REGISTRAR REGISTRAR - CITY OF HARLINGEN, ELECTRONICALLY FILED				

TEXAS DEPARTMENT OF STATE HEALTH SERVICES - VITAL STATISTICS UNIT

WARNING: The penalty for knowingly making a false statement in this form can be 2-10 years in prison and a fine up to \$10,000 (Health and Safety Code, Sec. 191.051)

VS-112 REV 1/2006

0000208364



This is a true and correct reproduction of the original record as recorded in this office. Issued under authority of Section 191.051, Health and Safety Code.

ISSUED **6/15/18**

Diana Vargas

Diana Vargas
Local Registrar



WARNING: THIS DOCUMENT HAS A DARK BLUE BORDER AND A COLORED BACKGROUND

DHS-20-0638-D-000032

ANY ALTERATION OF THIS CERTIFICATE

JOINT INTAKE

From: (b)(6); (b)(7)(C) <[redacted]@ice.dhs.gov>
Sent: Wednesday, May 16, 2018 10:26 PM
To: JOINT INTAKE
Cc: (b)(6); (b)(7)(C) [redacted]
Subject: Passing of Hospitalized ICE Detainee – San Antonio Field Office (PIDC, Los Fresnos, TX)

On May 16, 2018, at approximately 18:49hrs, ICE Health Service Corps at the Port Isabel Detention Center (PIDC) notified ERO San Antonio that ICE detainee CRUZ, Ronald A 078 963 293, DOB: January 24, 1979, a citizen from Honduras, was pronounced dead b (b)(6); (b)(7)(C) [redacted] after being hospitalized at the Valley Baptist Medical Center in Harlingen, Texas due to early symptoms of a stroke. The Honduras Consulate Office was notified via telephone of CRUZ's passing and the Honduras Consulate will be notifying CRUZ's next of kin of his passing.

(b)(6); (b)(7)(C) [redacted]

Acting Assistant Officer In Charge
Port Isabel Detention Center
27991 Buena Vista Blvd.
Los Fresnos Texas
Tel: (956) 547-1 (b)(6); (b)(7)(C) [redacted]
Cell # (956) 592 (b)(6); (b)(7)(C) [redacted]

JOINT INTAKE

From: (b)(6); (b)(7)(C)
Sent: Thursday, May 17, 2018 12:53 AM
To: JOINT INTAKE
Subject: JIC DUTY CALL - Death of Detainee
Attachments: JIC Duty Call May 17 2018 Death of Detainee.pdf

Please see attached – Case (b)(7)(E) as open, but JICMS says routed to ICE West.

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

Senior Special Agent
U.S. Customs and Border Protection
Office of Professional Responsibility
11606 City Hall Promenade, 4th Floor
Miramar, FL 33025
Cel. (305) 58 (b)(6);

JOINT INTAKE CENTER – TELEPHONE WORKSHEET

Date 05/17/2018	Time 1020	Duty Agent (b)(6); (b)(7)(C)	# (305) 587 (b)(6); (b)(7)(C)
Time Sensitive? ☒ Yes ☐ No		Arrests, assaults (physical/sexual), bribes, death, discharge of weapon, medical, media, serious injuries, suicide, workplace violence, e.g.	

Caller Data	
☐ Anonymous ☐ Detainee ☒ Source ☐ Subject ☐ Victim ☐ Witness	
Name Deportation Officer (b)(6); (b)(7)(C)	Phone Number (956) 547-1877
Language Spoken	City, State Los Fresnos, TX
A#	Facility Name Port Isabel Detention Center

Information	
☐ Allegation ☐ Management Issue ☒ Detainee Issue ☒ Incident ☐ Other	
Briefly Describe (Who/What/Where/When/Why)	
Death of Detainee at Hospital; detainee Ronald Cruz (A#078 963 293) Honduran national passed away from an unspecified medical condition. Detainee Cruz had been admitted to the Valley Bapsist Medical Center in Harligen, TX at 0253 on May 16, 2018. Further information contact Port Isabel Detention Center Duty Desk at (956) 547 - (b)(6); (b)(7)(C).	
☐ CBP ☒ ERO ☐ HSI ☐ Other	

Action Taken	
☒ JICMS File # 201807158 ☐ JIC Log #	
Requested ERO provide copy of any updates & SEN. Notified ICE OPR Duty Agent (b)(6); (b)(7)(C) Notified DHS OIG Duty Agent	
Referred To	
☐ OIG Duty Agent ☒ OPR Duty Agent ☐ CBP IA Duty ☐ Local ERO ☐ ERO CDH ☐ ERO JIC Email ☐ Other Agency	
Helpful Numbers	
Community and Detainee Helpline (CDM) - (888) 351-4024 (M-F 0800 – 1700) DOJ EOIR - (800) 898-7180 (immigration court dates, status of hearings) CIS NCSC - (800) 375-5283 (M-F 0800 – 1800, Case Status, Benefits, etc) LESC - (855) 448-6903 Detainee locator - www.ice.gov/locator	

ICE Significant Incident Report

Submitted Date and Time of Report: 5/16/2018 1027 EST

Incident Date: 5/16/2018	Incident Time: 0800	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Field Operations Division	Area: Western Operations
Case Number: No Case Involved	Office: XA - FOD SAN ANTONIO - SNA	Lead Agency: B - DHS / ICE
SEN Incident Number: (b)(7)(E)	Initial/Follow-Up: Initial	Event Status: Priority
Related SEN Number:	Related Case Number: -----	SEACATS Number:
Intel Number:	ENFORCE Number:	

Employee	Operational	Security	Other
☐ Shots Fired At Employee	☐ Air/Marine Incidents	☐ National Security Interest	☐ Escape
☐ Shots Fired By Employee	☐ Controlled Delivery	☐ Facility Disturbance	☐ Suicide Attempt
☐ Employee Assaulted	☐ Significant Seizure	☐ Terrorism Related	☐ Hunger Strike
☐ Employee Death	☐ Significant Arrest	☐ Foreign Military/Police Incursion	☐ Media Interest
☐ Employee Injured	☐ IPAS	☐ WMD/HAZMAT	☐ Alien Injury/Death
☐ Employee Arrested	☐ SCR	☐ Demonstrations	☐ Vehicle Incidents
☐ Firearms Discharge to Include Unintentional Discharge	☐ Rescue	☐ JTTF	☒ Other
☐ Use of Baton or other Impact Weapon	☐ Weapon Violations	☐ Bomb Threat	☐ Predator
☐ Use of OC Spray or other Chemical Agents	☐ Other Agency Interest	☐ DHS SAR	☐ Gang Related
☐ Other Use of Force			
☐ Loss or Theft of Firearm or Body Armor			

Principal Subject: Person	Last Name: Cruz	First Name: Ronald	Alien ID: 078 963 293
Date of Birth: 1/24/1979	Country of Birth: Honduras	Citizenship: Honduras	

Narrative

Report Title: ICE Detainee Admitted to Hospital- San Antonio Field Office (PIDC, Los Fresnos, TX)

On May 15, 2018, the ICE Health Service Corps at the Port Isabel Detention Center (PIDC) notified ERO San Antonio that ICE detainee CRUZ, Ronald A 078 963 293, DOB: January 24, 1979, a citizen from Honduras, was admitted to Valley Baptist Medical Center in Harlingen, Texas, for early symptoms of a stroke. Current Status: Critical.

IMMIGRATION HISTORY:

On May 09, 2018, CRUZ was encounter by a Border Patrol agent in the Rio Grande Valley and was determined to be inadmissible pursuant to Section 241 (a) (5) of the Immigration and Nationality Act and amendable to a reinstatement of a final order. CRUZ was identified as an alien having been previously ordered removed from the United States on September 25, 2002.

On May 14, 2018, CRUZ entered ICE custody at the Port Isabel Detention Center where he is currently awaiting his deportation to Honduras.

CRIMINAL HISTORY:

DHS-20-0638-D-000036

(b)(7)(E)

2020-ICLI-00057 1115

5/17/2018

CRUZ was convicted of Driving Under The Influence of Liquor on 1/14/2016 and received two days confinement.

MEDICAL HISTORY:

CRUZ has no relevant medical history.

FAMILY:

CRUZ's family resides in Honduras.

The Consulate of Honduras has been notified of CRUZ's admission to Valley Baptist Medical Center.

This SIR was reviewed and approved by DFOD Deborah Achim.

Violations of Law:**Action Taken:****Other Agencies Notified:**

Name	Agency	Phone	Date	Time
none				

Injuries: No	Injuries (Names and Extent of
Fatalities: No	Injury):
Damage: No	

Locations:

Type	Address	City	State	Zip
Other	27991 Buena Vista Blvd	Los Fresnos	Texas	78566

Reported to ICE Operations Center via Phone: No

Public Affairs Notified: No - Without comments

Comments:

Reported By	(b)(6); (b)(7)(C)	Phone: 956547	(b)(6); (b)(7)(C)	Cell/Pager: 956592	(b)(6); (b)(7)(C)
Supervisor:		Phone: 202500		Cell/Pager: 202500	

 DEPARTMENT OF HOMELAND SECURITY Immigration and Customs Enforcement REPORT OF INVESTIGATION		1. CASE NUMBER (b)(6); (b)(7)(C)
		PREPARED BY (b)(6); (b)(7)(C)
		2. REPORT NUMBER 001
3. TITLE CRUZ, Ronald/Non-Employee/0108 Death-Detainee/Alien (Unknown Cause)/HARLINGEN, CAMERON, TX		
4. FINAL RESOLUTION		
5. STATUS Initial Report	6. TYPE OF REPORT Allegation	7. RELATED CASES
8. TOPIC Death of ICE Detainee in Medical Center, Harlingen, TX.		
9. SYNOPSIS On May 17, 2018, the Joint Intake Center (JIC) Duty Agent received a call from Immigration and Customs Enforcement (ICE) Deportation Officer (DO) (b)(6); (b)(7)(C) Port Isabel Detention Center, Los Fresnos, TX, reporting the death of ICE detainee Ronald Cruz, Honduran national, A# 078 963 293. DO (b)(6); (b)(7)(C) reported, detainee Cruz passed away at Valley Baptist Medical Center in Harlingen, TX, of an unspecified medical condition; records indicate, detainee Cruz had been admitted to the hospital at 0253 on May 16, 2018.		
10. CASE OFFICER (Print Name & Title) (b)(6); (b)(7)(C) CBP OPR Special Agent	11. COMPLETION DATE 17-MAY-2018	14. ORIGIN OFFICE CBP OPR SAC MIAMI
12. APPROVED BY (Print Name & Title) (b)(6); (b)(7)(C) IC Supervisor	13. APPROVED DATE 17-MAY-2018	15. TELEPHONE NUMBER No Phone Number
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DEPARTMENT OF HOMELAND SECURITY

REPORT OF INVESTIGATION
CONTINUATION

1. CASE NUMBER

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

PREPARED BY

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

2. REPORT NUMBER

001

10. NARRATIVE

On May 17, 2018, the JIC Duty Agent received a call from ICE DO (b)(6); (b)(7)(C) Port Isabel Detention Center, Los Fresnos, TX, reporting the death of ICE detainee Ronald Cruz, Honduran national, A# 078 963 293. (b)(6); (b)(7)(C) reported, detainee Cruz passed away at Valley Baptist Medical Center in Harlingen, TX, of an unspecified medical condition; records indicate, detainee Cruz had been admitted to the hospital at 0253 on May 16, 2018 .

The following is a re-creation of the text from Acting Assistant Officer in Charge (b)(6); (b)(7)(C) email reporting the death of the detainee. No changes have been made to grammar, punctuation nor spelling.

<BEGIN>

From: (b)(6); (b)(7)(C)

Sent: Wednesday, May 16, 2018 10:10 PM

To: (b)(6); (b)(7)(C) ce.dhs.gov>

Subject: RE: Death of detainee

Yes sir

On May 16, 2018, at approximately 18:49hrs, ICE Health Service Corps at the Port Isabel Detention Center (PIDC) notified ERO San Antonio that ICE detainee CRUZ, Ronald A 078 963 293, DOB: January 24, 1979, a citizen from Honduras, was pronounced dead by (b)(6); (b)(7)(C) after being hospitalized at the Valley Baptist Medical Center in Harlingen, Texas due to early symptoms of a stroke. The Honduras Consulate Office was notified via telephone of CRUZ's passing and the Honduras Consulate will be notifying CRUZ's next of kin of his passing.

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

Acting Assistant Officer In Charge
Port Isabel Detention Center
27991 Buena Vista Blvd.
Los Fresnos Texas
Tel: (956) 547 (b)(6); (b)(7)(C)
Cell # (956) 54 (b)(6); (b)(7)(C)
<END>

DEPARTMENT OF HOMELAND SECURITY

REPORT OF INVESTIGATION
Exhibit List

1. CASE NUMBER

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

PREPARED BY

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

2. REPORT NUMBER

001

None

 DEPARTMENT OF HOMELAND SECURITY Immigration and Customs Enforcement REPORT OF INVESTIGATION		1. CASE NUMBER (b)(6); (b)(7)(C)
		PREPARED BY (b)(6); (b)(7)(C)
		2. REPORT NUMBER 002
3. TITLE CRUZ, Ronald/Non-Employee/0108 Death-Detainee/Alien (Unknown Cause)/HARLINGEN, CAMERON, TX		
4. FINAL RESOLUTION		
5. STATUS Interim Report	6. TYPE OF REPORT Other	7. RELATED CASES
8. TOPIC Initial Assessment		
9. SYNOPSIS On May 17, 2018, the Joint Intake Center (JIC) Duty Agent received a call from Immigration and Customs Enforcement (ICE) Deportation Officer (DO (b)(6); (b)(7)(C)) Port Isabel Detention Center, Los Fresnos, TX, reporting the death of ICE detainee Ronald Cruz, Honduran national, A# 078 963 293. (b)(6); (b)(7)(C) reported, detainee Cruz passed away at Valley Baptist Medical Center in Harlingen, TX, of an unspecified medical condition; records indicate, detainee Cruz had been admitted to the hospital at 0253 on May 16, 2018.		
10. CASE OFFICER (Print Name & Title) (b)(6); (b)(7)(C) ICE-OPR Special Agent	11. COMPLETION DATE 29-MAY-2018	14. ORIGIN OFFICE ICE OPR RAC Harlingen 2
12. APPROVED BY (Print Name & Title) (b)(6); (b)(7)(C) ICE-OPR Special Agent Supervisor	13. APPROVED DATE 30-MAY-2018	15. TELEPHONE NUMBER No Phone Number
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 DEPARTMENT OF HOMELAND SECURITY REPORT OF INVESTIGATION CONTINUATION	1. CASE NUMBER (b)(6); (b)(7)(C)
	PREPARED BY (b)(6); (b)(7)(C)
	2. REPORT NUMBER 002

10. NARRATIVE

DETAILS OF INVESTIGATION

On May 17, 2018, the JIC Duty Agent received a call from

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

 PIDC Los Fresnos, reporting the death of ICE detainee Cruz, DO

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

 reported, detainee Cruz passed away of an unspecified medical condition; records indicate, detainee Cruz had been admitted to the hospital at 0253 on May 16, 2018 .

On May 29, 2018, the file was assigned to Senior Special Agent (SSA

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

 Office of Professional Responsibility, Harlingen, TX (OPR Harlingen). This report serves as an initial assessment SSA

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

 will gather additional information regarding the death.

 DEPARTMENT OF HOMELAND SECURITY REPORT OF INVESTIGATION Exhibit List	1. CASE NUMBER (b)(6); (b)(7)(C)
	PREPARED BY (b)(6); (b)(7)(C)
	2. REPORT NUMBER 002
	None

 DEPARTMENT OF HOMELAND SECURITY Immigration and Customs Enforcement REPORT OF INVESTIGATION		1. CASE NUMBER (b)(6); (b)(7)(C)
		PREPARED BY (b)(6); (b)(7)(C)
		2. REPORT NUMBER 003
3. TITLE CRUZ, Ronald/Non-Employee/0108 Death-Detainee/Alien (Unknown Cause)/HARLINGEN, CAMERON, TX		
4. FINAL RESOLUTION		
5. STATUS Interim Report	6. TYPE OF REPORT Other	7. RELATED CASES
8. TOPIC File transferred to OPR External Reviews and Analysis Unit		
9. SYNOPSIS On May 17, 2018, the Joint Intake Center (JIC) Duty Agent received a call from Immigration and Customs Enforcement (ICE) Deportation Officer (DO) (b)(6); (b)(7)(C) Port Isabel Detention Center, Los Fresnos, TX, reporting the death of ICE detainee Ronald Cruz, Honduran national, A# 078963 293 (b)(6); (b)(7)(C) reported, detainee Cruz passed away at Valley Baptist Medical Center in Harlingen, TX, of an unspecified medical condition; records indicate, detainee Cruz had been admitted to the hospital at 0253 on May 16, 2018. The Office of Professional Responsibility, Harlingen, TX (OPR Harlingen) is transferring this file to OPR External Reviews and Analysis Unit for inquiry.		
10. CASE OFFICER (Print Name & Title) (b)(6); (b)(7)(C) - ICE-OPR Special Agent	11. COMPLETION DATE 18-JUN-2018	14. ORIGIN OFFICE ICE OPR RAC Harlingen 2
12. APPROVED BY (Print Name & Title) J (b)(6); (b)(7)(C) ICE-OPR Special Agent Supervisor	13. APPROVED DATE 18-JUN-2018	15. TELEPHONE NUMBER No Phone Number
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DEPARTMENT OF HOMELAND SECURITY

REPORT OF INVESTIGATION
CONTINUATION

1. CASE NUMBER

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

PREPARED BY

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

2. REPORT NUMBER

003

10. NARRATIVE

The Office of Professional Responsibility, Harlingen, TX (OPR Harlingen) is transferring this file to OPR External Reviews and Analysis Unit for inquiry.

DEPARTMENT OF HOMELAND SECURITY

REPORT OF INVESTIGATION
Exhibit List

1. CASE NUMBER

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

PREPARED BY

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

2. REPORT NUMBER

003

None

SYNOPSIS

On May 16, 2018, Ronal Francisco ROMERO,¹ a 39-year-old citizen of Honduras, died while in the custody of U.S. Immigration and Customs Enforcement (ICE) at the Valley Baptist Medical Center (VBMC), in Harlingen, Texas (TX). The State of Texas Certificate of Death documented ROMERO's cause of death as meningitis,² clinical history of diabetic ketoacidosis (DKA),³ and clinical history of sepsis.⁴

ROMERO was detained at Port Isabel Detention Center (PIDC), in Los Fresnos, TX, from May 14, 2018, until his death. PIDC is owned and managed by the ICE Office of Enforcement and Removal Operations (ERO) San Antonio Field Office. PIDC is required to comply with the ICE Performance Based National Detention Standards (PBNDS) 2011 (revised in 2016). Medical care at PIDC is provided by ICE Health Services Corps (IHSC) and supported by subcontractor InGenesis Medical Staffing (InGenesis). Ahtna Support and Training Services (Ahtna) provides security and transportation services for PIDC. At the time of ROMERO's death, PIDC housed approximately 1,004 male and female detainees of all classification levels for periods in excess of 72 hours.

DETAILS OF REVIEW

From June 19-20, 2018, the ICE Office of Professional Responsibility, External Reviews and Analysis Unit (ERAU) staff visited PIDC to review the circumstances surrounding ROMERO'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.⁵ As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to ROMERO, in addition to conducting in-person interviews of individuals employed by ERO, Ahtna, IHSC, and InGenesis.

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

¹ ICE and facility documents noted various names for the detainee. For purposes of this report, the detainee will be referred to as Ronal Francisco ROMERO.

² Meningitis is an inflammation of brain and spinal cord membranes caused by an infection.

³ Diabetic ketoacidosis is a diabetes complication in which the body produces excess acids in the blood through rapid breakdown of fat.

⁴ Sepsis is a potentially life-threatening complication of an infection that occurs when chemicals released into the bloodstream to fight the infection trigger inflammatory responses throughout the body.

⁵ See Exhibit 1: Creative Corrections Healthcare and Security Compliance Analysis.

IMMIGRATION AND CRIMINAL HISTORY

On May 15, 2002, CBP agents encountered and apprehended ROMERO near Carricitos, TX⁶ and served him with a Notice to Appear charging him with Inadmissibility pursuant to Section 212(a)(6)(A)(i) of the Immigration and Nationality Act (INA) for entering the United States without admission or parole.⁷

On September 25, 2002, an immigration judge issued a final order to remove ROMERO from the United States to Honduras.⁸

On August 26, 2015, Missouri Highway Patrol arrested ROMERO for Driving Under the Influence.⁹

On January 14, 2016, the State of Missouri, Jackson County Circuit Court, convicted ROMERO for Driving Under the Influence and sentenced him to two days in jail.¹⁰

On January 22, 2016, ERO arrested ROMERO at the Jackson County Jail in Kansas City, Missouri and transferred him to the Alexandria Staging Facility in Alexandria, Louisiana for removal.¹¹ On January 29, 2016, ERO removed ROMERO from the United States to Honduras.¹²

On May 9, 2018, CBP encountered and apprehended ROMERO near Rio Grande City, TX.¹³ On May 11, 2018, CBP served ROMERO with a Warrant of Removal/Deportation pursuant to Section 241(a)(5) of the INA.¹⁴

On May 14, 2018, CBP transferred ROMERO into ERO custody, and he was transported to PIDC.

NARRATIVE

On May 14, 2018 at 4:21 p.m., security staff booked ROMERO into PIDC.¹⁵ At 5:08 p.m., ROMERO entered staging cell five.¹⁶ An intake officer completed ROMERO's classification rating using the ICE Detainee Classification System Primary Assessment Form and appropriately classified the detainee as low risk. The classification rating was not reviewed or approved by a

⁶ See ICE ENFORCE Alien Detention Module (EADM) Encounters.

⁷ See ICE EADM Case Summary.

⁸ See ICE ENFORCE Alien Removal Module (EARM) Actions/Decisions. ROMERO's alien file contained no information regarding his whereabouts between September 25, 2002 to August 26, 2015.

⁹ See Federal Bureau of Investigation RAP Sheet, dated May 16, 2018.

¹⁰ *Id.*

¹¹ See ICE EARM Actions/Decisions.

¹² *Id.*

¹³ See Form I-213, Record of Deportable/Inadmissible Alien, dated May 11, 2018.

¹⁴ See Warrant of Removal/Deportation, dated May 11, 2018.

¹⁵ See Detainee Summary Form, dated May 15, 2018.

¹⁶ See Staging cell #5 video surveillance footage, dated May 14, 2018. In the staging area, detainees are placed in a holding cell, fed sack meals, classified, and receive a medical screening.

supervisor.¹⁷ ERAU notes intake staff did not document ROMERO's primary language on any intake documents.

At 7:00 p.m., InGenesis Licensed Vocational Nurse (LVN) (b)(6); (b)(7)(C) completed ROMERO's medical pre-screening and documented he did not use interpretation services because he is fluent in Spanish.¹⁸ ROMERO denied any current illnesses, health problems, or medications.

At 7:38 p.m., InGenesis LVN (b)(6); (b)(7)(C) completed ROMERO's medical and mental health screening in Spanish.¹⁹ She noted ROMERO's vital signs were within normal limits,²⁰ and he denied any current pain, medical problems, or medications. (b)(6); (b)(7)(C) documented ROMERO's mental health screening was normal, his chest x-ray was negative for tuberculosis, and she cleared him for housing in general population. During the encounter, ROMERO signed the IHSC Medical Consent Form.²¹ ERAU notes ROMERO denied taking medication during the medical health screening, and nurses documented that intake staff did not provide them with any medication from ROMERO's property, which is discussed in the next paragraph.

On May 15, 2018 at 3:45 a.m., PIDC officers moved 63 detainees, including ROMERO, from the staging area to the processing area.²² At 5:12 a.m., Processing Officer (b)(6); (b)(7)(C) inventoried ROMERO's personal property, which included unspecified medications.²³ ROMERO signed the property inventory form, and (b)(6); (b)(7)(C) stored the property.²⁴ (b)(6); (b)(7)(C) stated that staging officers provide medical staff with any medications accompanying a detainee during the staging phase of intake.²⁵ If any medications accompany the detainee to the processing area, (b)(6); (b)(7)(C) assumes medical staff have already assessed them, and they are ready to be inventoried and stored. (b)(6); (b)(7)(C) did not record that ROMERO arrived with funds.²⁶ PIDC Policy 4.1.3, Reception and Orientation, states, "Medicine the detainee brings into the facility upon arrival will be forwarded to IHSC for disposition." During their interviews, both Health Services Administrator (HSA) Commander (b)(6); (b)(7)(C) and Chief of Security (b)(6); (b)(7)(C) agreed that intake staff should have brought the medications to medical staff.²⁷

¹⁷ See Exhibit 2: ICE Detainee Classification System Primary Assessment Form, dated May 14, 2018.

¹⁸ See PIDC eClinical Works Progress Note by (b)(6); (b)(7)(C) dated May 14, 2018.

¹⁹ See Exhibit 3: PIDC eClinical Works Progress Note by (b)(6); (b)(7)(C), dated May 14, 2018.

²⁰ 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; and, normal blood pressure is less than 120/80.

²¹ See IHSC Medical Consent Form, dated May 14, 2018.

²² See Processing Logbook, dated May 15, 2018.

²³ During the onsite review, ERAU reviewed the contents of the ROMERO's personal property and found a bottle of antibiotic ear drops and three tablets of Azithromycin 250 mg to treat an ear infection.

²⁴ See Exhibit 4: Detainee Personal Property Record, dated May 15, 2018.

²⁵ ERAU interview with (b)(6); (b)(7)(C) dated June 20, 2018.

²⁶ As discussed later in the narrative, ROMERO had one 50 pesos note, one 200 pesos note, one lempira, and one 10 lempiras note.

²⁷ ERAU interview with HSA (b)(6); (b)(7)(C) and Chief of Security (b)(6); (b)(7)(C) dated June 19, 2018 and June 20, 2018, respectively.

At 8:50 a.m., while preparing detainees in the holding cell to be escorted to their housing units,²⁸ Officer (b)(6); (b)(7)(C) noticed that ROMERO seemed distraught.²⁹ In Spanish, Officer (b)(6); (b)(7)(C) asked ROMERO whether he was ok, and ROMERO replied no and asked to sit down. Officer Moran instructed another officer to escort ROMERO to medical where the detainee was immediately assessed by (b)(6); (b)(7)(C).

Although he did not document the assessment in the medical record, (b)(6); (b)(7)(C) stated he took ROMERO's vital signs and recalled that ROMERO said he had a bad headache and felt tired.³⁰ (b)(6); (b)(7)(C) stated ROMERO did not mention having an ear infection or taking any medications.

At 9:05 a.m. (b)(6); (b)(7)(C) contacted InGenesis Physician Assistant (PA) (b)(6); (b)(7)(C) to notify the provider that ROMERO had a fever and placed ROMERO in a wheelchair outside an occupied urgent care room.³¹ At 9:13 a.m., when the urgent care room was vacated, (b)(6); (b)(7)(C) wheeled ROMERO in and assisted him onto the bed. (b)(6); (b)(7)(C) arrived at an unknown time³² to evaluate ROMERO and documented the following during his assessment:³³

- Interpretation services were not used because (b)(6); (b)(7)(C) is fluent in Spanish.
- ROMERO complained of a fever, headache, left ear pain, sore throat, and body aches.
- ROMERO rated his pain level as 10 on the standardized pain scale.³⁴
- ROMERO reported receiving daily ear drops and antibiotics for a left ear infection while in CBP custody.
- ROMERO's temperature was elevated at 102.4 degrees, his heart rate was 100 beats per minute (bpm), and his blood pressure was elevated at 143/78.
- ROMERO's blood glucose level³⁵ was elevated at 266, his urine glucose level³⁶ was 500, ketones³⁷ were greater than 160, specific gravity³⁸ was greater than 1.030, protein was 100

²⁸ See Processing Logbook, dated May 15, 2018.

²⁹ ERAU interview with (b)(6); (b)(7)(C) dated June 20, 2018.

³⁰ ERAU interview with (b)(6); (b)(7)(C) dated June 19, 2018. (b)(6); (b)(7)(C) did not create any documentation of the assessment in the medical record; therefore, his account of the assessment is based on his memory.

³¹ See Medical records video surveillance footage, dated May 15, 2018.

³² ERAU was unable to confirm the exact time when (b)(6); (b)(7)(C) arrived to ROMERO's room and started his evaluation. Medical records video surveillance footage was cut off between 9:13 a.m. and 9:48 a.m. By 9:48 a.m., (b)(6); (b)(7)(C) was present in ROMERO's room.

³³ See PIDC eClinical Works Progress Note by (b)(6); (b)(7)(C) dated May 15, 2018.

³⁴ 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.

³⁵ A blood glucose test analyzes an individual's blood sugar levels. Normal range for blood glucose is 70 to 140, depending on whether it's a fasting or non-fasting test.

³⁶ A urine glucose test will determine whether there is sugar and ketones in the urine. Normal glucose in urine ranges from 0 to 0.8 millimoles per liter.

³⁷ Ketone is a chemical substance the body produces when it doesn't have enough insulin in the blood. Normal urine ketone level is less than 0.6.

³⁸ The urine specific gravity test compares the density of urine to water, and can help determine healthy kidney functions, infections, diabetes, or the presence of other diseases. The normal range for urine specific gravity is 1.002 and 1.030

mg,³⁹ and he had a small amount of blood in his urine. (b)(6); (b)(7)(C) noted these abnormal results were a possible result of dehydration due to the fever.

(b)(6); (b)(7)(C) documented that ROMERO appeared ill with mild redness to both ears, had red and inflamed tonsils with drainage to the left tonsil, and had swollen lymph glands on the left side of his neck. (b)(6); (b)(7)(C) documented the following diagnoses and treatments:

- Unspecified fever:
 - Acetaminophen 325 mg, three tablets as needed four times daily for ten days, and ibuprofen 600 mg, as needed three times daily for ten days on an alternating basis with acetaminophen.
 - A follow-up urinalysis, comprehensive metabolic panel,⁴⁰ complete blood count,⁴¹ and a comprehensive urine culture⁴² to be completed on May 16, 2018. The Clinical Director (b)(6); (b)(7)(C) stated (b)(6); (b)(7)(C) consulted her and based on the urine test results, they decided to test for diabetes.⁴³
 - Instructions to ROMERO to drink two to three liters of water daily to maintain hydration.
- Streptococcal pharyngitis:⁴⁴
 - Amoxicillin⁴⁵ 500 mg twice daily for ten days.
 - Instructions for ROMERO's admission to the medical housing unit (MHU) based on his Centor Criteria⁴⁶ score of four, swollen glands, enlargement of tonsils, presence of a fever, and absence of a cough. (b)(6); (b)(7)(C) indicated he diagnosed ROMERO based on physical symptoms because the clinic does not have a rapid strep test, admitted ROMERO to MHU, and directed that he be housed alone due to his fever.⁴⁷
- Unspecified abnormal findings in urine:
 - Intravenous (IV) administration of sodium chloride solution for hydration daily in the morning with IV flushing every nursing shift to keep the vein open. A dipstick urine test to be repeated following the completion of each IV flushing.

³⁹ Normal protein ranges from 0 to 20.

⁴⁰ A metabolic panel is a group of tests which measures different chemicals in the blood to determine the health of the kidneys, liver, blood glucose, blood proteins, electrolytes, and acid/base balances.

⁴¹ A complete blood count is a blood test used to evaluate a person's overall health and detect a wide range of disorders, including infection, anemia, or leukemia.

⁴² A comprehensive urine culture is a test used to detect bacteria in the urine which may be causing an infection.

⁴³ ERAU interview with (b)(6); (b)(7)(C) dated June 19, 2018.

⁴⁴ Streptococcal pharyngitis, commonly known as strep throat, is a bacterial inflammation of the throat.

⁴⁵ Amoxicillin is a drug used to treat infections and stomach ulcers.

⁴⁶ Centor Criteria is a set of criteria which may be used to identify the likelihood of a bacterial infection in adult patients complaining of a sore throat, along with other influenza like symptoms.

⁴⁷ ERAU interview with (b)(6); (b)(7)(C) dated June 19, 2018.

- (b)(6); (b)(7)(C) ordered follow-up laboratory tests for May 16, 2018, including the diabetes test HgbA1c with eAG Estimation,⁴⁸ blood tests to determine the level of thyroid function, a lipid panel,⁴⁹ and creatine kinase.⁵⁰

(b)(6); (b)(7)(C) ordered nurses take ROMERO's vital signs every eight hours and conduct nursing checks on an as-needed basis.⁵¹ Additionally, as ordered (b)(6); (b)(7)(C) nurse administered ROMERO doses of amoxicillin, acetaminophen, and a one-liter bag of sodium chloride via IV.⁵²

At 10:06 a.m., a nurse entered the urgent care room and handed ROMERO a cup for a urine sample.⁵³ Video surveillance footage shows ROMERO grimaced as he went to the restroom to provide the sample. At 10:10 a.m., ROMERO returned to the urgent care room with the sample cup.

At 11:17 a.m., a nurse assisted ROMERO into a wheelchair, and at 11:30 a.m., she wheeled him into isolation room five.⁵⁴

Between 12:31 p.m. and 12:47 p.m.⁵⁵, InGenesis Registered Nurse (RN) (b)(6); (b)(7)(C) conducted a nursing round and documented the following:⁵⁶

- (b)(6); (b)(7)(C) communicated with ROMERO in Spanish.
- ROMERO expressed a pain level of 7 out of 10.
- ROMERO's vital signs included an elevated temperature of 100 degrees, an elevated heart rate of 102 bpm, and elevated blood pressure of 147/84. His respirations and pulse oxygen were normal at 18 and 99, respectively.
- ROMERO was alert and cooperative, but appeared ill, uncomfortable due to pain, and was mildly distressed.
- ROMERO's throat was red and swollen with white pus on the tonsils.

(b)(6); (b)(7)(C) documented ROMERO was at risk of spreading the infection, and the treatment plan was to continue the current plan of care in the MHU. (b)(6); (b)(7)(C) provided ROMERO a water pitcher and instructed him to drink three to four liters of water each day. He also encouraged ROMERO to participate in outside recreation. ROMERO verbalized understanding he would remain in MHU until a provider discharged him.

⁴⁸ The Hgb A1c is a test which provides an average of blood glucose levels over a two to three-month period. Hgb A1c with eAG estimation is a new term in diabetes management which stands for estimated average glucose and can be calculated using the results of the A1c test.

⁴⁹ A lipid panel is a blood test that measures various cholesterol and triglycerides.

⁵⁰ Creatine kinase is an enzyme in the heart, brain, and skeletal muscles. High levels of creatine kinase can determine if a heart attack occurred or whether there is damage to the muscles.

⁵¹ See PIDC eClinical Works Progress Note b (b)(6); (b)(7)(C), dated May 15, 2018.

⁵² See Medication Administration Record, dated May 2018.

⁵³ See Medical records video surveillance footage, dated May 15, 2018.

⁵⁴ See MHU Logbook, dated May 15, 2018.

⁵⁵ ERAU was unable to determine the specific encounter time due to various documented vital sign times and a delayed electronic signature.

⁵⁶ See PIDC eClinical Works Progress Note b (b)(6); (b)(7)(C) dated May 15, 2018.

At 4:28 p.m., InGenesis (b)(6); (b)(7)(C) conducted an MHU nursing round and documented the following:⁵⁷

- ROMERO was lying in bed and was hard to awaken.
- ROMERO stated he spoke English, but he did not know where he was or what day it was.
- ROMERO's vital signs included an elevated temperature of 99.5 degrees, an elevated heart rate of 106 bpm, and elevated blood pressure readings of 170/104 and 180/107. His respirations and pulse oxygen were normal at 16 and 96, respectively.
- ROMERO's pupils were non-reactive to light, and his strength was decreased in both arms.
- ROMERO appeared ill, pale, confused, lethargic, and he required assistance to move or walk.

(b)(6); (b)(7)(C) documented her assessment of ROMERO was "acute confusion," and she notified InGenesis Nurse Practitioner (NP) (b)(6); (b)(7)(C) of ROMERO's status. During an interview, (b)(6); (b)(7)(C) stated due to ROMERO's high blood pressure readings, she assessed ROMERO for signs and symptoms of a stroke but her findings were negative.⁵⁸

At 4:39 p.m.,⁵⁹ (b)(6); (b)(7)(C) entered ROMERO's room and evaluated the detainee. He documented ROMERO was lying in bed face up, his responses were slow, and his pupils were sluggish and hyporeactive to light.⁶⁰ (b)(6); (b)(7)(C) stated he also evaluated ROMERO for signs and symptoms of a stroke but found none. After conducting a neurologic examination and observing that ROMERO was lethargic and only able to follow commands to a limited extent (b)(6); (b)(7)(C) ordered that ROMERO be transported to the Harlingen Medical Center (HMC) in Harlingen, TX, via emergency medical services (EMS).

(b)(6); (b)(7)(C) instructed InGenesis Medical Records Technician (b)(6); (b)(7)(C) to call EMS, and then assisted ROMERO onto a wheelchair and moved him to the common area of the medical unit to wait for EMS. (b)(6); (b)(7)(C) stated she immediately called EMS after receiving RN (b)(6); (b)(7)(C) direction⁶¹ and then called both the transportation lieutenant's office and the main gate to alert them an ambulance was en route to the facility to transport a detainee to the hospital.

At 4:58 p.m., EMS responders arrived to PIDC.⁶² At 5:03 p.m., they entered the medical area with a gurney and helped ROMERO move from the wheelchair to the gurney.⁶³ At 5:04 p.m., the EMS responders wheeled ROMERO to the ambulance, loaded him into it, and at 5:09 p.m., the ambulance exited the sally port.⁶⁴ After exiting the sally port, the ambulance pulled over to the

⁵⁷ See PIDC eClinical Works Progress Note by RN (b)(6); (b)(7)(C) dated May 15, 2018.

⁵⁸ ERAU interview with (b)(6); (b)(7)(C) dated June 20, 2018.

⁵⁹ See Isolation room 5 video surveillance footage, dated May 15, 2018.

⁶⁰ See PIDC eClinical Works Progress Note by (b)(6); (b)(7)(C) dated May 15, 2018.

⁶¹ ERAU interview with (b)(6); (b)(7)(C) dated June 20, 2018. The Los Fresnos Ambulance Service, Inc. report notes the call was received at 4:39 p.m.

⁶² See Los Fresnos Ambulance Service, Inc. report, dated May 15, 2018.

⁶³ See Observation rooms video surveillance footage, dated May 15, 2018.

⁶⁴ See Sally port video surveillance footage, dated May 15, 2018.

side of the perimeter road and remained parked there for approximately nine minutes.⁶⁵ The EMS report documents the ambulance stopped there to wait for a facility escort vehicle.⁶⁶ Surveillance footage shows that at 5:18 p.m., before an escort vehicle arrived, the ambulance pulled back onto the perimeter road and drove out of camera range, toward the main entry gate.⁶⁷

Officer (b)(6); (b)(7)(C), who were assigned to follow the ambulance in an escort vehicle, stated they were informed of the transportation detail by Lieutenant (b)(6); (b)(7)(C) as the ambulance arrived at the facility. They retrieved their body armor and transport equipment from a building located outside the facility's perimeter and then returned to the facility to complete transportation paperwork. (b)(6); (b)(7)(C) stated the ambulance was waiting at the main entry gate of the facility compound when he and (b)(6); (b)(7)(C) were ready to depart,⁶⁸ and documented in his notes that the escort vehicle departed PIDC behind the ambulance at 5:25 p.m.⁶⁹

According to the EMS report, because ROMERO was hypertensive, had a fever, and the left side of his face was drooping, the EMS responders redirected the ambulance to VBMC which has a stroke facility and, according to HSA Ahul, is recognized for its care of stroke patients.⁷⁰ VBMC is located approximately 20 minutes from PIDC.

The ambulance arrived to VBMC at approximately 5:47 p.m., and the EMS responders transferred ROMERO's care to VBMC staff at 5:55 p.m.⁷¹

VBMC Emergency Department (ED) physician (b)(6); (b)(7)(C) assessed ROMERO and documented his vital signs were elevated with his temperature at 103.3 degrees, heart rate at 112 bpm, and blood pressure at 172/92.⁷² (b)(6); (b)(7)(C) also noted ROMERO had an elevated white blood count of 24,600,⁷³ lactic acid of 2.4,⁷⁴ and that he initiated sepsis protocol including IV administration of two antibiotics. (b)(6); (b)(7)(C) also determined ROMERO was in DKA, and determined he needed to be moved to the medical intensive care unit (ICU) and assigned a one-to-one caregiver to provide round-the-clock care. (b)(6); (b)(7)(C) documented the following assessment and treatment plan:⁷⁵

- Follow DKA protocol which included restoring fluid loss with IV fluids, restoring potassium loss, maintaining acid balance, and treating infections and glucose levels with insulin, as needed.

⁶⁵ See External perimeter video surveillance footage, dated May 15, 2018.

⁶⁶ See Los Fresnos Ambulance Service, Inc. report, dated May 15, 2018.

⁶⁷ Once at the main gate, security staff visually search exiting vehicles and check the identity of vehicle occupants.

⁶⁸ ERAU interview with Officer (b)(6); (b)(7)(C), dated June 20, 2018.

⁶⁹ ERAU notes the Official Detail Transportation Report documents the escort began at 5:30 p.m. ERAU was unable to confirm the exact time the ambulance and escort vehicle exited the main gate.

⁷⁰ ERAU interview with HSA Ahul, dated June 19, 2018.

⁷¹ See Los Fresnos Ambulance Service, Inc. report, dated May 15, 2018.

⁷² See VBMC Emergency Department Records, dated May 15, 2018.

⁷³ Normal white blood count range is 4,500 to 11,000. Elevated levels determine the severity of the infection.

⁷⁴ Lactic acid is an acid produced in the muscle tissues during strenuous exercise. The normal level in unstressed patients is 0.5 to 1. Elevated levels of lactic acid can indicate sepsis.

⁷⁵ See VBMC Emergency Department Records, dated May 15, 2018.

- For sepsis, provide IV fluids, continue IV antibiotics, and monitor laboratory and culture levels.
- For altered mental state, test liver enzymes and ammonia level, monitor neurological and mental status closely, avoid psychoactive medication,⁷⁶ and keep ROMERO pain-free and comfortable at all times.
- Closely monitor electrolyte levels and adjust according to ICU protocol, avoid nephrotoxic⁷⁷ medications, and continuously check ROMERO's kidney function and adjust medications, as needed.
- Begin antacid treatment to prevent excess stomach acids that can cause ulcers in the gastrointestinal tract. Additionally, ROMERO was not to ingest anything by mouth.
- Monitor ROMERO closely for signs of bleeding, maintain his hemoglobin⁷⁸ levels at seven or above, unless there was active bleeding, and avoid blood or other fluid transfusions.
- Use compression items, such as stockings, to prevent deep vein blood clots and monitor the clotting time of ROMERO's blood.

At 11:45 p.m. (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) were relieved by (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) stated when he arrived at the hospital, ROMERO was in the ED.⁸⁰

On May 16, 2018 at approximately 12:25 a.m., VBMC staff moved ROMERO to an ICU room.⁸¹ At approximately 12:45 a.m., a doctor entered the room to check ROMERO's vital signs and noticed the detainee did not have a pulse.⁸² At 12:55 a.m., the doctor called a code blue and hospital staff entered the room to begin cardiopulmonary resuscitation (CPR).⁸³ (b)(6); (b)(7)(C) stated when the doctor called code blue, he stepped out of the room and notified his shift captain, Captain (b)(6); (b)(7)(C) via cellphone.⁸⁴ According to (b)(6); (b)(7)(C) hospital staff successfully restored ROMERO's pulse at 1:05 a.m.⁸⁵

At approximately 1:15 a.m., ROMERO went into cardiac arrest again,⁸⁶ and hospital staff resumed resuscitation efforts for 15 to 20 minutes before he stabilized.⁸⁷ (b)(6); (b)(7)(C) called Captain (b)(6); (b)(7)(C) to inform her ROMERO was stabilized at approximately 1:52 a.m.⁸⁸ (b)(6); (b)(7)(C) handed the duty cellphone to a doctor to speak with (b)(6); (b)(7)(C). The doctor stated he

⁷⁶ Psychoactive medication are drugs that acts upon the central nervous system and alters brain function, resulting in temporary changes in perception, mood, consciousness, and behavior.

⁷⁷ Nephrotoxic medications are drugs which are toxic to the kidneys and can result in the inability of the kidneys to properly function.

⁷⁸ Hemoglobin is a protein in red blood cells that carries oxygen throughout the body.

⁷⁹ See Incident Report by Officer (b)(6); (b)(7)(C) dated May 16, 2018.

⁸⁰ ERAU interview with Officer (b)(6); (b)(7)(C) dated June 20, 2018.

⁸¹ See Incident Report by Officer (b)(7)(C), dated May 16, 2018.

⁸² *Id.*

⁸³ ERAU was unable to determine why ten minutes lapsed before the hospital physician called a code blue.

⁸⁴ ERAU interview with Officer (b)(6); (b)(7)(C) dated June 20, 2018.

⁸⁵ ERAU interview with Officer (b)(7)(C) dated June 20, 2018.

⁸⁶ See Incident Report by Officer (b)(6); (b)(7)(C) dated May 16, 2018.

⁸⁷ See VBMC Critical Care Progress Note, dated May 16, 2018.

⁸⁸ See Incident Report by Captain (b)(6); (b)(7)(C) dated May 16, 2018.

believed ROMERO had a stroke but could not confirm until tests were conducted. The doctor also stated ROMERO was being kept alive by a ventilator and medications.⁸⁹

At 3:25 a.m., HSA Ahul arrived at the hospital to check on ROMERO.⁹⁰

At 4:00 a.m., Officer (b)(6); (b)(7)(C) relieved Officer (b)(6); (b)(7)(C) and at 6:45 a.m., Officer (b)(6); (b)(7)(C) stated ROMERO's eyes were swollen, and he had breathing tubes and numerous IV lines attached.⁹² At 8:20 a.m., (b)(6); (b)(7)(C) documented a nurse called a code blue after ROMERO again became unresponsive,⁹³ hospital staff-initiated resuscitation efforts, and ROMERO stabilized at 8:34 a.m.⁹⁴

According to Supervisory Detention and Deportation Officer (SDDO) (b)(6); (b)(7)(C) who arrived at the hospital at 8:25 a.m. to visit ROMERO, hospital staff told him ROMERO had no brain activity, and resuscitation efforts would ultimately not be effective.⁹⁵ SDDO (b)(6); (b)(7)(C) stated he remained at the hospital for approximately 20 minutes, and ROMERO was still alive when he departed.

At approximately 10:28 a.m. and again at approximately 2:44 p.m., SDDO (b)(6); (b)(7)(C) contacted ROMERO's family to inform them he had been resuscitated on two occasions and was currently on a ventilator receiving medications.⁹⁶

At 3:00 p.m., Officer (b)(6); (b)(7)(C) relieved Officer (b)(6); (b)(7)(C) Officer (b)(6); (b)(7)(C) stated ROMERO was unresponsive throughout the time he was at the hospital.⁹⁸ At 4:56 p.m., (b)(6); (b)(7)(C) evaluated ROMERO and documented his diagnostic findings as possible meningitis, DKA, acute kidney injury, low levels of magnesium in the blood, malnutrition, respiratory failure, at risk for deep vein thrombosis,⁹⁹ and gastrointestinal problems.¹⁰⁰ (b)(6); (b)(7)(C) documented that he spoke with (b)(6); (b)(7)(C) about ROMERO's condition a (b)(6); (b)(7)(C) on behalf of ICE, asked VBMC to keep ROMERO alive until his family visited. (b)(6); (b)(7)(C) noted that he agreed to (b)(6); (b)(7)(C) request but would reserve his clinical judgement in case care was determined futile.

At 6:25 p.m., ROMERO went into cardiac arrest, and a nurse called a code blue.¹⁰¹ As hospital staff tried to resuscitate ROMERO, (b)(6); (b)(7)(C) notified (b)(6); (b)(7)(C) and Captain (b)(6); (b)(7)(C) that a code blue was called.¹⁰² At 6:49 p.m., (b)(6); (b)(7)(C) instructed hospital staff to

⁸⁹ *Id.*

⁹⁰ See Incident Report by Officer (b)(6); (b)(7)(C) dated May 16, 2018.

⁹¹ See Hospital Logbook, dated May 16, 2018.

⁹² ERAU interview with Officer (b)(6); (b)(7)(C) dated June 19, 2018.

⁹³ See Hospital Logbook, dated May 16, 2018.

⁹⁴ See Incident Report by Officer (b)(6); (b)(7)(C), dated May 16, 2018.

⁹⁵ ERAU interview with SDDO (b)(6); (b)(7)(C) dated June 19, 2018.

⁹⁶ See Email by SDDO (b)(6); (b)(7)(C), dated May 16, 2018.

⁹⁷ See Hospital Logbook, dated May 16, 2018.

⁹⁸ ERAU interview with Officer (b)(6); (b)(7)(C), dated June 19, 2018.

⁹⁹ Deep vein thrombosis is a blood clot in a deep vein, usually in the leg.

¹⁰⁰ See Critical Care Progress Note by (b)(6); (b)(7)(C) dated May 16, 2018.

¹⁰¹ See Hospital Logbook, dated May 16, 2018.

¹⁰² See Incident Report by Officer (b)(6); (b)(7)(C) dated May 16, 2018.

cease CPR and pronounced ROMERO dead. Following the pronouncement, Officer [REDACTED] (b)(6); (b)(7)(C) notified [REDACTED] (b)(6); (b)(7)(C) and Captain [REDACTED] (b)(6); of the detainee's death.

At 7:34 p.m., Assistant HSA [REDACTED] (b)(6); (b)(7)(C) notified ERO of ROMERO's death, and at 7:48 p.m., ERO notified the Consulate of Honduras of ROMERO's death.¹⁰³

At 8:45 p.m., VBMC moved ROMERO's body to the morgue. [REDACTED] (b)(6); (b)(7)(C) returned to PIDC where he completed an incident report and submitted it to [REDACTED] (b)(6); (b)(7)(C).

At 10:39 p.m., Officer [REDACTED] (b)(6); (b)(7)(C) inventoried ROMERO's property and listed the following items:

- One 50 pesos note;
- One 200 pesos note;
- Two 1 lempiras¹⁰⁶ note;
- One 10 lempiras note;
- One cellphone with a broken screen;
- One battery; and
- One black watch.

ERAU notes none of these items were listed on the Detainee Personal Property form completed on May 15, 2018.

Post Death Events

On May 17, 2018, Assistant Officer in Charge (AOIC) [REDACTED] (b)(6); (b)(7)(C) notified ROMERO's brother of his death.

On May 23, 2018, Cameron County Forensic Pathology Medical Director [REDACTED] (b)(6); (b)(7)(C) conducted an autopsy of ROMERO's body and determined his cause of death was meningitis, and significant conditions contributing to his death were a clinical history of DKA and sepsis.¹⁰⁷

On June 15, 2018, the State of Texas issued a Certificate of Death documenting ROMERO's cause of death as meningitis, clinical history of DKA, clinical history of sepsis, and no evidence of trauma.¹⁰⁸

MEDICAL CARE AND SECURITY REVIEW

¹⁰³ See Email by SDDC [REDACTED] (b)(6); (b)(7)(C) dated May 18, 2018.

¹⁰⁴ See Hospital Logbook, dated May 16, 2018.

¹⁰⁵ ERAU interview with [REDACTED] (b)(6); (b)(7)(C), dated June 19, 2018.

¹⁰⁶ Lempira is the currency of Honduras.

¹⁰⁷ See Cameron County Forensic Pathology, Preliminary Autopsy Findings, dated May 23, 2018.

¹⁰⁸ See Exhibit 5: State of Texas Certificate of Death, dated June 15, 2018.

ERAU reviewed the medical care ROMERO was provided at PIDC, as well as the facility's efforts to ensure he was safe and secure while detained at the facility. Upon the conclusion of the review, ERAU found PIDC was fully compliant with the Medical Care standard of the ICE PBNDS 2011 (revised 2016), but deficient in several security-related standards, described below.

1. ICE PBNDS 2011 (revised 2016) Custody Classification System, section (V)(A)(4), which states, "Each detainee's classification shall be reviewed and approved by a first-line supervisor or classification supervisor."
 - On May 14, 2018, a supervisor did not review and approve ROMERO's classification rating.
2. ICE PBNDS 2011 (revised 2016) Emergency Plans, section (V)(D)(18), which states, "The post-emergency part of the plan shall include...: g) debriefing involved staff, and following-up for additional analysis and/or implicated changes in policy or procedures."
 - Following ROMERO's death, (b)(6); (b)(7)(C) who was on hospital duty and present during hospital staff's emergency resuscitation efforts, was not debriefed or offered employee assistance services.
3. ICE PBNDS 2011 (revised 2016) Funds and Personal Property, section (V)(D), which states, "Medical staff shall determine the disposition of all medicine accompanying an arriving detainee."
 - On May 15, 2018, Processing (b)(6); (b)(7)(C) inventoried and stored medication that arrived with ROMERO without notifying medical personnel. Additionally, during the onsite review, ERAU reviewed the contents of ROMERO's personal property and found two prescription medications.

This also violates PIDC Policy 4.1.3, Reception and Orientation, which states, "Medicine the detainee brings into the facility upon arrival will be forwarded to IHSC for disposition."

4. ICE PBNDS 2011 (revised 2016) 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."
 - On May 15, 2018, Processing (b)(6); (b)(7)(C) did not account for ROMERO's funds. Following ROMERO's death, (b)(6); (b)(7)(C) inventoried the detainee's property and noted funds not accounted for during processing.

5. ICE PBNDS 2011 (revised 2016) Funds and Personal Property, section (V)(I), which states, “An itemized inventory of all detainee baggage and personal 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 that the property was previously inventoried by another facility and is contained in a sealed bag.”
 - On May 15, 2018, Processing (b)(6); (b)(7)(C) did not properly list all of ROMERO’s personal property on the Detainee Personal Property Record form. Following ROMERO’s death, Captain (b)(6); accounted for the detainee’s personal property using the ICE Chain of Custody Form and noted items not listed on the Detainee Personal Property Record form.

AREAS OF CONCERN

Although not reflective of any violation of the requirements of the detention standards, ERAU notes the following concern:

- On May 16, 2018, the departure of the ambulance transporting ROMERO to the hospital was delayed approximately 16 minutes while it waited for a facility escort vehicle.

EXHIBITS

1. Creative Corrections Healthcare and Security Compliance Analysis.
2. ICE Detainee Classification System Primary Assessment Form, dated May 14, 2018.
3. PIDC eClinical Works Progress Note by LVN (b)(6); [redacted] dated May 14, 2018.
4. Detainee Personal Property Record, dated May 15, 2018.
5. State of Texas Certificate of Death, dated June 15, 2018.

ICE Health Service Corps

Consent for Psychotropic Medications for Adults

Detainee's Name: Tran, Huy Chi

Date: 06/04/2018

Interpreter Provided? ☐ Yes ☒ No Name or INT#: English

Detainee's A#: 216576678

My physician has prescribed the following medication(s) for the treatment of my psychiatric and/or behavioral problems:

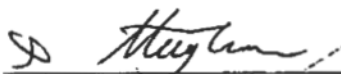
Name of Medication(s):

Haloperidol, fluoxetine, cogenin

The indications for the use on the above medication(s) have been discussed with me. I have had an opportunity to ask questions about the changes that I might expect to see, and to discuss the possible risks, benefits, and precautions associated with this/these medication(s).

The side effects of this/these medication(s) have also been discussed with me and additional information has been provided about the medication(s). I understand and accept the advantages and disadvantages of this treatment. Based on the information provided, I agree to comply with the instructions provided by my physician for giving the medication.

If I have further questions or concerns after I have started the medication, I understand that I should contact the prescribing physician as soon as possible.


Detainee's Signature

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

H. Chi Tran
06/04/2018
Date

H. Chi Tran
06/04/2018
Date

Last Name: Tran	First Name: Huy Chi
A#: <u>216576678</u> <u>037949945</u>	Nationality: Vietnam
Date of Arrival: 05/28/2018	DOB: 08/07/1970
Facility: Eloy CCA Detention Center	Sex: Male

CONFINEMENT RECORD (CR)

Facility Name		EDC			
Inmate Name		Tran, Hwy		Inmate Number	037949945
Date of Placement	06-05-18	Time	13:35	Original Housing	D-103
Placement Ordered By	(b)(6); (b)(7)(C)			Tentative Release Date	

I. **TYPE OF CONFINEMENT:** ☐ Restrictive Housing (Skip Section II below) ☐ Segregation (Complete Section II below)

II. **SEGREGATION STATUS - INITIAL (Check One):**

- ☐ Disciplinary Segregation ☐ Administrative Segregation – PROTECTIVE CUSTODY
☒ Administrative Segregation ☐ Administrative Segregation – Involuntary PREA Placement

ANY TIME AN INMATE/RESIDENT'S STATUS CHANGES, ANOTHER 10-1A MUST BE COMPLETED

III. **REASON FOR PLACEMENT (Check One):**

- ☐ Disciplinary Infraction
☐ Separation from general population for the purpose of protection from other inmates/residents for reason of personal safety
☐ Poses a serious threat to life, property, self, staff, or other inmates/residents
☐ Poses a threat to the security of the orderly operation of the facility
☐ Administrative order from the Chief of Security or higher authority or contracting agency
☐ Involuntary PREA Placement – No alternative means of separation can be arranged (note reason why below)

Reason why no alternative means of separation can be arranged: _____

IV. **SPECIAL CONDITIONS/PRECAUTIONS:**

***If "YES", you must explain. Attach additional sheets, if necessary.**

Recreation/Exercise Requirements: ☐ NO ☐ YES: _____

Restrictions on Personal Property (imposed by the placing authority for cause): ☐ NO ☐ YES: _____

Known Assault Risk: ☐ NO ☐ YES: _____

Modified Restraint Procedures: ☐ NO ☐ YES: _____

Medical/Mental Health Conditions: ☐ NO ☒ YES: _____

Special Diet (medical or religious): ☒ NO ☐ YES: _____

Medication Requirements (current prescriptions): ☐ NO ☒ YES: _____

Additional Search Requirements: ☐ NO ☐ YES: _____

Other: ☐ NO ☐ YES: _____

V. Is the inmate/resident's behavior abnormal, aggressive, violent, or unusual? ☐ NO ☐ YES "If "YES", Explain: _____

VI. **ADMINISTRATIVE REVIEW:** This section must be completed for initial placement, not required for a change in status.

The review must be conducted by the Chief of Security/Unit Management or higher authority.

Printed Name		(b)(6); (b)(7)(C)		Title		(b)(6); (b)(7)(C)	
Signature				Date		6.7.18	
				Time		0904	

VII. **RELEASE:**

A. **Special Release Orders:**

B. **Ordered By:**

Printed Name		Title	
Signature		Date	
		Time	

All inmates/residents in segregation, regardless of status, and restrictive housing will be personally observed by an officer assigned to the unit twice per hour, but no more than forty (40) minutes apart, on an irregular schedule. AT ELOY DETENTION CENTER, IN ACCORDANCE WITH ICE PBND 2.12 SPECIAL MANAGEMENT UNITS (SMU), DETAINEES IN SMU SHALL BE PERSONALLY OBSERVED AND LOGGED AT LEAST EVERY THIRTY (30) MINUTES ON AN IRREGULAR SCHEDULE. Any unusual or bizarre behavior will be reported to the supervisor in charge. If unusual or bizarre behavior warrants, additional checks may be necessary, and additional sheets may be attached. The daily medical visit also will be documented on this form.

[illegible]

Morning: _____ Noon: _____ Evening: _____

2020-ICLI-00057 1142

STATE OF ARIZONA

CERTIFICATION OF VITAL RECORD

ORIGINAL
STATE COPY

STATE OF ARIZONA DEPARTMENT OF HEALTH SERVICES-BUREAU OF VITAL RECORDS CERTIFICATE OF DEATH

State File Number
102-2018-028120

1. DECEDENT'S LEGAL NAME (FIRST, MIDDLE, LAST, SUFFIX) HUY, CHI, TRAN		2. AKA'S (IF ANY)		3. DATE OF DEATH 06/12/2018	
4. SEX MALE	5. SOCIAL SECURITY NUMBER 600-12-2610	6. DATE OF BIRTH 08/07/1970		7. AGE 47 YEARS	
8. CITY/TOWN, COUNTY AND ZIP OR LOCATION OF DEATH CASA GRANDE, PINAL, 85122					
9. PLACE OF DEATH (TYPE OF PLACE OF DEATH AND FACILITY NAME/ADDRESS) INPATIENT - BANNER CASA GRANDE MEDICAL CENTER					
10. BIRTHPLACE (CITY AND STATE OR FOREIGN COUNTRY) VIETNAM		11. MARITAL STATUS NEVER MARRIED		12. NAME OF SURVIVING SPOUSE PRIOR TO FIRST MARRIAGE (FIRST, MIDDLE, LAST, SUFFIX) NOT LISTED	
13. DECEDENT'S USUAL RESIDENCE ADDRESS (STREET, CITY, COUNTY, STATE, ZIP) 3725 E DECATUR STREET, MESA, MARICOPA, AZ, 85205					
14. DECEDENT'S HISPANIC ORIGIN(S) NO, NOT SPANISH/HISPANIC/LATINO		15. DECEDENT'S RACE(S) CHINESE		16. EVER IN ARMED FORCES NO	
18. FATHER'S NAME (FIRST, MIDDLE, LAST, SUFFIX) (b)(6); (b)(7)(C)		19. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (FIRST, MIDDLE, LAST, SUFFIX) (b)(6); (b)(7)(C)		17. OCCUPATION UNEMPLOYED	
20. INFORMANT'S NAME (FIRST, MIDDLE, LAST, SUFFIX) (b)(6); (b)(7)(C)				21. RELATIONSHIP SISTER	
22. INFORMANT'S MAILING ADDRESS (b)(6); (b)(7)(C) MESA, AZ, 85205					
23. NAME AND ADDRESS OF FUNERAL FACILITY OR RESPONSIBLE PERSON (b)(6); (b)(7)(C) 52 N MACDONALD, MESA, AZ, 85201		24. FUNERAL DIRECTOR'S NAME OR RESPONSIBLE PERSON ERIC, WILLIAMS		25. LICENSE NUMBER F1527	
26. METHOD(S) OF DISPOSITION BURIAL		27. NAME AND LOCATION OF 1ST DISPOSITION FACILITY CITY OF MESA CEMETERY, MESA, AZ, US		28. NAME AND LOCATION OF 2ND DISPOSITION FACILITY	
MEDICAL CERTIFICATION SECTION CAUSE OF DEATH PART I					
29. A. IMMEDIATE CAUSE OF DEATH PENDING				30. APPROXIMATE INTERVAL UNKNOWN	
31. B. DUE TO OR AS A CONSEQUENCE OF:				32. APPROXIMATE INTERVAL	
33. C. DUE TO OR AS A CONSEQUENCE OF:				34. APPROXIMATE INTERVAL	
35. D. DUE TO OR AS A CONSEQUENCE OF:				36. APPROXIMATE INTERVAL	
CAUSE OF DEATH PART II					
37. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART I:		38. INJURY? UNKNOWN	39. INJURY AT WORK? NO	40. MANNER OF DEATH PENDING INVESTIGATION	
		41. TIME OF DEATH 09:20	42. WAS AN AUTOPSY PERFORMED? YES	43. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? YES	
CAUSE AND MANNER CERTIFICATION					
44. NAME OF PERSON COMPLETING CAUSE OF DEATH (b)(6); (b)(7)(C)				45. DATE CERTIFIED 06/14/2018	
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.					
46. CERTIFIER'S ADDRESS 570 W ADAMSVILLE ROAD, FLORENCE, AZ, 85132					

Date Registered: 06/18/2018

Date Issued: 07/06/2018

VS-49 Rev. 12/2017



This is a true certification of the facts on file with the Arizona Department of Health Services, Bureau of Vital Records, PHOENIX, ARIZONA.
Revised 07/2016

Krystal Colburn
KRYSTAL COLBURN
ASSISTANT STATE REGISTRAR



DHS-20-0638-D-000064

This copy not valid unless prepared on a form displaying the State Seal and impressed with the raised seal of the issuing agency.

2020-ICLI-00057-1143

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

 DEPARTMENT OF HOMELAND SECURITY Immigration and Customs Enforcement REPORT OF INVESTIGATION		1. CASE NUMBER (b)(6); (b)(7)(C)
		PREPARED BY (b)(6); (b)(7)(C)
		2. REPORT NUMBER 001
3. TITLE TRAN, Huy Chi/Non-Employee/0109 Detainee/Alien - Death (Known Cause -Terminal Illness)/ELOY, PINAL, AZ		
4. FINAL RESOLUTION		
5. STATUS Initial Report	6. TYPE OF REPORT Other	7. RELATED CASES
8. TOPIC AOIC reports the death of detainee at Eloy Detention Center.		
9. SYNOPSIS On June 12, 2018, the Joint Intake Center (JIC) received information from Enforcement and Removal Operations (ERO) Assistant Officer in Charge (AOIC, (b)(6); (b)(7)(C)) stationed at the Eloy Detention Center in Eloy, AZ reporting the death of detainee Huy Chi TRAN (037959945) earlier on the same date. The preliminary cause of death is cardiac arrest.		
10. CASE OFFICER (Print Name & Title) (b)(6); (b)(7)(C) Joint Intake Specialist	11. COMPLETION DATE 13-JUN-2018	14. ORIGIN OFFICE Joint Intake Center
12. APPROVED BY (Print Name & Title) (b)(6); (b)(7)(C) - ICE-OPR Special Agent Supervisor	13. APPROVED DATE 13-JUN-2018	15. TELEPHONE NUMBER No Phone Number
THIS DOCUMENT IS LOANED TO YOU FOR OFFICIAL USE ONLY AND REMAINS THE PROPERTY OF THE DEPARTMENT OF HOMELAND SECURITY. ANY FURTHER REQUEST FOR DISCLOSURE OF THIS DOCUMENT OR INFORMATION CONTAINED HEREIN SHOULD BE REFERRED TO HEADQUARTERS, DEPARTMENT OF HOMELAND SECURITY, TOGETHER WITH A COPY OF THE DOCUMENT.		
THIS DOCUMENT CONTAINS INFORMATION REGARDING CURRENT AND ON-GOING ACTIVITIES OF A SENSITIVE NATURE. IT IS FOR THE EXCLUSIVE USE OF OFFICIAL U.S. GOVERNMENT AGENCIES AND REMAINS THE PROPERTY OF THE DEPARTMENT OF HOMELAND SECURITY IT CONTAINS NEITHER RECOMMENDATIONS NOR CONCLUSIONS OF THE DEPARTMENT OF HOMELAND SECURITY. DISTRIBUTION OF THIS DOCUMENT HAS BEEN LIMITED AND FURTHER DISSEMINATION OR EXTRACTS FROM THE DOCUMENT MAY NOT BE MADE WITHOUT PRIOR WRITTEN AUTHORIZATION OF THE ORIGINATOR.		

 DEPARTMENT OF HOMELAND SECURITY REPORT OF INVESTIGATION CONTINUATION	1. CASE NUMBER (b)(6); (b)(7)(C)
	PREPARED BY (b)(6); (b)(7)(C)
	2. REPORT NUMBER 001
10. NARRATIVE On June 12, 2018, the JIC received information from ERO AOIC (b)(6); (b)(7)(C) stationed at the Eloy Detention Center in Eloy, AZ reporting the death of detainee Huy Chi TRAN (037959945) earlier on the same date. The preliminary cause of death is cardiac arrest. According to the information received, on Tuesday, June 5, 2018 TRAN went into cardiac arrest. On June 12, 2018 at approximately 0920 hours, TRAN was pronounced dead. Originating documentation is attached to the case file. End of Report.	

 DEPARTMENT OF HOMELAND SECURITY REPORT OF INVESTIGATION Exhibit List	1. CASE NUMBER (b)(6); (b)(7)(C)
	PREPARED BY (b)(6); (b)(7)(C)
	2. REPORT NUMBER 001
None	

JOINT INTAKE CENTER – TELEPHONE WORKSHEET

Reset Form

Date 06/12/2018	Time 1800 Hours	Duty Agent (b)(6); (b)(7)(C)	202-325 (b)(6); (b)(7)(C)
Time Sensitive? ☐ Yes ☐ No		Arrests, assaults (physical/sexual), bribes, death, discharge of weapon, medical, media, serious injuries, suicide, workplace violence, e.g.	

Caller Data			
☐ Anonymous	☐ Detainee	☒ Source	☐ Subject ☐ Victim ☐ Witness
Name (b)(6); (b)(7)(C)		Phone Number 520-46 (b)(6); (b)(7)(C)	
Language Spoken English		City, State Eloy, AZ	
A#		Facility Name Eloy Detention Center	

Information			
☐ Allegation	☐ Management Issue	☒ Detainee Issue	☒ Incident ☐ Other
Briefly Describe (Who/What/Where/When/Why)			
Assistant Officer in Charge (AOIC) (b)(6); (b)(7)(C) alled to report the death of detainee Huy Chi TRAN (037959945). TRAN reportedly went into cardiac arrest last Tuesday, June 5, 2018 and was determined to be brain dead this morning at 0920 hours local time this morning.			
☐ CBP ☒ ERO ☐ HSI ☐ Other			

Action Taken	
☐ JICMS File #	☐ JIC Log #
Referred To	
☐ OIG Duty Agent ☐ OPR Duty Agent ☐ CBP IA Duty ☐ Local ERO ☐ ERO CDH ☐ ERO JIC Email ☐ Other Agency	
Helpful Numbers	
Community and Detainee Helpline (CDH) - (888) 351-4024 (M-F 0800 – 1700) DOJ EOIR - (800) 898-7180 (immigration court dates, status of hearings) CIS NCSC - (800) 375-5283 (M-F 0800 – 1800, Case Status, Benefits, etc) LESC - (855) 448-6903 Detainee locator - www.ice.gov/locator	

SYNOPSIS

On June 12, 2018, Huy Chi TRAN, a forty-seven-year-old citizen of Vietnam, died while in the custody of U.S. Immigration and Customs Enforcement (ICE) at Banner Casa Grande Medical Center (BCGMC) in Casa Grande, Arizona (AZ). The Pinal County Medical Examiner documented TRAN's cause of death as sudden cardiac death¹ due to coronary artery disease.²

TRAN was detained at Eloy Detention Center (EDC),³ in Eloy, AZ, from May 28, 2018, until his death. EDC is owned and operated by CoreCivic, formerly Corrections Corporation of America (CCA), under a Dedicated Intergovernmental Service Agreement (DIGSA). EDC is required to comply with the ICE Performance Based National Detention Standards (PBNDS) 2011, as revised in 2016. Medical care at EDC is provided by the ICE Health Service Corps (IHSC), with support from InGenesis contractors. At the time of TRAN's death, EDC housed approximately 889 male and 470 female detainees for periods in excess of 72 hours.

DETAILS OF REVIEW

From July 17 to 19, 2018, ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited EDC to review the circumstances surrounding TRAN's death. ERAU was assisted in its review by contract subject matter experts (SMEs) in correctional healthcare and security who are employed by Creative Corrections, a national management and consulting firm.⁴ As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to TRAN, in addition to conducting in-person interviews of individuals employed by CoreCivic, IHSC, InGenesis, and the local field office of ICE's Office of Enforcement and Removal Operations (ERO).

During the review, ERAU took note of any deficiencies observed in the detention standards as they relate to the care and custody of the deceased detainee and documented those deficiencies herein for informational purposes only. Their inclusion in this report should not be construed in any way as indicating the deficiencies contributed to the detainee's death. ERAU determined the following timeline of events, from the time TRAN entered ICE custody, through his detention at EDC, and eventual death at BCGMC.

¹ Sudden cardiac death is a sudden, unexpected death caused by loss of heart function.

² See Exhibit 1: Pinal County Forensic Examination Report, dated July 17, 2018; According to the American Heart Association (AHA), coronary artery disease occurs when plaque grows within the walls of the coronary arteries until the blood flow to the heart's muscle is limited.

³ Eloy Detention Center (EDC) is also known as Eloy Federal Contract Facility (EFCF).

⁴ See Exhibit 2: Creative Corrections Healthcare and Security Compliance Analysis.

IMMIGRATION AND CRIMINAL HISTORY⁵

On June 25, 1984, the former U.S. Immigration and Naturalization Service (INS) admitted TRAN into the United States in San Francisco, California, as an immigrant (i.e. child of an immigrant who is the brother or sister of a U.S. citizen).⁶

Between June 6, 1994 and October 25, 2000, the Superior Court of Arizona, Maricopa County, convicted TRAN for multiple crimes, detailed in **Table 1** of this report.

On November 9, 2000, INS Phoenix encountered TRAN at the Arizona Department of Corrections (ADOC), Arizona State Prison Complex (ASPC) Alhambra Reception Center (ARC) in Phoenix, AZ and lodged an Immigration Detainer-Notice of Action (Form I-247) with the facility.⁷

On March 25, 2003, a 287(g) officer encountered TRAN at ARC and issued a Warrant for Arrest of Alien/Notice to Appear (Form I-200).⁸ On March 29, 2003, the ADOC transferred TRAN to ERO Phoenix's custody. On the same date, ERO Phoenix served TRAN a Notice to Appear (Form I-862), charging removability pursuant to Section 237(a)(2)(A)(iii) of the Immigration and Nationality Act (INA), as amended, as an alien at any time after admission, convicted of an aggravated felony as defined in Section 101(a)(43)(F) of the INA, a crime of violence for which the term of imprisonment ordered was at least one year.⁹

On May 15, 2003, an immigration judge (IJ) found all of TRAN's applications for relief to be abandoned and ordered him removed to Vietnam. On the same date, TRAN's undated

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

On June 16, 2003, TRAN filed an appeal with the Board of Immigration Appeals (BIA).¹¹ On October 31, 2003, the BIA remanded the case to the IJ for further proceedings.¹² On December 10, 2003, the IJ found all TRAN's applications for relief to be abandoned and again ordered him removed to Vietnam.¹³ TRAN reserved his right to appeal.

⁵ The listed charges are those for which ERAU was able to determine a disposition from TRAN's records. ERAU was unable to determine a disposition for approximately 17 of TRAN's other arrests and/or offenses, dating from October 1995 to April 2007.

⁶ See DHS Form I-213, Record of Deportable/Inadmissible Alien, dated July 17, 2017.

⁷ See INS Form I-247, Immigration Detainer – Notice of Action, dated November 9, 2000.

⁸ See INS Form I-200, Warrant for Arrest of Alien, dated March 25, 2003.

⁹ See INS Form I-862, Notice to Appear, dated March 29, 2003.

¹⁰ See United States Department of Justice (DOJ) Executive Office for Immigration Review (EOIR) Immigration

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

¹¹ See BIA Inquiry System Case Appeal summary, marked as filed on June 16, 2003.

¹² See DOJ EOIR Decision of the Board of Immigration Appeals, dated October 31, 2003.

¹³ See EOIR U.S. Immigration Court, Eloy, Arizona, Decision and Order of the Immigration Court, dated December 10, 2003.

On January 8, 2004, TRAN filed an appeal with the BIA.¹⁴ On June 14, 2004, the BIA sustained TRAN's appeal and remanded the case back to the IJ for a decision.¹⁵

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

On January 10, 2005, ERO Phoenix determined that no significant likelihood of removal in the reasonably foreseeable future existed and released TRAN from custody on an Order of Supervision (OSUP). TRAN reported to ERO as required four times between January 27, 2005 and April 20, 2005.¹⁷

On July 8, 2005, ERO Phoenix sent TRAN a Call-In Letter (Form G-56), ordering him to present himself at their office on July 28, 2005.¹⁸ On July 28, 2005, TRAN failed to appear at ERO Phoenix as ordered; therefore, his case was referred to the ERO Fugitive Operations Team for location and arrest, with no result.¹⁹

On August 15, 2006, Chandler Police Department in Chandler, AZ arrested TRAN for shoplifting. On August 18, 2006, Chandler Police Department released TRAN into ERO Phoenix custody. ERO Phoenix released TRAN under the original OSUP issued on January 10, 2005, to complete his criminal proceedings.²⁰

Between May 11, 2007 and April 8, 2009, the Superior Court of Arizona, Maricopa County, convicted TRAN for multiple crimes, detailed in **Table 2** of this report.

On August 27, 2008, ERO Phoenix encountered TRAN at the Maricopa County Jail and lodged a Notice of Action-Immigration Detainer (Form I-247A).²¹

On April 13, 2009, ERO Phoenix encountered TRAN at the ASPC ARC and lodged a Form I-247A.²²

On August 14, 2013, ADOC transferred TRAN to ERO Phoenix's custody. ERO Phoenix released TRAN from custody under his original OSUP issued on January 10, 2005, as there was

¹⁴ See BIA Inquiry System Case Appeal summary, marked as filed on January 8, 2004.

¹⁵ See EOIR Decision of the Board of Immigration Appeals, dated June 14, 2004.

¹⁶ See INS Form I-205, Warrant of Removal/Deportation, dated September 21, 2004; see also Form I-294, Warning to Alien Ordered Removed or Deported, dated September 21, 2004.

¹⁷ See INS Form I-220B, Order of Supervision, dated January 10, 2005 and INS Order of Supervision Addendum, dated January 10, 2005; see also ICE Significant Incident Report, dated June 14, 2018.

¹⁸ See ICE Significant Incident Report, dated June 14, 2018.

¹⁹ See ICE Order of Supervision Appointment, Failed to Appear stamp, dated July 28, 2005; see also ICE Significant Incident Report, dated June 14, 2018.

²⁰ There is no record of TRAN reporting to ERO Phoenix after this date.

²¹ See DHS Form I-247A, Immigration Detainer – Notice of Action, dated August 27, 2008.

²² See DHS Form I-247A, Immigration Detainer – Notice of Action, dated April 13, 2009. There is no documentation regarding TRAN's transfer from the Maricopa County Jail to ASPC ARC.

no significant likelihood of removal. TRAN did not appear at ERO Phoenix for his first scheduled appointment on February 12, 2014, or any subsequent scheduled meeting.²³

On March 16, 2015, Chandler Police Department arrested TRAN for Criminal Damage. On August 14, 2015, the Superior Court of Arizona, Maricopa County, sentenced TRAN to 120 days' incarceration and 3 years' probation.

On January 21, 2017, Chandler Police Department arrested TRAN for Disorderly Conduct and Criminal Damage. Also, on this date, ERO Phoenix encountered TRAN at the Maricopa County Sheriff's Office (MCSO) Jail and lodged a Form I-247A. TRAN remained in MCSO custody pending criminal proceedings.

On July 10, 2017, the Superior Court of Arizona, Maricopa County, sentenced TRAN to one year and six months in jail with a credit of 171 days, time served. On July 17, 2017, a 287(g) Designated Immigration Officer encountered TRAN at the ASPC ARC and lodged a Form I-247A.²⁴

On May 25, 2018, ADOC released TRAN to ERO Phoenix's custody. ERO Phoenix served TRAN a Notice of Revocation of Release with the intention of reviewing TRAN's likelihood of removal.²⁵ ERO Phoenix booked TRAN into the TUCSON INS Hold Room in Tucson, AZ, then, later that day, transferred him to the Florence Staging Facility (FSF) in Florence, AZ.²⁶

On May 28, 2018, ERO Phoenix transferred TRAN to EDC in Eloy, AZ, to pursue his removal to Vietnam.²⁷

²³ See ICE Form I-220B, Order of Supervision, dated August 14, 2013; *see also* ICE ENFORCE Alien Removal Module (EARM) system.

²⁴ See DHS Form I-247A, Immigration Detainer – Notice of Action, dated July 17, 2017.

²⁵ See ICE Tucson Field Office Notice of Revocation of Release, dated May 25, 2018; *see also* EARM system, Detention History, dated May 25, 2018.

²⁶ See EARM system, Detention History, dated May 25, 2018.

²⁷ See EARM system, Detention History, dated May 28, 2018.

NARRATIVE

On May 25, 2018, at approximately 7:22 p.m., upon TRAN's arrival at FSF, Licensed Vocational Nurse (LVN) (b)(6); (b)(7)(C) conducted a medical pre-screening and documented the following:²⁸

- TRAN spoke English fluently.
- TRAN's appearance, behavior, and breathing were normal.
- TRAN's state of consciousness was alert and there were no noticeable restrictions or difficulties of movement.
- TRAN arrived with haloperidol²⁹ (5 mg) and fluoxetine³⁰ (20 mg), both prescribed for morning dosing and self-dosed at the gate.³¹
- TRAN's pre-screening assessment was normal and his pre-screening disposition identified him as having time sensitive medical conditions needing immediate care, pursuant to IHSC policy.³²

On May 26, 2018, at 4:48 a.m., Registered Nurse (RN) (b)(6); (b)(7)(C) signed off on TRAN's intake screening³³ and documented the following:

- TRAN's vital signs (VS) were within normal limits.³⁴
- TRAN acknowledged receiving treatment for depression for the past 20 years but denied suicidal and homicidal thoughts or a history of experiencing hallucinations.
- TRAN denied the use of drugs, alcohol, and tobacco.
- TRAN denied dental issues.
- TRAN's tuberculosis (TB) screening was negative.³⁵

²⁸ See eClinicalWorks (eCW) Pre-Screen by (b)(6); (b)(7)(C) dated May 25, 2018. ERAU approximated timing of medical events as best as possible. Medical times catalogued within the report are prioritized based on the time medical staff indicated a round time, VS, or electronically signed their note.

²⁹ Haloperidol, a generic for Haldol, is an antipsychotic medication used to treat certain types of mental disorders such as schizophrenia.

³⁰ Fluoxetine, a generic for Prozac, is a selective serotonin reuptake inhibitor that treats depression, obsessive-compulsive disorder, and panic disorders.

³¹ Due to the short amount of time TRAN was housed at the TUCSON INS Hold Room and the lack of medical documentation provided, ERAU was unable to confirm if he received any medications prior to May 26, 2018.

³² See IHSC Policy 03-08, Section 4-3 (a), dated January 19, 2015. Priority one detainees (PRI-1) are those identified with time-sensitive medical conditions needing immediate care, including but not limited to unconsciousness, altered level of consciousness, severely intoxicated or under the influence of drugs, medically or mentally unstable, suicidal/homicidal, and infectious/contagious.

³³ See eCW Initial Intake Assessment by RN (b)(6); (b)(7)(C) dated May 26, 2018.

³⁴ Normal temperature is 98.6; normal range for pulse is 60 to 100 beats per minute; normal range for respirations is 12 to 20 breaths per minute; and, normal blood pressure is 120/80 or less.

³⁵ TB is a potentially serious infectious bacterial disease that mainly affects the lungs. Symptoms of active TB include persistent coughing, coughing up blood, chest pain, unintentional weight loss, fatigue, fever, night sweats, chills and loss of appetite.

- (b)(6); (b)(7)(C) conducted an Abnormal Involuntary Movement Scale (AIMS)³⁶ and noted a score of zero.

(b)(6); (b)(7)(C) documented TRAN's intake screening as abnormal, referred him to a medical provider and noted she scheduled a physical exam.³⁷ (b)(6); (b)(7)(C) received an order per IHSC Command (b)(6); (b)(7)(C) Physician's Assistant (PA), to continue TRAN's medications for three days.³⁸ (b)(6); (b)(7)(C) scheduled TRAN for a mental health appointment for May 29, 2018, and medically cleared TRAN for custody.

At 2:46 p.m., Licensed Clinical Social Worker (LCSW) (b)(6); (b)(7)(C) signed off on TRAN's mental health follow-up assessment³⁹ and documented the following:

- TRAN reported a history of depression and treatment over the last 20 years.
- TRAN stated that before taking his medications, he heard voices and saw things other people did not but denied any current hallucinations.
- TRAN's appearance was bizarre, he was poorly groomed, his affect flat,⁴⁰ and he exhibited lethargic psychomotor activity.⁴¹

LCSW (b)(6); (b)(7)(C) diagnosed TRAN with schizophrenia,⁴² unspecified, and noted that TRAN would continue to take medications as prescribed.⁴³ TRAN received his medications as prescribed while at FSF.⁴⁴ LCSW (b)(6); (b)(7)(C) had a follow-up with TRAN on June 2, 2018.⁴⁵

On May 28, 2018, at 8:14 a.m., RN (b)(6); (b)(7)(C) signed TRAN's medical transfer summary and documented the following:⁴⁶

- TRAN's TB symptom screening was negative.

³⁶ The AIMS assess the occurrence of tardive dyskinesia (TD), a side effect of taking antipsychotic medication. Initial AIMS results may serve as a baseline for future monitoring or may prompt ordering of medication to address symptoms of the disorder. A score of zero indicates no occurrence of TD observed. Therefore, due to TRAN being on antipsychotic drugs, the RN conducted the AIMS assessment.

³⁷ There was no date noted for the physical exam and ERO transferred TRAN to EDC two days later.

³⁸ See eCW Initial Intake Assessment by (b)(6); (b)(7)(C), dated May 26, 2018. There were no additional details in the medical file regarding the date the order was completed.

³⁹ See eCW Follow-Up Mental Health Appointment by LCSW (b)(6); (b)(7)(C), dated May 26, 2018.

⁴⁰ A lack of emotional expressiveness.

⁴¹ Psychomotor activity are skills where movement and thinking are combined. This includes balance and coordination.

⁴² Schizophrenia is a serious mental disorder in which a person interprets reality abnormally, to include hallucinations, delusions, and extremely disordered thinking and behavior.

⁴³ See Florence Medical Administration Record (MAR).

⁴⁴ See eCW Follow-Up Mental Health Appointment by LCSW (b)(6); (b)(7)(C), dated May 26, 2018.

⁴⁵ ERAU could not confirm that medical scheduled the referenced follow-up appointment for June 2, 2018. ERAU notes ERO transferred TRAN to EDC the following day; while detained at EDC, medical staff completed mental health assessments, which are discussed herein.

⁴⁶ See eCW Transfer Summary by RN (b)(6); (b)(7)(C), dated May 28, 2018.

- (b)(6); (b)(7)(C) noted a diagnosis of schizophrenia and that TRAN arrived to FSF with the medications: haloperidol (5 mg) and fluoxetine (20 mg).
- (b)(6); (b)(7)(C) requested the receiving facility follow-up with TRAN regarding his medication.
- (b)(6); (b)(7)(C) medically cleared TRAN for travel and transfer to EDC.

At 9:26 a.m., TRAN arrived at EDC and was encountered by ICE ERO Deportation Officer (DO) (b)(6); (b)(7)(C) who was assigned to intake on this date.⁴⁷ DO (b)(6); (b)(7)(C) described TRAN as soaking wet from sweat and asked TRAN if he was okay but received no response.⁴⁸ DO (b)(6); (b)(7)(C) stated he asked the driver of the van and another detainee if the air conditioning had been on and working in the transport vehicle, to which they both replied yes. DO (b)(6); (b)(7)(C) then alerted his supervisor, Supervisory Detention and Deportation Officer (SDDO) (b)(6); (b)(7)(C), regarding his observations of TRAN.

At 9:28 a.m.,⁴⁹ SDDO (b)(6); (b)(7)(C) directed TRAN to the front of the medical pre-screening line due to his abnormal perspiration.⁵⁰ (b)(6); (b)(7)(C) conducted TRAN's pre-screening at this time and documented the following:⁵¹

- TRAN spoke English fluently.
- TRAN was alert and breathing normally but his appearance was anxious.
- TRAN denied pain or wanting to harm himself.
- RN Wilson observed no skin abnormalities, no noticeable restrictions or difficulties with movement.
- TRAN stated he was currently taking medication for a health issue.
- A medical transfer summary accompanied TRAN from FSF.

Although (b)(6); (b)(7)(C) did not make note of the sweating that (b)(6); (b)(7)(C) and SDDO (b)(6); (b)(7)(C) observed, she marked his pre-screening disposition as PRI-1.

At approximately 10:43 a.m., (b)(6); (b)(7)(C) conducted a medical intake assessment and, among other items, documented the following:⁵²

- TRAN's VS were within normal limits.
- TRAN denied experiencing any current pain.
- TRAN denied dental issues.
- TRAN denied a history of suicide attempts or current suicidal ideations.

⁴⁷ See Video Surveillance, North Intake, Rear Exterior, dated May 28, 2018.

⁴⁸ ERAU interview with ICE (b)(6); (b)(7)(C) dated July 18, 2018.

⁴⁹ See Video Surveillance, North Intake, Rear Sallyport, dated May 28, 2018.

⁵⁰ ERAU interview with ICE SDDO (b)(6); (b)(7)(C), dated July 17, 2018.

⁵¹ See eCW Pre-Screen by (b)(6); (b)(7)(C) dated May 28, 2018. (b)(6); (b)(7)(C) noted the time of arrival as 9:25 a.m.; however, video surveillance confirms R (b)(6); (b)(7)(C) encountered TRAN at 9:28 a.m.

⁵² See eCW Intake Appointment by (b)(6); (b)(7)(C) dated May 28, 2018. (b)(6); (b)(7)(C) noted she conducted an abbreviated intake screening as FSF completed a full intake screening on May 26, 2018.

- TRAN arrived with haloperidol (5 mg) and fluoxetine (20 mg) and reported last taking the medication the afternoon of May 27, 2018.⁵³
- (b)(6); (b)(7)(C) planted a purified protein derivative (PPD) skin test.⁵⁴

(b)(6); (b)(7)(C) documented TRAN's intake screening as abnormal, referred him to a provider, and noted a physical exam was scheduled.⁵⁵ TRAN signed the IHSC Medical Consent Form, and (b)(6); (b)(7)(C) medically cleared TRAN for custody.⁵⁶

At approximately 10:48 a.m., Correctional Officer (b)(6); (b)(7)(C) booked TRAN into EDC.⁵⁷ TRAN acknowledged receipt of the ICE National Detainee Handbook,⁵⁸ facility-issued⁵⁹ property and allowable personal property.⁶⁰ Officer (b)(6); (b)(7)(C) inventoried two checks totaling \$25.60 and deposited them into TRAN's commissary account.⁶¹ Officer (b)(6); (b)(7)(C) recalled that TRAN appeared slow, drooled, had snot coming out of his nose, and did not clean himself after sneezing or coughing.⁶²

Case Manager (CM) (b)(6); (b)(7)(C) completed TRAN's initial custody classification and appropriately classified him as high. (b)(6); (b)(7)(C) signed the form as both the classification officer and supervisor and did not seek out supervisory approval and signature. When asked why she did not have a supervisor review her work, (b)(6); (b)(7)(C) stated that the classification supervisor position was vacant at the time and since ICE designated TRAN as a high custody detainee, which she recommended adopting, it did not matter.⁶⁴

(b)(6); (b)(7)(C) also completed the Sexual Abuse Screening Tool form and within the Staff Observation/File Review section, circled "Yes" for "Detainee appears to be physically, developmentally, or mentally disabled." Furthermore, in the comments section, she wrote TRAN was, "slow, drools, sneezes boogers and spits/coughs."⁶⁵ (b)(6); (b)(7)(C) added she had to

⁵³ ERAU notes although TRAN states he received his medication the afternoon of May 27, 2018, the MAR at FSF shows he received both medications at 11:00 a.m.

⁵⁴ A purified protein derivative skin test is a solution is injected into the skin to determine whether a person has been infected with tuberculosis.

⁵⁵ Although (b)(6); (b)(7)(C) did not include a date for the physical exam within her note, a provider completed TRAN's physical exam the same day.

⁵⁶ See ICE Health Service Corps (IHSC) Medical Consent Form, dated May 28, 2018. Although TRAN's name was written in the Spanish language section of the form, it was confirmed by ICE and CoreCivic staff that he spoke English fluently.

⁵⁷ See Intake Surveillance Video, dated May 28, 2018.

⁵⁸ See Detainee Handbook Receipt, dated May 28, 2018.

⁵⁹ See Facility Issued Property Receipt, dated May 28, 2018.

⁶⁰ See Allowable Personal Property Inventory/Receipt, dated May 28, 2019.

⁶¹ See Transaction Receipts 9670302 and 9670303, dated May 28, 2018.

⁶² ERAU interview with Officer (b)(6); (b)(7)(C), dated July 17, 2018.

⁶³ See Exhibit 3: Initial Custody Classification Form 18-1B, dated May 28, 2018. (b)(6); (b)(7)(C) stated that although TRAN's initial classification scored at a medium custody level, because the ICE Risk Classification Assessment recommended a high custody classification level, she recommended overriding her own custody level score. She clarified that EDC always uses the custody classification level ICE recommends.

⁶⁴ ERAU interview with (b)(6); (b)(7)(C) dated July 19, 2018.

⁶⁵ See CCA Sexual Abuse Screening Tool, Form 14-2B-DHS/FRS, dated May 28, 2018. ERAU notes RN (b)(6); (b)(7)(C)'s intake screening entry makes no reference to the conditions observed by (b)(6); (b)(7)(C).

ask TRAN questions two or three times before he would reply.⁶⁶ When (b)(6); (b)(7)(C) as asked about medical receiving the information from the Sexual Abuse Screening Tool form, she stated she was unsure how it was routed to medical or mental health staff. She added that because health care professionals evaluate detainees, she assumed they would identify any special needs. The form distribution designates a copy should be forwarded to classification staff and the Health Services Department for further evaluation and screening.⁶⁷

At approximately 12:46 p.m., Nurse Practitioner (NP) (b)(6); (b)(7)(C) conducted TRAN's initial physical examination and documented, among other details, the following information:⁶⁹

- TRAN's VS were within normal limits.
- TRAN reported a 17-year history of schizophrenia and anxiety disorder⁷⁰ for which he was taking Haldol⁷¹ and fluoxetine, with no adverse side effects.
- (b)(6); (b)(7)(C) completed an AIMS assessment, which resulted in a score of zero.⁷²
- TRAN denied drug use but stated he smoked one pack of cigarettes per day for 13 years with his last use over a month prior and drank two alcoholic drinks per week with last use one to two years ago.
- TRAN denied experiencing chest pain with exertion, shortness of breath, irregular heartbeat, palpitations, weakness, loss of appetite, or weight gain.
- TRAN's dental examination showed no lower teeth or upper teeth, and no dental prosthesis.⁷³
- TRAN's demeanor was appropriate for the encounter, his cognitive function appeared intact, his judgment and insight were good, and his thought process was logical and goal directed without suicidal ideation or delusions.
- (b)(6); (b)(7)(C) prescribed haloperidol (5 mg), and fluoxetine (20 mg) each morning for two weeks, pending psychiatric evaluation.⁷⁴

⁶⁶ ERAU Interview with (b)(6); (b)(7)(C) dated July 19, 2018.

⁶⁷ ERAU notes although this is not a deficiency (b)(6); (b)(7)(C) did not route the form to medical in accordance with the instructions; therefore, medical never received the form.

⁶⁸ (b)(6); (b)(7)(C) employment at EDC ended prior to ERAU's site visit; therefore, the ERAU was unable to interview her.

⁶⁹ See eCW Initial PE-C Appointment by (b)(6); (b)(7)(C) dated May 28, 2018. (b)(6); (b)(7)(C) entered TRAN's VS for the PE-C at 11:46 a.m.

⁷⁰ Anxiety disorder is a medical condition that includes symptoms of intense anxiety or panic that are directly caused by a physical health problem.

(b)(6); (b)(7)(C) is a brand name for haloperidol.

⁷² During ERAU interview with (b)(6); (b)(7)(C) psychiatrist, dated June 19, 2018, he stated only properly trained healthcare professionals should administer an AIMS test. There was no documentation of AIMS training in (b)(6); (b)(7)(C) record; however, she may have been trained in its administration as part of her education.

⁷³ A dental prosthesis is device such as dentures used to restore or reconstruct defects in the mouth such as missing teeth, missing parts of teeth, and missing soft or hard structures of the jaw and palate. ERAU notes no other medical documentation listed issues with TRAN's teeth or the mouth. Furthermore, although (b)(6); (b)(7)(C) documented the dental issues, she did not order a soft diet for TRAN.

⁷⁴ (b)(6); (b)(7)(C) called and discussed these medications with (b)(6); (b)(7)(C) an IHSC Psychiatrist assigned to the Krome North Service Processing Center in Miami, Florida, but she did not document discussion of the potential side effects of these medications with TRAN, nor did she obtain his consent to take them. As discussed later in the report, EDC medical staff did not obtain TRAN's consent to psychotropic medication until June 4, 2018.

(b)(6); (b)(7)(C) ordered lab studies for completion on May 31, 2018,⁷⁵ which included thyroid studies,⁷⁶ lipid panel,⁷⁷ comprehensive metabolic panel (CMP),⁷⁸ complete blood count (CBC) with differential,⁷⁹ platelet count,⁸⁰ and hemoglobin A1c.⁸¹ Due to TRAN's mental health history, (b)(6); (b)(7)(C) documented TRAN's physical exam as abnormal and referred him to a mental health provider.

At 11:49 a.m., security staff initially assigned TRAN to housing unit Delta 100, cell 125, an upper tier and bunk;⁸² however, TRAN's cellmate⁸³ told Correctional Officer (b)(6); (b)(7)(C) assigned to the unit on this date, that TRAN was unable to climb to the top bunk and needed to be moved.⁸⁴ (b)(6); (b)(7)(C) stated he contacted the Unit Counselor (name unknown), who told him they could not move TRAN at that time because it was cell count and there would be no manager available to sign off on the move. (b)(6); (b)(7)(C) recalled moving TRAN's mattress to the cell floor until they could assign him to a low bunk on a lower tier. (b)(6); (b)(7)(C) mentioned TRAN would not make eye contact with him during their interaction.

At 6:54 p.m., CoreCivic staff moved TRAN to a low bunk in cell 103 located on the lower level of the Delta 100 housing unit.⁸⁵ TRAN's cellmate stated that TRAN never mentioned feeling sick to him, but he did observe TRAN walking slowly and taking him a long time to get up from his bunk.⁸⁶ The cellmate also added he had to wake TRAN for breakfast and lunch every day and would observe him falling asleep in the dayroom while watching TV.

On May 30, 2018, during morning pill call, medical staff administered TRAN the doses of haloperidol and fluoxetine,⁸⁷ more than two days after he reported taking his last doses.⁸⁸

At 3:00 p.m., R (b)(6); (b)(7)(C) read TRAN's PPD test as negative.⁸⁹

⁷⁵ See Lab Order, dated May 31, 2018.

⁷⁶ Thyroid studies are a series of blood tests used to measure how well the thyroid gland is working to produce major hormones.

⁷⁷ Lipid panel is a panel of blood tests which serve as initial screening for abnormalities in cholesterol and triglycerides.

⁷⁸ A CMP is a blood test that gives doctors information about the body's fluid balance, levels of electrolytes, and how well the kidneys and liver are working.

⁷⁹ CBC with differential is a blood test that gives doctors information about the cells in a patient's blood and the concentration of various proteins and minerals.

⁸⁰ Platelet count is a blood test which measures the number of blood-clotting cells.

⁸¹ Hemoglobin A1c is a blood test that provides a three-month average of glucose concentration in the blood.

⁸² See EDC Inmate Housing History with Cellmates for Huy TRAN, dated June 13, 2018.

⁸³ ERAU was unable to interview TRAN's first cellmate, as ICE released him on June 8, 2018, according to ICE's ENFORCE Alien Removal Module (EARM) system.

⁸⁴ ERAU interview with Officer (b)(6); (b)(7)(C) dated July 17, 2018.

⁸⁵ See EDC Inmate Housing History with Cellmates for Huy TRAN, dated June 13, 2018; *see also* ERAU interview with (b)(6); (b)(7)(C), dated July 17, 2018.

⁸⁶ ERAU Interview with TRAN's cellmate, dated July 19, 2018. TRAN's cellmate remained his cellmate until the day of his medical emergency.

⁸⁷ Because NP (b)(6); (b)(7)(C) did not sign her initial PE-C assessment note until 5:50 p.m., it delayed the pharmacy's receipt of TRAN's medication order, which generally closed at 4:30 p.m. (b)(6); (b)(7)(C) did not document whether she intended for medical staff to administer medication from the intake supply pending fulfillment by the pharmacy.

⁸⁸ See Exhibit 4: EDC Medical Administration Record (MAR) for Huy Chi Tran, dated May 2018.

⁸⁹ See eCW Progress Note by (b)(6); (b)(7)(C) dated May 30, 2018.

On May 31, 2018, at 1:57 a.m., CoreCivic staff escorted TRAN to medical for lab work.⁹⁰

At some point during his shift, (b)(6); (b)(7)(C) instructed TRAN to empty his property box so he could replace the lock. (b)(6); (b)(7)(C) recalled TRAN sat on his bunk and stared at him, unable to empty the box which only contained a pair of socks and underwear. (b)(6); (b)(7)(C) recalled TRAN walked like a “zombie” as if he was “sleepwalking.”

On June 1, 2018, medical staff received the results of TRAN’s laboratory tests. The results were all within normal limits, except for elevated calcium, sodium, and Thyroxine (T4).⁹²

On June 4, 2018, at 2:58 p.m. (b)(6); (b)(7)(C), psychiatrist, conducted TRAN’s mental health exam and documented the following:⁹³

- TRAN was alert, awake and oriented to time, place, and person.
- TRAN denied an increased sense of embarrassment, depressed mood, feelings of hopelessness or helplessness, and suicidal ideations.
- TRAN reported that although his auditory hallucinations started at age 20, he did not start medical treatment until two years ago. TRAN stated the voices would tell him to do things. TRAN also reported that he experienced visual hallucinations in the past and believed others could insert thoughts in his mind. TRAN added that since taking Haldol, it had been more than a year since he experienced visual or auditory hallucinations.
- TRAN denied thought broadcasting⁹⁴ or withdrawal and described his anxiety as restlessness and being uncomfortable around people.
- TRAN reported receiving outpatient treatment at Southwest Network in Chandler, AZ from 2013 to 2017 and treatment while in prison from 2017 to 2018.
- TRAN stated he did not take his medication for three months prior to an incident involving threats he made against his sister with a knife.
- TRAN reported last consuming alcohol two years ago, two cans per weekend, but denied illicit drug abuse. He admitted to smoking one pack of cigarettes a day for the past 13 years.
- (b)(6); (b)(7)(C) described TRAN as cooperative, tremulous, and showing mild psychomotor retardation.⁹⁵ TRAN demonstrated minimal arm swinging while walking and an intense, sustained stare.

⁹⁰ See TSH+Free T4, Lipid Panel, Comprehensive Metabolic Panel, and CBC With Differential Platelet Lab collection reports, dated May 31, 2018; see also CoreCivic Incident Investigation Report, Milestone video surveillance timeline, dated June 19, 2018.

⁹¹ On this date (b)(6); (b)(7)(C) worked the 6:00 a.m. to 2:00 p.m. shift.

⁹² See Laboratory Results, dated June 1, 2018. Elevation in sodium and calcium levels may result from dehydration. A T4 test is a blood test that identifies thyroid issues.

⁹³ See eCW Progress Note by (b)(6); (b)(7)(C) dated June 4, 2018. (b)(6); (b)(7)(C) did not sign the progress note until 4:57 p.m.

⁹⁴ Thought broadcasting is the belief others can hear or are aware of an individual’s thoughts.

⁹⁵ Psychomotor retardation refers to a slowing down of thoughts and a reduction of physical movements in an individual.

- TRAN's speech showed prolonged latent response periods, and his thought process was slow and impoverished.⁹⁶
- TRAN's mood was euthymic⁹⁷ and his affect blunt.
- TRAN was a poor historian, with inconsistencies in his reports of mental illness and medication treatment.

(b)(6); (b)(7)(C) completed an AIMS assessment and noted an overall score of three.⁹⁸ The assessment findings were schizophrenia and anxiety disorder, both unspecified. (b)(6); (b)(7)(C) continued TRAN on his prescribed medications; however, he rewrote the prescription administration times from morning to noon for fluoxetine and night for haloperidol. Dr. (b)(6); (b)(7)(C) explained that staff wake detainees around 4:00 a.m. if they receive morning doses of medication, and he felt it was necessary for TRAN to have uninterrupted sleep.⁹⁹ (b)(6); (b)(7)(C) documented that he discussed the risks, benefits, and alternatives to Haldol and fluoxetine with TRAN.¹⁰⁰ In his notes, (b)(6); (b)(7)(C) documented that TRAN exhibited extrapyramidal symptoms (EPS),¹⁰¹ which a Cogentin¹⁰² trial could address.¹⁰³ TRAN signed a consent form for haloperidol, fluoxetine, and Cogentin.¹⁰⁴

(b)(6); (b)(7)(C) directed medical staff to obtain TRAN's records from the ADOC and Southwest Network outpatient clinic.¹⁰⁵ (b)(6); (b)(7)(C) scheduled a psychiatric follow-up appointment for July 2, 2018.¹⁰⁶

On this date (time unknown), Delta 100 Unit Manager (UM) (b)(6); (b)(7)(C) submitted a Request for Mental Health Review which described TRAN as seeming distraught, eating very slowly, and not responding to unit staff when offered help.¹⁰⁷ (b)(6); (b)(7)(C) recalled TRAN caught her attention the day prior when he was taking a long time to eat a meal.¹⁰⁸ (b)(6); (b)(7)(C) stated Assistant Shift Supervisor (b)(6); (b)(7)(C) offered TRAN the opportunity to take his meal tray

⁹⁶ According to (b)(6); (b)(7)(C), impoverished responses were short, usually yes or no, without elaboration; ERAU interview with (b)(6); (b)(7)(C) dated July 19, 2018.

⁹⁷ Euthymic refers to a tranquil mood.

⁹⁸ According to the Encyclopedia of Mental Disorders, items on the AIMS test are rated on a scale severity from zero to four with a rating of one as minimal severity. (b)(6); (b)(7)(C) documented an overall score of three, but he applied level one scores for four symptoms; therefore, the correct overall score was four.

⁹⁹ ERAU interview with (b)(6); (b)(7)(C) dated July 19, 2018.

¹⁰⁰ See eCW Progress Note, by (b)(6); (b)(7)(C) dated June 4, 2018. (b)(6); (b)(7)(C) listed the risks associated with taking the prescribed medications as followed: fluoxetine as dry mouth, headaches, increased agitation/anxiety and nausea; Haldol as dry mouth, headaches, TD, malignant syndrome, sexual psychosis, depression, anxiety, irritability, homicidally, suicidality, and EPS.

¹⁰¹ EPS are drug-induced movement disorders which include acute and tardive symptoms.

¹⁰² Cogentin is the brand name for benztropine, a drug used to treat symptoms of Parkinson's disease and the side effects of other drugs.

¹⁰³ Although (b)(6); (b)(7)(C) documented that he would start TRAN on Cogentin to treat EPS, he did not write the order; he stated this was an oversight; ERAU interview with (b)(6); (b)(7)(C) dated July 19, 2018.

¹⁰⁴ See Exhibit 5: ICE Health Service Corps Consent for Psychotropic Medications for Adults, dated June 4, 2018.

¹⁰⁵ See eCW Progress Note, by (b)(6); (b)(7)(C) dated June 4, 2018. Medical staff did not receive the requested records until after TRAN's death.

¹⁰⁶ See eCW Pending Appointment, dated June 7, 2018.

¹⁰⁷ See Request for Mental Health Review form, dated June 4, 2018.

¹⁰⁸ ERAU interview with (b)(6); (b)(7)(C), dated July 18, 2018.

back to his housing unit, so he did not have to rush eating; however, TRAN declined and left with the other detainees. (b)(6); (b)(7)(C) stated she was concerned other detainees would bully him and that he walked like a zombie. (b)(6); (b)(7)(C) stated she delivered the mental health referral to an officer in medical herself because she considered it a priority.

On June 5, 2018, TRAN received morning doses of fluoxetine and haloperidol. Although Dr. (b)(6); (b)(7)(C) submitted an order to change the time of TRAN's medication the day prior, the pharmacy received the change request after it had closed.¹⁰⁹ Therefore, the pharmacy did not process the new medication orders until they opened that morning, which was after morning pill call. At noon pill call, TRAN received a second dose of fluoxetine per the order change.¹¹⁰

Also, on the morning of June 5, 2018, (b)(6); (b)(7)(C) followed-up on her mental health referral from the previous day during an EDC special needs meeting, which generally occurs every Tuesday morning.¹¹¹ She recalled during the meeting that (b)(6); (b)(7)(C) psychologist, said she was uncertain if she had received the referral but that medical would check.

At approximately 12:31 p.m. (b)(6); (b)(7)(C) conducted a mental health follow-up pursuant to (b)(6); (b)(7)(C)'s mental health review request and documented the following:¹¹³

- TRAN presented as depressed and apathetic. He exhibited flat affect with alogia.¹¹⁴
- TRAN was lethargic, moved extremely slow, and exhibited stilted movements.¹¹⁵ TRAN acknowledged that he had been moving more slowly overall in the last few weeks.
- TRAN made inconsistent eye contact and stared off into space while seeming disengaged.
- TRAN was soft spoken and hesitant in his responses.
- TRAN got out of his seat twice during the session, and when asked if he was alright, said he needed to move, without further explanation. (b)(6); (b)(7)(C) encouraged TRAN to step out into the hallway for a moment to briefly walk around.
- TRAN was sweating on his forehead, and his hands appeared to be shaking towards the end of the session.
- TRAN initially denied symptoms of depression; however, after (b)(6); (b)(7)(C) pointed out that his presentation was inconsistent with his self-report, he acknowledged experiencing some depression.

¹⁰⁹ Command (b)(6); (b)(7)(C) Chief Pharmacist, stated pharmacy hours are 8:00 a.m. to 4:30 p.m. and can extend to 6:00 p.m. ERAU could not confirm if the pharmacy hours were extended on June 4, 2018. ERAU interview with Commander (b)(6); (b)(7)(C) dated July 18, 2018.

¹¹⁰ See Medication Administration Record, dated June 5, 2018.

¹¹¹ ERAU interview with (b)(6); (b)(7)(C) dated July 18, 2018. ERO personnel, healthcare staff, unit managers, and security supervisors generally attend the meeting the weekly EDC special needs meeting.

¹¹² See Video Surveillance Footage, Medical South Hallway, dated June 5, 2018.

¹¹³ See eCW Mental Health Referral Follow-up Appointment, by (b)(6); (b)(7)(C) dated June 5, 2018. ERAU notes no VS were taken during this encounter; although not required per policy, Creative Corrections advised VS are a key function in the early detection of a life-threatening issue.

¹¹⁴ Alogia is a general lack of additional, unprompted content seen in normal speech.

¹¹⁵ Stilted movements refer to stiff or rigid movements, as if they are walking on stilts.

- TRAN denied past and current auditory or visual hallucinations.¹¹⁶
- TRAN stated that he had been consistently taking his psychotropic medication.
- TRAN reported attending recreation but said that he spent his time sitting. He stated that he talked to other detainees in his pod but also acknowledged that he had difficulty conversing with others, as he had felt nervous for the past several weeks. He was unable to clarify why he felt nervous.
- TRAN denied thoughts of self-harm, plan and intent.
- TRAN exhibited longer pauses between responses toward the end of the session and appeared somewhat distracted. At one point, TRAN asked wh (b)(6); (b)(7)(C) was asking the questions she was asking.
- TRAN was cooperative overall, though he ultimately said that he did not want to continue talking.

Based on her assessment (b)(6); (b)(7)(C) ordered TRAN's placement on mental health observation from June 5 to June 7, 2018 and completed a Special Needs Form directing nursing checks twice daily and welfare checks by security staff every 15 minutes.¹¹⁷ (b)(6); (b)(7)(C) marked the form as priority and scheduled a mental health follow-up appointment for June 7, 2018.¹¹⁸ (b)(6); (b)(7)(C) stated she determined TRAN should be placed in Bravo 600 because it was a more restricted environment; therefore, he could be more closely monitored.¹¹⁹

In response to (b)(6); (b)(7)(C) order, (b)(6); (b)(7)(C) provided medical clearance for TRAN's placement in administrative segregation for mental health observation.¹²⁰ (b)(6); (b)(7)(C) stated she only conducted a review of TRAN's record and did not assess him in person or input a medical clearance assessment in TRAN's medical record. Captain (b)(6); (b)(7)(C) Services Administrator (HSA), confirmed that medical should assess detainees in-person before medically clearing them for segregation.¹²¹

At 1:35 p.m., Capt (b)(6); (b)(7)(C) approved the segregation order.¹²²

At 2:49 p.m., Sergeant (b)(6); (b)(7)(C) escorted TRAN to the Bravo 600 Unit.¹²³ Sergeant (b)(6); (b)(7)(C) recalled that upon arrival to escort TRAN, the medical officer informed him TRAN was anxious.¹²⁴ Sergeant (b)(6); (b)(7)(C) stated TRAN would repeatedly stand up and ask if he could

¹¹⁶ ERAU notes this is inconsistent with TRAN's initial intake at FSF on May 26, 2018, during which he reported experiencing auditory and visual hallucinations prior to taking his psychotropic medication.

¹¹⁷ See ICE Special Needs Form for Huy Chi Tran, dated June 5, 2018 (b)(6); (b)(7)(C) informed the ERAU review team she handed the form to medical staff.

¹¹⁸ See eCW Mental Health Follow-up Appointment, scheduled for June 7, 2018.

¹¹⁹ ERAU interview with D (b)(6); (b)(7)(C) dated July 18, 2018.

¹²⁰ See Exhibit 6: Confinement Record Form, dated June 5, 2018. ERAU notes (b)(6); (b)(7)(C) did not input a medical clearance assessment into TRAN's medical record; she only documented the clearance on the Confinement Record Form placed in the detention file.

¹²¹ ERAU's second interview with (b)(6); (b)(7)(C) July 19, 2018.

¹²² See Exhibit 6: Confinement Record Form, dated June 5, 2018.

¹²³ See Surveillance Video, Medical South Hallway, dated June 5, 2018.

¹²⁴ ERAU interview with CoreCivic Sergeant (b)(6); (b)(7)(C) July 18, 2018.

leave. Sergeant (b)(6); (b)(7)(C) formed TRAN they were moving him to another unit so medical could keep a closer eye on him.

Unless otherwise noted, the following movements are based on both the CoreCivic Report completed by the Facility Investigator and EDC Milestone video surveillance footage.¹²⁵

At 2:54 p.m., TRAN arrived to Bravo 600 with Sergeant (b)(6); (b)(7)(C)

At 2:56 p.m., Correctional Officer (b)(6); (b)(7)(C) escorted TRAN to cell 606; Correctional Officer (b)(6); (b)(7)(C) was also assigned to Bravo 600 on this date, specifically to conduct constant watch on the detainee on suicide watch in cell 605, next door.

At 3:00 p.m., (b)(6); (b)(7)(C) entered TRAN's cell with a bag of linens and exited 35 seconds later.¹²⁶ From the time (b)(6); (b)(7)(C) placed TRAN in his cell and the medical emergency logged at 4:15 p.m., (b)(6); (b)(7)(C) documented he conducted welfare checks on TRAN at 3:09 p.m., 3:23 p.m., and 3:38 p.m.; however, video surveillance shows that from 3:00 p.m. to 3:47 p.m., Officer (b)(6); (b)(7)(C) is in the vicinity, or walked past TRAN's cell, on five separate occasions but never looked in to determine TRAN's welfare.¹²⁷ (b)(6); (b)(7)(C) confirmed he received TRAN's Special Needs Form and was aware he was to check on TRAN every 15 minutes.¹²⁸ When the Facility Investigator asked (b)(6); (b)(7)(C) about the discrepancies between his log entries and the video evidence, he stated the times may have been off because he does not make entries right away.¹²⁹ (b)(6); (b)(7)(C) claimed that he had looked into TRAN's cell as he walked by and every time TRAN was moving and breathing. (b)(6); (b)(7)(C) claimed TRAN was sitting on the edge of his bed for the first two documented security checks and, on the next check, was lying on his stomach with his arms tense and one leg elevated.

At 3:45 p.m., (b)(6); (b)(7)(C) placed an orange card¹³⁰ on TRAN's cell door but does not look in.

At 3:47 p.m., (b)(6); (b)(7)(C) placed an orange card on the cell door next to TRAN's cell and spoke to (b)(6); (b)(7)(C)

¹²⁵ See CoreCivic Investigation and Timeline, dated June 18, 2018; see also EDC Milestone video surveillance footage, dated June 5, 2018.

¹²⁶ See Surveillance Video, Bravo 600 East, dated June 5, 2018. During EDC Facility Investigator (b)(6); (b)(7)(C) interview with (b)(6); (b)(7)(C) he stated he entered TRAN's cell with bedding, but TRAN did not say a word and seemed to be shaking a little.

¹²⁷ Id; see also Exhibit 7: Confinement Watch Log, dated June 5, 2018.

¹²⁸ ERAU interview with EDC Investigator (b)(6); (b)(7)(C) dated July 18, 2018; see CoreCivic Incident Investigative Report Statement by Officer (b)(6); (b)(7)(C) dated June 5, 2018. ERAU notes (b)(6); (b)(7)(C) resigned on June 14, 2018.

¹²⁹ Officer (b)(6); (b)(7)(C) counted that during his shift, there were no Medical/Suicide Observation Checklists (IHSC-835 form) to document the 15-minute rounds, so he gathered and completed the Confinement Watch Log and the Confinement Activity Record. Officer (b)(6); (b)(7)(C) noted he requested more copies of the IHSC-835 form from Officer (first name unknown) (b)(6); (b)(7)(C). Therefore, ERAU notes that a Confinement Watch Log is utilized as the reference document for rounds documented by Officer Love on June 5, 2018. See CoreCivic Incident Investigative Report Statement by Officer (b)(6); (b)(7)(C) dated June 5, 2018.

¹³⁰ An orange card is used by security staff to signify when a detainee is in segregation for medical observation purposes.

At 3:51 p.m., (b)(6); (b)(7)(C) looked into TRAN's cell and marked the clipboard.¹³¹ He then stood at the door and looked in the cell again. (b)(6); (b)(7)(C) then moved from cell 605 to look in to TRAN's cell. (b)(6); (b)(7)(C) then opened the door to TRAN's cell walked in, walked back out, and closed the door. At 3:55 p.m., (b)(6); (b)(7)(C) left the east side of the Unit for the west side and returned at 4:04 p.m. After delivering a meal tray to another cell, he opened the food portal in TRAN's cell door and walked away. At 4:06 p.m., (b)(6); (b)(7)(C) handed (b)(6); (b)(7)(C) a sack meal for the detainee in cell 605 and then placed a meal tray on TRAN's food portal. After (b)(6); (b)(7)(C) moved away to deliver a tray to another cell (b)(6); (b)(7)(C) appeared to look into TRAN's cell.

At 4:08 p.m., (b)(6); (b)(7)(C) again appeared to look into TRAN's cell. At 4:11 p.m., (b)(6); (b)(7)(C) while on his way back to the officer's station, stopped briefly at TRAN's cell before moving on but did not look in.

At 4:12 p.m., (b)(6); (b)(7)(C) returned to TRAN's cell and looked directly in (b)(6); (b)(7)(C) removed the tray from the portal and exited the east side of Bravo 600. (b)(6); (b)(7)(C) returned to TRAN's cell at 4:13 p.m., opened the door, entered then exited quickly, leaving the door ajar. (b)(6); (b)(7)(C) recalled he entered the cell, touched TRAN's leg and hand, then shook his back; he stated TRAN's back was warm. (b)(6); (b)(7)(C) said that he then called out to TRAN and heard (b)(6); (b)(7)(C) tell him to call a medical emergency. (b)(6); (b)(7)(C) exited TRAN's cell and started to walk away but immediately returned and called a medical emergency.

At 4:15 p.m., (b)(6); (b)(7)(C) while on his radio, moved toward the front of the east side of Bravo 600 and motioned to the detainee in the dayroom to return to his cell. Another officer arrived and escorted the detainee to his cell and (b)(6); (b)(7)(C) returned to TRAN's cell and opened the door wider.

At 4:16 p.m., Correctional Counselor (b)(6); (b)(7)(C) and Correctional Officers (b)(6); (b)(7)(C) responded to the medical emergency. Officer (b)(6); (b)(7)(C) who was the designated camera operator for the emergency response team on this date, carried a handheld video camera.¹³² (b)(6); (b)(7)(C) stated she called out to TRAN three times from the doorway, but he did not respond. None of the officers entered the cell. (b)(6); (b)(7)(C) stated they did not enter for their safety as TRAN was a level three male detainee and could be feigning illness.¹³³

Lieutenant (Lt.) (b)(6); (b)(7)(C) and Correctional Officer (b)(6); (b)(7)(C) arrived seconds later and entered the cell. (b)(6); (b)(7)(C) confirmed that when he arrived, Counselor (b)(6); (b)(7)(C) Officer (b)(6); (b)(7)(C)

¹³¹ See Exhibit 7: Confinement Watch Log, dated June 5, 2018. ERAU notes Officer Love documented a welfare check time of 3:52 p.m.

¹³² ERAU Interview with Officer (b)(6); (b)(7)(C), dated July 18, 2018. For the first 46 seconds there is sound but no video as the lens cover would not fully open. When (b)(6); (b)(7)(C) arrived, he assisted in opening the jammed lens cover. ERAU Interview with Lieutenant (b)(6); (b)(7)(C), dated July 17, 2018, confirmed the lens cover was not operating properly, and it required maintenance after the emergency response.

¹³³ ERAU interview with Officer (b)(6); (b)(7)(C), dated July 18, 2018. EDC Policy 10-100, Segregation/Restrictive Housing Unit Management, Section 10-100.4, (E)(2)(c), states that staff members equal to the number of inmates/residents assigned to the cell will be present prior to opening any occupied cell door.

and (b)(6); (b)(7)(C) were standing outside of TRAN's cell.¹³⁴ The counselor and both officers then proceeded into the cell (b)(6); (b)(7)(C) recalled TRAN was laying on his stomach, face down, and when he rolled TRAN onto his right side, he was, stiff, cold to the touch, had a yellow/reddish discharge coming from his nose, and was not breathing (b)(6); (b)(7)(C) instructed security staff to begin cardiopulmonary resuscitation (CPR), to include rotating performance of chest compressions every four series to avoid fatigue.¹³⁵ (b)(6); (b)(7)(C) stated he then radioed for central control to call 911.¹³⁶

At 4:17 p.m. (b)(6); (b)(7)(C) stepped out of the cell to speak into his radio as (b)(6); (b)(7)(C) and Correctional Officer (b)(6); (b)(7)(C) arrived. (b)(6); (b)(7)(C) documented that TRAN was lying on the bed, unresponsive and not breathing, while officers performed CPR.¹³⁷ (b)(6); (b)(7)(C) applied a pulse oximeter to TRAN's right index finger which recorded an oxygen saturation¹³⁸ of 48 percent. She also noted she found a faint, irregular pulse on his right wrist.

At 4:18 p.m. (b)(6); (b)(7)(C) and two other nurses arrived on scene with a gurney and emergency bag.¹³⁹ (b)(6); (b)(7)(C) documented (b)(6); (b)(7)(C) took over as lead of the emergency response. (b)(6); (b)(7)(C) stated that because the officers were performing chest compressions and manual breaths well, he let them continue.¹⁴⁰ (b)(6); (b)(7)(C) checked TRAN's left wrist and noted he did not find a pulse.

Although the Central Control Log notated 911 was called at 4:21 p.m., the Eloy Fire District Prehospital Care Report indicated that at 4:19 p.m., the Eloy Fire District dispatched Emergency Medical Services (EMS) to EDC.¹⁴¹ (b)(6); (b)(7)(C) removed the automated external defibrillator (AED)¹⁴² from its case and attempted to apply the AED pads under TRAN's shirt.¹⁴³ He then asked a nurse to call for another provider.

At 4:20 p.m. (b)(6); (b)(7)(C) responded to the provider request, followed by Physician Assistant (b)(6); (b)(7)(C) at 4:22 p.m.¹⁴⁴ (b)(6); (b)(7)(C) cut TRAN's shirt, which revealed the AED pads were not properly placed or adhered on TRAN's upper abdomen. (b)(6); (b)(7)(C) medical record entry confirmed this observation and described the pads as partially adhered.¹⁴⁵ RN

¹³⁴ ERAU interview with (b)(6); (b)(7)(C) dated July 17, 2018.

¹³⁵ See Handheld Video, dated June 5, 2018.

¹³⁶ ERAU interview with (b)(6); (b)(7)(C) dated July 17, 2018.

¹³⁷ See eCW Progress Note, by RN (b)(6); (b)(7)(C) dated June 5, 2018.

¹³⁸ Oxygen saturation refers to the amount of oxygen found in the blood. Normal oxygen saturation levels range from 95 to 100 percent; any reading under 90 percent is considered hypoxia, i.e., when the body does not have enough oxygen.

¹³⁹ See eCW Progress Note, by (b)(6); (b)(7)(C), dated June 5, 2018.

¹⁴⁰ ERAU interview with (b)(6); (b)(7)(C), dated July 17, 2018.

¹⁴¹ See Eloy Fire District Prehospital Care Report, dated June 5, 2018; *see also* Central Control Log, dated June 5, 2018.

¹⁴² An AED is a portable electronic device that delivers an electric shock through the chest to the heart. The shock potentially stops an irregular heart beat and allows a normal rhythm to resume following a sudden cardiac arrest.

¹⁴³ See Handheld Video, dated June 5, 2018.

¹⁴⁴ See eCW Progress Note by (b)(6); (b)(7)(C) and eCW Progress Note by (b)(6); (b)(7)(C) both dated June 5, 2018.

¹⁴⁵ See eCW Progress Note by (b)(6); (b)(7)(C) dated June 5, 2018. For an AED machine to provide accurate analysis and effective shock during a sudden cardiac arrest, AED pads must make proper contact with the skin. Proper placement of AED pads is one pad on the front of the chest, above the right nipple, and the other pad on the left side

(b)(6); (b)(7)(C) then performed a sternal rub, with no response. (b)(6); (b)(7)(C) both documented the AED machine analyzed the patient multiple times during resuscitation but did not detect a shockable rhythm.

When (b)(6); (b)(7)(C) arrived, she placed an ambubag¹⁴⁶ over TRAN's face to administer oxygen, while officers continued chest compressions. The ambubag would not seal properly even with assistance from (b)(6); (b)(7)(C) holding the mouth piece. (b)(6); (b)(7)(C) took over the ambubag and vocalized it was not sealing. (b)(6); (b)(7)(C) then suggested tilting TRAN's head back, which allowed the ambubag to seal properly. During the emergency response, medical could not detect TRAN's blood pressure (bp) and his oxygen saturation and pulse fluctuated.¹⁴⁷ TRAN's blood glucose¹⁴⁸ was elevated at 208 and his peripheral pulse¹⁴⁹ ranged from a low 50 beats per minute (bpm) to an elevated 115 bpm. When security staff ceased chest compressions, the pulse oximeter device had no reading.¹⁵⁰ Throughout the emergency response, there were five attempts made by the three responding providers to establish an intravenous (IV) line, all of which were unsuccessful.¹⁵¹

At approximately 4:24 p.m. (b)(6); (b)(7)(C) instructed (b)(6); (b)(7)(C) to cease recording the medical emergency response efforts prior to EMS' arrival.¹⁵² Captain (b)(6); (b)(7)(C) affirmed that when he reported to the scene, he told (b)(6); (b)(7)(C) to have Officer (b)(6); (b)(7)(C) stop recording because he believed medical procedures were a Health Insurance Portability and Accountability Act (HIPAA)¹⁵³ concern.¹⁵⁴ When asked if he considered CPR a medical procedure, he replied that he never recorded CPR during his corrections career.

At 4:30 p.m., EMS responders arrived via ambulance at the EDC rear gate.¹⁵⁵ At 4:33 p.m., EMS responders entered the east side of Bravo 600.¹⁵⁶ Once EDC staff finished their round of

of the chest, below the breast area. Although the pads were later repositioned, their placement remained imperfect throughout the emergency response. During his interview with ERAU, (b)(6); (b)(7)(C) stated he did not know whether the AED pads had expired, which could have caused the gel on the pads to be dry and not adhere properly to the skin. His assumption was that the pads did not stick because TRAN's skin was moist and it did not occur to him to dry TRAN's skin or check the emergency bag for new pads. The emergency bag inventory did not include an extra set of AED pads.

¹⁴⁶ Ambubag is a hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately.

¹⁴⁷ Creative Corrections advised that during an emergency response, VS can fluctuate due to the administration of CPR.

¹⁴⁸ Blood glucose is the amount of glucose, a sugar that comes from foods we eat, that is found in the blood. A normal blood glucose level is roughly 70 to 100.

¹⁴⁹ Peripheral pulse is a pulse palpable in the hands and legs.

¹⁵⁰ See eCW Progress Note b (b)(6); (b)(7)(C), dated June 5, 2018.

¹⁵¹ An intravenous line is a portal, established by a hollow-bore needle and connected to plastic tubing, through which fluids and medications can be administered directly into the vein.

¹⁵² ERAU interview with Lieutenant (b)(6); (b)(7)(C), July 17, 2018.

¹⁵³ According to 45 Code of Federal Regulations (CFR) Parts 160 and 164, U.S. Department of Health and Human Services (HHS), HIPAA sets the standards for privacy of individually identifiable health information. Creative Corrections advised that HIPAA does not apply to those in custody of the Federal Government.

¹⁵⁴ ERAU interview with Captain (b)(6); (b)(7)(C), dated July 19, 2018.

¹⁵⁵ See EDC Rear Gate Logbook Entry at 1630, June 5, 2018.

¹⁵⁶ See Surveillance Video, Bravo 600 East, dated June 5, 2018.

CPR, EMS responders took over lifesaving efforts.¹⁵⁷ EMS responders documented that TRAN showed an idioventricular rhythm (IVR)¹⁵⁸ with no pulse and was in pulseless electrical activity (PEA).¹⁵⁹ At 4:35 p.m., EMS responders successfully started an interosseous¹⁶⁰ IV line in the anterior tibial area¹⁶¹ of the left leg and administered both Narcan¹⁶² (2 mg) and two doses of epinephrine¹⁶³ (1 mg).¹⁶⁴ (b)(6); (b)(7)(C) documented that EMS responders placed their own AED leads on TRAN and were able to obtain a weak pulse.¹⁶⁵

At 4:44 p.m., EMS responders placed TRAN on a gurney and departed the east side of Bravo 600.

At 4:45 p.m., (b)(6); (b)(7)(C) documented that the cardiac monitor showed sinus rhythm¹⁶⁶ before EMS moved TRAN to the ambulance.¹⁶⁷ EMS responders specifically documented a sinus tachycardia, which is sinus rhythm at a rate higher than 100 beats per minute.¹⁶⁸ At 4:53 p.m., the ambulance exited EDC for BCGMC.¹⁶⁹

Sergeant (b)(6); (b)(7)(C) assigned Correctional Officers (b)(6); (b)(7)(C) to hospital detail; Officer (b)(6); (b)(7)(C) drove the chase vehicle and Officer (b)(6); (b)(7)(C) rode in the ambulance with TRAN.¹⁷⁰ Officer (b)(6); (b)(7)(C) recalled that the ambulance drove with both lights and sirens activated and arrived at the hospital within approximately 15 minutes.¹⁷¹

At 5:14 p.m., the ambulance arrived at BCGMC.¹⁷² (b)(6); (b)(7)(C) stated that upon arrival to the emergency room (ER), BCGMC staff placed TRAN on a respirator in ER Room 2 and heard them say TRAN had a low pulse.¹⁷³ At 5:20 p.m., medical staff stabilized TRAN.¹⁷⁴ At 6:16 p.m., BCGMC staff transported TRAN to have a computed tomography (CT) scan, the

¹⁵⁷ See Eloy Fire District Prehospital Care Report, dated June 5, 2018.

¹⁵⁸ An idioventricular rhythm is an independent cardiac rhythm caused by repeated discharge of impulses at a rate of less than 60 beats per minute.

¹⁵⁹ PEA is when the monitor will show electrical activity in the heart but there will be no palpable pulse.

¹⁶⁰ Interosseous refers to marrow within bones.

¹⁶¹ The anterior tibial area of the leg is also called the shin.

¹⁶² Narcan is a drug used by emergency responders to reverse the effects of a narcotic overdose.

¹⁶³ Epinephrine is a hormone produced by the adrenal glands, which functions to increase cardiac output and to raise glucose levels in the blood.

¹⁶⁴ (b)(6); (b)(7)(C) explained that EMS responders most likely administered Narcan because it is a routine EMS procedure; ERAU interview with (b)(6); (b)(7)(C), dated July 17, 2018.

¹⁶⁵ See Emergency Response Note by (b)(6); (b)(7)(C) dated June 5, 2018.

¹⁶⁶ A sinus rhythm is a normal heart beat, both with respect to heart rate and rhythm. During a sinus rhythm, the heart rate is between 60 and 100 beats per minute.

¹⁶⁷ See eCW Progress Note, (b)(6); (b)(7)(C), dated June 5, 2018.

¹⁶⁸ See Eloy Fire District Prehospital Care Report, dated June 5, 2018.

¹⁶⁹ See CoreCivic Incident Investigation Report, Milestone video surveillance timeline, dated June 19, 2018; see also EDC Rear Gate Log entry at 1653, dated June 5, 2018.

¹⁷⁰ See EDC Incident Statement by Officer (b)(6); (b)(7)(C), dated June 12, 2018.

¹⁷¹ ERAU Interview with Officer (b)(6); (b)(7)(C), dated July 17, 2018.

¹⁷² See Hospital Logbook, dated June 5, 2018. ERAU notes the Eloy Fire District Prehospital Care Report states the ambulance arrived at the BCGMC at 5:11 p.m.

¹⁷³ ERAU interview with Officer (b)(6); (b)(7)(C), dated July 17, 2018.

¹⁷⁴ See Hospital Log book, dated June 5, 2018.

documented findings from which were negative.¹⁷⁵ At 8:16 p.m., BCGMC staff moved TRAN to the intensive care unit (ICU) room 8. A BCGMC provider documented a diagnosis of acute cardiopulmonary arrest¹⁷⁶ with return of spontaneous circulation,¹⁷⁷ and suspected anoxic brain injury.¹⁷⁸

Following the medical emergency, EDC Chief of Security (b)(6); (b)(7)(C)ified the EDC Warden via memo that he met with all EDC responders to assess how staff was coping and reminded them the Employee Assistance Program was available.¹⁷⁹

Unless otherwise noted, the events detailed from June 6 through June 12, 2018, are referenced from the hospital log maintained by CoreCivic Officers on hospital duty.

On June 6, 2018, the following events occurred:

- At 4:05 a.m., EDC RN (b)(6); (b)(7)(C) documented that per BCGMC, TRAN was on a ventilator and was receiving hypothermia therapy.¹⁸⁰ His most recent VS were a heart rate of 80 bpm, bp of 97/76, ventilator setting respiratory rate¹⁸¹ of 24, and a ventilator oxygen saturation of 98 percent. His medication treatment included Anectine,¹⁸² propofol,¹⁸³ Levophed,¹⁸⁴ Zosyn,¹⁸⁵ and normal saline.
- At 5:57 a.m., BCGMC staff took an X-ray of TRAN.
- At 6:45 a.m., BCGMC staff notified CoreCivic officers they were keeping TRAN under observation for 24 hours and cooling him down due to his cardiac arrest episode. BCGMC staff planned to warm TRAN back to regular temperature for further evaluation.
- At 10:15 a.m., BCGMC staff took labs. The doctor remarked that TRAN did not look promising but that they would have better insight into his medical state the next day.
- At 12:25 p.m., EDC RN (b)(6); (b)(7)(C) documented that per BCGMC, TRAN's condition remained unchanged and BCGMC scheduled rewarming¹⁸⁶ for 9:30 p.m.¹⁸⁷ His most

¹⁷⁵ A CT scan is an X-ray which produces computerized cross-sectional images of specific areas of the body.

¹⁷⁶ Cardiopulmonary arrest, or cardiac arrest, is the abrupt loss of heart function, breathing and consciousness.

¹⁷⁷ Spontaneous circulation is when a normal heart rhythm and pulse returns.

¹⁷⁸ An anoxic brain injury is an injury caused by a complete lack of oxygen being provide to the brain, which results in the death of brain cells after approximately four minutes of oxygen deprivation. *See* BCGMC Emergency Department Pertinent Report, dated June 14, 2018.

¹⁷⁹ *See* CISM Response to Incident #2018-0902-079-I, dated June 18, 2018. EDC Chief of Security Leeds is a member of the CoreCivic Critical Incident Stress Management (CISM) Team.

¹⁸⁰ Hypothermia therapy is a treatment used for patients who have a cardiac arrest. The body's temperature is lowered to around 89 to 93 degrees, using cooling devices, in an attempt to reduce damage to the brain. *See* eCW Hospital Update, by RN (b)(6); (b)(7)(C) dated June 6, 2018.

¹⁸¹ Ventilator respiratory rate is the set rate for delivering breaths per minute. The ventilator can adjust as the patient's respiratory rate changes, if the rate drops below the set rate the ventilator will adjust to breathe that rate for the patient.

¹⁸² Anectine is a muscle relaxant.

¹⁸³ Propofol is a type of drug which causes relaxation and sleepiness before and during medical procedures.

¹⁸⁴ Levophed is the brand name for norepinephrine, a drug used to treat low blood pressure and heart failure.

¹⁸⁵ Zosyn is an antibiotic medication used to treat infections.

¹⁸⁶ BCGMC targeted a temperature of 98.6 degrees Fahrenheit. The goal was to maintain that temperature for 72 hours.

¹⁸⁷ *See* eCW Hospital Update, by R (b)(6); (b)(7)(C) dated June 6, 2018.

recent VS were a heart rate of 91 bpm, bp of 93/65, ventilator setting respiratory rate of 24, and a ventilator oxygen saturation of 98 percent. TRAN's labs showed an elevated aspartate transferase (AST) and alanine transaminase (ALT)¹⁸⁸ and that he was positive for clostridium difficile infection (C-diff),¹⁸⁹ with blood in his stool. TRAN's CT scan and drug screen were negative. BCGMC staff planned to take TRAN off paralytic medication the following day.

- At 5:26 p.m., Captain (b)(6); (b)(7)(C) approved a visit by TRAN's father. In follow-up calls, Captain (b)(6); (b)(7)(C) also approved visits by TRAN's mother and sister.
- At 7:57 p.m., TRAN's mother and father arrived to visit; they left at 9:39 p.m.

On June 7, 2018, the following events occurred:

- At 2:00 a.m., BCGMC staff reversed sedation.
- At 2:04 a.m., EDC RN (b)(6); (b)(7)(C) documented that per BCGMC, TRAN remained unresponsive with no reflexes. BCGMC staff initiated the rewarming process the night before, discontinued paralytic medications, and prescribed Versed,¹⁹⁰ Protonix,¹⁹¹ normal saline, Flagyl,¹⁹² and Zosyn intravenously and vancomycin¹⁹³ via an orogastric (OG) tube.¹⁹⁴ BCGMC staff scheduled TRAN to see an intensivist¹⁹⁵ later that day. TRAN's most recent VS were a heart rate of 109 bpm, bp of 103/66, ventilator setting respiratory rate of 24, and a ventilator oxygen saturation of 96 percent.
- At 3:30 a.m., the doctors' tests results were negative, showing no higher brain function. The doctors' planned to return the next morning for further evaluation.
- At 9:25 a.m., TRAN's parents visited and doctors informed them that they were not optimistic about their son's recovery. TRAN's parents left at 10:50 a.m.
- At 11:13 a.m., EDC RN (b)(6); (b)(7)(C) documented, that per BCGMC, TRAN's condition remained unchanged.¹⁹⁶ TRAN had no pupillary reflex,¹⁹⁷ no pain response, and exhibited no signs of waking. BCGMC staff discontinued Versed earlier in the day, and he remained on the other medications. A neurologist waited to perform an electroencephalogram (EEG)¹⁹⁸ until medical staff discontinued the other medications. TRAN now showed evidence of kidney injury. TRAN's most recent VS were a heart rate of 109 bpm, bp of 132/85, ventilator setting respiratory rate of 24, and a ventilator oxygen saturation of 97 percent. TRAN's core body temperature was 98.8 degrees Fahrenheit.

¹⁸⁸ AST and ALT are enzymes found in the liver. Their ratio is commonly used to measure liver health.

¹⁸⁹ C-diff is an inflammation of the colon caused by the bacteria Clostridium difficile.

¹⁹⁰ Versed is a brand name for midazolam, a sedative medication used to help patients feel relaxed or sleepy before a medical procedure.

¹⁹¹ Protonix is a brand name for pantoprazole, a drug used to treat gastroesophageal reflux disease and a damaged esophagus.

¹⁹² Flagyl is a brand name for metronidazole, a drug used to treat infections.

¹⁹³ Vancomycin is a drug used to treat infections.

¹⁹⁴ An OG tube is a small tube placed in the mouth and end with the tip in the stomach, to administer feeding, medication or to remove the contents of the stomach. See eCW Hospital Update, by (b)(6); (b)(7)(C), dated June 7, 2018.

¹⁹⁵ An intensivist is a physician who specializes in the care of critically-ill patients, most often in the intensive care unit (ICU).

¹⁹⁶ See eCW Hospital Update, (b)(6); (b)(7)(C) dated June 7, 2018.

¹⁹⁷ Pupillary reflex refers to the changes in diameter of the pupils when exposed to light.

¹⁹⁸ An electroencephalogram (EEG) is a test used to record and monitor electrical activity of the brain.

- At 12:20 p.m., the ICU doctor stated TRAN may not wake up.
- At 1:45 p.m., nurses stated there was a very faint pupil reaction to light, a slight difference from the morning when there was none.

On June 8, 2018, the following events occurred:

- At 1:38 a.m., EDC RN (b)(6); (b)(7)(C) documented that per BCGMC, TRAN remained unresponsive except for a sluggish pupillary reflex to the left eye.¹⁹⁹ Blood tests and an EEG were planned for this date. TRAN's most recent VS were a heart rate of 100 bpm, bp of 114/65, ventilator setting respiratory rate of 24, a ventilator oxygen saturation of 94 percent, and a body temperature of 98.6 degrees Fahrenheit.
- At 10:45 a.m., a BCGMC doctor asked who could authorize TRAN's dialysis; the officer on watch advised the doctor that ICE could authorize the dialysis.
- At 11:33 a.m., a BCGMC doctor arrived to evaluate TRAN and his family arrived for visitation.
- At 12:00 p.m., a BCGMC doctor updated the family on TRAN's condition and treatment plan.
- At 1:10 p.m., BCGMC staff asked TRAN's family to leave so they could implant the dialysis²⁰⁰ tubing, which they planted in TRAN's neck at 1:45 p.m.
- At 7:55 p.m., TRAN's family returned and then departed at 10:00 p.m.

On June 9, 2018, the following events occurred:

- At 3:37 a.m., EDC RN (b)(6); (b)(7)(C) documented that per BCGMC, TRAN's responsive state and medications remained the same.²⁰¹ TRAN received dialysis the previous day, but BCGMC staff extracted no fluids. BCGMC staff started feedings through the OG tube late on June 8, 2019 to stabilize TRAN's glucose levels. Again, neurology planned to perform an EEG once medical staff discontinued all other medications and improvement was observed. TRAN's most recent VS were a heart rate of 96 bpm, bp of 105/66, ventilator setting respiratory rate of 24, a ventilator oxygen saturation of 95 percent and a body temperature of 97.3 degrees Fahrenheit. The labs showed a decrease in TRAN's AST and ALT and an increase in his creatinine, blood urea nitrogen (BUN)²⁰² and CO2.
- At 9:20 a.m., BCGMC staff began TRAN's dialysis, which ended at 6:00 p.m.
- Between 10:35 a.m. and 7:35 p.m., six family members visited TRAN.
- At 1:06 p.m., EDC RN (b)(6); (b)(7)(C) documented that per BCGMC, TRAN's condition remained unchanged.²⁰³ BCGMC staff planned to perform an EEG and brain stem testing in two days. TRAN's most recent VS were a heart rate of 96 bpm, bp of 105/66, ventilator setting respiratory rate of 24, and a ventilator oxygen saturation of 97 percent.²⁰⁴

¹⁹⁹ See eCW Hospital Update, by (b)(6); (b)(7)(C) dated June 8, 2018.

²⁰⁰ Dialysis is the clinical purification of blood, as a substitute for the normal function of a kidney.

²⁰¹ See eCW Hospital Update, by (b)(6); (b)(7)(C) dated June 9, 2018. An addendum was added at 3:38 a.m.

²⁰² BUN is a medical test that measures the amount of urea nitrogen found in blood. The liver produces urea in the urea cycle as a waste product of the digestion of protein.

²⁰³ See eCW Hospital Update, by (b)(6); (b)(7)(C) dated June 9, 2018.

²⁰⁴ If provided, (b)(6); (b)(7)(C) did not document TRAN's body temperature within the progress note.

- At 8:23 p.m., TRAN's sister arrived and stayed until 11:00 p.m.

On June 10, 2018, the following events occurred:

- At 1:08 a.m., EDC (b)(6); (b)(7)(C) documented that per BCGMC, TRAN's condition remained unchanged.²⁰⁵ His pupils were fixed and dilated, he had no pain response, and exhibited no signs of waking. TRAN's most recent VS were a heart rate of 93 bpm, bp of 120/67, ventilator setting respiratory rate of 24, a ventilator oxygen saturation of 94 percent and a body temperature of 97.7 degrees Fahrenheit. BCGMC staff's treatment goal was to continue monitoring his neurological status.
- At 12:12 p.m., TRAN's sister arrived and departed at 1:33 p.m.
- At 5:00 p.m., TRAN's parents arrived and his sister later returned. The last visitor left at 10:40 p.m.

On June 11, 2018, the following events occurred:

- At 6:31 a.m., EDC (b)(6); (b)(7)(C) documented that per BCGMC, TRAN's condition remained unchanged.²⁰⁶ TRAN remained on dialysis and medical staff planned to perform a CT scan to determine if any brain changes had occurred from the baseline scan completed on June 5, 2018. TRAN's VS were within normal limits, except for an increased heart rate of 103 bpm and an elevated bp of 160/110.
- At 9:00 a.m., medical staff conducted a test to determine if TRAN could breathe on his own; it was determined he could not.
- At 9:25 a.m., a family member arrived, and others continued to arrive throughout the day.
- At 9:55 a.m., BCGMC doctors informed TRAN's sister that there was little chance he would survive.
- At 10:21 a.m., EDC RN (b)(6); (b)(7)(C) documented that per BCGMC, TRAN's condition remained unchanged.²⁰⁷ BCGMC staff ordered a CT scan. TRAN's VS remained within normal limits, except for an elevated blood pressure of 154/106.
- At 11:15 a.m., a BCGMC doctor spoke with TRAN's family members about the possibility of organ donation if there was no brain function after testing.
- At 11:55 a.m., BCGMC staff conducted an echocardiogram.²⁰⁸
- At 2:55 p.m., BCGMC staff conducted a neural X-ray.²⁰⁹
- At 4:42 p.m., BCGMC staff started TRAN's dialysis, which ended at 7:08 p.m.

June 12, 2018, Day of Death

- At 1:42 a.m., EDC RN (b)(6); (b)(7)(C) documented that per BCGMC, TRAN's condition remained unchanged, VS were within normal limits and MRI results were pending.²¹⁰

²⁰⁵ See eCW Hospital Update, b (b)(6); (b)(7)(C) dated June 10, 2018.

²⁰⁶ See eCW Hospital Update, b (b)(6); (b)(7)(C) dated June 11, 2018.

²⁰⁷ See eCW Hospital Update, b (b)(6); (b)(7)(C) dated June 11, 2018.

²⁰⁸ An echocardiogram is a test using ultrasound to make pictures of the heart.

²⁰⁹ A neural X-ray refers to a particular kind of brain X-ray used to determine proof of brain death.

²¹⁰ See eCW Hospital Update (b)(6); (b)(7)(C) dated June 11, 2018.

- At 8:43 a.m., Correctional Officer (b)(6); (b)(7)(C) recorded BCGMC staff conducted a test to determine if TRAN showed any brain activity.²¹¹
- At 11:42 a.m., BCGMC RN (b)(6); (b)(7)(C) notified Officer (b)(6); (b)(7)(C) Punnakattu pronounced TRAN brain dead²¹² at 9:20 a.m.²¹³ Officer (b)(6); (b)(7)(C) stated this was the first he heard of TRAN's death.²¹⁴
- At 11:43 a.m., Officer (b)(6); (b)(7)(C) called Shift Supervisor (b)(6); (b)(7)(C) to notify him that although medical staff had pronounced TRAN deceased at 9:20 a.m., they just informed him of the news.
- At 2:00 p.m., Officers (b)(6); (b)(7)(C) relieved Officers (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C). At 2:30 p.m., the Pinal County Medical Examiner arrived to take TRAN's fingerprints.
- At 2:40 p.m., BCGMC medical staff removed TRAN from life support and pronounced his cardiac death.²¹⁶
- At 3:43 p.m., BCGMC RN Staine completed a Banner Health AZ Human Remains Release form and documented the diagnosis as anoxic encephalopathy,²¹⁷ acute respiratory failure,²¹⁸ and acute renal failure.²¹⁹ Additionally, (b)(6); (b)(7)(C) (first name unknown), a representative from the Medical Examiner's office, signed for custody of TRAN's body.²²⁰
- At 3:55 p.m.,²²¹ EDC RN (b)(6); (b)(7)(C) documented that per BCGMC, medical staff conducted an EEG at 7:29 a.m. that showed no brain activity.²²² BCGMC staff confirmed these findings through apneic testing.²²³ (b)(6); (b)(7)(C) further documented a BCGMC doctor declared TRAN brain dead at 9:20 a.m. and that TRAN's family members were notified of his passing and were expected to arrive at the hospital that afternoon. Medical staff planned to discontinue the ventilator at that time.
- At 3:59 p.m., (b)(6); (b)(7)(C) departed the hospital with TRAN's remains.

²¹¹ ERAU telephonic interview with (b)(6); (b)(7)(C) July 18, 2018.

²¹² Brain death is irreversible brain damage causing the end to independent breathing.

²¹³ See D. Houston Incident Statement, dated June 12, 2018.

²¹⁴ ERAU telephonic interview with (b)(6); (b)(7)(C) July 18, 2018.

²¹⁵ Both Officers (b)(6); (b)(7)(C) submitted incident statements on June 12, 2018; however, the times they provide in their statements are not consistent with entries in the hospital log they kept. Within this report, entries made in the hospital log are used.

²¹⁶ See Exhibit 1: Pinal County Forensic Examination Report, dated July 17, 2018. Cardiac death is when the heart stops beating.

²¹⁷ Anoxic encephalopathy is a condition where brain tissue is deprived of oxygen and there is a global loss of brain function.

²¹⁸ Acute respiratory failure occurs when fluid builds up in the air sacs in the lungs. When this happens, the lungs cannot release oxygen into the blood.

²¹⁹ Acute renal failure occurs when the kidneys suddenly lose the ability to eliminate excess salts, fluids, and waste material from the blood. See Banner Health AZ Human Remains Release Form, dated June 12, 2018.

²²⁰ See Banner Health AZ Human Remains Release Form, dated June 12, 2018.

²²¹ Although the note is marked that it was entered at 3:55 p.m., this may indicate the time the RN signed the note and not the actual time the hospital provided information as TRAN was taken off the ventilator at 2:40 p.m.

²²² See eCW Telephone Encounter, by (b)(6); (b)(7)(C), dated June 12, 2018.

²²³ Apneic testing is an essential component in the clinical determination of brain death. The main objective of apnea testing is to prove the absence of respiratory control system reflexes in the brainstem when intense physiologic stimulation to breathe takes place.

Post Death Events

On June 13, 2018, Phoenix Field Office Director (FOD) Enrique Lucero signed a letter to TRAN's family offering his condolences for their loss.²²⁴

On June 19, 2018, the Consulate General of Vietnam in San Francisco wrote that TRAN's family received his body and conducted his burial. They requested ICE clarify the cause of death and share other information related to TRAN's death.²²⁵

The Facility Investigator signed the Incident Investigation Report she began at Warden Michael Donahue's request on June 5, 2018.²²⁶

On June 20, 2018, EDC staff mailed TRAN's property and funds to his father in Mesa, AZ and on **June 21, 2018**, the package was received and signed for.²²⁷

On July 6, 2018, the State of Arizona Certification of Vital Record issued a Certificate of Death documenting TRAN's immediate cause of death as pending investigation.²²⁸

On July 17, 2018, Chief Medical Examiner (b)(6); (b)(7)(C) signed the completed forensic examination report, stating the cause of death was coronary artery disease.²²⁹

MEDICAL CARE AND SECURITY REVIEW

ERAU reviewed the medical care EDC provided TRAN, as well as the facility's efforts to ensure that he was safe and secure while detained at the facility. ERAU found deficiencies in EDC's compliance with certain requirements of the ICE PBNDS 2011 (as revised in 2016).

1. ICE PBNDS 2011, *Medical Care*, Section (II)(20), which states, "Prescriptions and medications shall be ordered, dispensed and administered in a timely manner and as prescribed by a licensed health care professional. This shall be conducted in a manner that seeks to preserve the privacy and personal health information of detainees."
 - Although the (b)(6); (b)(7)(C) prescribed TRAN fluoxetine and haloperidol at intake on May 28, 2018, TRAN did not receive his first dose of either medication until May 30, 2018. If TRAN received a dose from the intake supply, medical staff did not document the administration of the medications. (b)(6); (b)(7)(C) ended her employment with EDC prior to the site visit; therefore, ERAU could not discuss this issue with (b)(6); (b)(7)(C) to determine whether the break in medication was determined acceptable.

²²⁴ See Written correspondence from Phoenix FOD Enrique M. Lucero, dated June 13, 2018.

²²⁵ ERAU notes EDC was unable to confirm a follow-up response to the Vietnam Consulate.

²²⁶ See CoreCivic Incident Investigation Report, dated June 19, 2018.

²²⁷ See U.S. Postal Service Certified Mail Receipt.

²²⁸ See Exhibit 8: State of Arizona Certification of Vital Record: Certificate of Death, dated July 6, 2018.

²²⁹ See Exhibit 1: Pinal County Forensic Examination Report, dated July 17, 2018.

2. ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(4), which states, “Prior to the administration of psychotropic medications, a separate documented informed consent, that includes a description of the medication’s side effects shall be obtained.”
 - Medical staff did not obtain a signed consent form from TRAN at FSF for psychotropic medications started on May 26, 2018.
 - Medical staff did not obtain a signed consent form from TRAN at EDC for psychotropic medications started on May 30, 2018 until June 4, 2018. The signed consent form documents the psychiatrist discussed the side effects with TRAN but does not list any side effects. The side effects were, however, listed in the psychiatrist’s encounter note.
3. ICE PBNDS 2011, *Custody Classification System*, Section (V)(A)(4), which states, “Each detainee’s classification shall be reviewed and approved by a first-line supervisor or classification supervisor.”
 - A supervisor did not approve the classification rating assigned to TRAN on May 28, 2018.
4. ICE PBNDS 2011, *Special Management Units*, Section (V)(M), which states, “Close Supervision Detainees in SMU shall be personally observed and logged at least every 30 minutes on an irregular schedule. For cases that warrant increased observation, the SMU personnel shall personally observe detainees accordingly.”
 - Per the psychologist’s order, due to placement on MHO, CoreCivic officers were to conduct welfare checks on TRAN every 15 minutes. Surveillance footage evidence showed the CoreCivic officer on duty issued TRAN linens at 3:00 p.m. but did not look into TRAN’s cell again until 3:51 p.m. During the 51-minute period, the officer documented three welfare checks, none of which were supported by video surveillance.

AREAS OF CONCERN

ERAU noted the following generalized concerns regarding TRAN’s medical care:

- Because the pharmacy did not receive (b)(6); (b)(7)(C) orders to change the administration times of TRAN’s medication during pharmacy hours, the pharmacy did not process his orders until the next day, after TRAN already received his once-daily dose of fluoxetine. As a result, he received twice the prescribed daily dose of fluoxetine.
- (b)(6); (b)(7)(C) did not order Cogentin to treat TRAN’s EPS symptoms as intended. He stated that his failure to order Cogentin was an oversight.
- EDC medical staff did not take TRAN’s VS during his mental health appointments on June 4, 2018 and June 5, 2018. Although policy did not require VS, Creative Corrections advised they are a key factor in the early detection of life-threatening conditions.

- CoreCivic staff observed TRAN unresponsive in his SMU cell within approximately three hours after the psychologist ordered his assignment to MHO. The segregation medical clearance completed by (b)(6); (b)(7)(C) consisted only of a medical record review. Per (b)(6); (b)(7)(C) medical should assess detainees in-person before medically clearing them for segregation. As (b)(6); (b)(7)(C) did not conduct an in-person assessment, she did not obtain TRAN's VS nor did she conduct an assessment of his physical condition.
- During the medical emergency response, the medical team leader did not place the AED pads in the proper position and did not dry TRAN's skin before attempting placement after noticing his skin was moist. The pads did not adhere, rendering the AED ineffective in analyzing heart activity. ERAU cannot determine whether the pads did not adhere because they had expired or because TRAN was perspiring. The emergency bag inventory did not list AED pad expiration dates, nor did it include a second set of pads. Thorough inventories of emergency bag contents, to include review of AED pad expiration dates and a second set of pads, helps to ensure necessary equipment is available and operable during medical emergency events.
- (b)(6); (b)(7)(C) physical examination entry included documentation that TRAN had no lower teeth and was missing other upper teeth, but she did not order a special diet to assure TRAN's nutritional intake was adequate.

ERAU noted the following concerns related to safety and security:

- After (b)(6); (b)(7)(C) called the medical emergency, the first security responders arrived within an estimated three minutes. They stood at the cell but did not enter to render aid. (b)(7)(E) and one correctional counselor being present, one responding officer stated they did not enter out of concern for their safety. (b)(6); (b)(7)(C) and another male officer arrived on scene shortly thereafter and entered the cell, followed by the initial responders. Following the emergency response, (b)(6); (b)(7)(C) clarified to the responding officers that when (b)(7)(E) are present, regardless of the gender of the detainee or responders, they should enter the cell.
- For the first 46 seconds of the medical emergency recording, the handheld camera lens cover would not fully open. Following the medical emergency, (b)(6); (b)(7)(C) sent the handheld camera out for repair of the slide action that jammed to correct the identified malfunction.
- When (b)(6); (b)(7)(C) arrived on site, he asked (b)(6); (b)(7)(C) to stop recording the medical emergency, prior to EMS arriving, as he believed it was a HIPAA violation. (b)(6); (b)(7)(C) incorrectly viewed the recording of CPR as a HIPAA violation, as Creative Corrections advised that HIPAA does not apply to those in custody of the Federal Government.

TABLE ONE		
Offense	Conviction Date	Sentence
Disorderly Conduct	June 6, 1994	12 months of probation
Shoplifting	December 5, 1996	Fined \$320.00
Shoplifting	December 4, 1996	Fined \$300.00
Disorderly Conduct	August 22, 1997	Three years of probation
Disorderly Conduct	April 30, 1999	Three years of probation
Driving with License Suspended; Failure to Appear/Failure to Pay	November 18, 1999	18 days incarceration
Aggravated Assault	October 25, 2000	3 years, 6 months incarceration (credit 210-days' time served)
Aggravated Assault		Three years of probation

TABLE TWO		
Offense	Conviction Date	Sentence
Disorderly Conduct	May 11, 2007	120 days incarceration
Criminal Damage		One year of probation
Shoplifting	May 11, 2007	One year of probation
Criminal Damage (Two Counts)	November 10, 2008	90 days incarceration
Aggravated Assault	April 8, 2009	Five years' incarceration (credit 224-days' time served)

EXHIBITS

1. Pinal County Forensic Examination Report, dated July 17, 2018.
2. Creative Corrections Healthcare and Security Compliance Analysis.
3. Initial Custody Classification Form 18-1B, dated May 28, 2018.
4. EDC Medical Administration Record (MAR) for Huy Chi Tran, dated May 2018.
5. Immigration Health Services Corp Consent Form for Psychotropic Medications for Adults, dated June 4, 2018.
6. Confinement Record Form, dated June 5, 2018.
7. Confinement Watch Log, dated June 5, 2018.
8. State of Arizona Certification of Vital Record: Certificate of Death, dated July 6, 2018.



U.S. Immigration
and Customs
Enforcement

JUL - 5 2019

MEMORANDUM FOR: Nathalie Asher
Executive Associate Director
Office of Enforcement and Removal Operations

THROUGH:

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

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

Associate Director

Office of Professional Responsibility

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

FROM:

Acting Assistant Director

SUBJECT: Findings for the Death of ICE Detainee

Huy Chi TRAN (A#037949945) (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 death of ICE detainee Huy Chi TRAN. TRAN died on June 12, 2018, while in ICE custody at the Banner Casa Grande Medical Center (BCGMC), in Casa Grande, Arizona (AZ). The Pinal County Medical Examiner documented TRAN's cause of death as sudden cardiac death¹ due to coronary artery disease.²

On June 25, 1984, the former U.S. Immigration and Naturalization Services (INS) admitted TRAN into the United States in San Francisco, California as an immigrant (i.e. child of an immigrant who is the brother or sister of a U.S. citizen). From June 1994 to July 2017, TRAN was arrested and/or convicted of various criminal offenses.³ An immigration judge ordered TRAN removed to Vietnam three times before the ICE Office of Enforcement and Removal Operations (ERO) Phoenix determined there was no significant likelihood of removal in the reasonably foreseeable future; therefore, ERO released him on an order of supervision on January 10, 2005. On July 17, 2017 a 287(g) officer lodged a detainer against TRAN while he was in Arizona Department of Corrections (ADOC) custody. On May 25, 2018, ADOC released TRAN into ERO Phoenix custody. On the same date, ERO Phoenix booked TRAN into the Tucson INS Hold Room in Tucson, AZ and then later that day, the Florence Staging Facility (FSF) in Florence, AZ. On May 28, 2018, ERO Phoenix transferred TRAN from FSF to the Eloy

¹ Sudden cardiac death is a sudden, unexpected death caused by loss of heart function.

² Coronary artery disease occurs when plaque grows within the walls of the coronary arteries until the blood flow to the heart's muscle is limited.

³ ERAU was unable to determine the disposition for approximately 17 of TRAN's arrests and/or offenses.

Detention Center (EDC) in Eloy, AZ, to pursue his removal to Vietnam.

On May 25, 2018, upon admission to FSF, a Licensed Vocational Nurse (LVN) conducted a medical pre-screen and documented TRAN arrived with the medications haloperidol and fluoxetine, both of which are antipsychotic medications. Consequently, the LVN determined TRAN had a sensitive medical condition needing immediate medical care in accordance with IHSC policy.⁴ On May 26, 2018, a Registered Nurse (RN) performed TRAN's medical and mental health intake screening, during which TRAN acknowledged receiving treatment for depression for the past 20 years. He also denied current suicidal ideations, homicidal thoughts, and hallucinations. Based on the findings, the medical provider, via telephone order, continued TRAN on the same medication regimen. The RN conducted an Abnormal Involuntary Movement Scale (AIMS)⁵ and noted a score of zero. On that same date, a Licensed Clinical Social Worker (LCSW) conducted TRAN's mental health follow-up and documented that TRAN denied current hallucinations but had hallucinated in the past. The LCSW documented TRAN's appearance as bizarre, poorly groomed, affect flat,⁶ and that he exhibited lethargic psychomotor activity.⁷ The LCSW diagnosed TRAN with schizophrenia,⁸ unspecified, and noted TRAN would continue his medications as prescribed.

On May 28, 2018, FSF transferred TRAN to EDC. Upon arrival to EDC, an ERO Deportation Officer (DO) assigned to EDC Intake that day, noted that TRAN arrived soaking wet and sweating profusely. The DO alerted a Supervisory Detention and Deportation Officer (SDDO) who confirmed that the air conditioning was working properly. The SDDO accompanied TRAN to the front of the medical pre-screen line, and the RN immediately conducted TRAN's medical pre-screen. The RN did not note profuse sweating as described by ERO staff in either pre-screen or intake screening. The RN recorded TRAN's intake assessment as abnormal due to his mental health issues and referred him to a mental health provider. Later that day, the same RN conducted TRAN's abbreviated intake medical screening. A Case Manager (CM) completed TRAN's initial custody classification and appropriately classified him as high; however, the CM signed for both the classification officer and supervisor and did not seek supervisory approval.

On this same date, a Nurse Practitioner (NP) performed TRAN's physical examination⁹ and documented on TRAN's reported mental health history and his lack of lower teeth and other upper teeth with no dental prothesis. The NP conducted an AIMS assessment

⁴ See IHSC Policy 03-08, Section 4-3(a), dated January 19, 2015.

⁵ The AIMS assess the occurrence of tardive dyskinesia (TD), a side effect of taking antipsychotic medication. Initial AIMS results may serve as a baseline for future monitoring or may prompt ordering of medication to address symptoms of the disorder. A score of zero indicates no occurrence of TD observed. Therefore, due to TRAN being on antipsychotic drugs, the RN conducted the AIMS assessment.

⁶ Flat affect is a lack of emotional expressiveness.

⁷ Psychomotor activity are skills where movement and thinking are combined. This includes balance and coordination.

⁸ Schizophrenia is a serious mental disorder in which a person interprets reality abnormally, to include hallucinations, delusions, and extremely disordered thinking and behavior.

⁹ This exam is the initial health assessment of patients with chronic conditions, conducted by a provider.

and noted a score of zero. The NP continued TRAN on the same medication regimen until a mental health provider could assess him.

On May 30, 2018, medical staff administered TRAN his first doses of haloperidol and fluoxetine, two days after he reported taking his last dose.

On June 4, 2018, a psychiatrist assessed TRAN, diagnosing him with schizophrenia and an anxiety disorder. The psychiatrist continued TRAN on the same medication but submitted an order to the pharmacy to change the administration times from morning to noon for fluoxetine and evening for haloperidol. The psychiatrist documented an AIMS score of three and that TRAN was exhibiting extrapyramidal symptoms (EPS),¹⁰ which he noted Cogentin¹¹ could address. However, the psychiatrist did not write the Cogentin order, which he later stated was an oversight. Furthermore, on this date, TRAN signed a consent form for the haloperidol and fluoxetine for the first time since arriving to EDC.

On June 5, 2018, TRAN received morning doses of fluoxetine and haloperidol. Although the psychiatrist submitted an order to change the time of TRAN's medication the day prior, the pharmacy received the change request after it had closed; therefore, the pharmacy did not process the new medication orders until they opened that morning, which was after morning pill call. At noon pill call, TRAN received a second dose of fluoxetine.

During the EDC special needs meeting a Unit Manager followed-up on a mental health referral for TRAN she submitted to medical the previous day. At 12:31 p.m., a psychologist assessed TRAN and noted he was extremely slow moving, lethargic, exhibited rigid movements with occasional hand tremors, and was sweating on his forehead. The psychologist placed TRAN on mental health observation (MHO) from June 5 to June 7, 2018, with nursing checks twice daily and security welfare checks every 15 minutes. An RN signed off on TRAN's medical clearance for MHO. At 2:49 p.m., an officer escorted TRAN to the Bravo 600 unit in MHO. At 3:00 p.m., the officer issued linens to TRAN in his cell.

The officer assigned to observe TRAN while in MHO documented that he checked the detainee at 3:09 p.m., 3:23 p.m., 3:38 p.m., 3:52 p.m., and 4:06 p.m. Video surveillance, however, does not support the first three welfare checks documented. At 3:51 p.m., per video surveillance footage, the officer first observed TRAN as he looked into his cell. Then at 4:13 p.m. the officer noticed TRAN was unresponsive, and at 4:15 p.m., the officer called a medical emergency.

At 4:16 p.m., additional officers responded and started cardiopulmonary resuscitation (CPR). Medical staff arrived two minutes later and assisted with rescue breaths, applied automated external defibrillator (AED) pads and performed other lifesaving efforts. It

¹⁰ Extrapyramidal symptoms are drug-induced movement disorders which include acute and tardive symptoms.

¹¹ Cogentin is the brand name for benzotropine, a drug used to treat symptoms of Parkinson's disease and the side effects of other drugs.

was later determined that medical staff applied the AED pads incorrectly, as they were only partially adhered. Medical staff performed CPR for 17 minutes until Emergency Medical Services (EMS) arrived at 4:33 p.m. and took over life-saving efforts. At 4:53 p.m., EMS transported TRAN to BCGMC and at 5:15 p.m., BCGMC initiated patient care.

Over the next seven days, doctors performed a series of tests to determine brain function and TRAN's capacity to breathe on his own. On June 12, 2018, BCGMC medical staff confirmed TRAN could not breathe on his own and pronounced brain death at 9:20 a.m. and cardiac death at 2:20 p.m.

On July 17, 2018, the Chief Medical Examiner of Pinal County signed the Forensic Examination Report and documented the cause of death as coronary artery disease.

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

1. ICE PBNDS 2011, *Medical Care*, Section (II)(20), which states, "Prescriptions and medications shall be ordered, dispensed and administered in a timely manner and as prescribed by a licensed health care professional. This shall be conducted in a manner that seeks to preserve the privacy and personal health information of detainees." Although the EDC NP prescribed fluoxetine and haloperidol at intake on May 28, 2018, TRAN did not receive his first dose for two days, May 30, 2018.
2. ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(4), which states, "Prior to the administration of psychotropic medications, a separate documented informed consent, that includes a description of the medication's side effects shall be obtained." FSF and EDC medical staff did not obtain a signed consent form from TRAN for psychotropic medication prior to administration on May 26 and May 30, 2018, respectively. When TRAN finally signed a consent form on June 4, 2018 at EDC, side effects were not listed.
3. ICE PBNDS 2011, *Custody Classification System*, Section (V)(A)(4), which states, "Each detainee's classification shall be reviewed and approved by a first-line supervisor or classification supervisor." A supervisor did not approve the classification rating assigned to TRAN on May 28, 2018.
4. ICE PBNDS 2011, *Special Management Units*, section (V)(M), which states, "Close Supervision Detainees in SMU shall be personally observed and logged at least every 30 minutes on an irregular schedule. For cases that warrant increased observation, the SMU personnel shall personally observe detainees accordingly." Per the psychologist's order, and following placement in MHO, CoreCivic officers were to conduct welfare checks on TRAN every 15 minutes. Surveillance footage evidence showed the CoreCivic officer on duty issued TRAN linens at 3:00 p.m. but

did not look into TRAN's cell again until 3:51 p.m. During the 51-minute period, the officer documented three welfare checks, none of which were supported by video surveillance.¹²

ERAU also noted several areas of concern, which are detailed in the attached report. If you have any questions, please contact me or have a member of your staff contact ERAU Acting Unit Chief (b)(6); (b)(7)(C) at (202) 71 (b)(6); (b)(7)(C)

Attachment

cc: Matthew Albence
Tae Johnson
Stewart Smith
(b)(6); (b)(7)(C)

¹² This officer resigned prior to ERAU's completion of this review (i.e. the week of July 17, 2018).



PINAL COUNTY
WIDE OPEN OPPORTUNITY

FORENSIC EXAMINATION REPORT
HUY-CHI TRAN
PINAL COUNTY ME CASE #18-303
CASA GRANDE POLICE DEPARTMENT
CASE #18-00036663

Pinal County

JUL 17 2018

Medical Examiner

A handwritten signature in dark ink, appearing to be 'HCT' or similar, located below the page number.

Report of Examination

ME Case number: 18-303
Agency, number: CGPD, 18-00036663
Decedent: Huy-Chi Tran
Date of birth: August 7, 1970
Date of death: June 12, 2018
Date of examination: June 14, 2018
Time of examination: 1000 hours
Investigator: (b)(6); (b)(7)(C)
Forensic Technician: (b)(6); (b)(7)(C)
Present at examination: (b)(6); (b)(7)(C) ICE

Cause of Death: Coronary artery disease
Manner of Death: Natural

July 17, 2018

Date Signed

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

Chief Medical Examiner

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

REPORTED CIRCUMSTANCES OF DEATH

The decedent was a 47-year-old unmarried Asian male who was an inmate at a prison in Eloy, Arizona. On June 5, 2018, he was found unresponsive in his single-man cell. Resuscitative efforts were initiated on scene, and the decedent was transported to Banner Casa Grande Medical Center. He was placed on life support in the Intensive Care Unit. When there was no response to treatment, those measures were removed. Brain death was pronounced at 0920 hours on June 12, 2018. He was then taken off of the ventilator, and cardiac death was pronounced at 1440 hours on June 12, 2018.

Past Medical/Social History

According to Banner Health Medical records

The decedent was reportedly found unconscious in his cell, and had been down for an unknown period of time. He received chest compressions for 10 minutes before EMS arrival. He was found to be in PEA, and received two rounds of epinephrine. A heartbeat subsequently returned and he was transported to Banner Casa Grande Medical Center. After admission he was diagnosed with clostridium difficile in the stool. He was declared brain dead. His condition continued to decline until death was pronounced on June 12, 2018.

- A. Acute kidney injury, likely due to severe hemodynamic acute tubular necrosis from cardiac arrest
- B. Anoxic brain injury
- C. Cardiogenic shock
- D. Acute respiratory failure
- E. Schizophrenia
 - a. Haloperidol
 - b. Fluoxetine
- F. Metabolic acidosis/respiratory alkalosis
- G. Possible clostridium difficile infection
- H. Leukocytosis
- I. Thrombocytopenia, possibly antibiotic related
- J. Gastrointestinal bleeding
- K. Status post cardiac arrest, on hypothermia protocol
- L. Acute renal and hepatic failure
- M. CT of the brain on June 5, 2018
 - a. No intracerebral arterial or venous activity
- N. Subsequently declared brain dead, initial CT of head negative for trauma
- O. Initial urine drug screen unremarkable
- P. CT of head in June 5, 2018
 - a. No acute intracranial abnormality identified
 - b. Findings suggestive of chronic sinusitis

- c. Presumed enteric tube appears coiled at the level of the nasopharynx

According to the medical records from Banner Casa Grande Medical Center

"This 47-year-old male was seen for evaluation 4B and nonresponsive. Medical staff responded to medical emergency call at 14:15 hours. Patient has no pulse and is not breathing, no reaction noted with sternal rub. Oxygen saturation was 48% at room air. Ambulance bagging with oxygen at 15 L/m was initiated while CPR was being done. Patient's shirt was cut in the middle of and AED pads were applied. Nursing staff attempted to obtain the patient's blood pressure but was unable to get a reading. Blood glucose was checked with a glucose which shows 280 mg/dL. Peripheral intravenous catheter insertion was attempted twice without success. Oxygen saturation reading was between 48% to 93% with peripheral pulse ranging from 50-115 during CPR. Provided examined oral cavity for up structuring and was returned. CPR lasted 17 minutes before the paramedics arrived. AED shocked the patient multiple times during the resuscitation but without a shockable rhythm. EMS assume resuscitation on 1633 hrs. IV was started via intravenous route. Patient was given Narcan and epinephrine. Cardiac monitor showed sinus rhythm. Patient was transferred to the ambulance en route to Banner Casa Grande Medical Center."

INITIAL EXTERNAL EXAMINATION

The body is received in a zippered body pouch secured by evidence seal number 00002659.

CLOTHING AND PERSONAL EFFECTS

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

EVIDENCE OF MEDICAL INTERVENTION

There is an endotracheal tube present in the mouth. There is an orogastric tube present in the mouth. There is a central line present on the right neck. There is a central line present on the left neck. There is an oval shaped compression pad present on the midline chest. There are two defibrillator pads present on the front of the chest. There are multiple EKG leads present on the front of the chest. There is a foley catheter in place. There is a pulse oximeter probe affixed to the right index finger. There are multiple needle puncture marks present on the left antecubital fossa. There is a needle puncture mark present on the right antecubital fossa.

EVIDENCE OF TRAUMA

There are bluish contusions on the midline lower chest from cardiopulmonary resuscitation. There are bilateral anterior rib fractures. There is a vertical fracture of the lower sternum with intercostal muscle contusion. There are mild infiltrative hemorrhages in the mediastinum.

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

SCARS, TATTOOS, AND OTHER IDENTIFYING BODY FEATURES

There are no significant scars or tattoos identified.

GENERAL EXTERNAL EXAMINATION

The body is cold to touch, subsequent to refrigeration. Rigor mortis is fully developed. Posterior red-purple lividity is partially fixed.

The body is that of a normally developed Asian male, measuring 68 inches in length and weighing 192 pounds. The general appearance is compatible with the reported age of 47 years. Scalp hair is black. The irises are brown, and there is no jaundice or lesions of sclera or conjunctivae. The nose is unremarkable. There is facial hair of a beard and mustache. The ears are unremarkable. The mouth is unremarkable. Teeth are natural. The neck is unremarkable. There are no palpable axillary, cervical, abdominal, or inguinal masses. The chest and back are symmetrical and unremarkable.

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

INTERNAL EXAMINATION

The body is opened by a standard Y-shaped thoracoabdominal incision. All viscera occupy their appropriate anatomic relationships. Subcutaneous adipose tissue ranges up to 3 cm in thickness over the abdominal wall. Serous surfaces are smooth and glistening throughout. There are no adhesions or significant free fluid accumulations in the body cavities.

CARDIOVASCULAR SYSTEM

The pericardium is unremarkable. The heart weighs 490 grams. The heart occupies its usual mediastinal site, and has a smooth epicardial surface. The external configuration is not remarkable. All major vessels arise in their appropriate anatomic relationships. The coronary ostia are normally placed and

are patent. The coronary arteries arise normally, are distributed in a right dominant pattern, and contain severe atherosclerotic changes, with stenosis ranging from 30% in the proximal right coronary artery, 20% in the distal right coronary artery, 75% in the left circumflex artery, 30% in the left anterior descending coronary artery, and 50% in the left main coronary artery. The atria and ventricles are of normal caliber, and are free of gross anomalies and thrombi. The myocardium is red-brown and firm, with focal red areas in the upper part of the interventricular septum measuring 1 x 0.5 x 2.5 cm. The dark red area is close to the atrial ventricular valve. A histologic section from this area is obtained. This is consistent with acute myocardial ischemia. The rest of the myocardium is grossly unremarkable. The ventricular thicknesses are as follows: left ventricle 1.2 cm, interventricular septum 1.1 cm, right ventricle 0.2 cm, with 0.7 cm epicardial fatty tissue present.

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

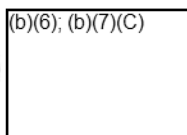
The aorta is of normal caliber, with all major arterial branches arising in their appropriate anatomic relationship. The intimal surfaces contain mild atherosclerotic changes in the abdominal aorta, without aneurysm formation or dissection. No systemic venous abnormalities or thrombi are present.

RESPIRATORY SYSTEM

The upper airway, larynx, and trachea are patent, with no evidence of edema, ulceration, or obstruction. There is a small amount of gastric contents present in the trachea. The right lung weighs 640 grams and the left lung weighs 630 grams. The pleural surfaces are smooth and glistening. The parenchyma is well expanded. Sectioning reveals pink to red-purple tissue with no areas of induration, consolidation, hemorrhage, or gross scarring. The bronchi and pulmonary vessels are patent and of normal caliber.

DIGESTIVE SYSTEM

The tongue is unremarkable. The oropharynx is grossly normal and unobstructed. The esophagus is of normal caliber, with a smooth, gray-white mucosal lining. The gastroesophageal junction is well defined. The stomach has intact mucosal surfaces. The lumen contains 900 mL of brown fluid with a large amount of partially digested food. There are multifocal mucosal hemorrhages in the gastric lumen. There is no evidence of bleeding in the gastric lumen. There are no areas of mucosal ulceration, erosion, or scarring. The small and large intestines are not remarkable. The appendix is present in the right lower quadrant and is unremarkable. The tan-gray, lobular pancreas has no focal abnormalities. The pancreatic ducts are patent and of normal caliber.



HEPATOBIILIARY SYSTEM

The 2190 gram liver has a smooth capsule, covering red-brown parenchyma with focal mottled appearance. The liver tissue appears to be friable. The cut surfaces show no diffuse or focal abnormalities. The intrahepatic and extrahepatic biliary ducts are unremarkable. The gallbladder contains viscid olive green bile, and is free of calculi. The gallbladder mucosa is grossly normal.

GENITOURINARY SYSTEM

The right kidney weighs 200 grams and the left kidney weighs 230 grams. The kidneys are similar in shape, with intact capsules covering smooth, red-brown parenchyma. The capsules strip with ease. The cut surfaces show poorly defined corticomedullary junctions. The calyces, pelves, and ureters are unremarkable. The renal vessels are patent and of normal caliber.

The urinary bladder contains no urine. There is approximately 20 mL of dark yellow urine in the foley catheter bag. The mucosal surfaces are flat and pink-tan. The prostate gland appears to be slightly enlarged with multiple nodules.

RETICULOENDOTHELIAL SYSTEM

The 170 gram spleen has an intact, smooth, and glistening capsule covering dark purple, moderately soft parenchyma. Regional lymph nodes have their usual distribution and appearance.

ENDOCRINE SYSTEM

The thyroid and adrenal glands are grossly not remarkable.

NECK

The cervical spine, hyoid bone, and thyroid cartilage are intact and unremarkable. An anterior layer by layer neck dissection reveals focal hemorrhages on the surface of the left omohyoid muscle measuring 2 x 0.2 cm and on the left sternohyoid muscle surface measuring 1 x 0.2 cm. These hemorrhages appear to be superficial and do not involve the muscular parenchyma. There is no other hemorrhage in the strap muscles or soft tissues of the neck.

MUSCULOSKELETAL SYSTEM

The bony framework, supporting musculature, and soft tissues are grossly normal.

NERVOUS SYSTEM

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

The dura and dural sinuses are unremarkable except for a thrombus in the superior sagittal sinus. There are no epidural, subdural, or subarachnoid hemorrhages. The brain weighs 1470 grams. The leptomeninges are thin and clear. The cerebral hemispheres are symmetrical, extremely soft, and disintegrate upon removal from the cranial cavity. The external landmarks for the superior cerebral surfaces are unremarkable with normal convolutional patterns, however the gyri appear to be edematous, with narrowing of the sulci. There are no uncal, subfalcial, transtentorial, or tonsillar herniations. Multiple sections of cerebrum, cerebellum, and brain stem reveal poorly defined gray-white borders and the brain tissue is extremely soft, consistent with anoxic encephalopathy. The ventricular system is symmetrical and compressed.

TOXICOLOGY SPECIMENS

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

- Vitreous fluid.
- Blood.
- Urine.
- Heart tissue.
- Admission specimens

The toxicology report is separate in the file.

MICROSCOPIC EXAMINATION

Multiple microscopic sections are reviewed. Apart from information listed below, histology findings correspond to the gross diagnoses and provide no further information.

Cassettes:

Heart: Multiple focal myocardial ischemia and necrosis with mild neutrophil infiltrates.

Lungs: Multiple microscopic foci and pneumonia; focal atelectasis; marked increase of macrophages.

FINAL SUMMARY

Based on the forensic examination findings and investigative history as available to me, it is my opinion that Huy-Chi Tran, a 47-year-old Asian male, died as a result of coronary artery disease.

The manner of death is natural.

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

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

Significant findings

- I. Sudden cardiac death due to coronary artery disease
 - a. Cardiopulmonary arrest, status post resuscitation
 - b. Myocardial ischemia and necrosis
 - c. Multiple organ failure
 - i. Multiple microscopic foci of pneumonia
 - ii. Myocardial ischemia and necrosis
 - iii. Acute renal failure
 - iv. Anoxic brain injury
 - v. Cardiogenic shock
 - vi. Acute respiratory failure
 - vii. Metabolic acidosis
 - viii. Possible clostridium difficile infection
 - ix. Thrombocytopenia
 - x. History of gastrointestinal bleeding
 - xi. Hepatic failure
 - xii. CT of the brain revealed no acute intracranial hemorrhage
 - xiii. Anoxic encephalopathy
- II. Schizophrenia
- III. Toxicology negative
- IV. No evidence of trauma

Laboratory Case Number: 3149324	Subject's Name: TRAN, HUYCHI
Client Account: 14185 / PCME01 Physician: Report To: Pinal County AZ Med Exam Offic ATTN: Pinal County 570 W. Adamsville Road Florence, AZ 85132 FX: 520-866-7296	Agency Case #: 18-303 Date of Death: 06/12/2018 Test Reason: Other Investigator: (b)(6); Date Received: 06/18/2018 Date Reported: 06/26/2018

Laboratory Specimen No: 40728713	Date Collected: 06/14/2018 10:30
Container(s): 01:RTB Blood, ILIAC	Test(s): 70530 Drugs of Abuse Panel, Blood

Analyte Name	Result	Concentration	Units	Therapeutic Range	Loc
AMPHETAMINES	Negative				
BARBITURATES	Negative				
BENZODIAZEPINES	Negative				
CANNABINOIDS	Negative				
COCAINE/METABOLITES	Negative				
FENTANYL	Negative				
METHADONE/METABOLITE	Negative				
OPIATES	Negative				
OXYCODONE/METABOLITE	Negative				
PHENCYCLIDINE	Negative				
PROPOXYPHENE/METABOLITE	Negative				
ALCOHOL	Negative				
Methanol	Negative				
Ethanol	Negative				
Acetone	Negative				
Isopropanol	Negative				
ANALGESICS	Negative				
BUPRENORPHINE	Negative				
STIMULANTS	Negative				
TRAMADOL/METABOLITE	Negative				

Specimens will be kept for two year from the date received.

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

Laboratory Director

TRAN, HUYCHI

Case Reviewer

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

Ph.D., F-ABFT

Laboratory Case #:3149324

Print Date/Time:06/26/2018, 10:02

Page: 1 of 1

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

DETAINEE DEATH REVIEW: Huy Chi TRAN, A037949945
Healthcare and Security Compliance Analysis
Eloy Federal Contract Facility
Eloy, Arizona

As requested by the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU), Creative Corrections participated in a review of the death of detainee Huy Chi TRAN while in the custody of the Eloy Federal Contract Facility in Eloy, Arizona. A site visit was conducted July 17-19, 2018 by ERAU staff (b)(6); (b)(7)(C) Management and Program Analyst and team leader, (b)(6); (b)(7)(C) Inspection and Compliance Specialist, and Creative Corrections contract personnel (b)(6); (b)(7)(C) Security Subject Matter Expert and (b)(6); (b)(7)(C) RN, Healthcare Subject Matter Expert. Contractor participation was requested to assess compliance with the ICE Performance Based National Detention Standards (PBNDS) 2011, revised 2016, governing medical care and security operations.

This report is a collaborative effort on the part of the SMEs who participated in the site visit and (b)(6); (b)(7)(C) Program Manager for the OPR/ERAU contract. Included in this report is a case synopsis, description of the facility and its healthcare services, a narrative summary of events, and conclusions. The information and findings herein are based on analysis of detainee TRAN's medical record and detention file; tour of the medical clinic, housing unit, and intake area; interviews of staff; and review of policies, video surveillance footage, and available incident related documentation.

SYNOPSIS

Huy Chi TRAN, 47 years old, was admitted to the Florence Special Processing Center on May 25, 2018 and was transferred to the Eloy Federal Contract Facility three days later, on May 28, 2018. He reported a long term history of schizophrenia and depression for which treated with psychiatric medications. A medical provider examined TRAN the day he was admitted and after consultation with a psychiatrist, ordered the medications which arrived with TRAN, Haldol and fluoxetine, pending psychiatric review. The medications were started the second day after they were ordered.

Pursuant to referrals from the provider and the intake nurse, the facility psychiatrist evaluated TRAN on June 4, 2018. The psychiatrist continued the medications, changing the administration times from morning to later in the day, and documented his intent to order Cogentin on a trial basis to address observed side effects of Haldol. The Cogentin was not ordered; the orders changing administration times for Haldol and fluoxetine were not processed until the next day, June 5, 2018. As a result of the delay, TRAN received two doses of fluoxetine within four hours. Determination of whether he was given two doses of Haldol is not possible due to ambiguous entries on the medication administration record.

The same day, June 5, 2018, a psychologist directed detainee TRAN's placement in the special management unit for mental health observation. The psychologist's evaluation resulted from a referral by security staff following observation that the detainee appeared lethargic and generally non-responsive to communications.

Approximately 75 minutes after TRAN was placed in segregation, he was found unresponsive in his cell and medical emergency was called. Prior to the medical emergency, the officer documented but did not conduct monitoring rounds every 15 minutes as ordered by the psychologist. Response to the emergency call by security and medical personnel was swift, although there was a brief delay while the first three security responders, all women, waited for male responders before entering the cell. Cardiopulmonary resuscitation was initiated by officers and 911 was called immediately. Officers continued chest compressions after medical staff arrived and performed life-saving efforts until paramedics took over care.

TRAN was taken by ambulance to the local hospital and was admitted to the intensive care unit. He remained on life support for one week, during which he was visited by family. Death was pronounced at 9:20 a.m. on June 12, 2018. The autopsy report cites cardiac arrest as the cause of death.

FACILITY DESCRIPTION

The Eloy Federal Contract Facility has been owned and operated by CoreCivic, formerly Corrections Corporation of America, since 1994. The facility is a dedicated Intergovernmental Service Agreement facility housing both male and female ICE detainees. The capacity is 1500. The population on the date of detainee TRAN's death was 1359, including 889 males and 470 females.

The facility has a double fence with razor wire on top and between the fences. The interior fence is equipped with stun technology to deter escapes. Staff and visitors enter from the main lobby, first placing their belongings through an x-ray machine, then passing through a metal detector. All persons entering the secure section of the facility must display a staff or visitor identification badge. Video surveillance cameras positioned throughout the facility monitor and record events.

The direct supervision model of detainee supervision is in place in general population housing units. Meals are served to general population detainees in a central dining hall. The control center is located off the main entrance and is staffed at all times (b)(7)(E) (b)(7)(E) handles radio traffic, the logbook and the shift report. The other officer controls doors and monitors cameras. During an emergency, the officer is able to access video from the closest camera in the area.

On each shift, a team of officers is designated to serve on the Emergency Response Team (ERT). As defined in CoreCivic Policy and Procedure 9-16, Emergency Response Team, the ERT is comprised of five members who respond to emergency calls with a specific piece of equipment such as a handheld video camera, fire extinguisher and cardiopulmonary resuscitation (CPR) valve. The ERT responded when medical emergency was called for detainee TRAN.

HEALTHCARE SERVICES

Eloy Federal Contract Facility received accreditation by the National Commission on Correctional Health Care (NCCCHC) in March 2015 and was audited for reaccreditation on May 31 and June 1, 2018. The health services department is staffed 24 hours a day, seven days a week by ICE Health Services Corp (IHSC) and contractor InGenesis Medical Staffing. The staffing plan authorizes 79 total positions, ten of which are commissioned officers of the U.S. Public Health Service. They include the Health Services Administrator (HSA), two assistant HSAs, one advanced practice provider¹, a nurse manager, two pharmacists, program manager, registered dental hygienist, and registered nurse (RN). There are two General Schedule (GS) for Federal Pay physician positions, one of which is the designated Clinical Director (CD). According to the HSA, the CD position has been vacant for four years. Until the position is filled, IHSC regional and headquarters physicians share responsibility for clinical oversight. InGenesis positions include a staff physician, psychiatrist, 21 RNs, an administrative assistant, seven advanced practice practitioners, five behavioral health professionals, one dentist, one dental assistant, 12 licensed practical nurses (LPN), six medical records technicians, two pharmacy technicians, and a radiology technician. Part time contract positions include one pharmacist and one psychiatrist; as needed positions include four RNs and two LPNs. The HSA reported that in addition to the CD position, the GS staff physician position was vacant at the time of the site visit.

The reviewer confirmed the credentials of healthcare staff were current and primary source verified. Training records for all medical and security personnel involved in the emergency response include documentation of cardio pulmonary resuscitation training in the past year.

The facility uses IHSC's e-Clinical Works (eCW) electronic medical record system. The reviewer notes that times the encounters were actually conducted are not available; therefore, medical encounter times identified in this report reflect system-generated time stamps documenting when associated vital signs were taken or providers electronically signed their notes.

DETENTION SUMMARY

Per the Telnate Report of telephone calls, detainee TRAN attempted seven phone calls during his detention, two of which were completed. Both completed calls were placed on May 29, 2018 and

¹ Advanced practice providers include nurse practitioners and physician assistants.

lasted seven and five minutes respectively. The calls were conducted in a language believed to be Vietnamese. Detainee TRAN had no visits. There was no documentation he filed any requests or grievances, and no record of any disciplinary reports.

Detainee TRAN was classified high custody by ERO. Although he qualified for medium custody based on the CoreCivic classification system, his rating was overridden to high based on the rating applied by ERO. TRAN was first assigned to a top bunk on an upper tier in a general population unit; then, within approximately six hours, he was moved to a lower bunk on the bottom tier because he had difficulty climbing to the top bunk. On the eighth day of his detention at EFCF, TRAN was transferred to the special management unit for mental health observation. He was in the special management unit for approximately 75 minutes before medical emergency was called.

SUMMARY OF EVENTS

Florence Service Processing Center (FSPC)

Friday, May 25, 2018

A medical pre-screen documented b(b)(6); (b)(7)(C) LVN notes detainee TRAN's time of arrival at the staging facility was 7:22 p.m. He was medically cleared for travel/transfer, with instruction to the receiving facility to follow up with his mental health diagnosis and treatment.

Saturday, May 26, 2018

At 4:48 a.m. b(b)(6); (b)(7)(C), RN completed the intake screen, noting detainee TRAN had been treated for depression for the past 20 years. He denied any suicidal history or current thoughts of self-harm. Vital signs entered at 4:46 a.m. were as follows: temperature 98.4, pulse 69, respirations 16, and blood pressure 109/75, all within normal limits. He height was five feet, four inches and he weighed 177.3 pounds. He was referred to the medical provider and medically cleared for custody.

A mental health note completed by b(b)(6); (b)(7)(C) CSW at 2:46 p.m. documents detainee TRAN was referred to her by medical staff. He reported a history of depression for the past 20 years but denied any past suicide attempts. He was not exhibiting any signs of a serious mental disorder or condition, and he denied auditory or visual hallucinations. Follow up appointment was scheduled for June 2, 2018.

Eloy Federal Contract Facility

Monday, May 28, 2018

Video surveillance footage from the north intake rear sallyport shows detainee TRAN exited a van with three other detainees at 9:26 a.m. At 9:28 a.m., Supervisory Deportation and Detention

Officer (SDDO (b)(6); (b)(7)(C)) is seen pointing to direct TRAN to enter the hallway. On interview, SDDO (b)(6); (b)(7)(C) recalled he directed TRAN to the hallway because the detainee was “sweating profusely” and he wanted the nurse to see him first for medical pre-screening. SDDO (b)(6); (b)(7)(C) said that when he asked TRAN if he was alright, he did not respond. He commented that a lot of detainees do not respond to questions because they are upset when they arrive. Other than perspiring, TRAN “seemed fine” to SDDO (b)(6); (b)(7)(C). During interview of ICE Deportation Officer (b)(6); (b)(7)(C) he confirmed SDDO (b)(6); (b)(7)(C) moved detainee TRAN to the head of the line so he would be the first to see the nurse. He recalled TRAN was sweating so much that he asked another detainee if the air conditioning was working in the van. The detainee stated it was. Officer (b)(6); (b)(7)(C) said that he asked TRAN if he was okay but received no response. He commented the detainee looked like he “was somewhere else.”

(b)(6); (b)(7)(C) was assigned to intake this date. On the video, she is seen speaking with detainee TRAN at **9:28 a.m.** and at **9:30 a.m.**, he signed some paperwork and entered the Intake area. Over the course of the next hour, TRAN was pat searched, walked through a medical detector, was given a property box, showered, changed into a facility uniform, and was placed in a holding cell with three other detainees. Once in the cell, he ate a sack meal. The EFCF Receiving and Discharge Log documents the time of his booking was **9:45 a.m.**

At **10:10 a.m.**, (b)(6); (b)(7)(C) signed a pre-screening note documenting TRAN was alert and his behavior and breathing were normal, but his appearance was anxious. The note also documents he spoke English fluently, that a medical transfer summary accompanied him from another facility, and that he was taking medications for current health problems. The pre-screening disposition was priority one.

Note: The video does not show any interaction between TRAN and medical personnel between 9:28 a.m. and 10:30 a.m. when he left the holding cell, ostensibly for medical intake screening (see below). Therefore, the reviewers conclude (b)(6); (b)(7)(C) pre-screening note documents her interaction with TRAN at 9:28 a.m. (b)(6); (b)(7)(C) made no reference to the profuse sweating observed by SDDO (b)(6); (b)(7)(C) and Officer (b)(6); (b)(7)(C).

The transfer summary referenced by (b)(6); (b)(7)(C) prepared at FSPC on the day TRAN was transferred and admitted to EFCF. The summary documents a diagnosis of schizophrenia and that he arrived at FSF with haloperidol² 5 milligrams (mg) to be taken once daily and fluoxetine³ 20 mg, also to be taken once daily. The summary includes the note, “Please follow up at receiving facility medication attached.” (b)(6); (b)(7)(C) RN, documents TRAN’s statement, “I have been treated for depression for past 20 years”. He denied suicidal or homicidal thoughts or history of hallucinations. He stated he had arrived with haloperidol and fluoxetine, both prescribed for morning dosing. He denied a history of attempting to harm himself or others or of being a victim

² Haloperidol, commonly known by the trade name Haldol, is an antipsychotic medication.

³ Fluoxetine treats depression and anxiety.

of physical or sexual assault. He denied smoking or having ever used alcohol or illicit drugs. The screen for symptoms of tuberculosis was negative, and he denied any dental problems. Vital signs entered at 4:46 a.m., were all within normal limits, as follows: temperature 98.4, pulse 69, respirations 16, blood pressure 109/75, and oxygen saturation 96. He denied pain, and he was found to be absent of adverse side effects related to use of the two psychotropic medications. The examination noted normal physical and emotional characteristics, with no disabilities, no disorganization of thoughts or behaviors, no agitation, and no barriers to communication. The skin assessment showed no abnormalities. The intake assessment was abnormal, he was referred to a medical provider for a complex physical examination, and he was medically cleared for custody.

At **10:30 a.m.**, TRAN is seen on video exiting the holding cell to see the nurse, presumably for intake screening.

Note: (b)(6); (b)(7)(C) entered an abbreviated intake screening in eCW, explaining during interview that she did not complete a full screening because TRAN was screened at FSF two days earlier.

Vitals signs entered at **10:43 a.m.** were all within normal limits, as follows: temperature 98.8, pulse 92, respirations 18, blood pressure 120/78, and oxygen saturation 95. His height was 64 inches; his weight was 176.4 pounds. He denied pain. His vision tested at 20/70 in the left eye, 20/100 in the right eye, and 20/70⁴ in both eyes (b)(6); (b)(7)(C) did not document whether TRAN was wearing corrective lenses or whether he was asked if he wore them in the past.

Note: Captain (b)(6); (b)(7)(C), HSA, stated during interview that detainees who are found to have vision deficits are either referred to optometry or are given a commissary form for purchase of reading glasses in a designated strength. A copy of the form is then filed in the medical record. Neither an optometry referral nor a commissary form were located in TRAN's record.

In her screening note, (b)(6); (b)(7)(C) described detainee TRAN as appropriate in behavior, in no acute distress, well developed, and well-nourished. He reported taking Haldol and fluoxetine for depression for a period of five years, and that he last took medications the previous afternoon. He denied hallucinations, anxiety, and depression. No symptoms of tuberculosis infection were observed and a purified protein derivative skin test was planted. The test was read as negative two days later. The assessment finding was "abnormal intake screening, referred to medical provider." In the Notes section of her intake screening entry (b)(6); (b)(7)(C) wrote that telephone encounters were sent to a provider and mental health for further evaluation. The telephone encounters, provided to reviewers on site, were sent to (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) psychiatrist.

⁴ 20/20 vision is considered normal, based on being able to see an object at 20 feet away. If vision is not 20/20, corrective lenses may be necessary.

Note: As discussed below, TRAN was examined by (b)(6); (b)(7)(C) later the same day; Dr. (b)(6); (b)(7)(C) evaluated TRAN on June 4, 2018.

Patient education brochures were provided and the detainee said he understood the teaching and instruction. TRAN signed a consent for general treatment.

During interview (b)(6); (b)(7)(C) explained that detainees who arrive with medications or with mental health issues are a priority and TRAN met both criteria. She stated her first impression was that he was okay but then noted he did not seem to fit in with the other detainees. She did not know if it was because they were Spanish speaking and TRAN spoke English, or if TRAN was simply anxious.

The video shows TRAN returned to the holding cell at **10:39 a.m.** He exited the holding cell at **10:48 a.m.** and reported to the Intake desk where his property was inventoried and documents were signed. Intake Officer (b)(6); (b)(7)(C) recalled during interview that detainee TRAN appeared “slow, he drooled and he didn’t clean himself.” She also stated he had “snot coming out of his nose.” She said she was not concerned about possible contagion because she assumed medical staff would have separated him from other detainees if he presented a health risk.

Officer (b)(6); (b)(7)(C) confirmed TRAN spoke and understood English. She commented that his fingertips were black and when asked if he smoked, he said he did. She took his fingerprints and photograph and entered his property in the computer. The property records show he arrived with one shirt and one pair each of underwear, pants, socks and shoes. He was allowed to maintain possession of various paperwork he brought with him. He signed acknowledgement of understanding that EFCF may monitor his mail and non-attorney phone calls. He also signed a receipt for the National ICE Detainee Handbook. The detainee provided the name (b)(6); (b)(7)(C) with a Phoenix area phone number as his emergency contact.

Detainee TRAN’s funds were inventoried by Officer (b)(6); (b)(7)(C) and another officer. He arrived with two checks in the amounts of \$24.47 and \$1.13. The total, \$25.60, was deposited into a commissary account. The Receiving and Discharge Checklist documents completion of all mandated admission processes, including that he was given the opportunity to make a telephone call and was issued linens, uniforms, hygiene items, the Prison Rape Elimination Act (PREA) Pamphlet and PREA Zero-Tolerance Policy. Officer (b)(6); (b)(7)(C) said that after she completed the intake processes she is responsible for, she sent the detainee to classification.

Case Manager (b)(6); (b)(7)(C) completed a CoreCivic Initial Custody Classification form, applying a total of six points. Per the form, six points qualified TRAN for a rating of moderate. Because high custody was documented on the ICE ENFORCE Application Suite Risk Classification Assessment Detailed Summary provided by ERC (b)(6); (b)(7)(C) recommended override of moderate to high custody. She signed her recommendation and the section, “Assistant

Warden/Administrator Review and Comments of Discretionary Over-Ride” approving her own action. When asked why she did not have a supervisor review her work, (b)(6); (b)(7)(C) stated that the classification supervisor position was vacant at the time and that “ICE had him Max” so it did not matter. Asked if she recalled detainee TRAN, she said she did because he had “snot” all over his face and did not wipe it off. She described him as “disgusting.” She said he was “very slow” and she had to ask each question two or three times before he replied.

(b)(6); (b)(7)(C) also completed the Sexual Abuse Screening Tool form and circled YES next to the question, “Detainee/resident appears to be physically, developmentally, or mentally disabled?” In the comments section, she wrote, “Slow, drools. Sneezes boogers + spits/cough”. In the check box for known victimization history or risk, Not Applicable is checked. When asked about the routing of this form, including whether it was shared with medical or mental health staff, Ms. (b)(6); (b)(7)(C) stated she was not sure. She added that because health care professionals evaluate detainees, she assumed they would identify any special needs. The form distribution designates a copy should be forwarded to the Health Services Department and a copy placed in the medical file.

Note: There is no evidence a copy of the form was forwarded to medical.

Note: (b)(6); (b)(7)(C) intake screening entry makes no reference to the conditions observed by (b)(6); (b)(7)(C) and Officer (b)(6); (b)(7)(C).

The video shows that at **11:00 a.m.**, detainee TRAN sneezed and was handed a tissue by the officer before he was returned to the holding cell. At **11:04 a.m.**, he was handed a second sack meal. He laid on a bench until called out at **11:07 a.m.**, returning two minutes later. He laid on the bench for most of time in the holding cell, exiting at **11:42 a.m.**

At **11:52 a.m.**, TRAN walked through Intake in a dark blue uniform signifying high custody and was provided with an identification bracelet. Per report of facility investigator (b)(6); (b)(7)(C) completed following TRAN’s death, he left intake at **11:56 a.m.** and was moved to North Medical. There, he waited until **12:47 p.m.** when escorted to an examination room for evaluation by NP (b)(6); (b)(7)(C).

Vital signs associated with (b)(6); (b)(7)(C) encounter with TRAN, entered at 12:46 p.m., were all within normal limits, as follows: temperature 98.8, pulse 92, respirations 16, blood pressure 120/78, and oxygen saturation 96. He denied pain. (b)(6); (b)(7)(C) medical record entry documents TRAN spoke fluent English. He reported a 17-year history of schizophrenia and anxiety disorder for which he was taking Haldol and fluoxetine with no adverse side effects. (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) was not interviewed by the review team. The HSA stated that for reasons unrelated to TRAN, her employment at EFCF ended prior to the site visit.

completed an Abnormal Involuntary Movement Scale (AIMS)⁶ to assess tardive dyskinesia, applying a score of zero.

Note: Tardive dyskinesia, a disorder characterized by involuntary movements, is a possible side effect of long term use of antipsychotic medications. Initial AIMS results may serve as a baseline for future monitoring or may prompt ordering of medication to address symptoms of the disorder. During interview of (b)(6); (b)(7)(C), Medical Doctor/Doctor of Osteopathy, Psychiatrist, he stated the AIMS test should be administered by properly trained healthcare professionals. There was no documentation of AIMS training in (b)(6); (b)(7)(C) record; however, she may have been trained in its administration as part of her education.

TRAN reported tobacco use, one pack per day for 13 years, with his last use over a month ago. He denied drug abuse and said he consumed two drinks per week; most recently, one to two years ago. He denied experiencing chest pain with exertion, shortness of breath, irregular heartbeat, palpitations, weakness, loss of appetite, or weight gain. The general examination noted all normal findings, including normal heart sounds. Dental examination found TRAN had no upper or lower teeth, and no dental prosthesis.

Note: (b)(6); (b)(7)(C) did not note the detainee had no teeth on the intake screening form. As noted, the FSF screening form documents he had no dental problems.

Note: There is no documentation (b)(6); (b)(7)(C) ordered a soft diet to assure safe and adequate nutritional intake.

In the "Psych" section of the form's General Examination section, (b)(6); (b)(7)(C) entered normal findings, including that TRAN was cooperative and oriented to person, place, and time. He had good eye contact and was cooperative with the examination. His demeanor was appropriate for the encounter; cognitive function appeared intact; judgment and insight was good; and his thought process was logical and goal directed without suicidal ideation or delusions (b)(6); (b)(7)(C) documented patient education included information on good hydration, hygiene, and access to medical, dental, and mental health care.

Note: The observations of CoreCivic intake personnel relating to slow movement and responses and mucous and spittle on TRAN's face were not noted by (b)(6); (b)(7)(C).

Prescribed treatment included Haldol 5 mg, one tablet orally for 14 days and fluoxetine 20 mg orally each morning for two weeks pending psychiatric evaluation. (b)(6); (b)(7)(C) wrote that the medications were discussed in a telephone call with (b)(6); (b)(7)(C) IHSC psychiatrist. She completed a mental health referral and signed her note at 5:50 p.m.

⁶ The AIMS scale assesses occurrence of tardive dyskinesia in patients receiving neuroleptic medications.

Note: The medication administration record (MAR) documents TRAN was given the first doses of Haldol and fluoxetine on May 30, 2018, two days and an unknown number of hours after he reported taking his last. The fact that (b)(6); (b)(7)(C) did not sign her May 28, 2018 note until 5:50 p.m. suggests she likely did not enter her medication orders until after the pharmacy closed, which would have delayed their processing until after morning medication administration time on May 29, 2018. Initial administration of the medications pursuant to (b)(6); (b)(7)(C) order was therefore, 5:00 a.m. on May 30, 2018. Whether or not (b)(6); (b)(7)(C) intended for TRAN to be given medication from the intake supply pending fulfillment of her orders cannot be determined based on documentation.

Note: (b)(6); (b)(7)(C) did not document discussion of the potential side effects of the medications with TRAN, nor did she obtain his specific consent to take them. He signed consent on June 4, 2018, six days after the medications were started.

A telephone encounter initiated by (b)(6); (b)(7)(C) 6:04 p.m. documents, "Encounter for general adult medical examination with abnormal findings", and lists lab studies to be done on May 31, 2018 to include thyroid studies⁷, lipid panel⁸, comprehensive metabolic panel (CMP)⁹, complete blood count (CBC) with differential¹⁰ and platelet count¹¹, and hemoglobin A1c¹². Laboratory results reported on June 1, 2018, showed all normal results, with the exception of very mild elevations in calcium and sodium levels¹³.

Note: (b)(6); (b)(7)(C) makes no reference to ordering lab tests in her encounter note.

Per Investigator (b)(6); (b)(7)(C) report, TRAN left the examination room at 1:22 p.m. and walked to the Delta Unit. Delta Unit Manager (b)(6); (b)(7)(C) informed the review team that at the time, the Delta Unit housed detainees classified medium high and high. Delta Unit is comprised of five separate pods off a main vestibule. The "desk officer" assigned to the vestibule controls slider doors to each pod. The five pods are numbered from left to right starting with pod D100. The pods are directly supervised by an officer posted in each dayroom between 5:00 a.m. and 10:00 p.m. From 10:00 p.m. to 5:00 a.m. (b)(7)(E) assigned to the unit share responsibility for making rounds in each pod. Each unit has a unit manager and two correctional counselors.

⁷ Thyroid studies are a series of blood tests used to measure how well the thyroid gland is working to produce major hormones.

⁸ Lipid panel is a panel of blood tests which serve as initial screening for abnormalities in cholesterol and triglycerides.

⁹ A CMP is a blood test that gives doctors information about the body's fluid balance, levels of electrolytes, and how well the kidneys and liver are working.

¹⁰ CBC with differential is a blood test that gives doctors information about the cells in a patient's blood and the concentration of various proteins and minerals.

¹¹ Platelet count is a blood test which measures the number of blood-clotting cells.

¹² Hemoglobin A1c is a blood test that provides a three-month average of glucose concentration in the blood.

¹³ Elevation in sodium and calcium levels may result from dehydration.

The pod to which detainee TRAN was assigned, D100, has 25 two-person rooms. Rooms 101 through 112 are on the lower tier and are numbered from left to right; rooms 113 through 125 are on the upper tier and are also numbered from left to right. There is a staircase in the middle of the tiers. The pod has a central dayroom with six metal tables, each of which has eight attached seats. There are individual shower stalls located along the right side. Telephones, televisions and a microwave oven are also available in the dayroom.

Detainee TRAN was initially assigned to the upper bunk in cell 125. According to Officer (b)(6); (b)(7)(C) who was assigned as to D100 this date, the other detainee assigned to cell 125 reported TRAN was unable to climb to the top bunk and needed to be moved. Officer (b)(6); (b)(7)(C) told the review team that detainee TRAN was, "in La La Land." He stated TRAN would look "right through you and made no eye contact." Officer (b)(6); (b)(7)(C) contacted one of the unit counselors and was told he could not move TRAN because the time for count was approaching. Officer (b)(6); (b)(7)(C) then instructed detainee TRAN to place his mattress on the floor of the cell until transfer could be arranged. He recalled that the other detainee¹⁴ in the cell was upset and stated, "I can't live with this guy."

Phone records show that between **3:21 p.m.** and **5:05 p.m.**, detainee TRAN attempted four telephone calls. None were successfully completed.

Per Investigator (b)(6); (b)(7)(C) report, TRAN moved to cell 103 on the lower level at **7:06 p.m.** Cell 103 has a metal door with a viewing window in the upper portion. A metal desk is attached to the left wall; a window with bars is on the back wall. The bunk bed set is on the back right wall and toward the front is a porcelain toilet and sink. A distress button near the door alerts at the pod officer's desk and in central control.

The review team interviewed TRAN's cellmate in cell 103, (b)(6); (b)(7)(C). He stated detainee TRAN told him he was from China. For the first four days they were housed together, TRAN did not shower. Detainee (b)(6); (b)(7)(C) stated he told TRAN that other detainees were complaining that their cell stunk and he needed to shower. Detainee TRAN said he did not have any soap, (b)(6); (b)(7)(C) informed him soap was available for free in the showers. Detainee TRAN took a shower that day and every two days thereafter. (b)(6); (b)(7)(C) stated he woke TRAN for breakfast and lunch each day, and did not recall TRAN ever leaving the unit for activities such as library or recreation. (b)(6); (b)(7)(C) reported that on only one occasion did TRAN go to the dayroom to watch television and he fell asleep in his chair. Detainee (b)(6); (b)(7)(C) stated that detainee TRAN never mentioned feeling sick, but he did observe TRAN walked slowly and it took him a long time to get up from his bunk. (b)(6); (b)(7)(C) said he thought the slow movements may have been related to TRAN's culture but looking back, he realized TRAN "probably was sick."

¹⁴ The review team did not interview this detainee because according to Investigator (b)(6); (b)(7)(C)'s report, he was released on June 8, 2018.

Tuesday, May 29, 2018

Detainee (b)(6); (b)(7)(C) TRAN signed a Unit Admission and Orientation Acknowledgement form. Investigator (b)(6); (b)(7)(C) report documents he left the unit for recreation at **9:16 a.m.** and returned at **11:23 a.m.** He also left the unit for all three meals and for pill call¹⁵.

At **4:58 p.m.**, he unsuccessfully attempted a telephone call. He completed a call at **7:06 p.m.** which lasted five minutes and another at **7:58 p.m.** which lasted seven minutes. Both were made to the number listed for his emergency contact.

Wednesday, May 30, 2018

Investigator (b)(6); (b)(7)(C) report documents TRAN left the unit for all three meals and for pill call. He also went to visitation from **12:16 p.m.** to **1:19 p.m.** SDDO (b)(6); (b)(7)(C) informed the review team that he met with his assigned DO at this time, (b)(6); (b)(7)(C)

Thursday, May 31, 2018

Investigator (b)(6); (b)(7)(C) report documents the detainee left the unit and went to medical at **1:57 a.m.** He also attended all three meals and reported for pill call.

Note: There is no documentation of a medical or mental health encounter this date.

Officer (b)(6); (b)(7)(C) returned to work after two days on leave. He recalled that TRAN came out of his cell and sat in a chair to watch a movie with other detainees. Soon, detainee TRAN's head was down and appeared to be either sleeping or daydreaming. Officer (b)(6); (b)(7)(C) stated another detainee walked behind TRAN and flicked the back of his neck with his finger. Officer (b)(6); (b)(7)(C) stated TRAN did not react and he told the other detainee to leave TRAN alone.

At some point during his shift, Officer (b)(6); (b)(7)(C) stated that a new lock had to be placed on detainee TRAN's property box. Officer (b)(6); (b)(7)(C) instructed TRAN to empty the box so he could temporarily remove the box from the cell and replace the lock. He stated detainee TRAN just sat on the bunk and stared at him. Officer (b)(6); (b)(7)(C) recalled the property box contained no personal property and no commissary; just a pair of socks and underwear. Officer (b)(6); (b)(7)(C) stated it would have taken "two minutes" to empty the box but detainee TRAN could not do it. He stated detainee TRAN "walked like a zombie, like he was sleepwalking."

Friday, June 1, 2018

Investigator (b)(6); (b)(7)(C) report documents the detainee left the unit for all three meals and for pill call. He also went to visitation. Per SDDO (b)(6); (b)(7)(C) detainee TRAN met with DO (b)(6); (b)(7)(C) the facility's travel document request/consulate liaison officer.

¹⁵ Pill call refers to times medications are given to detainees by nursing staff.

Saturday, June 2, 2018

Investigator (b)(6); (b)(7)(C) report documents the detainee left the unit for all three meals and for pill call. He also played a game with other detainees in the dayroom and briefly watched television.

Sunday, June 3, 2018

Investigator (b)(6); (b)(7)(C) report documents the detainee left the unit for all three meals and for pill call.

UM (b)(6); (b)(7)(C) stated on interview that detainee TRAN first came to her attention this date because he took a long time to eat his meal in the dining hall. She stated that at one point, the captain offered TRAN the opportunity to take his meal tray back to the unit so he need not rush to eat. TRAN declined and left with the other detainees. UM (b)(6); (b)(7)(C) stated the detainee was "almost zombie like" and had "tunnel vision."

Monday, June 4, 2018

Investigator (b)(6); (b)(7)(C) report documents TRAN left the unit for all three meals and for pill call. He also spent approximately one hour in the dayroom with the other detainees.

UM (b)(6); (b)(7)(C) completed a mental health referral this date stating, "He seems very distraught, yesterday I observed Tran while he was eating very slow. When asked by the Assistant Shift Supervisor (b)(6); (b)(7)(C) if he would like to take his tray back to the unit he stated "No" Tran does not respond to unit staff when help is offered to him." UM (b)(6); (b)(7)(C) stated on interview that she delivered the referral to the officer in medical because she considered it urgent. She shared she has a special needs child so she is particularly alert and sensitive to persons with special needs.

At **1:02 p.m.**, detainee TRAN left Delta Unit for medical, arriving at **1:06 p.m.** At **2:58 p.m.**, he went with the psychiatrist to his office. At **3:30 p.m.**, he walked in the hallway while the psychiatrist watched him and then returned to the psychiatrist's office.

Detainee TRAN's evaluation was conducted by (b)(6); (b)(7)(C). In his medical record entry, Dr. (b)(6); (b)(7)(C) documented he completed a "face-to-face, with sound privacy" assessment to address TRAN's history of schizophrenia with medication treatment. He explained during interview that the encounter was conducted in his office, with a Core Civic officer standing outside his door in full view of the detainee. Although described as alert, awake and oriented to time, place, and person, (b)(6); (b)(7)(C) found TRAN was a poor historian, with inconsistencies in his reports of mental illness and medication treatment.

Note: TRAN's vital signs were not taken for this encounter.

In the social history section of his note, (b)(6); (b)(7)(C) wrote that TRAN was born in Vietnam but at the age of 12, he and his family escaped their country and moved to Thailand. At age 14, he migrated to the United States and went as far as the twelfth grade in school. His work history consisted of working in a warehouse for one week.

TRAN reported he began hearing voices at age 20 but started medication treatment just two years ago. He stated he used to hear voices “telling him to do things.” He also reported that he experienced visual hallucinations in the past and that he believed others can insert thoughts in his mind. TRAN stated since taking Haldol, “its [*sic*] been more than a year since he last heard voices, seeing things, or thought that people can insert thoughts in his mind.” He denied thought broadcasting¹⁶ or withdrawal, and described his anxiety as restlessness and being uncomfortable around people. He reported taking fluoxetine for anxiety. TRAN denied chest pain, dizziness, increased sense of embarrassment, depressed mood, feelings of hopelessness or helplessness, and suicidal ideation, intent or plan.

TRAN reported he received outpatient treatment at Southwest Network in Chandler, AZ from 2013 to 2017; also, that he was treated while in prison from 2017 to 2018. (b)(6); (b)(7)(C) noted his criminal history included aggravated assault and disorderly conduct, and that his last conviction involved threats made against his sister with a knife. TRAN reported he did not take his medication for three months prior to the incident. He last used alcohol two years ago, two cans per weekend, but denied illicit drug abuse. He admitted to smoking one pack of cigarettes per day for the past 13 years.

The mental status findings described TRAN as cooperative, tremulous, and showing mild psychomotor retardation¹⁷. He demonstrated minimal arm swinging while walking and was described as having an intense, sustained stare. His speech showed prolonged latent response periods, and his thought process was “slow and impoverished¹⁸.” His mood was described as euthymic¹⁹ and his affect as blunt. TRAN’s thought content showed no suicidal or homicidal ideation, intent or plan, and his insight and judgment were determined fair.

The examination findings included an AIMS assessment which resulted in a documented score of three.

Note: Although (b)(6); (b)(7)(C) wrote that the total score was three, he applied level one scores for four symptoms²⁰. The correct score was four.

The assessment findings were schizophrenia and anxiety disorder. (b)(6); (b)(7)(C) continued fluoxetine and Haldol in the same doses for treatment of anxiety and schizophrenia, respectively, but rewrote the orders to change administration times. Instead of morning administration, fluoxetine was to be given at noon and Haldol at night. (b)(6); (b)(7)(C) explained during interview

¹⁶ Thought broadcasting is the belief others can hear or are aware of an individual’s thoughts.

¹⁷ Psychomotor retardation refers to a slowing down of thoughts and a reduction of physical movements in an individual.

¹⁸ According to (b)(6); (b)(7)(C) impoverished responses were short, usually yes or no, without elaboration.

¹⁹ Euthymic refers to a tranquil mood.

²⁰ According to the Encyclopedia of Mental Disorders, items on the AIMS test are rated on a scale severity from zero to four. A rating of one is minimal severity.

that patients who receive morning doses are awakened at 4:00 a.m., and he felt it was necessary for TRAN to have uninterrupted sleep. (b)(6); (b)(7)(C) wrote in his note that he discussed the risks, benefits and alternatives to fluoxetine and Haldol with TRAN. The risks associated with fluoxetine listed in the note were dry mouth, headache, increased agitation/anxiety and nausea. Dry mouth and headache were also listed as risks associated with Haldol, as were tardive dyskinesia, malignant syndrome (MS)²¹, and sexual psychosis, depression, anxiety, irritability, homicidality, suicidality, and extrapyramidal symptoms (EPS)²². (b)(6); (b)(7)(C)'s note includes his observation that TRAN was, in fact, exhibiting EPS "which will be addressed with cogentin²³ trial." Detainee TRAN signed a consent form for both Haldol and fluoxetine.

Note: The consent form states potential side effects were explained to TRAN but does not list them. As noted previously, TRAN did not sign a consent before the psychiatric medications were started on May 30, 2018.

Note: Consistent with his note, (b)(6); (b)(7)(C) ordered discontinuation of the initial fluoxetine and Haldol orders in favor of a new prescriptions changing administration times to noon and night, respectively. However, Commander (b)(6); (b)(7)(C) Chief Pharmacist, stated during interview that because the orders were written after normal pharmacy hours, they were not processed until after TRAN was given early morning doses of both medications the next day, June 5, 2018. According to the MAR, he was erroneously given a second dose of fluoxetine at 12:00 p.m. per the new prescription. The same error did not occur with respect to Haldol; however, the MAR includes both a note stating an evening dose of Haldol was not given due to "Detainee at hospital" and a 4:00 p.m. entry consisting of a partially circled letter A that HSA (b)(6); (b)(7)(C) was unable to interpret. This documentation on the MAR suggests the medication may have been offered had TRAN not been taken to the hospital before its administration was due. As detailed below, a medical emergency was called at 4:15 p.m., resulting in TRAN's transport to the hospital.

Note: Although (b)(6); (b)(7)(C) documented in his note that Cogentin was to be started for treatment of EPS, he did not write the order. He stated during interview that failure to write the order was an oversight. The reviewer notes that if Cogentin had been ordered, and unless ordered stat, the medication would not have been given until the next day because as discussed above, the pharmacy was closed when (b)(6); (b)(7)(C) wrote medication orders resulting from his encounter with TRAN.

²¹ Malignant Syndrome is a rare, but life-threatening, idiosyncratic reaction to neuroleptic medications characterized by fever, muscular rigidity, altered mental status, and autonomic dysfunction. It often occurs shortly after the initiation of neuroleptic treatment, or after dose increases.

²² Extrapyramidal symptoms are drug-induced movement disorders which include acute and tardive symptoms.

²³ Cogentin is the brand name for benztropine, a drug to treat Parkinson symptoms and side effects of other drugs.

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

directed that TRAN's records from the Arizona Department of Corrections and Southwest Network outpatient clinic be requested. Psychiatric follow-up was scheduled for four weeks.

Note: The requested records were received by EFCF; however, (b)(6); (b)(7)(C) informed the review team they were not provided prior to TRAN's death.

The video shows TRAN exited the psychiatrist's office at **3:42 p.m.** and returned to Delta Unit at **3:49 p.m.**

Tuesday, June 5, 2018

Investigator (b)(6); (b)(7)(C) report documents detainee TRAN left the unit for breakfast, lunch and pill call. He twice placed a chair in front of the TV but appeared to fall asleep with his head down.

UM (b)(6); (b)(7)(C) informed the review team that she discussed TRAN at a morning meeting convened by the Warden to discuss detainees with special needs. She stated meetings for this purpose are held weekly and attended by ERO personnel, healthcare staff, unit managers and security supervisors. UM (b)(6); (b)(7)(C) stated she reported she had submitted a referral and health care staff noted his name.

Per Investigator (b)(6); (b)(7)(C) report, an officer went to TRAN's cell at **12:15 p.m.** and the detainee left the unit for medical thereafter. Video footage shows he entered the medical waiting room at **12:22 p.m.** At **12:31 p.m.**, he followed (b)(6); (b)(7)(C) Schroeder, psychologist, down the hallway and into her office.

(b)(6); (b)(7)(C) stated on interview that she received a "vague referral" from CoreCivic which stated he seemed distressed at lunch.

Note: As discussed above, (b)(6); (b)(7)(C) submitted a written referral the day before.

(b)(6); (b)(7)(C) stated detainee TRAN walked very slowly and seemed "sluggish." As they walked to her office, she kept looking behind her to make sure he was following. He sat slowly in a chair but kept his arms in the air. She said he made "inconsistent eye contact", was "staring off into space", and seemed "disengaged." (b)(6); (b)(7)(C) described him as soft spoken and hesitant in his responses. She recalled asking him multiple times if he was OK and he replied, "I'm fine." He got up and walked around a few times while in the office.

(b)(6); (b)(7)(C) medical record entry documents the same information. Following is the text of her narrative note:

“[Patient] presented as depressed and apathetic. He exhibited flat affect with alogia²⁴. Additionally, he presented as extremely slow moving, lethargic, and exhibited rigid movements with occasional hand tremors. [Patient] got out of his seat twice during this session, and when asked if he was alright, said that he ‘needed to move,’ without further explanation. [Patient] was encouraged to step out into the hallway for a moment to walk briefly. It appeared that [patient] was sweating on his forehead, and his hands appeared to be shaking toward the end of the session. Initially [patient] denied [symptoms] of depression; however, later in the discussion, after pointing out that his presentation was inconsistent with his self-report, he later acknowledged experiencing ‘some depression [sic]. [Patient] acknowledged that he has been moving more slowly overall, which began in the last few weeks. [Patient] denied issues with sleep or appetite. [Patient] denied past and current [auditory visual hallucinations]. It should be noted that during his initial intake on 5/2/18 at Florence, he reported experiencing [auditory visual hallucinations] prior to taking his psychotropic medication. [Patient] said that he has been consistently taking his psychotropic medication. [Patient] exhibited longer pauses between responses toward the end of the session. He appeared somewhat distracted. At one point, [patient] asked why he was being asked these questions. [Patient] was cooperative overall, though he ultimately said that he didn’t want to talk anymore. In terms of coping mechanisms, [patient] reported that he attends recreation, but said that he spends his time sitting. He said that he talks to other males in his pod, but also acknowledged that he has had difficulty conversing with others, as he feels nervous, for the past several weeks. He was unable to identify why he felt nervous. [Patient] denied thoughts of self-harm, plan, and intent.”

Note: Given the physical symptoms TRAN exhibited, referral to a prescribing provider may have been prudent.

(b)(6); (b)(7)(C) note states TRAN was to be placed on mental health observation status with nursing checks twice daily and checks by Core Civic every 15 minutes. She also directed follow-up in two to three days.

(b)(6); (b)(7)(C) stated that she determined the detainee should be placed in Bravo 600 so he would be in a more restricted environment and could be monitored more closely. The review team was informed this unit houses special needs detainees with sex-based crimes who cannot safely be housed in the general population, and detainees needing mental health observation and suicide watch. Consistent with her medical record entry (b)(6); (b)(7)(C) completed a Special Needs Form directing twice daily nursing checks and checks by the unit officer every 15 minutes. Dr. (b)(6); (b)(7)(C) informed the review team that she handed the form to the medical officer.

²⁴ Alogia is a poverty of speech, in which a general lack of additional, unprompted content is seen in normal speech.

Based on the Special Needs Form, an administrative segregation order was approved by Captain (b)(6); (b)(7)(C). (b)(6); (b)(7)(C) stated that before a detainee can be placed in segregation for medical observation, both a Special Needs Form and medical clearance are required. Medical clearance is documented on TRAN's administrative segregation order by way of a stamp signed by RN (b)(6); (b)(7)(C).

Note: The medical record does not document medical clearance for segregation. During interview, (b)(6); (b)(7)(C) acknowledged that she reviewed TRAN's record, only, and did not assess him in person. Asked about documenting clearance in the medical record, she said that if she did not make an entry, she was supposed to. (b)(6); (b)(7)(C) confirmed that detainees being placed in segregation are to be seen in person.

Video shows TRAN exiting (b)(6); (b)(7)(C) office at **1:07 p.m.**, then reversing course and returning to her office. At **1:10 p.m.** an officer arrived and he, along with the psychologist, escorted TRAN down the medical corridor where the officer appears to instruct him to take a seat. At **2:50 p.m.** Senior Correctional Officer (Sergeant) (b)(6); (b)(7)(C) arrived to escort detainee TRAN to Bravo 600 Unit. Sergeant (b)(6); (b)(7)(C) stated TRAN was seated in front of the medical officer who informed him TRAN was anxious. Sergeant (b)(6); (b)(7)(C) said the detainee kept standing up and asked if he could leave. When Sergeant (b)(6); (b)(7)(C) replied yes, TRAN asked where he was going. The sergeant told him he was being moved to another unit so medical could keep a closer eye on him. Sergeant (b)(6); (b)(7)(C) stated the detainee was "not all there" and seemed like someone "burnt out on drugs."

Video footage shows detainee TRAN was escorted into Bravo 600 Unit at **2:54 p.m.** and to cell 606 at **2:56 p.m.** by Officer (b)(6); (b)(7)(C) the officer assigned to the unit. Bravo 600 has 24 cells, 12 to the left of the officer's station, designated as the west side, and 12 on the right, designated as the east side. Sex offenders are housed on the west side; detainees on mental health observation status and suicide watch are housed on the east side. The east and west sides are accessed through separate gates.

Detainee TRAN's cell, 606, is the second cell on the east side. The cell is solid steel with a window on the top half and a food/handcuff portal on the lower half. A concrete slab is located in the center of the cell with a mattress placed on top. On the rear wall is a window with bars. A stainless steel combination sink and toilet fixture is located to the right front of the cell. The east side dayroom has steel tables and affixed stools, a shower stall to the left of the entryway and an outdoor recreation area at the rear.

The EFCF Post Orders for the Bravo 600 officer require that the officer, "conduct any special watches as directed by medical staff" and that all security checks be "properly documented and logged." EFDC Policy 10-100, Segregation/Restrictive Housing Unit Management, states that all detainees housed in SMU "will be personally observed by an officer." EFCF does not have an electronic system for recording security rounds; therefore, officers document cell checks on the

Confinement Watch Logs posted on clipboards outside each cell and in the unit logbook. Between TRAN's placement in cell 606 at 2:56 p.m. and the medical emergency logged at 4:15 p.m., Officer (b)(6); (b)(7)(C) documented on TRAN's Confinement Watch Log that he checked on him at 3:09 p.m., 3:23 p.m., 3:38 p.m., 3:52 p.m., and 4:06 p.m.

As detailed below, video evidence does not support that (b)(6); (b)(7)(C) made the first three checks documented. Investigator (b)(6); (b)(7)(C) informed the review team that (b)(6); (b)(7)(C) resigned from CoreCivic on June 14, 2018, and shared that he would have been terminated had he not resigned. In her report, Investigator (b)(6); (b)(7)(C) discussed her interview of (b)(6); (b)(7)(C) prior to his resignation. He confirmed he received the Special Needs Form and was aware detainee TRAN was to be checked every 15 minute checks. When Investigator (b)(6); (b)(7)(C) asked (b)(6); (b)(7)(C) about the discrepancies between his log entries and the video evidence, he stated the times may have been off because he does not make entries right away. He claimed he looked into TRAN's cell as he walked by and that every time, the detainee was moving and breathing. Per Investigator (b)(6); (b)(7)(C) report, (b)(6); (b)(7)(C) stated TRAN was sitting on the edge of his bed for the first two documented security checks and on the next check, was laying on his stomach with his arms tense and one leg elevated.

Based on the reviewer's analysis of housing unit video, (b)(6); (b)(7)(C) entered TRAN's cell with a bag at **3:00 p.m.**, exiting 35 seconds later. Per Investigator (b)(6); (b)(7)(C) report, the bag contained linens. Officer (b)(6); (b)(7)(C) informed her that when he brought TRAN his bedding, the detainee did not say a word and seemed to be shaking a little.

Over the course of the next 51 minutes, video shows Officer (b)(6); (b)(7)(C) in the vicinity or walking past detainee TRAN's cell on five occasions, never looking in to confirm the detainee's welfare. At **3:15 p.m.**, he marked clipboards at three nearby cells but does not look in any of the three. After marking the clipboards, he passed TRAN's cell at **3:17 p.m.** without stopping. At **3:27 p.m.**, Officer (b)(6); (b)(7)(C) is seen at the clipboard by TRAN's cell but does not look in. At **3:45 p.m.**, the video shows Officer (b)(6); (b)(7)(C) placing an orange card on TRAN's cell door to indicate he was on medical observation status but again, he does not look in the cell. At **3:47 p.m.**, Officer (b)(6); (b)(7)(C) placed an orange card on the cell door next to TRAN's, 605, and spoke to Officer (b)(6); (b)(7)(C) who was assigned to constant watch vigil for the detainee assigned to the cell. At **3:51 p.m.**, (b)(6); (b)(7)(C) is seen on video looking into TRAN's cell and marking the clipboard. He then stood at the door looking in. (b)(6); (b)(7)(C) then moved from cell 605 to look in TRAN's cell, after which Officer (b)(6); (b)(7)(C) opened then closed the door to the cell. He did not enter.

(b)(6); (b)(7)(C) left the east side at **3:55 p.m.** He returned at **4:04 p.m.** and after delivering a meal tray to another cell, opened the food portals in TRAN's and another detainee's cells. At **4:06 p.m.**, (b)(6); (b)(7)(C) handed (b)(6); (b)(7)(C) sack meal for the detainee on suicide watch and placed a meal tray on TRAN's food portal. After (b)(6); (b)(7)(C) moved away to deliver a tray to another cell, (b)(6); (b)(7)(C) appears to look in TRAN's cell. At **4:08 p.m.** when (b)(6); (b)(7)(C) passed the sack meal to the detainee on suicide watch, TRAN's tray remained on the food portal. Officer

(b)(6); (b)(7)(C) then looked again into TRAN's cell. At **4:11 p.m.**, (b)(6); (b)(7)(C) delivered a meal to another cell. On his way back to the officer's station, he stopped at TRAN's cell briefly before moving on, but does not look in. A minute later, **4:12 p.m.**, Officer (b)(6); (b)(7)(C) returned to the cell and looked directly in. He turned to speak to a detainee in the dayroom, then returned his gaze to inside TRAN's cell. (b)(6); (b)(7)(C) removed the tray from the portal and exited the east side. He returned at **4:13 p.m.** and opened the cell door. He entered then exited quickly, leaving the door ajar. Investigator (b)(6); (b)(7)(C) report documents that (b)(6); (b)(7)(C) told her that when he entered the cell, he touched TRAN's leg, then touched his hand and shook his back. He noted the detainee's back was warm. (b)(6); (b)(7)(C) said he then yelled out to TRAN and heard (b)(6); (b)(7)(C) tell him to call a medical emergency. The video shows that after (b)(6); (b)(7)(C) exited the cell, he started to leave the immediate vicinity then returned to the cell and spoke into his radio.

Note: The reviewer concludes that when (b)(6); (b)(7)(C) is seen speaking into his radio, he called medical emergency. The time entered in the Confinement Watch Log, likewise, the Central Control log, was 4:15 p.m., reasonably close to the time shown on video.

The video shows (b)(6); (b)(7)(C) moving away from TRAN's cell at **4:14 p.m.** and at **4:15 p.m.**, he moved toward the front of the east side, motioning to the detainee in the dayroom to return to his cell. Another officer arrived and escorted the detainee to his cell as (b)(6); (b)(7)(C) returned to TRAN's cell and opened the door wider.

Correctional Counselor (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) were first to respond to the medical emergency call, arriving at **4:16 p.m.** Officer (b)(6); (b)(7)(C), who was the designated camera operator for the ERT this date, carried a handheld video camera. None of the three entered the cell. Upon interview and in their statements to Investigator (b)(6); (b)(7)(C) they all stated they did not enter for their own safety. They noted TRAN was a level three male detainee and they could not be certain he was not feigning illness. (b)(6); (b)(7)(C) reported that when she arrived, she passed (b)(6); (b)(7)(C) who was exiting the area. He pointed to cell 606 and said, "This is the cell." She called out to TRAN three times from the doorway but he did not respond.

Note: EFDC Policy, Segregation/Restrictive Housing Unit Management, 10-100, section 10-100.4, (E)(2)(c) states, "Staff members equal to the number of inmates/residents assigned to the cell will be present prior to opening any occupied cell door."

Per the video footage, Lieutenant (b)(6); (b)(7)(C) and Officer (b)(6); (b)(7)(C) arrived 22 seconds later and entered the cell. Officers (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) followed. Lieutenant (b)(6); (b)(7)(C) confirmed that when he arrived on the unit (b)(6); (b)(7)(C) were standing outside the cell. He said that when he and Officer (b)(6); (b)(7)(C) entered TRAN's cell, he was laying on his stomach with his face in the pillow. Lieutenant (b)(6); (b)(7)(C) reported that when he rolled the detainee onto his right side, TRAN was "cold to the touch and stiff." He recalled that a yellow/reddish discharge was coming from the detainee's nose and that the detainee was not breathing. He stated on interview that he instructed security staff to begin CPR, later instructing that they rotate

performance of chest compressions after every four series to avoid fatigue. Office (b)(6); (b)(7)(C) conducted the first round. Lieutenant (b)(6); (b)(7)(C) said that after directing initiation of CPR, he immediately radioed Central Control to direct calling 911. The video shows he stepped out of the cell at **4:17 p.m.** and spoke into his radio, presumably to direct the 911 call.

Note: Although the Central Control log documents the call was not made until 4:21 p.m., the Eloy Fire District Prehospital Care Report documents a unit was dispatched at 4:19 p.m., suggesting the call was made quickly after Lieutenant (b)(6); (b)(7)(C) direction. The Central Control log details other events with times inconsistent with video evidence. Because the officers in Control were not in a position to directly witness events, the reviewer concludes the entries were made as information was reported and do not reflect the times events occurred. For that reason, Central Control log entries are not included in the below recounting of events unless not documented elsewhere.

The video shows (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) arrived at **4:17 p.m.** At **4:18 p.m.**, three additional medical staff are seen on video entering the east side with a gurney and the emergency bag. They included NP (b)(6); (b)(7)(C) and two nurses. At **4:20 p.m.**, NP (b)(6); (b)(7)(C) arrived, followed at **4:22 p.m.** by PA (b)(6); (b)(7)(C). At **4:23 p.m.**, Captain (b)(6); (b)(7)(C) arrived and stood outside the cell for one minute before leaving. He stated during interview that he stayed only briefly because Lieutenant (b)(6); (b)(7)(C) had the incident under control.

Video taken by (b)(6); (b)(7)(C) with the handheld camera captures events within the cell. For 46 seconds there was sound but no video. (b)(6); (b)(7)(C) explained on interview that the lens cover would not fully open, necessitating Lieutenant (b)(6); (b)(7)(C) assistance before the camera started recording video. Despite the delay, the video captures emergency response efforts by security and medical staff, detailed below. The video ends after eight minutes and 43 seconds, prior to arrival of emergency medical services (EMS) responders. (b)(6); (b)(7)(C) stated that he instructed Office (b)(6); (b)(7)(C) to stop recording after he asked Captain (b)(6); (b)(7)(C) if the event should be recorded. Captain (b)(6); (b)(7)(C) confirmed that when he reported to the scene, he told the lieutenant to stop recording because "it was a medical procedure." When asked if he considers CPR a medical procedure, he replied that never in his career in corrections has he recorded CPR.

As noted (b)(6); (b)(7)(C) was the first medical responder to arrive on scene. In her medical record entry, she wrote TRAN was laying on the bed, unresponsive and not breathing; also, that officers had started CPR. The video from the handheld camera shows she applied a pulse oximeter²⁵ to the detainee's right index finger which, according to her note, resulted in a very low finding of 48 percent. She noted a sternal rub was performed without effect, and a faint irregular pulse was found on the right wrist.

²⁵ A pulse oximeter is a small piece of equipment placed on the finger to measure pulse oxygen.

(b)(6); (b)(7)(C) is seen on the video entering the cell 46 seconds after (b)(6); (b)(7)(C). Per the RN's note, he took over as leader of the emergency response. In NP (b)(6); (b)(7)(C) medical record entry, he noted officers were performing chest compressions and manual breaths. During interview of Officer M (b)(6); (b)(7)(C) she confirmed she performed two rescue breaths using the CPR mask she brought to the scene. (b)(6); (b)(7)(C) remarked to the review team that because officers were performing chest compressions very well, he made the decision to let them continue. On the video, he is seen checking TRAN's left wrist for a pulse and according to his note, found none. (b)(6); (b)(7)(C) note also documents the detainee was not breathing and he had no reaction to a sternal rub.

The video shows (b)(6); (b)(7)(C) removed the automated external defibrillator (AED) from the case and attempted to apply the pads under TRAN's shirt. He is heard asking for another provider. (b)(6); (b)(7)(C) then seen cutting TRAN's shirt, revealing that the AED pads were placed on the upper abdomen and did not adhere to TRAN's body. (b)(6); (b)(7)(C) medical record entry (see below) confirms this observation, describing the pads as "partially adhered."

Note: Proper placement of AED pads is one pad on the front of the chest above the right nipple and the other one on the left side of the chest below the breast area. Although the pads were later repositioned, their placement remained imperfect throughout the emergency response.

Note: For an AED to provide accurate analysis and effective shock during a sudden cardiac arrest, AED pads must make proper contact with the patient's skin.

During interview (b)(6); (b)(7)(C) said he did not know whether the pads were expired, which may have caused the gel to be dry and non-adhering. He stated his assumption that the pads did not stick because TRAN was perspiring profusely. (b)(6); (b)(7)(C) stated it did not occur to him to dry TRAN's skin and if available in the emergency bag, apply new pads.

Note: The reviewer found the emergency bag inventory did not include an extra set of AED pads.

Per (b)(6); (b)(7)(C) note, "AED analyzed the patient multiple times during resuscitation but without a shockable rhythm." (b)(6); (b)(7)(C) note cites three as the number of times no shock was advised.

The video shows and (b)(6); (b)(7)(C) note documents other rescue efforts, including placement of an ambu bag for administration of oxygen while CPR was performed. The video recording shows the ambu bag did not seal properly until TRAN's head was tilted. (b)(6); (b)(7)(C) informed the review team that she made the suggestion to do so, commenting that the medical responders seemed overwhelmed and nervous. A medical record entry by (b)(6); (b)(7)(C) documents she maintained the ambu bag mask in position to ensure it remained sealed until EMS responders

arrived. (b)(6); (b)(7)(C) also documented two attempts to establish an intravenous (IV) line²⁶ were unsuccessful, and that nursing staff could not find a blood pressure. A glucometer reading showed blood glucose was significantly elevated at 208²⁷. During CPR, oxygen saturation fluctuated between an abnormally low level of 48 to a near normal level of 93, with peripheral pulse ranging from a low 50 beats per minute to an elevated 115.

As noted previously, (b)(6); (b)(7)(C) heard on the handheld camera video requesting that another provider be called to the scene. The medical record entries of (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) both document that they responded to the request. (b)(6); (b)(7)(C) wrote that she helped lead the team and coordinated care between security and medical responders to relieve (b)(6); (b)(7)(C) pending arrival of EMS. She assisted with the ambu bag and attempted to insert an IV without success. Her assessment of femoral and brachial pulses²⁸ were without positive result.

(b)(6); (b)(7)(C) note documents that he “took a brief medical/psych history to Bravo 600 where patient was housed.” When he arrived, officers were performing chest compressions and NP (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) were managing the airway and giving two breaths every 30 compressions. (b)(6); (b)(7)(C) wrote that twice while TRAN was assisted with breathing, he listened for heart sounds or breath sounds and heard breath sounds, only. (b)(6); (b)(7)(C) also documented the information discussed above concerning the AED and the fluctuation in pulse oxygen noted by (b)(6); (b)(7)(C) adding that there was no reading when the compressions were stopped. Concerning attempts to insert an IV (b)(6); (b)(7)(C) wrote that the first attempt was successful for a short time, but not long enough to administer fluids. He made the second attempt and was unsuccessful.

An entry to the Rear Gate Logbook documents the ambulance arrived at **4:30 p.m.** The Eloy Fire District Report corroborates this time. Video from the housing unit camera shows EMS responders entered the east side at **4:33 p.m.**, their arrival having been facilitated by Officer (b)(6); (b)(7)(C). During interview Officer (b)(6); (b)(7)(C) stated Captain (b)(6); (b)(7)(C) had earlier instructed him to open both entrance gates near Bravo 600 so the ambulance could pull right in.

As reported by Lieutenant (b)(6); (b)(7)(C) and documented by (b)(6); (b)(7)(C) EMS responders took over CPR upon arrival. The Eloy Fire District report notes the responders observed “an AED had been placed by medical staff, while ventilations and high quality CPR were being performed”.

Note: CPR by EFCF personnel lasted 17 minutes before the paramedics arrived. Officers rotated performance of chest compressions throughout while medical personnel performed other life-saving efforts.

²⁶ An intravenous line is a portal, established by a hollow-bore needle and connected to plastic tubing, through which fluids and medications can be administered directly into the vein.

²⁷ A normal blood glucose level is roughly 70 to 140.

²⁸ Femoral and brachial pulses are those felt in the inner thigh and inner aspect of the elbow.

Per (b)(6); (b)(7)(C) medical record entry, EMS responders started an IV line via interosseous²⁹ route. (b)(6); (b)(7)(C) entry specifies access was obtained on the anterior tibial area of the left leg. Both document Narcan³⁰ and one dose of epinephrine³¹ were administered. Asked for his understanding of why Narcan was administered, (b)(6); (b)(7)(C) explained it is a routine EMS procedure. (b)(6); (b)(7)(C) documented EMS responders placed their own AED leads on TRAN and were able to obtain a weak pulse. TRAN was placed on a back board and moved to an EMS gurney. (b)(6); (b)(7)(C) note also documents that the cardiac monitor showed sinus rhythm³² before the detainee was moved to the ambulance for transport to the Banner Casa Grande Medical Center. The Eloy Fire District Report corroborates the information documented by the EFCF providers.

The housing unit video shows TRAN's placement on the EMS gurney at **4:44 p.m.** and the responders' departure with the gurney from the east side at **4:45 p.m.** Video from the Bravo Entrance Walk shows the gurney was lifted onto the ambulance which at **4:51 p.m.**, moved through the first perimeter gate. Per entry to the Rear Gate Logbook, the ambulance exited the secure compound at **4:53 p.m.** The Eloy Fire District report documents the time of departure was 4:51 p.m.

Officers (b)(6); (b)(7)(C) were assigned to hospital detail, Officer (b)(6); (b)(7)(C) driving the chase vehicle and Officer (b)(6); (b)(7)(C) in the ambulance. Officer (b)(6); (b)(7)(C) recalled on interview that the ambulance drove with both lights and siren activated and arrived at the hospital in approximately 15 minutes. The time of arrival documented in the Hospital Logbook is **5:14 p.m.**; the time of arrival documented in the Eloy Fire District report is 5:11 p.m. (b)(6); (b)(7)(C) stated that upon arrival in the emergency room, TRAN was placed on a respirator and he heard medical staff say he had a low pulse. The detainee was then moved to the intensive care unit (ICU). Officer (b)(6); (b)(7)(C) made appropriate entries to the Hospital Logbook for the remainder of his shift, as did officers assigned to vigil duty during TRAN's hospitalization until the time of his death (see below).

According to the Pertinent Report of the Banner Health Emergency Department, provider care was initiated by (b)(6); (b)(7)(C) at **5:15 p.m.** Following testing, the documented diagnosis was "acute cardiopulmonary arrest with return of spontaneous circulation, suspect anoxic brain injury." The report states TRAN was to be admitted to the ICU.

Chief of Security (b)(6); (b)(7)(C) notified the Warden that following the emergency, he met with all EFCF responders in his role as a member of the CoreCivic Incident Stress Management Team. He assessed how they were coping and reminded them that the Employee Assistance Program was available.

²⁹ Interosseous refers to marrow within bones.

³⁰ Narcan is used to treat narcotic overdose in an emergency situation.

³¹ Epinephrine is a hormone produced by the adrenal glands which functions to increase cardiac output and to raise glucose levels in the blood.

³² Sinus rhythm refers to a normal heart beat.

Wednesday, June 6, 2018

A hospital update electronically signed at 4:05 a.m. by RN (b)(6); (b)(7)(C) documents TRAN was stable with vital signs within normal limits. He was on a ventilator and receiving hypothermia therapy³³, and his current medication treatment included anodyne³⁴, propofol³⁵, Levophed³⁶, Zosyn³⁷ and normal saline.

Officers' Hospital Logbook entries include the following:

Time	Entry
5:57 a.m.	X-ray taken.
6:45 a.m.	Detainee "being held under observation for 24 hours, being cooled down due to suffering from cardiac arrest per medical staff."
9:00 a.m.	Detainee would be "warmed to regular temp for further evaluation."
10:15 a.m.	Labs being taken. Per the doctor, "did not look promising" but tomorrow "would tell Tran's mental state."
5:26 p.m.	Captain Meiner approved visit by detainee's father (b)(6); (b)(7)(C). In follow up calls, Captain (b)(6); (b)(7)(C) approved visits by the detainee's sister and mother.
7:57 p.m.	Detainee TRAN's mother and father arrived to visit, leaving at 9:39 p.m.

Thursday, June 7, 2018

A hospital update signed at 2:04 a.m. by (b)(6); (b)(7)(C) documents TRAN's condition was unchanged. He remained unresponsive with no reflexes. A rewarming process was initiated the night before and his target temperature was reached at 37 degrees Celsius³⁸. The goal was to maintain that temperature for 72 hours. Paralytic³⁹ medication was discontinued, and his current medications included Versed⁴⁰, Protonix⁴¹, normal saline, Flagyl⁴² and Zosyn via IV and vancomycin⁴³ via oral-gastric tube. He was scheduled to see an intensivist⁴⁴ later that day.

³³ Sinus rhythm refers to a normal heart beat.

³⁴ Anodyne is a drug used to lessen pain by reducing the sensitivity of the brain or nervous system.

³⁵ Propofol is a type of drug which causes relaxation and sleepiness before and during medical procedures.

³⁶ Levophed is the brand name for norepinephrine, a drug used to treat low blood pressure and heart failure.

³⁷ Zosyn is an antibiotic medication used to treat infections.

³⁸ 37 degrees Celsius is 98 degrees Fahrenheit.

³⁹ Paralytics are drugs which cause muscle paralysis.

⁴⁰ Versed is a brand name for midazolam, a sedative medication used to help patients feel relaxed or sleepy before a medical procedure.

⁴¹ Protonix is a brand name for pantoprazole, a drug used to treat gastroesophageal reflux disease and damaged esophagus.

⁴² Flagyl is a brand name for metronidazole, a drug used to treat infections.

⁴³ Vancomycin is a drug used to treat infections.

⁴⁴ An intensivist is a physician who specializes in the care of critically ill patients, most often in the ICU.

A second update was signed by (b)(6); (b)(7)(C) at 11:13 a.m. TRAN's condition remained unchanged. He was unresponsive with no pupillary reflex⁴⁵, pain response, or signs of waking. His core body temperature remained steady at 37.1 Celsius⁴⁶. The treatment goal was to continue monitoring his neurological status. Versed was discontinued at 3:00 a.m. Current medications were Flagyl and Zosyn intravenously and vancomycin via oral-gastric tube. The most recent vital signs were elevated pulse of 109, elevated blood pressure of 132/85, and respirations 24 and oxygen saturation 97 percent, both per ventilator settings. There was evidence of kidney injury. The neurologist wanted to wait to perform an electrocardiogram (EEG)⁴⁷ until other medications were discontinued.

Officers' Hospital Logbook entries include the following:

Time	Entry
2:30 a.m.	Per nurses, sedation was reversed at 2:00 a.m.
3:30 a.m.	"Tests from doctors have turned up negative results so far showing no higher brain functions. Dr.'s will be in to see Detainee Tran in the morning for further evaluation."
9:15 a.m.	TRAN's parents visited for one hour. During the visit, the doctor informed them that their son's recovery "did not look good."
12:20 p.m.	The ICU doctor stated TRAN "may not wake up."
1:45 p.m.	A nurse stated there was "some pupil reaction to light very faint but there was some difference from the morning there was none."

Friday, June 8, 2018

A hospital update signed at 1:38 a.m. by RN (b)(6); (b)(7)(C) documents TRAN's condition remained unchanged. He was essentially unresponsive with the exception of some sluggish pupillary reflex to the left eye. There were no signs of waking or pain response. Vitals signs were essentially within normal limits as follows: temperature 37 Celsius, pulse 100, blood pressure 114/65, respirations 24 based on vent setting, and oxygen saturation 94 via ventilator with 30 percent room oxygen. The plan was to perform an EEG that day.

Officers' Hospital Logbook entries include the following:

Time	Entry
10:45 a.m.	The doctor asked who can authorize dialysis. He was referred to ICE.
11:33 a.m.	The doctor arrived to evaluate TRAN and the family arrived for visitation.
12:00 p.m.	The doctor updated the family on TRAN's condition and treatment plan.

⁴⁵ Pupillary reflex refers to the changes in diameter of the pupils when exposed to light.

⁴⁶ 37.1 degrees Celsius is 98.7 degrees Fahrenheit.

⁴⁷ An EEG is a test used to record and monitor electrical activity of the brain.

1:10 p.m.	The family was asked to leave so dialysis ⁴⁸ tubing could be implanted. The tube was planted in detainee TRAN's neck at 1:45 p.m.
7:55 p.m.	TRAN's family returned at 7:55 p.m. and departed at 10:00 p.m.

Saturday, June 9, 2018

(b)(6); (b)(7)(C) signed a hospital update at 3:37 a.m. documenting the following vital signs within normal limits: temperature 36.3 Celsius⁴⁹, pulse 96, blood pressure 105/66, respirations 24 per vent setting, and oxygen saturation 95 on ventilator with 30 percent room air. In an addendum timed 3:38 a.m., (b)(6); (b)(7)(C) wrote that TRAN's condition was unchanged; he remained unresponsive with no pupillary reflex, no pain response, and no signs of waking. He received dialysis the day before and no fluids were taken out. The current treatment goal was to continue monitoring his neurological status. His medications remained the same. Tube feeding was started late the day before to help stabilize his blood glucose levels. An EEG was to be performed after all medications were discontinued, more improvement was observed, and sedating medication had been discontinued for a minimum of 72 hours.

A second update was signed by (b)(6); (b)(7)(C) 1:06 p.m. TRAN's condition remained unchanged. He was unresponsive with pupils fixed and dilated, had no pain response, and no signs of waking. Dialysis was underway. The treatment goal was to continue monitoring his neurological status. Most recent vital signs were within normal limits. An EEG and brain stem testing were to be done "most likely Monday."

Officers' Hospital Logbook entries include the following:

Time	Entry
9:20 a.m.	Dialysis was started and ended at 6:00 p.m.
10:35 a.m.	Three family members arrived to visit detainee TRAN. A fourth family member joined the group at 1:00 p.m. and two additional family members arrived at 2:55 p.m. The group visited throughout the day. The last visitor left at 7:53 p.m.
8:23 p.m.	TRAN's sister arrived and stayed until 11:00 p.m.

Sunday, June 10, 2018

A hospital update signed at 1:08 a.m. by (b)(6); (b)(7)(C) documented TRAN's condition remained unchanged; pupils fixed and dilated, no pain response, and no signs of waking. Vital signs were normal. The treatment goal was to continue monitoring his neurological status.

Officers' Hospital Logbook entries include the following:

⁴⁸ Dialysis is the clinical purification of blood, as a substitute for the normal function of a kidney.

⁴⁹ 36.3 degrees Celsius is 97.3 degrees Fahrenheit.

Time	Entry
12:12 a.m.	TRAN's sister arrived and stayed until 1:33 a.m.
5:00 p.m.	TRAN's parents arrived. His sister returned later. The last visitor left at 10:40 p.m.

Monday, June 11, 2018

A hospital update signed at 6:31 a.m. by (b)(6); (b)(7)(C) documents TRAN's condition remained the same. His pulse and blood pressure were abnormally elevated at 103 and 160/106, respectively; respirations at 16 and oxygen saturation at 96 were normal on the ventilator. A CT scan⁵⁰ may be done to determine any brain changes from the baseline scan done on June 5, 2018.

A second update was signed by R (b)(6); (b)(7)(C) at 10:21 a.m. TRAN's condition remained unchanged. His blood pressure was abnormally elevated at 154/106. Other vital signs were within normal limits. A CT scan was to be completed that day.

Officers' Hospital Logbook entries include the following:

Time	Entry
9:00 a.m.	A test was conducted to determine if TRAN could breathe on his own. "He did not breath [sic] on his own without the machine."
9:25 a.m.	A family member arrived. Others arrived throughout the day
9:55 a.m.	Two doctors informed TRAN's sister "there is little chance Detainee Tran will pull through."
11:55 a.m.	An echo cardiogram was conducted.
1:15 p.m.	A doctor spoke with TRAN's family members about organ donation if there is no brain functioning after testing.
2:55 p.m.	A neuron X-ray ⁵¹ was conducted.
4:42 p.m.	Dialysis was started and continued until 7:08 p.m.

Tuesday, June 12, 2018 – Day of Death

A hospital update signed at 1:42 a.m. by (b)(6); (b)(7)(C) documents TRAN's condition remained unchanged. Results of a MRI⁵² were pending. Reported vital signs were within normal limits.

Office (b)(6); (b)(7)(C) was assigned to hospital vigil duty for the 2:00 a.m. to 2:00 p.m. shift. He reported during interview that hospital staff conducted a test to determine if the detainee had brain waves. Per entry to the hospital logbook, the test began at 8:43 a.m. Office (b)(6); (b)(7)(C) said that

⁵⁰ A CT scan is an x-ray which produces computerized cross-sectional images of specific areas of the body.

⁵¹ A neuron x-ray refers to a particular kind of brain x-ray used to determine proof of brain death.

⁵² An MRI is a non-invasive test which uses a powerful magnetic field, radio frequency pulses, and a computer to produce detailed picture of specific areas of the body.

after the test, hospital staff left the room and a few hours later, a woman came to inquire about organ donation, asking to speak with an EFCF supervisor. When connected via telephone with a captain, she informed him TRAN had been pronounced dead at 9:20 a.m. Officer (b)(6); (b)(7)(C) said this was the first he heard that death had been pronounced. He remarked that he was confused because the detainee remained on a ventilator throughout his shift, which ended at 2:00 p.m. (b)(6); (b)(7)(C) later completed an incident report documenting these events.

A telephone encounter by (b)(6); (b)(7)(C) dated 3:55 p.m. documents an EEG conducted early that morning showed no brain activity. Findings were confirmed with apneic testing⁵³ also conducted that morning. Detainee TRAN was declared brain dead at 9:20 a.m. Family members had been notified and were expected to arrive to the hospital that afternoon. The plan was to discontinue the ventilator at that time.

Note: As noted, the time the telephone encounter was entered was 3:55 p.m. The time the information was received from the hospital is not documented but based on the information below, is presumed to be earlier.

Officer (b)(6); (b)(7)(C) was relieved by Officers A (b)(6); (b)(7)(C). Both submitted incident reports documenting that at 3:39 p.m. detainee TRAN was removed from life support. At 3:53 p.m. two medical examiners arrived and took photos of TRAN. At 4:06 p.m., Officer (b)(6); (b)(7)(C) was given documentation stating custody of the body was transferred to the Pinal County Medical Examiner's Office. At 4:04 p.m., Officers (b)(6); (b)(7)(C) escorted the medical examiners to their transport van. Officer (b)(6); (b)(7)(C) stated during interview that TRAN's family members were at the hospital when the coroner arrived. He reported a Casa Grande Police Department officer arrived as well.

Note: The incident reports of Officers (b)(6); (b)(7)(C) do not document that the family was present when the medical examiner arrived, nor do they document that a police officer arrived.

Hospital logbook entries document different times for events described in the officers' incident reports. Entries state TRAN was taken off life support at 2:39 p.m., the medical examiner took photos at 3:09 p.m., and the body was moved to the medical examiner's vehicle at 3:59 p.m.

Note: It is unknown whether the incident reports or log book entries document the correct times.

⁵³ Apneic testing is an essential component in the clinical determination of brain death. The main objective of apnea testing is to prove the absence of respiratory control system reflexes in the brainstem when intense physiologic stimulation to breathe takes place.

Post-Death Documentation and Actions

- The hospital discharge summary dated June 12, 2018 documents the following:

“A 47-year-old male with unknown medical history was brought into the emergency department after code arrest. The patient was incarcerated, and two corrections officers saw the patient unresponsive while they were doing room checks, which prompted them to call emergency services. Chest compressions were started prior to EMS arrival. Patient received several rounds of epinephrine along with CPR. Upon arrival to hospital patient was admitted to the ICU. He was found unresponsive and was intubated. Patient remained intubated and unresponsive while work up was completed, no clear evidence of any trauma was found. An extensive discussion was had with parents at bedside, with the sister on phone, and explained about the patient’s critical condition, about comatose state, and told them chances of meaningful neurological recovery would be very low. Family understood. On June 11, brain nuclear study was ordered to prove brain death. There was a technical error with the contrast and the tracer returning incomplete results, and the plan was to repeat the study in 24 hours. On June 12, case discussed with [neurology] and ICU, and instead of repeating imaging, apnea test⁵⁴ was performed and returned positive for brain death. Clinical [neurological] examination was also positive for brain death. Care withdrawal today in coordination with organ donor network”.

- Per the Banner Health Human Remains Release Form, detainee TRAN was pronounced dead by (b)(6); (b)(7)(C) of Banner Casa Grande Medical Center at 9:20 a.m. The listed diagnosis was, “Anoxic encephalopathy, post code, Acute Respiratory Failure, no respiration, Acute Renal Failure.”
- The State of Arizona Certification of Vital Records, Certificate of Death issued June 14, 2018 lists the immediate cause of death as pending.
- A letter from the Consulate General of Vietnam dated June 19, 2018 documents TRAN’s body was turned over to the family for burial.
- The Pinal County Forensic Examination Report, dated July 17, 2018, documents the cause of death as coronary artery disease and the manner of death as natural. There was no evidence of trauma.
- EFCF Investigator (b)(6); (b)(7)(C) conducted a review of events during detainee TRAN’s full period of detention. She reported she was given this assignment by the Warden on the day of TRAN’s death, June 12, 2018. In conducting the review, Investigator (b)(6); (b)(7)(C) interviewed

⁵⁴ Apneic testing is a brain death assessment in which all ventilator support is temporarily removed. A positive test is defined by a total absence of respiratory effort under this condition.

security and medical staff and analyzed video footage showing TRAN's movements. In her report, signed June 19, 2018, she concluded the following:

- Information received regarding detainee's placement in Bravo 600 for mental health observation was minimal and provided little insight for security staff to address detainee's needs.
 - **Note:** (b)(6); (b)(7)(C) commented that detainees' health information is not shared with officers.
- Detainee TRAN was not examined by a medical practitioner prior to mental health observation placement as he would have been had he been placed in segregation.
 - **Note:** TRAN was, in fact, assigned to administrative segregation when placed in Bravo 600 for mental health observation. The nurse documented medical clearance based on review of his chart, but failed to see him in person.
- Officer (b)(6); (b)(7)(C) did not complete checks at the required intervals and did not properly document those checks.
- As the reporting party, Officer (b)(6); (b)(7)(C) did not exhibit a sense of urgency given the nature of the emergency.
- Responding female security staff were observed outside of the detainee's cell and did not enter the cell until male staff arrived.
- Officer (b)(6); (b)(7)(C), who was on constant watch at the next cell, did not maintain the required visual observation of his assigned detainee.
- During CPR, airway head tilt and AED pad placement were noted as concerns.
 - **Note:** As discussed above, the concern regarding the airway head tilt related to the fact that medical responders did not take this action until suggested by Officer (b)(6); (b)(7)(C).

Although not discussed in her report, Investigator (b)(6); (b)(7)(C) stated during interview that she "thought it strange" that some medical responders remained in the Bravo 600 dayroom while officers conducted the chest compressions. She also commented that AEDs were previously removed from all housing units and turned in to medical. Investigator Potter noted that despite having multiple AEDs available, medical ironically ended up with one where the pads did not stick. HSA (b)(6); (b)(7)(C) explained that AEDs were removed from housing units because the requirement to inspect them daily and replace them regularly was resource intensive. He said response to medical emergencies was not compromised because medical staff must arrive at the scene within four minutes, with AED.

Note: Failure of the pads to adhere may have been caused by TRAN's perspiration rather than expired or faulty pads. Regardless, as noted, a second set of pads was not available in the emergency bag when the first set did not adhere.

- (b)(6); (b)(7)(C) informed the review team that following the medical emergency, he clarified with the responding officers that a cell may be entered when (b)(7)(E) are present, regardless of the gender of the detainee or responders. He also stated the handheld camera was sent for repair of the slide action that jammed during the emergency.
- On June 20, 2018, TRAN's property and funds were mailed via U.S. Postal Service to his father in Mesa, AZ and signed as received on June 21, 2018.

CONCLUSIONS

Medical

ERO officers ensured detainee TRAN was given priority for medical pre-screening based on their observation that he was sweating profusely upon arrival at EFCF. Video evidence supports that an RN expedited his pre- and full intake screening, although her documentation includes no reference to excessive perspiration. She also did not document any observation of conditions noted by EFCF intake personnel, including that he was very slow to respond and that he drooled and had mucous on his face. Based on his history of schizophrenia and arrival at EFCF with psychiatric medications last taken the day before, the RN referred him for examination by a provider and to the psychiatrist.

(b)(6); (b)(7)(C) conducted the initial health appraisal within hours of the intake screening. She documented TRAN's self-reported 17 year history of schizophrenia and anxiety disorder for which he took Haldol and fluoxetine with no side effects. An AIMS test to identify possible side effects of long term use of Haldol resulted in a score of zero. After consulting IHSC psychiatrist Dr. (b)(6); (b)(7)(C) by telephone, (b)(6); (b)(7)(C) ordered Haldol and fluoxetine once daily for 14 days in the same dosage as the medications that arrived with TRAN. He received the first doses on May 30, 2018. Assuming he was not given any doses of the intake supply which, if occurred, was not documented, he was without the medications for two days, May 28 and 29, 2018. Ostensibly, the delay in starting the medications was attributable to the timing of (b)(6); (b)(7)(C) orders vis-à-vis pharmacy hours.

(b)(6); (b)(7)(C) referred TRAN to mental health. She did not specify that the referral was for psychiatric follow up; however, because TRAN was a mental health patient with a long history of taking psychiatric medications, follow up by a psychiatrist was appropriate.

Pursuant to the referrals by (b)(6); (b)(7)(C), TRAN was evaluated by (b)(6); (b)(7)(C) six days later, June 4, 2018. An AIMS test pointed to symptoms of EPS, leading to his decision to add Cogentin to the medication regimen to address side effects of Haldol. Although intended, (b)(6); (b)(7)(C) did not order Cogentin. He issued new orders changing the administration times of

fluoxetine and Haldol; however, the orders were not received and processed by the pharmacy until after early morning doses of both medications were given the next day, June 5, 2018. The MAR documents he received a second dose of fluoxetine four hours after the first, constituting a medication error. TRAN was not given a second dose of Haldol, although an entry to the MAR suggests it would have been erroneously offered had he not been taken to the hospital. Based on the fact that the orders changing administration times for fluoxetine and Haldol were not processed until the day after (b)(6); (b)(7)(C) examined TRAN, the reviewer concludes that Cogentin, had it been ordered as intended, would not have been administered to TRAN until sometime on June 5, 2018.

Detainee TRAN was seen by (b)(6); (b)(7)(C), psychologist, on June 5, 2018 within 24 hours after security staff submitted a referral. In her encounter note, (b)(6); (b)(7)(C) documented physical symptoms that included sweating, muscular rigidity, slow movements, and lethargy. During interviews, CoreCivic intake personnel, the housing unit officer, and TRAN's cellmate also consistently remarked on the detainee's slowness in movement and response. (b)(6); (b)(7)(C) directed TRAN's placement on mental health observation status with follow up in two to three days, but did not refer him to a higher level, prescribing provider based on observed physical symptoms. An RN cleared him for segregation by reviewing his medical record only, without evaluating him in person and taking his vital signs. TRAN's vital signs were last taken during physical examination nine days earlier, on May 28, 2018.

Medically cleared on paper for segregation, TRAN was moved to the mental health observation section of the special management unit. Approximately 75 minutes later, the officer found TRAN unresponsive in his cell and called medical emergency. Security staff responded promptly and initiated CPR, followed quickly by medical responders. Officers rotated performance of chest compressions while medical professionals performed other life-saving efforts, including use of the AED. Video evidence and documentation reflects the AED pads were not properly placed by response team leader (b)(6); (b)(7)(C) and did not properly adhere; therefore, proper analysis of heart activity was impeded. At the request of (b)(6); (b)(7)(C), two additional providers responded and participated in life-saving efforts until EMS personnel arrived and took over care. To the credit of EFCF security responders, the EMS report documents quality CPR was being performed when EMS arrived on scene.

For the week following TRAN's admission to the hospital, EFCF nursing staff obtained and documented daily updates on his status until his death on June 12, 2018.

Compliance Findings

The reviewer identified the following deficiencies in the ICE 2011 PBNDS, Medical Care, revised 2016.

Medical Care, section (V)(AA)(4), which states, “Prior to the administration of psychotropic medication, a separate documented informed consent, that includes a description of the medication’s side effects shall be maintained.”

- TRAN did not sign consent for psychotropic medications started May 30, 2018 until June 4, 2018. The signed consent documents side effects were discussed with the detainee but does not list any side effects. Side effects were, however, listed in the psychiatrist’s encounter note.

Creative Corrections notes that beyond the above deficiencies, there may be issues with respect to TRAN’s care that are not within the scope of an RN or this analysis to address because they lie within the province of provider clinical judgment. The following fact-based observations, within scope, are cited.

- TRAN reported during intake that he last received doses of Haldol and fluoxetine the afternoon before he was admitted to EFCF, May 27, 2018. Although the medications were received with him and were ordered by NP Ochieng the day he arrived, May 28, 2018, medical record documentation indicates he did not receive them until May 30, 2018. This constitutes a break in continuity of care. If TRAN was, in fact, given doses from the intake supply, administration of the medications was not documented. If doses were not given from the intake supply, it is possible that (b)(6); (b)(7)(C) recognized and was not concerned that entry of her orders after pharmacy hours would delay administration of the medications to TRAN until May 30, 2018. Because (b)(6); (b)(7)(C) left employment at EFCF prior to the site visit, reviewers could not determine whether the break in medication treatment was determined acceptable, or was unintended.
- (b)(6); (b)(7)(C) orders changing administration times for fluoxetine and Haldol were not received during pharmacy hours; consequently, they were not processed until the next day, after TRAN received his once-daily doses of the medications. As a result, he received twice the prescribed daily dose of fluoxetine and had he not been taken to the hospital, may have been offered a second dose of Haldol.
- (b)(6); (b)(7)(C) did not order Cogentin to treat EPS symptoms as intended. He stated during interview that his failure to order Cogentin was an oversight. Reviewers note that had he ordered Cogentin, the medication may not have been administered prior to the medical emergency.
- TRAN was observed unresponsive in his SMU cell within approximately four hours after the psychologist ordered his assignment to mental health observation status. The RN who medically cleared TRAN for segregation reviewed his record, only. She did not determine whether his placement in segregation was medically safe and appropriate by taking his vital signs and conducting an in person assessment of his physical condition. Reviewers recommend reinforcement of the expectation to conduct in-person assessments before clearing detainees of placement in segregation (see Security Compliance Findings, below).
- During the medical emergency response, the medical team leader did not place the AED pads in proper position and did not dry TRAN’s skin before attempting placement. The

pads did not adhere, rendering the AED ineffective in analyzing heart activity. The reviewer cannot determine whether the pads did not adhere because they were expired, or because TRAN was perspiring. The emergency bag inventory did not list AED pad expiration dates, nor did it include a second set of pads. The reviewers recommend that inventory of emergency bag contents include review of AED pad expiration dates, and that a second set of pads be included in the bag.

- (b)(6); (b)(7)(C) physical examination entry included documentation that TRAN had no upper or lower teeth. She did not order a special diet to assure adequate nutritional intake.

Security

Starting with the SDDO and DO present when TRAN arrived at EFCF, continuing through every CoreCivic staff person interviewed, observations were shared that point to behaviors and conditions of concern. The ERO personnel appropriately ensured TRAN was seen quickly by a nurse, and the CoreCivic officers in intake and his first housing unit understandably assumed that the medical personnel who cleared him for general population would have directed alternative placement, if necessary. After TRAN was in general population for seven nights (b)(6); (b)(7)(C) the Unit Manager, saw fit to submit a mental health referral based on her own observations and concerns. The next day, she mentioned TRAN at the weekly multi-disciplinary meeting where detainees with special needs are discussed. Unit Manager (b)(6); (b)(7)(C) actions were appropriate and demonstrated conscientious attention to detainee healthcare issues. Pursuant to her referral, TRAN was seen promptly by a psychologist who directed his placement in segregation for mental health observation with checks every 15 minutes by the officer. As discussed in Medical Conclusions, above, an RN medically cleared TRAN's placement in segregation without assessing him in person.

Officer (b)(6); (b)(7)(C) the officer assigned to the SMU at the time of TRAN's placement, did not make rounds every 15 minutes and falsely documented rounds he did not make. Contrary to the video evidence, the officer documented he checked on TRAN at 3:09 p.m., 3:23 p.m., and 3:38. By contrast, the video evidence shows that after Officer (b)(6); (b)(7)(C) issued linens to TRAN at 3:00 p.m., shortly following the detainee's placement in the SMU, he did not look in the cell again until 3:51 p.m. Video does not allow determination of whether Officer (b)(6); (b)(7)(C) did, in fact, confirm TRAN was alive at that time.

After the 3:51 p.m. check, Officer (b)(6); (b)(7)(C) next seen looking in TRAN's cell at 4:12 p.m. He removed the food tray from the portal and carried it off the unit, returning to TRAN's cell and immediately opening the door at 4:13 p.m. This action suggests that Officer (b)(6); (b)(7)(C) observed TRAN was not moving when he looked in the cell at 4:12 p.m., yet he took no action until he carried the food tray away. After he opened the cell door, Officer (b)(6); (b)(7)(C) called medical emergency upon the advice of an officer on constant watch duty at the next cell. Officer (b)(6); (b)(7)(C) did not enter the cell again.

The first security responders, all women, arrived within an estimated three minutes after the medical emergency was called. They stood at the cell front and did not enter to render aid. Despite the fact (b)(7)(E) and one correctional counselor were present, the responding female staff said they did not enter out of concern for their safety. Lieutenant (b)(6); (b)(7)(C) and another male officer arrived on scene a minute later and entered the cell, followed by the female responders.

Lieutenant (b)(6); (b)(7)(C) quickly directed initiation of CPR and instructed Central Control to call EMS. Upon the arrival of medical staff, officers continued to perform chest compressions while medical professionals performed other life-saving efforts pending the arrival of EMS personnel. EMS access to the facility and SMU was efficiently expedited. As noted in Medical Conclusions, the EMS report documents that when the EMS responders arrived, “quality CPR” was being performed. This observation is a credit to the officers and their trainers.

Following the emergency event, all responding staff completed incident reports and employee counseling services were offered to staff. The facility investigator completed a thorough after action review that included interviews of involved staff and review of video appropriately retained for analysis. As a result of the after action review, Officer (b)(6); (b)(7)(C) resigned in lieu of termination and the female staff who did not immediately enter TRAN’s cell when they arrived on scene were counseled.

Compliance Findings

The reviewer identified the following deficiencies in the ICE 2011 PBNDS, revised 2016 governing safety and security.

Custody Classification System, section (V)(A)(4), which states, “Each detainee’s classification shall be reviewed and approved by a first-line supervisor or classification supervisor.”

- A supervisor did not approve the classification rating assigned to detainee TRAN on May 28, 2018.

Special Management Units, section (V)(M), which states, “Close Supervision Detainees in SMU shall be personally observed and logged at least every 30 minutes on an irregular schedule. For cases that warrant increased observation, the SMU personnel shall personally observe detainees accordingly.”

- Per the psychologist’s order communicated via Special Needs form, officers were to check on TRAN every 15 minutes following placement in the SMU. Video evidence shows TRAN was not observed for 51 minutes after the officer issued linens. Specifically, the officer issued TRAN linens at 3:00 p.m. and is next seen looking in the cell at 3:51. During

the 51 minute period, the officer documented three welfare checks video shows he did not make, at 3:09 p.m., 3:23 p.m., and 3:38 p.m.

Special Management Units, section (V)(P), which states, “Detainees must be evaluated by a medical professional prior to placement in an SMU (or when that is infeasible, as soon as possible and no later than within 24 hours of placement). The assessment should include a review of whether the detainee has been previously diagnosed as having a mental illness.”

- The nurse assigned to evaluate the detainee for placement in the SMU did not conduct a face to face assessment.

This also violates EFDC policy Segregation/Restrictive Housing Unit Management 10-100 which requires screening by a health care professional prior to placement of any detainee in segregation.

INITIAL CUSTODY CLASSIFICATION

CCA Facility: EDC

Initial Classification Date: 05/28/18

I. IDENTIFICATION

Inmate/Resident Name: Tran

LAST

Admission Date 05/28/18

FIRST

M.I.

CCA/Jurisdiction ID# 037949945 Most Serious Current Charge/Offense: Agg Assault

Legal Status: Pretrial Sentenced Parole Violator Probation Violator Other (list) Detainee

If Sentenced, Is the Offense a Felony Misdemeanor Technical Infraction

II. CUSTODY EVALUATION

A. Severity of Current Offense (Score the most severe current offense or detainer charge.)

Lowest Agg Assault x3 CONV 1
 Moderate 3
 High 5
 Greatest 10/25/2000 x2, 4/8/09 7

B. Severity of Prior Criminal Convictions (Score the most severe prior conviction in the past 10 years.)

None 1
 Lowest Denmark Probation CONV 8/14/15, 5/10/05 3
 Moderate x2 3
 High 5
 Greatest 7

C. History of Escape or Attempts to Escape

No escapes or attempts to escape 0
 Escape (or attempt) from low security or community corrections facility
 Over 1 year ago 1
 Within the past year 3
 Escape (or attempt) from medium or high security OR any escape with actual or threatened violence
 Over 10 years ago 5
 Within the past 10 years 7

D. History of Institutional Violence (Score the most serious documented incident in the past 10 years.)

None 0
 Behavior NOT involving a weapon or resulting in serious injury 5
 Behavior involving a weapon or resulting in serious injury 7

HIGH CUSTODY SCORE (Add items A - D. Enter score at right.)

(If score is 10 or higher, inmate should be assigned to High Custody.)

SUBTOTAL SCORE (Add Items A

E. Prior Felony Convictions - Adult or Juvenile - (in the past 10 years)

None 1
 One Disorderly Conduct x3 11/3/96, 11/24/96, 2/2/02 1
 Two or more 7/10/17 5/8/94 2

F. Drug/Alcohol History (in the past 5 years)

No use 0
 Occasional or recreational use 1
 Serious dependence/alcoholic/addict or introduction of drugs or alcohol into a correctional facility. 2

G. Age

24 or younger 1
 25 to 35 0
 36 or older 8/7/70 46 -2

H. Education

No High School Diploma or GED 0
 High school diploma or GED -1

I. Employment

Not Employed 0
 Employed for at least 1 year at time of arrest -1

SUBTOTAL SCORE (ADD ITEMS E - I)

TOTAL CUSTODY SCORE (ADD ITEMS A - I)

(b)(7)(E)

III. CUSTODY SCALE AND RECOMMENDATION

Assign Custody Level Indicated by Scale Below

HIGH CUSTODY SCORE (items A – D) 10 or more points	Custody Level HIGH
TOTAL CUSTODY SCORE (items A – I) 12 or more points.....	Custody Level HIGH
5 to 11 points.....	MOD
4 or fewer points.....	LOW

(b)(7)(E)

Check (✓) All Factors that Apply to this Inmate for Purpose of Over-Riding Scored Custody Level

Non-Discretionary – Low Custody Restrictions

☐ Sex Offender
☐ Hold w/o Bond
☐ High Bail Amount (100K or above)
☐ Time Left to Serve (over 5 years)
☐ Felony detainee or warrant (ICE)
☐ Escape From Secure Facility (W/I 10 yr)

Discretionary Over-Ride – Higher Custody

☐ Known Management Problem
☐ Prison Disturbance/Riot History
☐ Suspected Drug Trafficker inside Institution
☐ Current Escape Threat
☐ Serious Violence Threat
☐ Known Gang Affiliation/Disruptive Group
☐ Threatened Government Official
☐ Other (specify) _____

Discretionary Over-Ride – Lower Custody

☐ Prior Good Institutional Conduct
☐ Isolated Prior Institutional Misconduct

Is Over-Ride of Scored Custody Level Recommended?

☒ Yes

☐ No

If yes, give rationale (required):

Pen Rca Hsh

Recommend Population Assignment and Custody Level

Population Assignment
(Select code from the list below)

Code

Custody Level
(Select code from the list below)

Code

General Population GP
Administrative Segregation AS
Disciplinary Segregation DS
Juvenile Unit JU

HIGH
MOD
LOW

Inmate/Resident Signature: *Huythun*

Date 05/28/18

Classification Officer /Case Manager/Counselor Signat

Date 05/28/18

IV. ASSISTANT WARDEN/ADMINISTRATOR REVIEW AND COMMENTS OF DISCRETIONARY OVER-RIDE:

Classification Supervisor/Designee Signature

Date 05/28/18

Assistant Warden/ Assistant Administrator Review & Comments

Assistant Warden/ Assistant Administrator Signature

Date

V. WARDEN/ADMINISTRATOR APPROVAL OF OVER-RIDE

Approve Recommended Population Assignment and Custody Level?

☐ Yes

☐ No

If no, give rationale (required):

Final Population Assignment and Custody Level

Population Assignment
(Select code from the list below)

Code

Custody Level
(Select code from the list below)

Code

General Population GP
Administrative Segregation AS
Disciplinary Segregation DS
Juvenile Unit JU

HIGH
MOD
LOW

Warden/Administrator Signature

Date

Facility: Eloy

Medication Administration Record

Month/Year: 5/2018

Prescriptions	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Order Date: <u>5-28-18</u> Exp. Date: <u>6-11-18</u> RX #: <u>14 days</u> <u>Haloperidol 5mg</u> <u>1 tablet daily AM x</u> <u>14 days</u>	AM																															
Order Date: <u>5-28-18</u> Exp. Date: <u>6-11-18</u> RX #: <u>14 Days</u> <u>Fluoxetine 20mg</u> <u>1 capsule daily AM</u> <u>14 Days</u>	AM																															
Jrd Date: <u>05/29/18</u> Exp Date: <u>06/11/18</u> Rx #: <u>1085907</u> TRAN, HUY <u>037949945</u> TAKE 1 CAPSULE BY MOUTH EACH MORNING <u>AM 5/29/18 @ 1033</u> FLUOXETINE 20MG CAP	AM																															
Ord Date: <u>05/29/18</u> Exp Date: <u>06/11/18</u> Rx #: <u>1085908</u> TRAN, HUY <u>037949945</u> TAKE 1 TABLET BY MOUTH EACH MORNING <u>AM 5/29/18 @ 1033</u> HALOPERIDOL 5MG TAB	AM																															
Order Date																																
Exp. Date																																
RX #																																
Order Date																																
Exp. Date																																
RX #																																
Order Date																																
Exp. Date																																
RX #																																

Documentation Codes:	H - Hold	R - Refused	DC - Discontinued Order	S - Self Administered	NS - No Show	O - Other
TRAN, HUY	HT:	WT:	Allergies: <u>NKDA</u>	Diagnosis:		
037949945	: TRAN, HUY CHI		Registration #: <u>037949945</u>	Physician:		
EYL - D/1/03/L						
05/29/2018						

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DHS-20-0638-D-000152

(b)(6), (b)(7)(C)

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OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

Washington, DC 20528 / www.oig.dhs.gov

June 9, 2020

MEMORANDUM FOR: Waldemar Rodriguez
Associate Director
Office of Professional Responsibility
U.S. Immigration and Customs Enforcement

FROM:

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

SUBJECT:

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

Contract Corrections Officer (former)
U.S. Immigration and Customs Enforcement
Lumpkin, GA

CASE NUMBER:

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

Attached is our Report of Investigation (ROI) on the above subject.

The ROI is furnished to you to evaluate and make an administrative decision regarding the above listed subject. Should you take any administrative action in response to our ROI, please inform this office so we can update our records. Please destroy the ROI upon disposition of this matter.

Should you have any questions regarding the contents of the ROI or need additional information, you may contact me at 404-824-(b)(6); [redacted].

Attachment

**DEPARTMENT OF HOMELAND SECURITY
OFFICE OF INSPECTOR GENERAL**

REPORT OF INVESTIGATION

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



THIS REPORT CONTAINS SENSITIVE LAW ENFORCEMENT MATERIAL. IT MAY NOT BE LOANED OUTSIDE YOUR AGENCY AND, EXCEPT IN CONNECTION WITH OFFICIAL AGENCY ACTION, NO PORTION OF THE REPORT MAY BE COPIED OR DISTRIBUTED WITHOUT THE KNOWLEDGE AND CONSENT OF THE INSPECTOR GENERAL.

DHS-20-0638-D-000155



OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

REPORT OF INVESTIGATION

Case Number:	I18-ICE-ATL-34012
Case Title:	(b)(6); (b)(7)(C) Contract Corrections Officer (former) U.S. Immigration and Customs Enforcement Lumpkin, GA
Report Status:	Final
Alleged Violation(s):	Title 18 U.S. Code § 1001, False Statements, Entries or Concealing or Covering Up a Material Fact

SYNOPSIS

The Department of Homeland Security (DHS), Office of Inspector General (OIG) initiated an investigation based upon information received from U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) which reported the death of Efrain De La Rosa, detainee, Stewart Detention Center (SDC), Lumpkin, GA. SDC is a privately operated detention facility managed by CoreCivic with oversight from ICE.

The DHS OIG reviewed the investigation conducted by the Georgia Bureau of Investigation (GBI) and the autopsy by the Stewart County Medical Examiner (SCME). The SCME determined that the cause of death was by hanging and the manner of death was suicide. The investigation was closed by the GBI based on the evidence, information, interviews, video surveillance footage, and the autopsy report certifying De La Rosa's death as suicide. Additionally, DHS OIG reviewed the Mortality Review conducted by ICE Health Service Corps (IHSC), and the subsequent Detainee Death Review conducted by the External Reviews and Analysis Unit (ERAU), Office of Professional Responsibility (OPR), ICE.

Reporting Agent		Distribution:	
Name: (b)(6); (b)(7)(C)	Signature: (b)(6); (b)(7)(C)	Atlanta FO	Original
Title: Special Agent	Date:	Headquarters	1 cc
Approving Official		Component(s) ICE	1 cc
Name: (b)(6); (b)(7)(C)	Signature: (b)(6); (b)(7)(C)	Other	cc
Title: Asst. Special Agent in Charge	Date:		

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REPORT OF INVESTIGATION

A review of the ERAU report showed that (b)(6); (b)(7)(C), Officer, SDC, (b)(6); (b)(7)(C) GA, falsified log reports that he looked into De La Rosa's cell when conducting security rounds. (b)(6); (b)(7)(C) also logged that additional rounds were conducted; however, video surveillance footage confirmed (b)(6); (b)(7)(C) did not look in De La Rosa's cell at these times.

SDC terminated (b)(6); (b)(7)(C) from his employment. The DHS OIG presented its investigative findings to the United States Attorney's Office (USAO), Middle District of Georgia, Macon, GA. The USAO declined to prosecute the matter with the expectation that ICE will utilize the reviews and implement any corrective actions that are deemed necessary.

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REPORT OF INVESTIGATION

DETAILS

The DHS OIG initiated an investigation on July 10, 2018, upon receipt of information from the U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO), Lumpkin, GA, which reported the death of Efrain Romero De La Rosa, ICE detainee #A209 910 301. The Southwest Georgia Regional Medical Center (SGRMC) in Cuthbert, GA, indicated the preliminary cause of death as self-induced strangulation. (Exhibit 1)

Allegation: Review of the in-custody detainee death of Efrain Romero De La Rosa.

On June 20, 2018, the DHS OIG contacted (b)(6); (b)(7)(C) Special Agent (SA), GBI, Americus, GA, who was assigned to investigate the circumstances surrounding the death of De La Rosa.

(b)(6); (b)(7)(C) advised that, based upon his observation, the use of several socks tied together was used in the possible suicide by De La Rosa. (b)(6); (b)(7)(C) confirmed that on-site cell processing was completed and video and pictures were obtained from the involved pod and cell. (Exhibit 2)

On September 25, 2018, The DHS OIG conducted an on-site visit to the SDC. DHS OIG obtained documents and records for review to include audio, video, and photographs and a copy of the SDC Investigation Report of the incident. (Exhibit 3)

On November 26, 2018, the DHS OIG contacted (b)(6); (b)(7)(C) Inspections and Compliance Specialist (ICS), ICE, Washington, DC, and (b)(6); (b)(7)(C) Unit Chief (Acting), ERAU, ICE, OPR, Washington, DC, who conducted a detainee death investigation of the incident. (b)(6); (b)(7)(C) advised that a review of the detainee in-custody death was being conducted, and a copy of the reports would be sent to DHS OIG upon completion. (Exhibit 4)

On February 28, 2019, the DHS OIG received records from the GBI to include compact, SDC video surveillance footage, and the SDC Handheld Video Camera Footage for review. (Exhibit 5)

On March 20, 2019, the DHS OIG contacted (b)(6); (b)(7)(C) Assistant United States Attorney (AUSA), Middle District of Georgia, Columbus, GA, (b)(6); (b)(7)(C) was provided with a preliminary review of the investigation. (b)(6); (b)(7)(C) advised that the USAO would decline to prosecute the matter barring any evidence of criminal misconduct. (Exhibit 6)

The DHS OIG completed a review of the GBI investigation and coroner's report. The DHS OIG determined that the Stewart County Medical Examiner (SCME), Lumpkin, GA, determined that the cause of death was by hanging and the manner of death was suicide. The GBI advised that their investigation was closed based on the evidence, information, interviews, video surveillance footage, and the autopsy report certifying De La Rosa's death as suicide. DHS OIG reviewed the GBI case file and final investigative report for completion, and determined it to be a thorough investigation with no discrepancies. (Exhibit 7)

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REPORT OF INVESTIGATION

The DHS OIG reviewed a copy of a Detainee Death Review report received from (b)(6); (b)(7)(C) along with the IHSC report. The OIG identified no inconsistencies.

ERAU's Detainee Death Report depicted the following synopsis:

On July 10, 2018, Efrain DE LA ROSA (DE LA ROSA), a forty-year-old citizen of Mexico, died while in custody of U.S. Immigration and Customs Enforcement (ICE) at the Southwest Georgia Regional Medical Center (SGRMC) in Cuthbert, Georgia (GA). DE LA ROSA's preliminary cause of death is self-induced strangulation. The Georgia Bureau of Investigation (GBI), Associate Medical Examiner, documented DE LA ROSA's cause of death as suicide by hanging. DE LA ROSA was detained at Stewart Detention Center (SDC) in Lumpkin, GA, from March 13, 2018 until his death on July 10, 2018. SDC is a dedicated facility governed by an Intergovernmental Service Agreement, owned and operated by CoreCivic (CC), and is required to comply with the ICE Performance Based National Detention Standards (PBNDS) 2011.

A review of the ERAU report stated that at 8:40 p.m., on the evening of the De La Rosa's death, (b)(6); (b)(7)(C) conducted a security round and looked into De La Rosa's cell. (b)(6); (b)(7)(C) logged that he conducted additional rounds at 9:12 p.m., 9:41 p.m., and 10:04 p.m.; however, video surveillance footage confirmed (b)(6); (b)(7)(C) did not look in De La Rosa's cell at these times. Video surveillance footage showed (b)(6); (b)(7)(C) signing documents on the clipboard next to the detainee's cell, but he did not look in the cell to personally observe De La Rosa.

At 10:05 p.m., (b)(6); (b)(7)(C) Officer, SDC, entered Pod 7B to assume the 3rd shift post. At 10:08 p.m., (b)(6); (b)(7)(C) escorted a nurse to a cell on the opposite side of the room from De La Rosa. At 10:33 p.m., (b)(6); (b)(7)(C) conducted his first security round. He approached De La Rosa's cell, looked in and began to move to record his round on the clipboard. (b)(6); (b)(7)(C) advised when interviewed that he then looked into the cell again after he observed De La Rosa standing by the bunk with his chin down. (b)(6); (b)(7)(C) reported that he knocked on the cell door several times, and after he received no response, called for medical emergency by radio. (b)(6); (b)(7)(C) noted he saw multiple socks wrapped around the top bunk rail. Emergency procedures were initiated to attempt to revive De La Rosa which but were unsuccessful.

ICE Restrictive Housing Unit detention policy states:

SDC Restrictive House Unit (RHU) Post Orders, Section (III)(B)(1)(i), states, "Detainees in SMU shall be personally observed and logged at least every thirty (30) minutes on an irregular Schedule. Observation will include looking in each cell to ensure that no unusual or unauthorized activities are occurring."

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REPORT OF INVESTIGATION

The ERAU Detainee Death Review report indicated that detainee round counts were not conducted in accordance with ICE policy. (Exhibit 8)

The DHS OIG reviewed documents provided by SDC to include (b)(6); (b)(7)(C) written statement (b)(6); (b)(7)(C) stated that on July 10, 2018, prior to his shift ending at 10:00 p.m., he assisted making rounds with (b)(6); (b)(7)(C), Registered Nurse, SDC (b)(6); (b)(7)(C) stated the rounds were exceeding his shift end time so he asked (b)(6); (b)(7)(C), Officer, SDC, Lumpkin, GA, to finish escorting (b)(6); (b)(7)(C) medical rounds so he could conduct his last rounds for the night and make sure all of the paperwork was complete. (b)(6); (b)(7)(C) stated that he gave Officer (b)(6); (b)(7)(C) brief of his shift then left the facility. (b)(6); (b)(7)(C) stated in an interview with SDC that sometime between 5:19 p.m., 6:17 p.m. and 7:15 p.m. he was giving out and picking up trays and was inaccurate in the times he documented his rounds. (b)(6); (b)(7)(C) written statement made no reference of an intent to falsify or not completing the required round checks. SDC terminated (b)(6); (b)(7)(C) on July 26, 2018, for failing to properly observe De La Rosa while conducting his rounds. (Exhibit 9)

On February 6, 2020, the DHS OIG contacted (b)(6); (b)(7)(C) and provided the additional information learned from the investigation, including the findings of (b)(6); (b)(7)(C) violation of ICE policy and the potential falsification of round count document (b)(6); (b)(7)(C) advised that the documents would be forwarded to the Criminal Division, for a prosecutorial decision using the additional information and possible criminal violation. (Exhibit 10)

On April 7, 2020 (b)(6); (b)(7)(C) advised the DHS OIG that the USAO reviewed the investigative documents and declined to prosecute the matter due to a lack of criminal intent by (b)(6); (b)(7)(C) (Exhibit 11)

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REPORT OF INVESTIGATION

EXHIBITS

NUMBER	DESCRIPTION
1	Memorandum of Activity, ICE Significant Incident Report, dated July 16, 2018
2	Memorandum of Activity, Records Review—ICE Significant Incident Report/Review of GBI Documents, July 20, 2018
3	Memorandum of Activity, Other—Records Review, dated September 25, 2018
4	Memorandum of Activity, Other—ICE ICS Report Status, dated November 26, 2018
5	Memorandum of Activity, Other—Records Receipt from GBI, dated February 28, 2019
6	Memorandum of Activity, Other—Declination, dated March 20, 2019
7	Memorandum of Activity, Other—Records Review from GBI, dated June 18, 2019
8	Memorandum of Activity, Other— ERAU Detainee Death Report Review, dated August 23, 2019
9	Memorandum of Activity, Records Review—(b)(6); (b)(7)(C) t Incident Statement Review, dated September 13, 2019
10	Memorandum of Activity, Other—USAO Contact, (b)(6); (b)(7)(C) dated February 6, 2020
11	Memorandum of Activity, Other—Declination, dated April 7, 2020

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EXHIBIT #1



OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

MEMORANDUM OF ACTIVITY

Type of Activity: Records Review: ICE Significant Incident Report

Case Number	(b)(6); (b)(7)(C); (b)(7)(E)	Case Title: Efrain De La Rosa
-------------	------------------------------	-------------------------------

On July 16, 2018, (b)(6); (b)(7)(C) Special Agent (SA), Department of Homeland Security (DHS), Office of Inspector General (OIG), Atlanta Field Office, completed a review of documents received from (b)(6); (b)(7)(C); Assistant Field Office Director (AFOD), Immigration and Customs Enforcement (ICE), Lumpkin, GA, pertaining to the death of Efrain De La Rosa (A#: 209910301) at Stewart Detention Center (SDC), Lumpkin, GA. At this time, De La Rosa is believed to have committed suicide by hanging himself in his detention cell. Pursuant to normal protocol, the Georgia Bureau of Investigation (GBI) conducted the processing of the involved cell.

(b)(6); provided the ICE Significant Incident Notification Report which was reviewed and yielded the following information in sum (additional details can be found in the attached ICE report):

On July 10, 2018, ICE, Enforcement Removal Operations (ERO) Atlanta, GA, reported the death of ICE detainee Efrain Romero DE LA ROSA, A209 910 301, a 40-year-old citizen of Mexico, at the Southwest Georgia Regional Medical Center (SGRMC) in Cuthbert, GA. The medical staff pronounced De La Rosa deceased at 11:29 p.m. EDT. Medical staff identified the preliminary cause of death as self-induced strangulation.

On July 10, 2018, at approximately 10:34 p.m., CoreCivic (CC) staff at SDC, while conducting normal rounds noticed De La Rosa appeared to be hanging by his neck in his cell. CC staff entered the cell and cut the restraining garments, socks, and began to administer cardiopulmonary resuscitation (CPR).

At approximately 10:38 p.m., SDC medical staff assisted with CPR while awaiting the arrival of Emergency Medical Services.

At approximately 10:45 p.m., CC staff reported the self-inflicted strangulation of DE LA ROSA to ERO Atlanta.

At approximately 10:56 p.m., Stewart County Emergency Medical Services (SCEMS) entered the cell.

At approximately 11:06 p.m., SCEMS departed SDC with De La Rosa.

Name, Title, Signature, and Date	(b)(6); (b)(7)(C)	(b)(6); (b)(7)(C)
Jason Mann Special Agent		

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MEMORANDUM OF ACTIVITY

At approximately 11:29 p.m., SGRMC medical staff in Cuthbert, GA, pronounced De La Rosa deceased.

(b)(6);
(b)(7)(C) also advised that (b)(6); (b)(7)(C) SA, GBI, was leading the investigation. The GBI was contacted by DHS OIG which will be documented in a separate report.

Attachment:

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ICE Significant Incident Report

Submitted Date and Time of Report: 7/11/2018 2156 EST

Incident Date: 7/10/2018	Incident Time: 2329	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Field Operations Division	Area: Eastern Operations
Case Number: No Case Involved	Office: ER - FOD ATLANTA - ATL	Lead Agency: B - DHS / ICE
SEN Incident Number: (b)(7)(E)	Initial/Follow-Up: Initial	Event Status: Routine
Related SEN Number:	Related Case Number: -----	SEACATS Number:
Intel Number:	ENFORCE Number:	

Employee	Operational	Security	Other
☐ Shots Fired At Employee	☐ Air/Marine Incidents	☐ National Security Interest	☐ Escape
☐ Shots Fired By Employee	☐ Controlled Delivery	☐ Facility Disturbance	☐ Suicide Attempt
☐ Employee Assaulted	☐ Significant Seizure	☐ Terrorism Related	☐ Hunger Strike
☐ Employee Death	☐ Significant Arrest	☐ Foreign Military/Police Incursion	☐ Media Interest
☐ Employee Injured	☐ IPAS	☐ WMD/HAZMAT	☒ Alien Injury/Death
☐ Employee Arrested	☐ SCR	☐ Demonstrations	☐ Vehicle Incidents
☐ Firearms Discharge to Include Unintentional Discharge	☐ Rescue	☐ JTTF	☐ Other
☐ Use of Baton or other Impact Weapon	☐ Weapon Violations	☐ Bomb Threat	☐ Predator
☐ Use of OC Spray or other Chemical Agents	☐ Other Agency Interest	☐ DHS SAR	☐ Gang Related
☐ Other Use of Force			
☐ Loss or Theft of Firearm or Body Armor			

Principal Subject: Person
Date of Birth: 9/17/1977

Last Name: DE LA ROSA
Country of Birth: Mexico

First Name: Efrain
Citizenship: Mexico

Alien ID: 209910301

Narrative

Report Title: ICE ERO Atlanta - Detainee Death - Stewart Detention Center

ISSUE:

On July 10, 2018, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) Atlanta reported the death of ICE detainee Efrain Romero DE LA ROSA, A209 910 301, a 40-year-old citizen of Mexico, at the Southwest Georgia Regional Medical Center (SGRMC) in Cuthbert, GA. The medical staff pronounced DE LA ROSA deceased at 11:29 p.m. EDT. Medical staff identified the preliminary cause of death as self-induced strangulation.

Consistent with ICE policy, ERO Atlanta notified the U.S. Department of Homeland Security, Office of Inspector General, and the ICE Office of Professional Responsibility via the Joint Intake Center. ERO Atlanta also notified the Consulate of Mexico in Atlanta, GA, of DE LA ROSA's death, who, in turn, notified DE LA ROSA's next of kin.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

(b)(7)(E)

2020-ICLI-00057 1244

DHS-20-0638-D-000165
/13/2018

On an unknown date and location, DE LA ROSA illegally entered the United States without being admitted or paroled by an immigration official.

On July 15, 2004, the Circuit Court for Fairfax, VA, convicted DE LA ROSA of driving while intoxicated, and sentenced him to 30 days' confinement.

On July 22, 2004, the Circuit Court for Alexandria, VA, convicted DE LA ROSA of possession of burglary tools, and sentenced him to two years' confinement, with the possibility of one and one-half years suspended for good behavior, and two years' probation.

On August 30, 2004, the Circuit Court for Alexandria, VA, convicted DE LA ROSA of carjacking, and sentenced him to 20 years' confinement, with the possibility of 12 years suspended for good behavior, and five years' probation.

On October 13, 2004, the Circuit Court for Fairfax, VA, convicted DE LA ROSA of carjacking, and sentenced him to 15 years confinement, with the possibility of nine years and six months suspended for good behavior.

On October 25, 2004, the Circuit Court for Fairfax, VA, convicted DE LA ROSA of receiving stolen property, and sentenced him to six months' confinement and six months' supervised probation.

On December 6, 2004, the Fairfax County General District Court, Fairfax, VA convicted DE LA ROSA of escape without force by misdemeanor and sentenced him to 30 days confinement with 30 days suspended.

On February 10, 2005, the Circuit Court for Fairfax, VA, convicted DE LA ROSA of violating the terms of his release, and remanded him to the custody of the Fairfax County Sheriff's Office in Fairfax, VA, to serve the remainder of his previous 30 days' confinement.

On April 5, 2017, ERO Washington encountered DE LA ROSA at the Virginia Department of Behavioral Health and Developmental Service (VDBHDS) - Marion Correctional Treatment Center (MCTC) pursuant to a referral from the Virginia Department of Corrections, following his conviction for carjacking. The VDBHDS detained DE LA ROSA at MCTC as he suffered from schizophrenia and a determination of mental incompetence to participate in his criminal proceedings.

On May 5, 2017, ERO Washington issued DE LA ROSA a Notice to Appear, Form I-862, charging removability pursuant to Section 212(a)(6)(A)(i) of the Immigration and Nationality Act (INA), as an alien present in the United States without being admitted or paroled, or who arrived in the United States at any time or place other than as designated by the Attorney General; Section 212(a)(2)(A)(i)(I) of the INA, as an alien who has been convicted of, or who admits having committed, or who admits committing acts which constitute the essential elements of a crime involving moral turpitude (other than a purely political offense) or an attempt or conspiracy to commit such a crime; and Section 212(a)(2)(B) of the INA, as an alien who has been convicted of two or more offenses (other than purely political offenses) for which the aggregate sentences to confinement were five years or more.

On September 8, 2017, ERO Washington lodged an Immigration Detainer - Notice of Action, Form I-247A, with the MCTC; however, on the same date, based on the recommendation of the Washington Office of Chief Counsel (OCC), ERO Washington lifted the detainer pursuant to 8 CFR 236.2(b), as an alien confined due to mental instability in an institution shall not be accepted into physical custody by the service until an order of removal has been entered.

On an unknown date, MCTC released DE LA ROSA.

On February 9, 2018, a designated immigration officer (DIO) from the Wake County 287(g) Program encountered DE LA ROSA at the Wake County Detention Center (WCDC) in Raleigh, NC, following his arrest for larceny. The DIO lodged a Form I-247A with the WCDC.

On March 9, 2018, the Wake County District Court in Raleigh, NC, convicted DE LA ROSA of larceny and sentenced him to 28 days' confinement with 28 days' credit for time served.

On March 11, 2018, WDCD released DE LA ROSA to the custody of ERO Atlanta.

On March 13, 2018, ERO Atlanta transferred DE LA ROSA to Stewart Detention Center (SDC).

On March 22, 2018, the Atlanta OCC filed a motion with the Executive Office for Immigration Review (EOIR) to change the venue of DE LA ROSA's removal proceedings from Arlington, VA, to Lumpkin, GA. On this same date, OCC submitted a request for medical records with ICE Health Services Corps (IHSC).

On April 3, 2018, Core Civic (CC) staff placed DE LA ROSA in segregated housing after he solicited for sexual acts from a CC employee.

On April 6, 2018, CC's Institutional Disciplinary Panel conducted a disciplinary hearing of DE LA ROSA's offense and sentenced him 30 days of segregation in the Special Management Unit (SMU).

On April 12, 2018, CC's Confinement Review Committee reviewed DE LA ROSA's placement in the SMU, and determined that he should remain segregated from the facility's general population.

On April 16, 2018, CC staff notified ERO Atlanta of DE LA ROSA's scheduled return to general population on May 2, 2018.

On April 18, 2018, EOIR granted the motion for a change of venue.

On April 24, 2018, IHSC staff placed DE LA ROSA in SMU for mental health observation and suicide watch with monitoring protocols.

On April 26, 2018, an immigration judge (IJ) in Lumpkin, GA, rescheduled the master hearing for June 5, 2018, to allow DE LA ROSA time to obtain legal counsel.

On May 4, 2018, ERO Atlanta transferred DE LA ROSA to the Columbia Regional Care Center (CRCC) in Columbia, SC, for mental health treatment.

On June 5, 2018, an IJ in Lumpkin, GA, rescheduled the master hearing for June 26, 2018, due to DE LA ROSA's transfer to CRCC.

On June 12, 2018, upon completion of treatment, ERO Atlanta transferred DE LA ROSA from CRCC to SDC.

On June 19, 2018, CC staff placed DE LA ROSA in SMU for a Code 207 violation (making sexual proposals) after an allegation that he called a CC officer beautiful, and touched her in an inappropriate way.

On June 21, 2018, CC's Institutional Disciplinary Panel conducted a disciplinary hearing of DE LA ROSA's violation and sentenced him to 30 days' segregation.

On June 26, 2018, an IJ in Lumpkin, GA, granted a continuance and rescheduled the master hearing for July 3, 2018, to allow DHS time to provide EOIR with DE LA ROSA's judgement and conviction documents.

On June 27, 2018, CC's Confinement Review Committee reviewed DE LA ROSA's placement in SMU and determined that he should remain removed from general population for disciplinary reasons.

On June 28, 2018, IHSC provided OCC with DE LA ROSA's medical records indicating a history of schizophrenia. On this same date, OCC filed a motion for consideration of medical/mental health records with EOIR.

On July 2, 2018, CC staff notified ERO Atlanta of DE LA ROSA's scheduled return to general population on July 18, 2018.

On July 3, 2018, an IJ in Lumpkin, GA, ordered DE LA ROSA removed from the United States to Mexico.

On July 10, 2018, at approximately 10:34 p.m. EDT, CC staff conducting normal rounds noticed DE LA ROSA appeared to be hanging by his neck in his cell. CC staff entered the cell and cut the restraining garments, socks, and began to administer cardiopulmonary resuscitation (CPR) on DE LA ROSA.

At approximately 10:38 p.m. EDT, SDC medical staff assisted with CPR while awaiting the arrival of Emergency Medical Services.

At approximately 10:45 p.m. EDT, CC staff reported the self-inflicted strangulation of DE LA ROSA to ERO Atlanta.

At approximately 10:56 p.m. EDT, Stewart County Emergency Medical Services (SCEMS) entered the cell.

At approximately 11:06 p.m. EDT, SCEMS departed SDC with DE LA ROSA.

At approximately 11:29 p.m. EDT, SGRMC medical staff in Cuthbert, GA, pronounced DE LA ROSA deceased.

At approximately 11:31 p.m. EDT, ERO Atlanta notified ERO Headquarters of DE LA ROSA's death.

At approximately 11:51 p.m. EDT, ERO Atlanta telephonically notified the Joint Intake Center and the Office of Professional Responsibility (OPR) duty agent of DE LA ROSA's death.

On July 11, 2018 at 12:54 a.m. EDT, ERO Atlanta emailed notification to the OPR duty agent as requested.

At approximately 9:13 a.m. EDT, ERO Atlanta notified the Consulate of Mexico in Atlanta, GA, of DE LA ROSA's death.

DE LA ROSA is the eighth detainee to pass away in ICE custody in fiscal year 2018.

Violations of Law:

Action Taken:

Other Agencies Notified:

Name	Agency	Phone	Date	Time
none				

Injuries:	Injuries (Names and Extent of
Fatalities:	Injury):
Damage:	

Locations:

Type	Address	City	State	Zip
Other	146 CCA Road	Lumpkin	Georgia	31815

Reported to ICE Operations Center via Phone:

Public Affairs Notified: Yes**Officer Notified: Bryan Cox****Date: 7/10/2018****Time: 0000****Comments:**

Reported: (b)(6); (b)(7)(C)**Phone:** 229-83 (b)(6); (b)(7)(C)**Cell/Pager:** 229-32 (b)(6); (b)(7)(C)**Supervisor:****Phone:** 229-83**Cell/Pager:** 229-52

EXHIBIT #2



OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

MEMORANDUM OF ACTIVITY

Type of Activity: Telephone Contact (b)(6); (b)(7)(C) GBI

Case Number: (b)(6); (b)(7)(C); (b)(7)(E)

Case Title: Efrain De La Rosa

On July 20, 2018, (b)(6); (b)(7)(C) Special Agent (SA), Department of Homeland Security (DHS), Office of Inspector General (OIG), Atlanta Field Office, contacted (b)(6); (b)(7)(C) SA, Georgia Bureau of Investigation (GBI), Americus, GA. The DHS OIG and GBI are investigating the death of Efrain De La Rosa (A#: 209910301) at Stewart Detention Center (SDC), Lumpkin, GA. At this time, the detainee is believed to have committed suicide by hanging himself in his detention cell. Pursuant to normal protocol, the Georgia Bureau of Investigation (GBI) will conduct processing of the involved cell.

(b)(6); (b)(7)(C) previously advised that on-site cell processing was completed and video and pictures were obtained from the involved pod and cell and which will be provided to DHS OIG. GBI will also notify DHS OIG when the cell processing report and coroner's report is complete.

(b)(6); (b)(7)(C) advised that the use of several socks tied together was used in the suicide by De La Rosa.

[Agent's Note: DHS OIG, Atlanta Field Office, was contacted by the DHS OIG Inspections Division, Denver, CO, to provide information related to the manner in which suicides were occurring, specifically if bedsheets were utilized, which will be documented in a separate report. However, based upon the information obtained by (b)(6); (b)(7)(C) there is no evidence at this time that the use of bed sheets was utilized in this incident.]

DHS OIG will conduct interviews with Immigration and Customs Enforcement (ICE) and SDC management and SDC detention officers upon receipt of the investigative information requested.

Name, Title, Signature, and Date: (b)(6); (b)(7)(C)	Reviewing Office: (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C)	(b)(6); (b)(7)(C)

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EXHIBIT #3



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

MEMORANDUM OF ACTIVITY

Type of Activity: Other: Records Receipt

Case Number: (b)(6); (b)(7)(C); (b)(7)(E)

Case Title: Efrain De La Rosa

On September 25, 2018, (b)(6); (b)(7)(C), Special Agent (SAs), Department of Homeland Security (DHS), Office of Inspector General (OIG), Atlanta Field Office, visited the Stewart Detention Center (SDC), Lumpkin, GA. Agents obtained documents and records for review reference the DHS OIG and Georgia Bureau of Investigation (GBI) death investigation of Efrain De La Rosa (A#: 209910301) who is believed to have committed suicide by hanging himself in his detention cell. Pursuant to normal protocol, the GBI is conducting processing of the involved cell.

DHS OIG received the following records for review:

- 5 DVD's, containing pictures, video and documents labeled "Documents & Pictures, HV 2, HV 4, HV 6 and HV 8; received from (b)(6); (b)(7)(C); (b)(7)(F) Assistant Field Office Director, Immigration and Customs Enforcement, SDC.
- Investigation Report Form, #20185-2505-087-1, 12 pages; received from (b)(6); (b)(7)(C); (b)(7)(F) Investigator, CoreCivic (CC), SDC.
- (b)(6); folder containing approximately 150 pages of miscellaneous documents; received from (b)(6); (b)(7)(C); Assistant Warden, CC, SDC.

[Agent's Note: (b)(6); advised that he had made multiple folders containing the same documents provided to DHS OIG for ICE and CC counsel. Review of the items received will be documented in a separate report due to the volume of information received.]

Name, Title, Signature, and Date

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

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

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

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INV FORM-09

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Item #:3

DHS-20-0638-D-000172

2020-ICLI-00057 1251

EXHIBIT #4



OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

MEMORANDUM OF ACTIVITY

Type of Activity: Other: ICE ICS Report Status

Case Number: (b)(6); (b)(7)(C); (b)(7)(E)	Case Title: Efrain De La Rosa
--	--------------------------------------

On November 26, 2018 (b)(6); (b)(7)(C), Special Agent, U.S. Department of Homeland Security (DHS), Office of Inspector General (OIG), Atlanta, GA, contacted (b)(6); (b)(7)(C) Inspections and Compliance Specialist (ICS), Immigration and Customs Enforcement (ICE), Washington, DC, for a status on a pending investigative report. The DHS OIG and ICE are investigating the death of Efrain De La Rosa (A#: 209910301) at Stewart Detention Center (SDC), Lumpkin, GA. At this time, the detainee is believed to have committed suicide by hanging himself in his detention cell. Pursuant to normal protocol, the GBI conducted the processing of the involved cell and ICE ICS conducts a detainee death investigation of the incident.

Walder advised that the report was still in pending status and indicated that the report would be sent to DHS OIG upon completion.

Name, Title, Signature, and Date: Jason Mann Special Agent	(b)(6); (b)(7)(C)	(b)(6); (b)(7)(C)
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EXHIBIT #5



OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

MEMORANDUM OF ACTIVITY

Type of Activity: Other: Records Receipt from GBI

Case Number: (b)(6); (b)(7)(C); (b)(7)(E)

Case Title: Efrain De La Rosa

On February 28, 2019, (b)(6); (b)(7)(C) Special Agent (SA), Department of Homeland Security (DHS), Office of Inspector General (OIG), Atlanta, GA, received records from (b)(6); (b)(7)(C) SA, Georgia Bureau of Investigation (GBI), Americus, GA. The DHS OIG and GBI are investigating the death of Efrain De La Rosa (A#: 209910301), federal immigration detainee, at Stewart Detention Center (SDC), Lumpkin, GA. At this time, the detainee is believed to have committed suicide by hanging himself in his detention cell. Pursuant to normal protocol, the GBI conducted the processing of the involved detention cell and Immigration and Customs Enforcement (ICE), Inspections and Compliance Specialist (ICS), Washington, DC, conducts a detainee death investigation of the incident. Reference is made to a previous report dated January 10, 2019, related to the coordination of obtaining available records.

DHS OIG received the following from (b)(6); for review:

- Compact Discs #1-9: dated 7/10/18, SDC Video Surveillance Footage
- Compact Disc: dated 7/10/18, SDC Handheld Video Camera Footage

A separate report will be generated after review of the material received is completed.

Name, Title, Signature, and Date: (b)(6); (b)(7)(C)		Reviewing Official Name, Title, Signature, and Date:	
(b)(6); (b)(7)(C)		(b)(6); Acting Assistant	(b)(6); (b)(7)(C)

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EXHIBIT #6



OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

MEMORANDUM OF ACTIVITY

Type of Activity: Other: Declination

Case Number: (b)(6); (b)(7)(C); (b)(7)(E)	Case Title: Efrain De La Rosa
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On March 20, 2019, (b)(6); (b)(7)(C) Special Agent (SA), U.S. Department of Homeland Security (DHS), Office of Inspector General (OIG), Atlanta, GA, met with (b)(6); (b)(7)(C), Assistant United States Attorney (AUSA), United States Attorneys' Office (USAO), Middle District of Georgia, Columbus, GA, regarding the investigation of the death of Efrain De La Rosa (A#: 209910301) at Stewart Detention Center (SDC), Lumpkin, GA. The Georgia Bureau of Investigation (GBI) had conducted the processing of the involved cell and has closed their investigation. The Stewart County Coroner's Office, Lumpkin, GA had ruled the death as a suicide by hanging.

(b)(6); (b)(7)(C) was updated on the investigation and advised that the final report from Immigration and Customs Enforcement (ICE), Inspections and Compliance Division, Washington, DC, was pending completion, however, no evidence of a criminal violation exists to date. (b)(6); (b)(7)(C) advised that the USAO would decline to prosecute this matter.

Name, Title, Signature, and Date:	Reviewing Official Name, Title, Signature, and Date:
(b)(6); (b)(7)(C) Special Agent	(b)(6); (b)(7)(C) Acting Assistant Special

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EXHIBIT #7

**GEORGIA BUREAU OF INVESTIGATION
REGION 3
INVESTIGATIVE SUMMARY**

03-0008-01-19

FINAL DISPOSITION

On Tuesday, October 23, 2018, at approximately 12:15 p.m., GBI Special Agent (b)(6); (b)(7)(C) was located at the GBI Region 3 Field Office, Americus, Sumter County, Georgia. While at that location (b)(6); (b)(7)(C) reviewed this case file in preparation to close this case file. (b)(6); (b)(7)(C) reviewed the summaries documenting the witness interviews, processing of the crime scene, video surveillance footage, received documents, and the autopsy report.

EFRAIN DE LA-ROSA was identified as the victim regarding this investigation. DE LA-ROSA was further identified as an inmate at the Stewart Detention Center, Lumpkin, Stewart County, Georgia, at the time of the incident. Based on the evidence, information, interviews, video surveillance footage, and the autopsy report certifying DE LA-ROSA's death as suicide, (b)(6); (b)(7)(C) requests this case be closed.

Investigative activity concluded at approximately 1:00 p.m.

SPECIAL AGENT J (b)(6); (b)(7)(C) 10/23/2018
jl: 10/23/2018

EXHIBIT #8



OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

MEMORANDUM OF ACTIVITY

Type of Activity: Other: ERAU Detainee Death Report Review

Case Number: I18-ICE-ATL-34012

Case Title: Efrain De La Rosa

On August 23, 2019, (b)(6); (b)(7)(C) Special Agent (SA), Department of Homeland Security (DHS), Office of Inspector General (OIG), Atlanta, GA, completed its review of a Detainee Death Review report received from (b)(6); (b)(7)(C) Unit Chief (Acting), External Reviews and Analysis Unit (ERAU), Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), Washington, DC, regarding the investigation of the death of Efrain De La Rosa (A#: 209910301) at Stewart Detention Center (SDC), Lumpkin, GA. The Georgia Bureau of Investigation (GBI) had conducted the processing of the involved cell and has closed their investigation. The Stewart County Coroner's Office, Lumpkin, GA had ruled the death as a suicide by hanging. ERAU conducts an independent review of custodial detainee death incidents which documents its findings and makes recommendations related to the specific incident.

DHS OIG reviewed the following document:

- DETAINEE DEATH REVIEW – Efrain DE LA ROSA JICMS #201809140, 46 pages

A review of the document related that the following was a synopsis of ERAU's review:

On July 10, 2018, Efrain DE LA ROSA (DE LA ROSA), a forty-year-old citizen of Mexico, died while in custody of U.S. Immigration and Customs Enforcement (ICE) at the Southwest Georgia Regional Medical Center (SGRMC) in Cuthbert, Georgia (GA). DE LA ROSA's preliminary cause of death is self-induced strangulation. The Georgia Bureau of Investigation (GBI), Associate Medical Examiner, documented DE LA ROSA's cause of death as suicide by hanging. DE LA ROSA was detained at Stewart Detention Center (SDC) in Lumpkin, GA, from March 13, 2018 until his death on July 10, 2018. SDC is a dedicated facility governed by an Intergovernmental Service Agreement, owned and operated by CoreCivic (CC), and is required to comply with the ICE Performance Based National Detention Standards (PBNDS) 2011. ICE Health Services Corp (IHSC) provides medical care at SDC and is supported by contract company InGenesis; InGenesis subcontracts with STG International, Maxim Healthcare Services, Prestige Healthcare, and Akahi Associates to ensure adequate levels of care are provided at SDC. At the time of DE LA ROSA's death, SDC housed approximately 1,835 male detainees of all classification levels for periods in excess of 72 hours.

Name, Title, Signature, and Date:	(b)(6); (b)(7)(C)	Reviewing Official Name, Title, Signature, and Date:	(b)(6); (b)(7)(C)
(b)(6); (b)(7)(C)		(b)(6); (b)(7)(C)	(b)(6); (b)(7)(C)

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MEMORANDUM OF ACTIVITY

A review of the document related that the following were the details of the review:

From August 14 to 16, 2018, ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited SDC to review DE LA ROSA's detention and the circumstances surrounding his death while in ICE custody. ERAU was assisted in its review by contract subject matter experts (SME) in correctional healthcare and security, who are employed by Creative Corrections, a national management and consulting firm. As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to DE LA ROSA, in addition to conducting in-person interviews of individuals employed by CoreCivic, IHSC, InGenesis (to include subcontractors), and ICE Office of Enforcement and Removal Operations (ERO) staff. During the review, the ERAU review team took note of any deficiencies observed in the facility's compliance with the relevant detention standards as they relate to the care and custody of the deceased detainee and documented those deficiencies herein for informational purposes only. Their inclusion in the report should not be construed in any way as indicating the deficiency contributed to the death of the detainee. ERAU determined the following timeline of events, from the time of DE LA ROSA's encounter with ERO, through his detention at SDC, and his eventual death at the SGRMC.

[Agent's Note: The DHS OIG utilized GBI cell processing and investigative reports; a pre-decisional incident report conducted by ICE Health Services Corps (IHSC) and the ERAU report. A review of this specific incident was conducted with an emphasis on documenting any similarities to a previous suicide incident at the facility (reference case# (b)(6); (b)(7)(C); (b)(7)(E))]

A review of the ERAU report yielded that at 8:40 p.m., on the evening of the De La Rosa's death, (b)(6); (b)(7)(C), Officer, SDC, conducted a security round and looked into De La Rosa's cell. At 9:12 p.m., 9:41 p.m., and 10:04 p.m., (b)(6); (b)(7)(C) logged conducting additional rounds; however, video surveillance footage confirmed (b)(6); (b)(7)(C) did not look in De La Rosa's cell at these times. Video surveillance footage showed (b)(6); (b)(7)(C) signing documents on the clipboard next to the detainee's cell, but he did not look in the cell to personally observe De La Rosa.

At 10:05 p.m., (b)(6); (b)(7)(C) Officer, SDC, entered Pod 7B to assume the 3rd shift post. At 10:08 p.m., (b)(6); (b)(7)(C) escorted a nurse to a cell on the opposite side of the room from De La Rosa. At 10:13 p.m., (b)(6); (b)(7)(C) Officer, assigned to Pod 7A, entered 7B, looked through paperwork at the officer's desk, and then left the pod. At 10:15 p.m., (b)(6); (b)(7)(C) returned to the center of the unit and at 10:17 p.m., moved to his desk. (b)(6); (b)(7)(C) stated when he assumed post, he started to fill out the detainee information on each CAR and CWL for the following day because at midnight, he would need to post the new ones on their clipboards. (b)(6); (b)(7)(C) added that while escorting a nurse to another detainee's cell, he noticed the last recorded security round conducted by (b)(6); (b)(7)(C) was at 10:04 p.m.; therefore, he believed he had time before the next required round to start paperwork needed for the following day during his shift.

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MEMORANDUM OF ACTIVITY

At 10:33 p.m., (b)(6); conducted his first security round. He approached De La Rosa's cell, looked in, moved to record his round, and then looked in the cell again after he observed De La Rosa standing by the bunk with his chin down. (b)(6); knocked on the cell door several times, and after he received no response, called for medical emergency by radio. (b)(6); (b)(7)(C) noted he saw multiple socks wrapped around the top bunk rail. Emergency procedures were initiated to attempt to revive De La Rosa which but were unsuccessful.

SDC Restrictive House Unit (RHU) Post Orders, Section (III)(B)(1)(i), states, "Detainees in SMU shall be personally observed and logged at least every thirty (30) minutes on an irregular schedule... Observation will include looking in each cell to ensure that no unusual or unauthorized activities are occurring."

(b)(6); (b)(7)(C) was 2nd Shift Officer (2:00 p.m. to 10:00 p.m.), assigned to Pod 7B. ERAU was unable to interview (b)(6); as SDC terminated (b)(6); (b)(7)(C) on July 26, 2018 for failing to properly observe De La Rosa while conducting his rounds.

Attachment

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SYNOPSIS

On July 10, 2018, Efrain DE LA ROSA (DE LA ROSA), a forty-year-old citizen of Mexico, died while in custody of U.S. Immigration and Customs Enforcement (ICE) at the Southwest Georgia Regional Medical Center (SGRMC) in Cuthbert, Georgia (GA). DE LA ROSA's preliminary cause of death is self-induced strangulation. The Georgia Bureau of Investigation (GBI), Associate Medical Examiner, documented DE LA ROSA's cause of death as suicide by hanging.¹

DE LA ROSA was detained at Stewart Detention Center (SDC) in Lumpkin, GA, from March 13, 2018 until his death on July 10, 2018. SDC is a dedicated facility governed by an Intergovernmental Service Agreement, owned and operated by CoreCivic (CC), and is required to comply with the ICE Performance Based National Detention Standards (PBNDS) 2011. ICE Health Services Corp (IHSC) provides medical care at SDC and is supported by contract company InGenesis; InGenesis subcontracts with STG International, Maxim Healthcare Services, Prestige Healthcare, and Akahi Associates to ensure adequate levels of care are provided at SDC. At the time of DE LA ROSA's death, SDC housed approximately 1,835 male detainees of all classification levels for periods in excess of 72 hours.

DETAILS OF REVIEW

From August 14 to 16, 2018, ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited SDC to review DE LA ROSA's detention and the circumstances surrounding his death while in ICE custody. ERAU was assisted in its review by contract subject matter experts (SME) in correctional healthcare and security, who are employed by Creative Corrections, a national management and consulting firm.² As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to DE LA ROSA, in addition to conducting in-person interviews of individuals employed by CoreCivic, IHSC, InGenesis (to include subcontractors), and ICE Office of Enforcement and Removal Operations (ERO) staff.

During the review, the ERAU review team took note of any deficiencies observed in the facility's compliance with the relevant detention standards as they relate to the care and custody of the deceased detainee and documented those deficiencies herein for informational purposes only. Their inclusion in the report should not be construed in any way as indicating the deficiency contributed to the death of the detainee. ERAU determined the following timeline of events, from the time of DE LA ROSA's encounter with ERO, through his detention at SDC, and his eventual death at the SGRMC.

¹ See Exhibit 1: Georgia Bureau of Investigation, Division of Forensic Sciences Autopsy, Official Report, dated October 2, 2018.

² See Exhibit 2: Creative Corrections Detainee Death Review Healthcare and Security Analysis.

EXHIBIT #9



OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

MEMORANDUM OF ACTIVITY

Type of Activity: Records Review (b)(6); (b)(7)(C) Incident Statement Review

Case Number: (b)(6); (b)(7)(C); (b)(7)(E) Case Title: Efrain De La Rosa

On September 13, 2019, (b)(6); (b)(7)(C) Special Agent (SA), Department of Homeland Security (DHS) Office of Inspector General (OIG), Atlanta, GA, obtained records from (b)(6); (b)(7)(C) Investigator, CoreCivic, Lumpkin, GA, pertaining to the investigation of the death of Efrain De La Rosa (A#: 209910301) at Stewart Detention Center (SDC), Lumpkin, GA. The Georgia Bureau of Investigation (GBI) had conducted the processing of the involved cell and has closed their investigation. The Stewart County Coroner's Office, Lumpkin, GA had ruled the death as a suicide by hanging. Reference is made to a previous report dated August 23, 2019, documenting a review of the Detainee Death Review report completed by the External Reviews and Analysis Unit (ERAU), Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), Washington, DC, which indicated that detainee round counts were not conducted in accordance with ICE detention policy.

A review of the ERAU report yielded that at 8:40 p.m., on the evening of the De La Rosa's death, (b)(6); (b)(7)(C) Officer, SDC, conducted a security round and looked into De La Rosa's cell. At 9:12 p.m., 9:41 p.m., and 10:04 p.m., (b)(6); (b)(7)(C) logged conducting additional rounds; however, video surveillance footage confirmed (b)(6); (b)(7)(C) did not look in De La Rosa's cell at these times. Video surveillance footage show (b)(6); (b)(7)(C) signing documents on the clipboard next to the detainee's cell, but he did not look in the cell to personally observe De La Rosa.

SDC Restrictive House Unit (RHU) Post Orders, Section (III)(B)(1)(i), states, "Detainees in SMU shall be personally observed and logged at least every thirty (30) minutes on an irregular schedule... Observation will include looking in each cell to ensure that no unusual or unauthorized activities are occurring."

(b)(6); (b)(7)(C) as 2nd Shift Officer (2:00 p.m. – 10:00 p.m.), assigned to Pod 7B. ERAU was unable to interview (b)(6); (b)(7)(C) as SDC terminated (b)(6); (b)(7)(C) on July 26, 2018, for failing to properly observe De La Rosa while conducting his rounds.

DHS OIG reviewed documents provided by (b)(6); (b)(7)(C) include (b)(6); (b)(7)(C) written statement he provided following the suicide of De La Rosa. (b)(6); (b)(7)(C) stated that on July 10, 2018, prior to his shift ending at 10:00 p.m., he assisted making rounds with (b)(6); (b)(7)(C) registered Nurse,

Name, Title, Signature, and Date: (b)(6); (b)(7)(C)	Reviewing Office (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C)	(b)(6); (b)(7)(C) Assistant Special Agent in Charge

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MEMORANDUM OF ACTIVITY

SDC. (b)(6); (b)(7)(C) stated the rounds were exceeding his shift end time so he asked (b)(6); (b)(7)(C) Officer, SDC, Lumpkin, GA, to finish escorting (b)(6); (b)(7)(C) with her medical rounds so he could conduct his last rounds for the night and make sure all of the paperwork was complete. (b)(6); (b)(7)(C) stated that he gave (b)(6); (b)(7)(C) Officer, SDC, Lumpkin, GA, a brief then left the facility. (b)(6); (b)(7)(C) later stated in an interview with (b)(6); (b)(7)(C) that sometime between 5:19 p.m., 6:17 p.m. and 7:15 p.m. he was giving out and picking up trays and was inaccurate in the times he documented his rounds. (b)(6); (b)(7)(C) written statement made no reference to falsifying or not completing the required round checks.

[Agent's Note: based upon the review of the ERAU report and (b)(6); (b)(7)(C) being terminated thereafter for allegedly falsifying round count documents DHS OIG will continue this investigation.]

Attachments

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INCIDENT STATEMENT

Facility	SDC			Incident Number	B018-245-027-I		
Incident Date	7/10/18			Incident Time (HRS)	2234		
Person Name	ID Number (Employee #/Inmate #/Civilian ID)	Person Type (Employee/Inmate/Civilian)	Person Role (Witness or Participant)				
(b)(6); (b)(7)(C)	37767061	Employee	Witness				
Housing Location (For Inmates/Residents Only)							

Based on your own knowledge, what did you (b)(6); (b)(7)(C) and do?

On 7/10/2018 I off (b)(6); (b)(7)(C) was conducting rounds with Medford Staff RN (b)(6); (b)(7)(C) when I checked one of the (b)(6); (b)(7)(C) I asked officer to escort Nurse Harris to finish her medical rounds. I then proceeded to finish my last rounds for the night and make sure all the paper work was complete. After conducting rounds and making sure all was good, I gave off J. McCall a briefing. Then I exited the facility. - End of Statement

Did you receive any injuries? YES or NO (If YES, Explain Below)

NO

Were you evaluated (b)(6); (b)(7)(C)

Printed Name: _____

Signature: _____

Typed By: _____

Date: 7/12/18

This section to be completed by CCA staff if the civilian/other or inmate/resident refused to complete the 5-1C.

Place an "X" in the appropriate box:

☐	Inmate/Resident refused to complete this 5-1C
☐	Civilian/Other refused to complete this 5-1C
Employee/Witness Printed Name	Date:
Employee/Witness Signature	
Employee/Witness Printed Name	Date:
Employee/Witness Signature	

EXHIBIT #10



OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

MEMORANDUM OF ACTIVITY

Type of Activity: Other: USAO Contact

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

Case Number: (b)(6); (b)(7)(C)

Case Title: Efrain De La Rosa

On February 6, 2020, (b)(6); (b)(7)(C) Special Agent (SA), Department of Homeland Security (DHS), Office of Inspector General (OIG), Atlanta, GA, contacted (b)(6); (b)(7)(C) Assistant United States Attorney (AUSA), United States Attorneys' Office (USAO), Middle District of Georgia, Columbus, GA, regarding the investigation of the death of Efrain De La Rosa (A#: 209910301) at Stewart Detention Center (SDC), Lumpkin, GA. The Georgia Bureau of Investigation (GBI) had conducted the processing of the involved cell and has closed their investigation. The Stewart County Coroner's Office, Lumpkin, GA had ruled the death as a suicide by hanging. Reference is made to a previous report regarding previous contact with the USAO regarding this investigation.

(b)(6); (b)(7)(C) was updated on the investigation to date and was provided with the final report from Immigration and Customs Enforcement (ICE), Inspections and Compliance Division, Washington, DC, and DHS OIG documents pertaining to the ongoing investigation.

(b)(6); (b)(7)(C) advised that the documents would be forwarded to the USAO, Criminal Division, in Macon, GA, for management review. (b)(6); (b)(7)(C) indicated that DHS OIG would be contacted following the completion of that review.

Name, Title, Signature, and Date:	Reviewing Official Name, Title, Signature, and Date:
(b)(6); (b)(7)(C) Special Agent	(b)(6); (b)(7)(C) Assistant Special

IMPORTANT NOTICE

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EXHIBIT #11



OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

MEMORANDUM OF ACTIVITY

Type of Activity: Other: Declination

Case Number: I18-ICE-ATL-34012

Case Title: Efrain De La Rosa

On April 7, 2020, (b)(6); (b)(7)(C) Special Agent (SA), U.S. Department of Homeland Security (DHS), Office of Inspector General (OIG), Atlanta, GA, received advisement from (b)(6); (b)(7)(C) Assistant United States Attorney (AUSA), United States Attorneys' Office (USAO), Middle District of Georgia, Columbus, GA, regarding the investigation of the death of Efrain De La Rosa (A#: 209910301) at Stewart Detention Center (SDC), Lumpkin, GA. The Georgia Bureau of Investigation (GBI) had conducted the processing of the involved cell and has closed their investigation. The Stewart County Coroner's Office, Lumpkin, GA had ruled the death as a suicide by hanging. Reference is made to a previous report indicating the investigation was being reviewed for prosecution by the USAO.

(b)(6); (b)(7)(C) advised the USAO declined to prosecute the matter. This case will be closed.

Name, Title, Signature, and Date:	(b)(6); (b)(7)(C)	Reviewing Officer	(b)(6); (b)(7)(C)	Signature	(b)(6); (b)(7)(C)
(b)(6); (b)(7)(C)		(b)(6); (b)(7)(C)	Assistant Special Agent in Charge		

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SYNOPSIS

On July 10, 2018, Efrain DE LA ROSA (DE LA ROSA), a forty-year-old citizen of Mexico, died while in custody of U.S. Immigration and Customs Enforcement (ICE) at the Southwest Georgia Regional Medical Center (SGRMC) in Cuthbert, Georgia (GA). DE LA ROSA's preliminary cause of death is self-induced strangulation. The Georgia Bureau of Investigation (GBI), Associate Medical Examiner, documented DE LA ROSA's cause of death as suicide by hanging.¹

DE LA ROSA was detained at Stewart Detention Center (SDC) in Lumpkin, GA, from March 13, 2018 until his death on July 10, 2018. SDC is a dedicated facility governed by an Intergovernmental Service Agreement, owned and operated by CoreCivic (CC), and is required to comply with the ICE Performance Based National Detention Standards (PBNDS) 2011. ICE Health Services Corp (IHSC) provides medical care at SDC and is supported by contract company InGenesis; InGenesis subcontracts with STG International, Maxim Healthcare Services, Prestige Healthcare, and Akahi Associates to ensure adequate levels of care are provided at SDC. At the time of DE LA ROSA's death, SDC housed approximately 1,835 male detainees of all classification levels for periods in excess of 72 hours.

DETAILS OF REVIEW

From August 14 to 16, 2018, ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited SDC to review DE LA ROSA's detention and the circumstances surrounding his death while in ICE custody. ERAU was assisted in its review by contract subject matter experts (SME) in correctional healthcare and security, who are employed by Creative Corrections, a national management and consulting firm.² As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to DE LA ROSA, in addition to conducting in-person interviews of individuals employed by CoreCivic, IHSC, InGenesis (to include subcontractors), and ICE Office of Enforcement and Removal Operations (ERO) staff.

During the review, the ERAU review team took note of any deficiencies observed in the facility's compliance with the relevant detention standards as they relate to the care and custody of the deceased detainee and documented those deficiencies herein for informational purposes only. Their inclusion in the report should not be construed in any way as indicating the deficiency contributed to the death of the detainee. ERAU determined the following timeline of events, from the time of DE LA ROSA's encounter with ERO, through his detention at SDC, and his eventual death at the SGRMC.

¹ See Exhibit 1: Georgia Bureau of Investigation, Division of Forensic Sciences Autopsy, Official Report, dated October 2, 2018.

² See Exhibit 2: Creative Corrections Detainee Death Review Healthcare and Security Analysis.

IMMIGRATION AND CRIMINAL HISTORY

In the year 2000, at an unknown date and time, DE LA ROSA claimed to have illegally entered the United States near the U.S.-Mexico border near Arizona, without being admitted or paroled by an immigration official.³

On July 8, 2004, the Circuit Court of Fairfax County, Virginia (VA), convicted DE LA ROSA of driving while intoxicated, sentenced him to 30 days' confinement⁴ and suspended his driver's license for 12 months.

On July 22, 2004, the Circuit Court of the City of Alexandria, VA, convicted DE LA ROSA of possession of burglary tools and sentenced him to two years' confinement, with the possibility of one and one-half years suspended for good behavior, and two years' probation.⁵

On August 30, 2004, the Circuit Court of the City of Alexandria, VA, convicted DE LA ROSA of carjacking and sentenced him to 20 years' confinement, with the possibility of 12 years suspended for good behavior, and five years' probation.⁶

On October 13, 2004, the Circuit Court of Fairfax County, VA, convicted DE LA ROSA of carjacking and sentenced him to 15 years' confinement, with the possibility of nine years and six months suspended for good behavior, and five years' probation.⁷

On October 25, 2004, the Circuit Court of Fairfax County, VA, convicted DE LA ROSA of receiving stolen property, and sentenced him to six months' confinement and six months' supervised probation.⁸

On November 22, 2004, the Commonwealth of Virginia Department of Corrections (VADOC) booked DE LA ROSA into the Alexandria City Jail.⁹

On December 6, 2004, the Fairfax County General District Court, Fairfax, VA, convicted DE LA ROSA of escape without force and sentenced him to 30 days' confinement with 30 days suspended.¹⁰

³ See Enforce Alien Removal Module (EARM) Narrative, dated May 10, 2017.

⁴ Initially, the Circuit Court of Fairfax County suspended all 30 days of the jail sentence, contingent upon his good behavior for one year. On February 10, 2005, the Circuit Court of Fairfax County determined DE LA ROSA violated the terms of his release and ordered him to serve the remainder of his previous 30 days' confinement. See Circuit Court of Fairfax County Final Order, dated February 10, 2005.

⁵ See Circuit Court of the City of Alexandria Sentencing Summary, dated October 1, 2004.

⁶ See Circuit Court of the City of Alexandria Sentencing Summary, dated October 29, 2004.

⁷ See Circuit Court of Fairfax County Sentencing Order, dated January 11, 2005.

⁸ See Circuit Court of Fairfax County Sentencing Order, dated January 7, 2005.

⁹ See Commonwealth of Virginia Department of Corrections DE LA ROSA Transfer Dates Report, dated November 22, 2004 - July 11, 2018.

¹⁰ See United States Department of Justice Criminal Record, dated February 9, 2018.

On January 11, 2005, VADOC transferred DE LA ROSA from Alexandria City Jail to Fairfax County Adult Detention Center. From this date through January 15, 2013, VADOC transferred DE LA ROSA to five separate facilities.¹¹

On January 15, 2013, VADOC transferred DE LA ROSA to Marion Correctional Treatment Center (MCTC).¹²

On April 5, 2017, ERO Washington encountered DE LA ROSA at the Virginia Department of Behavioral Health and Developmental Service (DBHDS), MCTC,¹³ pursuant to a referral from the VADOC. The DBHDS detained DE LA ROSA at MCTC as he suffered from schizophrenia and was found to be mentally incompetent and was therefore unable to participate in his criminal proceedings.¹⁴

On August 29, 2017, ERO Washington issued DE LA ROSA a Notice to Appear, Form I-862, charging removability pursuant to Sections 212(a)(6)(A)(i),¹⁵ 212(a)(2)(A)(i)(I),¹⁶ and 212(a)(2)(B)¹⁷ of the Immigration and Nationality Act (INA).¹⁸

On September 8, 2017, ERO Washington lodged an Immigration Detainer – Notice of Action, Form I-247A, with the MCTC; however, on this same date, based on the recommendation of the Washington ICE Office of Chief Counsel (OCC), ERO Washington lifted the detainer pursuant to 8 CFR 236.2(b).¹⁹

On September 11, 2017, MCTC released DE LA ROSA.²⁰

On February 9, 2018, a designated immigration officer (DIO) from the Wake County 287(g) program encountered DE LA ROSA at the Wake County Detention Center (WCDC) in Raleigh, North Carolina (NC), following his arrest for larceny. The DIO lodged a Form I-247A with the WCDC.²¹

¹¹ See Commonwealth of Virginia Department of Corrections DE LA ROSA Transfer Dates Report, dated November 22, 2004 - July 11, 2018.

¹² *Id.*

¹³ MCTC is a behavioral health unit (BHU) licensed for acute care, outpatient, and residential mental health services. It houses male offenders determined in need of care outside the scope of services available in prisons.

¹⁴ See EARM Narrative, dated May 10, 2017; See ICE Significant Incident Report, dated July 11, 2018.

¹⁵ An alien present in the United States without being admitted or paroled, or who arrived in the United States at any time or place other than as designated by the Attorney General.

¹⁶ An alien who has been convicted of, or who admits having committed, or who admits committing acts which constitute the essential elements of a crime involving moral turpitude (other than a purely political offense) or an attempt or conspiracy to commit such a crime.

¹⁷ An alien who has been convicted of two or more offenses (other than purely political offenses) for which the aggregate sentences to confinement were five years or more.

¹⁸ See DHS Form I-862, Notice to Appear, dated August 29, 2017.

¹⁹ An alien confined due to mental instability in an institution shall not be accepted into physical custody by the service until an order of removal has been entered. See ICE Significant Incident Report, dated July 11, 2018.

²⁰ See Commonwealth of Virginia Department of Corrections DE LA ROSA Transfer Dates Report, dated November 22, 2004 - July 11, 2018.

²¹ See DHS Form I-247A, Immigration Detainer – Notice of Action, dated February 9, 2018.

On March 9, 2018, the Wake County District Court in Raleigh, NC, convicted DE LA ROSA of larceny and sentenced him to 28 days' confinement with 28 days' credit for time served.²²

On March 12, 2018, WCDC released DE LA ROSA to the custody of ERO Atlanta.²³

On March 13, 2018, ERO Atlanta transferred DE LA ROSA to SDC.²⁴

On March 22, 2018, the Atlanta OCC filed a motion with the Executive Office for Immigration Review (EOIR) to change the venue of DE LA ROSA's removal proceedings from Arlington, VA, to Lumpkin, GA.²⁵ On this same date, the ICE Office of the Principal Legal Advisor (OPLA) submitted a request for mental health reviews with IHSC.²⁶

On April 18, 2018, EOIR granted the motion for a change of venue.²⁷

On June 28, 2018, IHSC provided OPLA with DE LA ROSA's medical records, which indicated a history of schizophrenia. On this same date, Atlanta OCC filed a motion for consideration of medical/mental health records with EOIR.²⁸

On July 3, 2018, an Immigration Judge in Lumpkin, GA, ordered DE LA ROSA removed from the United States to Mexico.²⁹

NARRATIVE

On March 13, 2018, at approximately 1:07 p.m.,³⁰ SDC admitted DE LA ROSA. At an unknown time, Office (b)(6); (b)(7)(C) completed DE LA ROSA's initial ICE Custody Classification Worksheet and appropriately classified DE LA ROSA as high; a supervisor did not approve the classification until March 29, 2018.³¹

At 10:55 p.m.,³² (b)(6); (b)(7)(C) Registered Nurse (RN), completed DE LA ROSA's pre-screening and documented DE LA ROSA denied having any current health problems or taking any medications.³³ (b)(6); (b)(7)(C) also noted that DE LA ROSA appeared alert, with normal

²² See Raleigh/Wake City-County Bureau of Identification Criminal Disposition Inquiry, dated March 11, 2018.

²³ See EARM Custody Actions & Decisions, dated March 12, 2018.

²⁴ See EARM Custody Actions & Decisions, dated March 13, 2018.

²⁵ See Department of Justice EOIR Immigration Court, Motion to Change Venue, dated March 22, 2018.

²⁶ See IHSC, OPLA Request for Medical Records, dated March 22, 2018.

²⁷ See ICE Significant Incident Report, dated July 11, 2018.

²⁸ See DHS Motion for Consideration of Medical/Mental Health Records, dated June 28, 2018.

²⁹ See Order of the Immigration Judge, July 3, 2018.

³⁰ See Inmate Information Sheet, dated March 13, 2018.

³¹ See ICE Custody Classification Assessment, dated March 13, 2018. ERAU notes Office (b)(6); (b)(7)(C) omitted any notes regarding special vulnerabilities (i.e., mental illness) on the assessment form.

³² ERAU approximated timing of medical events as best as possible. Medical times catalogued within the report are prioritized based on the time medical staff indicated a round time, vital signs, or electronically signed their note.

³³ See eClinicalWorks (eCW) Progress Note by (b)(6); (b)(7)(C) dated March 13, 2018. (b)(6); (b)(7)(C) Progress Note documented DE LA ROSA's time of arrival as 10:30 p.m., which is inconsistent with the Inmate Information Sheet.

behavior and appearance, and exhibited no noticeable restrictions or difficulties in movement or breathing.

On March 14, 2018, at 1:51 a.m.,³⁴ Officer (b)(6); (b)(7)(C) booked DE LA ROSA into SDC.³⁵

At 2:45 a.m. (b)(6); (b)(7)(C) completed DE LA ROSA's medical and mental health screening and documented the following:³⁶

- (b)(6); (b)(7)(C) conducted the screening in the detainee's native language of Spanish, although DE LA ROSA reported he spoke fluent English.
- DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 119/80.³⁷
- DE LA ROSA disclosed a history of drug (cocaine), alcohol, and tobacco use, with last consumption in January 2018, December 2017, and February 2018, respectively.
- DE LA ROSA reported feeling good and denied pain, medical or dental problems, withdrawal or tuberculosis (TB) symptoms.
- DE LA ROSA stated that while incarcerated in Virginia, the MCTC treated him for schizophrenia.³⁸ DE LA ROSA also reported taking eight different medications but stated he ceased use approximately three months before he arrived at SDC because he could not sleep.
- In response to the question, "Do you ever hear voices that others do not hear?" DE LA ROSA responded he hears God talk to him.
- In response to the question, "Do you believe someone can control your mind?" DE LA ROSA stated, "No, only God."
- DE LA ROSA appeared to have normal speech, comprehension, focus, physical characteristics, and emotional attributes.
- DE LA ROSA arrived with a Transfer Summary³⁹ from WDCD, discussed below.

³⁴ It is unknown why the booking time differs from the March 13, 2018, 1:07 p.m. admission time noted on Inmate Information Sheet.

³⁵ See Detainee Commitment Summary, dated March 14, 2018.

³⁶ See eCW Progress Note by (b)(6); (b)(7)(C) dated March 14, 2018.

³⁷ A normal temperature is considered 98.6; the normal range for a pulse is 60 to 100 beats per minute; the normal range for respirations is 12 to 20 breaths per minute; and, a normal blood pressure is 120/80 or less. According to the American Heart Association (AHA), this blood pressure reading indicates stage one hypertension. Stage one hypertension is characterized by a systolic reading of 130 to 139 or a diastolic reading of 80 to 89.

³⁸ Schizophrenia is a chronic mental health disorder that affects how a person thinks, feels, and behaves, often losing touch with reality. It is characterized by possible auditory and visual hallucinations (apparent perception of something not present), delusions (belief that is firmly maintained despite being contradicted by reality), depression, self-harm and harm to others.

³⁸ Schizophrenia is a chronic mental health disorder that affects how a person thinks, feels, and behaves, often losing touch with reality. It is characterized by possible auditory and visual hallucinations (apparent perception of something not present), delusions (belief that is firmly maintained despite being contradicted by reality), depression, self-harm and harm to others.

³⁹ See WDCD Medical Summary (4 pages), reviewed by (b)(6); (b)(7)(C) March 13, 2018.

According to the WCDC Transfer Summary,⁴⁰ DE LA ROSA was not currently taking medication and per a purified protein derivative (PPD)⁴¹ test completed on February 10, 2018, was negative for TB. The Problem List⁴² included seven items; legible entries included a scar to the dorsal⁴³ side of the right hand, prior incarceration in the VADOC, and schizophrenia.

Based on her findings (b)(6); (b)(7)(C) documented the following:⁴⁴

- The mental health screening was negative for suicidal or homicidal ideation.
- RN Benavidez explained the TB test and chest x-ray to DE LA ROSA and completed the process with appropriate shielding.⁴⁵
- As DE LA ROSA had an abnormal intake screening, the RN referred him to a medical provider.
- (b)(6); (b)(7)(C) cleared DE LA ROSA for custody.

ERAU notes that during DE LA ROSA's first detention period at SDC, medical staff did not obtain a signed IHSC Medical Consent Form for general treatment from DE LA ROSA.

At 4:50 a.m. (b)(6); (b)(7)(C) completed a risk classification assessment and documented answers of "No" to all questions.⁴⁶ At 10:02 a.m., SDC assigned DE LA ROSA to general population unit 6, pod A, cell 110.⁴⁷

On March 15, 2018, at 9:30 a.m., (b)(6); (b)(7)(C) Nurse Practitioner (NP), conducted DE LA ROSA's initial physical assessment, and documented the following:⁴⁸

- DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 113/80.
- DE LA ROSA denied a history of chronic medical conditions and dental problems.
- DE LA ROSA reported a history of schizophrenia and hospitalization for the disease in 2004 and 2010.
- DE LA ROSA could not recall the names of his past medications and stated he ceased use of them after informing a doctor in NC that he could not sleep.

⁴⁰ *Id.*

⁴¹ A PPD skin test is a solution injected into the skin to determine whether a person has been infected with tuberculosis.

⁴² A Problem List is a running list of a patient's medical problems. Problem Lists are maintained in the medical record to support continuity of care during patient encounters.

⁴³ Dorsal refers to the top side.

⁴⁴ See eCW Progress Note by (b)(6); (b)(7)(C), RN, dated March 14, 2018.

⁴⁵ ERAU notes the SDC medical record was void of a chest x-ray report. Creative Corrections advised if completed, the reason is unclear as the WCDC Transfer Summary documented TB clearance through PPD testing just one month earlier and the ICE PBNDS 2011 standard, *Medical Care*: TB Management states, "For detainees that have been in continuous law enforcement custody, symptom screening plus documented TB screening within one year of arrival may be accepted for intake screening purposes."

⁴⁶ See Assessment Questionnaire Form: Initial Screening Tool, dated March 14, 2018. The assessment questionnaire is utilized to screen for victimization and predatory history/risk, among other factors to be considered when evaluating housing options for a detainee.

⁴⁷ See SDC Cellmate Housing History, dated March 13, 2018 – May 4, 2018.

⁴⁸ See eCW Progress Note by (b)(6); (b)(7)(C) dated March 15, 2018.

- DE LA ROSA again stated hearing voices from God, the last time in September 2017.
- DE LA ROSA denied suicidal or homicidal ideations.
- DE LA ROSA was not currently exhibiting symptoms of a serious mental disorder or cognitive impairment.

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

advised DE LA ROSA to continue daily activities even if he did not feel like it, regularly exercise, and notify an officer or nurse if he started having thoughts of harming himself or others or hearing voices.⁴⁹ Additionally, (b)(6); (b)(7)(C) referred DE LA ROSA to mental health.

(b)(6); (b)(7)(C) Clinical Director, co-signed the note on March 17, 2018.

On March 16, 2018, at 5:25 p.m., IHSC (b)(6); (b)(7)(C) psychologist, signed off on a mental health assessment conducted pursuant to (b)(6); (b)(7)(C)'s referral and documented the following:⁵⁰

- (b)(6); (b)(7)(C) conducted the assessment in English.
- During discussion of his past schizophrenia diagnosis, DE LA ROSA adamantly denied suicidal or homicidal ideations, gestures, or plan.
- DE LA ROSA mentioned God told him he would speak in the lands of Israel, Iraq, and “Arabia” and would go to Heaven in the future.
- DE LA ROSA reported a history of drugs and alcohol.
- DE LA ROSA reported a conviction of driving under the influence of alcohol and going to prison in 2004, and then to a mental health prison years later.
- DE LA ROSA stated he had friends to talk to for support, including his brother, and that he speaks to God.
- (b)(6); (b)(7)(C) described DE LA ROSA as appropriately dressed and future-oriented.
- (b)(6); (b)(7)(C) also noted DE LA ROSA showed no abnormalities in psychomotor activity or body movement and his affect,⁵¹ mood, speech, insight, thought content, and judgement were normal.

(b)(6); (b)(7)(C) determined there were no current symptoms of a serious mental disorder or condition, but in the treatment section of the notes, he listed treatment planning and supportive psychotherapy intervention. The plan included multiple elements that focused on DE LA ROSA's general wellness, coping and stress management skills, and direction/understanding that he would notify staff if he had any issues or felt unsafe with himself. (b)(6); (b)(7)(C) documented discussing this plan with DE LA ROSA, who verbalized understanding and agreed to follow the plan. (b)(6); (b)(7)(C) discussed information on progressive muscle relaxation, meditation, and positive thinking; DE LA ROSA stated he would use the techniques when necessary. (b)(6); (b)(7)(C) also noted staff scheduled DE LA ROSA for a psychiatry evaluation and a mental health follow-up. DE LA ROSA consented to receiving tele-psychiatry services.⁵²

⁴⁹ *Id.*

⁵⁰ See eCW Progress Note by (b)(6); (b)(7)(C) dated March 16, 2018.

⁵¹ Affect refers to the emotional tone a person expresses, which can be appropriate or inappropriate in relationship to the situation.

⁵² See IHSC Consent to Receive Tele-Psychiatry Services (Form 792), dated March 16, 2018.

On April 3, 2018, at 5:45 p.m., Officer (b)(6); (b)(7)(C) reported to Case Counselor (b)(6); (b)(7)(C) and Unit Manager (b)(6); (b)(7)(C) that DE LA ROSA exhibited inappropriate behavior towards her.⁵³ Security staff removed DE LA ROSA from the pod and Unit Manager (b)(6); (b)(7)(C) instructed him to stop making inappropriate comments to staff; however, DE LA ROSA did not comply. Unit Manager (b)(6); (b)(7)(C) recalled that she counseled DE LA ROSA regarding his actions (b)(7)(E) reported to her that DE LA ROSA was being inappropriate. When DE LA ROSA failed to listen, Unit Manager (b)(6); (b)(7)(C) instructed the officers to submit their reports.⁵⁴ Officer (b)(6); (b)(7)(C) and the second officer, Officer (b)(6); (b)(7)(C), proceeded to document their separate interactions with DE LA ROSA.⁵⁵ Officer (b)(6); (b)(7)(C) completed an Incident of Prohibited Acts and Notice of Charges document and cited DE LA ROSA for Making Sexual Proposals or Threats.⁵⁶ Subsequently, Shift Supervisor (b)(6); (b)(7)(C) ordered DE LA ROSA's placement in disciplinary segregation.⁵⁷

At 8:20 p.m., (b)(6); (b)(7)(C) RN, completed DE LA ROSA's segregation clearance assessment.⁵⁸ RN (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 128/89. (b)(6); (b)(7)(C) noted that DE LA ROSA denied suicidal or homicidal ideations and visual or auditory hallucinations. (b)(6); (b)(7)(C) also noted DE LA ROSA did not appear to have any acute or unresolved medical conditions which might worsen in segregation. (b)(6); (b)(7)(C) educated DE LA ROSA on how to access medical, mental, and dental care while in segregation and cleared him for housing.

At 8:52 p.m., security staff placed DE LA ROSA into restricted housing unit (RHU)⁵⁹ Pod 7A, cell 205.⁶⁰ Security staff created and accurately completed the Confinement Activity Record (CAR)⁶¹ and Confinement Watch Log (CWL)⁶² for this date.⁶³

At 10:15 p.m., (b)(6); (b)(7)(C) submitted a telephone encounter to the Mental Health Unit stating she cleared DE LA ROSA for housing in segregation.⁶⁴

⁵³ See Incident Statement by Officer (b)(6); (b)(7)(C) dated April 3, 2018.

⁵⁴ ERAU interview with Unit Manager (b)(6); (b)(7)(C) dated August 15, 2018.

⁵⁵ See Incident Statement by Officer (b)(6); (b)(7)(C) and Incident Statement by Officer (b)(6); (b)(7)(C) dated April 3, 2018.

⁵⁶ See Incident of Prohibited Acts and Notice of Charges, dated April 3, 2018.

⁵⁷ See Confinement Record, dated April 3, 2018.

⁵⁸ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated April 3, 2018.

⁵⁹ The SDC RHU is a special management unit (SMU) as defined in the ICE detention standards.

⁶⁰ See Cellmate Housing History Report, dated March 13, 2018 – May 4, 2018.

⁶¹ The CAR is a multi-purpose form posted on a clipboard outside each cell within segregation and details which meals, recreation, visits, and other activities the detainee partook in that day. RNs also sign this record during their rounds.

⁶² As SDC does not have an electronic system for recording rounds, officers manually record the time of their rounds on the CWL. Additionally, each shift supervisor is required to sign the form, and RNs are required to document the time of their rounds, as well as morning, noon, and/or evening delivery of medication, when applicable.

⁶³ ERAU notes during DE LA ROSA's placements in segregation, multiple CARs and CWLs were void of entries or signatures, or were missing altogether. ERAU identifies missing records within the narrative, while Appendix 1 documents specifics regarding refused activities and meals recorded on DE LA ROSA's CARs during his placements in segregation.

⁶⁴ See Telephone Encounter by (b)(6); (b)(7)(C), dated April 3, 2018.

On April 4, 2018, at 10:43 a.m., Sergeant (Sgt.) (b)(6); (b)(7)(C) initiated an investigation related to DE LA ROSA's offense. (b)(6); (b)(7)(C) interviewed DE LA ROSA, during which he admitted to the offenses charged. (b)(6); (b)(7)(C) noted referral to the Institution Disciplinary Panel (IDP).⁶⁶ At 10:48 a.m. (b)(6); (b)(7)(C) issued DE LA ROSA his Detainee Rights at the IDP Hearing,⁶⁷ which DE LA ROSA signed as having received.⁶⁸

At 11:27 a.m. (b)(6); (b)(7)(C) RN, completed an initial segregation round.⁶⁹ For questions related to thoughts of suicide, medical complaints or requests, and referral for health care services, (b)(6); (b)(7)(C) made no changes to the pre-populated answers of "No." Additionally, the pre-populated segregation evaluation template language remained unedited in the Examination section. Therefore (b)(6); (b)(7)(C)'s entry failed to include subjective findings reflecting an individualized assessment of DE LA ROSA.⁷⁰

ERAU further notes that during DE LA ROSA's multiple segregation placements, RNs completed daily medical segregation rounds but all entries contained the same template language with no supplemental information reflecting an individualized assessment of the detainee.⁷¹

At 3:17 p.m. (b)(6); (b)(7)(C) Licensed Clinical Social Worker (LCSW), signed off on DE LA ROSA's clinical segregation assessment pursuant to (b)(6); (b)(7)(C) referral and documented the following:⁷²

- DE LA ROSA's thoughts, mood, and affect were consistent with previous reports.
- DE LA ROSA stated he was fine and adjusting well to being in segregation.
- DE LA ROSA denied having suicidal and homicidal ideations, intent, or plan.
- DE LA ROSA's dress was appropriate and his grooming and hygiene were adequate.

⁶⁵ See Investigation Report, dated April 4, 2018. (b)(6); (b)(7)(C) concluded the investigation at 10:52 a.m.

⁶⁶ An IDP is a higher-level disciplinary panel that adjudicates detainee incident reports. The panel is comprised of either three individuals appointed by the facility administrator or one single disciplinary hearing officer.

⁶⁷ See Detainee Rights at the IDP Hearing, dated April 4, 2018.

⁶⁸ See Incident of Prohibited Acts and Notice of Charges, dated April 3, 2018.

⁶⁹ See eCW Progress Note by (b)(6); (b)(7)(C) dated April 4, 2018. ERAU notes RN (b)(6); (b)(7)(C) did not sign his note until April 9, 2018, at 8:23 a.m., five days after the round. Although ERAU did not interview (b)(6); (b)(7)(C) regarding this delay, during (b)(6); (b)(7)(C) interview on August 16, 2018, she explained nurses handwrite their notes during rounds and enter them in eCW following return to the clinic. She further stated, although nurses are expected to make all entries prior to the end of their shift, occasionally some are missed.

⁷⁰ Per IHSC Directive 03-06, Health Evaluation of Detainees in Special Management Units, Section 5.2: On-going Medical Rounds in the SMU, "(a) The RN or medical provider conducts daily rounds in the SMU; (b) The RN or medical provider queries each individual regarding medical, dental and behavioral health concerns or requests. Particular consideration is given to the possibility of suicidal ideations or attempts; and (c) The RN or medical provider documents the medical rounds in the SMU log book and in the patient's health record. The progress note is in the SOAP (Subjective, Objective, Assessment, Plan) format and summarizes the patient's disposition (to include whether the patient is stable; has no medical or psychiatric concerns voiced or homicidal or suicidal plan or intent; and if the patient will continue to receive monitoring daily while in the SMU)."

⁷¹ Unless a significant event occurred related to a daily medical segregation round, completion of medical segregation rounds and the use of template language are not discussed further within the report.

⁷² See eCW Progress Note by (b)(6); (b)(7)(C), dated April 4, 2018. LCSW (b)(6); (b)(7)(C) utilized SOAP format within her note.

- DE LA ROSA was receiving mental health treatment by way of talk therapy.⁷³
- LCSW (b)(6); (b)(7)(C) instructed and reminded DE LA ROSA of the process to request mental health services if he had any issues.

LCSW (b)(6); (b)(7)(C) noted mental health providers were to follow up on a weekly basis, continue to monitor, and report any changes. LCSW (b)(6); (b)(7)(C) determined DE LA ROSA did not meet serious mental illness (SMI) criteria; therefore, he was stable enough to remain in segregation.⁷⁴ IHSC Lieutenant (Lt.) Commander (LCDR) (b)(6); (b)(7)(C), LCSW, co-signed the note on April 19, 2018, concurring with LCSW (b)(6); (b)(7)(C) conclusions regarding SMI and segregation. LCSW Cannon further recommended continuity of care needs as medically indicated to address coordination of chronic care management.

SDC was unable to produce a CWL for this date.

On April 5, 2018, at an unknown time, SDC security staff issued DE LA ROSA a Notice of IDP Hearing with a documented hearing date of April 6, 2018.⁷⁵

On April 6, 2018, at 12:42 p.m., the IDP conducted a disciplinary hearing at which DE LA ROSA again admitted to making inappropriate statements.⁷⁶ The IDP sentenced DE LA ROSA to 30 days of segregation; Shift Supervisor (b)(6); (b)(7)(C) (first name unknown) signed off on the sanction the same day.⁷⁷ Assistant Shift Supervisor (b)(6); (b)(7)(C) (first name unknown) delivered a copy of the IDP Report to DE LA ROSA three days later.⁷⁸

On April 10, 2018, at an unknown time, Officer (b)(6); (b)(7)(C) completed a special classification review using the ICE Custody Classification Worksheet.⁷⁹ Officer (b)(6); (b)(7)(C) added

⁷³ Talk therapy, also referred to as psychotherapy, involves an encounter by a mental health professional to help patients cope with their feelings, problem solve, and change behavior patterns that might contribute to their symptoms.

⁷⁴ IHSC Directive 07-05, *Serious Mental Disorders or Conditions*, states, “Detainees with SMI need to be monitored closely to ensure consistent and adequate care. The Behavioral Health Unit at IHSC Headquarters monitors detainees with significant psychiatric impairments. The Behavioral Health Provider (BHP) at the facility completes and submits a weekly report to BHU for notification and continued monitoring of their seriously mentally ill detainees. SMI determination is based on significant psychiatric impairment of the detainee. The detainee must meet one or more of the following criteria based on the evaluation completed by the mental health care provider: (a) One or more active psychiatric symptoms: disorganization of thought or behavior, active hallucinations or delusions, catatonia, severe depressive symptoms, suicidal ideation, homicidal ideation, severe exacerbation of manic symptoms and marked anxiety and impulsivity; (b) History of more than two psychiatric hospitalization in the past three months and still presenting moderate to severe symptoms; (c) Presently taking psychiatric medications and still presenting active moderate to severe symptoms; (d) Continues to display harm to self or others in spite of psychiatric treatment and/or psychiatric hospitalizations; and (e) Serious limitations in mental functioning (communicating, taking care of activities of daily living, social skill, etc.) due to mental disability or severe medical conditions impairing mental function i.e. dementia or traumatic brain injury.”

⁷⁵ See Notice of IDP Hearing, dated April 5, 2018.

⁷⁶ See IDP Report, dated April 6, 2018.

⁷⁷ *Id.*; see also Disciplinary Segregation Order, dated April 6, 2018.

⁷⁸ See IDP Report, dated April 9, 2018.

⁷⁹ See ICE Custody Classification Assessment, dated April 10, 2018.

two additional points for the disciplinary infraction, maintaining the current classification level of high; a supervisor approved the classification the next day.

On April 11, 2018, at 11:46 a.m., IHSC (b)(6); (b)(7)(C) SW, completed the weekly mental health segregation round.⁸⁰ LCSW (b)(6); (b)(7)(C) noted that she perceived DE LA ROSA to be calm, cooperative, and with no suicidal or homicidal potential. LCSW (b)(6); (b)(7)(C) utilized the eCW Clinical Segregation Assessment checklist and determined DE LA ROSA did not meet SMI criteria. LCSW (b)(6); (b)(7)(C) co-signed the note on April 19, 2018, and noted concurrence with LCSW (b)(6); (b)(7)(C) conclusions regarding SMI.

On April 13, 2018, in accordance with the ICE PBNDS 2011, a security supervisor or equivalent was due to conduct an interview with DE LA ROSA as part of a seven-day review of his status in disciplinary segregation. There is no record in DE LA ROSA's detention file indicating the review occurred.

On April 16, 2018, at approximately 12:00 p.m., LCSW (b)(6); (b)(7)(C) documented a mental health follow-up.⁸¹ LCSW (b)(6); (b)(7)(C) noted that DE LA ROSA denied auditory or visual hallucinations and stated he only hears the voice of God; he denied thoughts of self-harm and any content that was commanding, threatening or stressful in nature. DE LA ROSA also stated he began to hear voices in 2005 while in prison, and that the voices give him peace because they are there with him. DE LA ROSA refused evaluation for medication stating he did not need medication and signed a refusal form.⁸² The refusal form included standard language concerning the potential health consequences of refusing treatment or procedure and a hand-written note from LCSW Harvey explaining the consequences of his refusal.

LCSW (b)(6); (b)(7)(C) determined DE LA ROSA was not a danger to himself or others. ERAU notes LCSW (b)(6); (b)(7)(C) did not utilize the eCW Clinical Segregation Assessment checklist; therefore, she did not complete the data checklist that specifically addressed whether DE LA ROSA met SMI criteria. LCSW (b)(6); (b)(7)(C) note also did not include any change to DE LA ROSA's current treatment plan and on April 25, 2018, (b)(6); (b)(7)(C) documented confirmatory sign-off of LCSW (b)(6); (b)(7)(C) note without further comment.

SDC was unable to produce a CWL for **April 17, 2018**.

On April 18, 2018, at 10:58 a.m., LCSW (b)(6); (b)(7)(C) signed off on a mental health segregation round⁸³ and noted that DE LA ROSA presented in a calm manner with no signs of ineffective coping or acute emotional distress. LCSW (b)(6); (b)(7)(C) utilized the eCW Clinical Segregation Assessment checklist and determined DE LA ROSA did not meet SMI criteria. LCSW (b)(6); (b)(7)(C)

⁸⁰ See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated April 11, 2018.

⁸¹ See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated April 16, 2018. LCSW (b)(6); (b)(7)(C) electronically signed the note on April 17, 2018, but included a comment stating the encounter was a late entry and occurred on April 16, 2018. ERAU concluded the encounter occurred around 12:00 p.m. as the refusal form documents this time.

⁸² See Refusal Form, dated April 16, 2018. The form was signed by LCSW (b)(6); (b)(7)(C) witnessed by LCSW (b)(6); (b)(7)(C).

⁸³ See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated April 18, 2018.

made no change to DE LA ROSA's assessment or treatment plan; there was no confirmatory sign-off by another provider on the note.⁸⁴

At 6:10 p.m., SDC transferred DE LA ROSA to general population unit 7B, cell 113.⁸⁵ Neither the Confinement Record nor the Disciplinary Segregation Order forms provided specific reasoning as to why SDC released DE LA ROSA 15 days into his 30 days of disciplinary segregation.⁸⁶ According to the Confinement Record, which he signed two days later, Security Chief (b)(6); (b)(7)(C) ordered DE LA ROSA's release from segregation, but no documentation provided supports that the facility administrator approved the early release.⁸⁷ Furthermore, security staff did not complete a special re-classification for DE LA ROSA within 24 hours prior to his release from segregation.⁸⁸

On this date, DE LA ROSA's medical record included an initial psychiatry appointment progress note by (b)(6); (b)(7)(C) but the contents of the note were blank.⁸⁹ (b)(6); (b)(7)(C) did not sign her note until July 19, 2018, nine days after DE LA ROSA's death. As discussed later in the report, the next time a prescribing mental health provider assessed DE LA ROSA was on April 24, 2018, during an initial suicide risk assessment.

On April 19, 2018, at 12:41 p.m., SDC transferred DE LA ROSA to unit 5B, cell 212, where he remained until facility staff placed him in protective custody on April 24, 2018.⁹⁰

On April 21, 2018, DE LA ROSA dated an incident statement, completed in Spanish with his name at the top but unsigned, which requested transfer to another cell as he alleged his cellmate told him he was going to kill him.⁹¹ There is no response or follow-up action from SDC documented on the form. According to the SDC Cellmate Housing History record, DE LA ROSA had one cellmate on this date, who SDC moved on April 23, 2018.⁹²

⁸⁴ ERAU notes although the ICE PBNDS 2011 Standards and IHSC or SDC policy do not require confirmatory sign-offs by another provider in these instances, observations related to a confirmatory sign-off, or the lack of one, are detailed within the report for consistency purposes. Furthermore, Creative Corrections advised that review and sign-off by another mental health professional supports quality mental health and suicide prevention management.

⁸⁵ See SDC Cellmate Housing History, dated March 13, 2018 – May 4, 2018.

⁸⁶ See Confinement Record, dated April 3, 2018; See Disciplinary Segregation Order, dated April 6, 2018.

⁸⁷ See Confinement Record, dated April 3, 2018. In accordance with the ICE PBNDS 2011 Standard, *Security Management Units*, Section (V)(B)(3), "The supervisor may recommend the detainee's early release from the SMU upon finding time in disciplinary segregation is no longer necessary to regulate the detainee's behavior; an early release recommendation must have the facility administrator's approval before the detainee may be returned to the general population."

⁸⁸ In accordance with the ICE PBNDS 2011, *Custody Classification System*, Section (V)(H)(3), "Staff shall complete a special reclassification within 24 hours before a detainee leaves the SMU..."

⁸⁹ See eCW Progress Note by (b)(6); (b)(7)(C) z, dated April 18, 2018.

⁹⁰ See SDC Cellmate Housing History, dated March 13, 2018 – May 4, 2018.

⁹¹ See Incident Statement, dated April 21, 2018. Multiple other areas on the form were void of information, to include answers to injury and medical questions.

⁹² See SDC Cellmate Housing History, dated March 13, 2018 – May 4, 2018.

On April 24, 2018, at 10:23 a.m., SDC re-assigned DE LA ROSA to RHU pod 7A, cell 201, pending investigation for protective custody.⁹³ At approximately 10:51 a.m.,⁹⁴ Commander

(b)(6); (b)(7)(C) Psychiatric Mental Health Nurse Practitioner (PMHNP), conducted a mental health assessment and noted the reason for the assessment was auditory hallucinations.⁹⁵ PMHNP (b)(6); (b)(7)(C) documented the following:

- DE LA ROSA's vital signs were all within normal limits, except for an elevated blood pressure of 135/88.
- DE LA ROSA was calm, cooperative, and fully oriented, and his affect was broad but with some inappropriate laughter⁹⁶ at times.
- DE LA ROSA had no loose associations⁹⁷ or flight of ideas.⁹⁸
- DE LA ROSA made multiple statements about being the Antichrist but also being filled with the Holy Spirit.
- DE LA ROSA stated he would be dead within three days, that he might die three times, and that he wanted to be alone and relax.
- DE LA ROSA denied low mood, anxiety, and suicidal or homicidal ideations, plans, or intent.
- DE LA ROSA declined medication treatment.

PMHNP (b)(6); (b)(7)(C) requested LCSW (b)(6); (b)(7)(C) join the interview due to her previous encounters with DE LA ROSA. PMHNP (b)(6); (b)(7)(C) noted DE LA ROSA was vague in his responses but repeated the same statements about dying and being the Antichrist to LCSW (b)(6); (b)(7)(C). PMHNP (b)(6); (b)(7)(C) and LCSW (b)(6); (b)(7)(C) collectively determined DE LA ROSA was a potential danger to himself and others. PMHNP (b)(6); (b)(7)(C) completed an initial suicide risk assessment⁹⁹ and determined DE LA

⁹³ *Id.*; see also CoreCivic memorandum re: Pending Investigation, dated April 24, 2018.

⁹⁴ Certain vital signs are time stamped at 10:51 a.m., while others are time stamped at 1:33 p.m. PMHNP (b)(6); (b)(7)(C) did not document a specific encounter time within the note and did not electronically sign-off on the note until 4:40 p.m.

⁹⁵ See eCW Progress Note by PMHNP (b)(6); (b)(7)(C), dated April 24, 2018. ERAU notes there was no documentation of a referral by healthcare or security staff for evaluation for auditory hallucinations.

⁹⁶ Inappropriate laughter is laughter that is unexpected due to dissociation from the topic or circumstance.

⁹⁷ Loose associations occur when a patient's responses are not relative to the questions being posed to him.

⁹⁸ Flight of ideas refers to disconnected rambling or a rapid shifting of ideas with only superficial associated connection between them.

⁹⁹ See eCW Progress Note by PMHNP (b)(6); (b)(7)(C) dated April 24, 2018. The suicide risk assessment includes risk and protective factors and mental status examination elements.

ROSA was at “Moderate Acute Risk”¹⁰⁰ for suicide; he ordered one-on-one suicide watch¹⁰¹ and scheduled mental health follow-up for the next day.

At 1:45 p.m., PMHNP (b)(6); (b)(7)(C) approved a Special Needs Form completed by LCSW (b)(6); (b)(7)(C) which directed DE LA ROSA’s placement on suicide watch in a safety cell.¹⁰² LCSW (b)(6); (b)(7)(C) included handwritten instructions for security to maintain one-on-one visuals and allow only a smock, blanket, and finger foods.

At 2:37 p.m., Shift Supervisor (b)(6); (b)(7)(C) documented DE LA ROSA’s placement on suicide watch per medical.¹⁰³ According to a memorandum submitted by Unit Manager (b)(6); (b)(7)(C) to Chief of Unit Management (b)(6); (b)(7)(C), SDC placed DE LA ROSA in segregation pending investigation for protective custody.¹⁰⁴ This memorandum was also signed by DE LA ROSA.

At 2:48 p.m., Officers (b)(6); (b)(7)(C) conducted a strip search of DE LA ROSA.¹⁰⁵ The documented reason for the search was suicide watch and Shift Supervisor (b)(6); (b)(7)(C) signed the form.

At 4:45 p.m., security placed DE LA ROSA into RHU 7A, cell 112, where he remained until transfer to Columbia Regional Care Center (CRCC) on May 4, 2018.¹⁰⁶ Security staff initiated a

¹⁰⁰ According to the IHSC Significant Self-Harm and Suicide Prevention and Intervention Operations Memorandum (OM 16-002), moderate acute risk would require one-on-one suicide watch. Consideration for moderate acute risk include, but are not limited to, the presence of suicidal ideation with vague plan and/or intent in the presence of multiple risk factors and high acute distress.

¹⁰¹ According to OM 16-0002, suicide watch always involves continuous visual observation of one detainee by one security staff member (one-to-one). All detainees on suicide watch must be housed individually in a cell deemed safe by custody staff and medical staff. Custody staff collaborate with on-site medical staff to review the cell housing a suicide watch detainee and ensure the cell is as suicide resistant as possible (e.g., no protrusions of any kind that would enable hanging or inflicting self-harm). Suicide watch detainees have their belongings and issued clothing removed, wear a suicide smock, use a suicide blanket, have a mattress to sleep on the floor or on a fixed bed, and are given food that can be consumed without the use of utensils (i.e., finger foods). Custody staff document welfare checks every 15 minutes, and a health care provider (RN or higher) document a welfare check at least every 8 hours.

¹⁰² See Special Needs Form, dated April 24, 2018.

¹⁰³ See Confinement Record, dated April 24, 2018.

¹⁰⁴ See Memorandum Re: Pending Investigation, dated April 24, 2018. ERAU was unable to confirm if DE LA ROSA’s placement in segregation pending investigation for protective custody is related to his April 21, 2018, incident statement or a separate event altogether.

¹⁰⁵ See Record of Search, dated April 24, 2018.

¹⁰⁶ See SDC Cellmate Housing History, dated March 13, 2018 – May 4, 2018. During ERAU’s interview with IHSC Commander (b)(6); (b)(7)(C), Health Services Administrator (HSA), on August 14, 2018, he explained SDC utilized the RHU as medical health overflow, to include suicide watch. At the time of DE LA ROSA’s detention, renovations in the Medical Health Unit (MHU) were underway, therefore observation cells were limited, and DE LA ROSA was placed in RHU. He acknowledged although those cells are not anti-ligature, detainees placed on suicide watch in these cells are on one-on-one observation.

Suicide Observation Checklist¹⁰⁷ for this date and documented welfare checks every 15 minutes.¹⁰⁸

At 5:45 p.m., (b)(6); (b)(7)(C) conducted a suicide watch nursing assessment¹⁰⁹ and documented DE LA ROSA denied pain and was compliant with the assessment.¹¹⁰ (b)(6); (b)(7)(C) noted that DE LA ROSA's comments remained consistent and he denied suicidal and homicidal ideations or auditory and visual hallucinations. (b)(6); (b)(7)(C) also documented security staff placed DE LA ROSA in a suicide smock and blanket and initiated suicide watch. (b)(6); (b)(7)(C) noted medical rounds, to include the completion of vital signs each shift, and mental health rounds would occur each day.

On April 25, 2018, at 1:00 a.m., (b)(6); (b)(7)(C) completed a suicide watch nursing assessment and documented DE LA ROSA was compliant with the assessment.¹¹¹ (b)(6); (b)(7)(C) noted that DE LA ROSA denied auditory and visual hallucinations and suicidal ideation but stated he had conversations with God. Additionally, it was noted that DE LA ROSA's vital signs were all within normal limits, except for an elevated blood pressure of 132/87.

At 9:45 a.m., (b)(6); (b)(7)(C) RN, completed a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits, except for an elevated blood pressure of 147/83.¹¹² (b)(6); (b)(7)(C) noted that DE LA ROSA reported hearing voices the previous night but felt better since he was able to sleep through the night.

At 1:16 p.m., (b)(6); (b)(7)(C) signed off on DE LA ROSA's mental health assessment and documented that DE LA ROSA denied suicidal or homicidal ideations but stated God was trying to kill him.¹¹³ (b)(6); (b)(7)(C) also documented DE LA ROSA's vital signs were all within normal limits, except for an elevated blood pressure of 147/83. (b)(6); (b)(7)(C) determined medical staff would continue to monitor DE LA ROSA in MHU for concern of suicidal ideations.

At an unknown time, (b)(6); (b)(7)(C) documented a follow-up suicide risk assessment and noted that DE LA ROSA continued to discuss his relationship with God, that he had already died, and

¹⁰⁷ The Suicide Observation Checklist is utilized to record the detainee's activity every 15 minutes, such as sleeping, walking, or standing at the door. Security also maintains a CAR during suicide watch.

¹⁰⁸ See Suicide Observation Checklist, dated April 24, 2018. Unless ERAU discovered a significant issue related to future Suicide Observation Checklists, they are not further discussed within the report.

¹⁰⁹ Per the ICE PBNDS 2011, *Significant Self-harm and Suicide Prevention and Intervention*, Section F: Housing and Monitoring, "All suicidal detainees placed in an isolated confinement setting will receive...welfare checks at least every 8 hours conducted by clinical staff;" and IHSC OM 16-002, Section 5: Policies and Procedures, g. Housing and Monitoring, "While on-site, a health care provider (RN or higher) must perform rounds and document observations in the health record at least every eight hours." The eCW form used by RNs to document suicide watch rounds is not the same one used for segregation rounds. The suicide watch form includes vital signs and SOAP elements.

¹¹⁰ See eCW Progress Note by (b)(6); (b)(7)(C) dated April 24, 2018.

¹¹¹ See eCW Progress Note by (b)(6); (b)(7)(C), dated April 25, 2018.

¹¹² See eCW Progress Note by (b)(6); (b)(7)(C) dated April 25, 2018. According to the AHA, this blood pressure reading indicates stage two hypertension; stage two hypertension is characterized by a systolic reading of at least 140 or a diastolic reading of at least 90.

¹¹³ See eCW Progress Note by (b)(6); (b)(7)(C) dated April 25, 2018.

if he died again he would be raised from the dead.¹¹⁴ (b)(6); (b)(7)(C) documented that DE LA ROSA stated he wanted to return to Mexico and see females and did not want to be in general population as he did not want to fight with people. LCSW Harris assessed DE LA ROSA's level of insight and judgement as poor and noted that he would remain on suicide watch due to delusions, hallucinations, and fixations with death. (b)(6); (b)(7)(C) co-signed the note on April 30, 2018, and noted concurrence with (b)(6); (b)(7)(C) assessment and treatment plan.

On April 26, 2018, at approximately 9:00 a.m., a Supervisory Immigration and Enforcement Agent (SIEA), or equivalent, conducted an Administrative Segregation Review (ICE Form I-885) of DE LA ROSA.¹¹⁵ The ICE Form I-885 documented "Yes" responses for the questions, "Does the reason for initial placement remain valid" and, "Is the detainee unwilling or unable to live in general population." Although the ICE Form I-885 directions state, "If any of the above factors are marked 'Yes,' the detainee must continue his/her existing status, unless the Officer in Charge (OIC) determines otherwise," the reviewer recommended DE LA ROSA's removal from protective custody. Furthermore, if the reviewer interviewed DE LA ROSA, the reviewer did not document so on the ICE Form I-885 or elsewhere in the detention file.¹¹⁶ The Field Office Director, or representative, signature line and date is blank but the box "Continue Status" is checked.

At 9:50 a.m.,¹¹⁷ (b)(6); (b)(7)(C) RN, conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 137/88.¹¹⁸ (b)(6); (b)(7)(C) noted DE LA ROSA had no complaints and denied experiencing suicidal/homicidal ideations or hallucinations.

At 10:43 a.m.,¹¹⁹ (b)(6); (b)(7)(C) conducted a mental health assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 137/88.¹²⁰ (b)(6); (b)(7)(C) noted that DE LA ROSA denied suicidal or homicidal ideations and stated no one was trying to kill him. (b)(6); (b)(7)(C) made no changes to DE LA ROSA's treatment or follow-up plans. When asked about DE LA ROSA's repeatedly elevated blood pressure readings, (b)(6); (b)(7)(C) stated DE LA ROSA's blood pressure was abnormal on an irregular basis, so she believed it was potentially anxiety related versus a medical issue.¹²¹

¹¹⁴ See eCW Progress Note (b)(6); (b)(7)(C) dated April 25, 2018. (b)(6); (b)(7)(C) did not sign her note until April 26, 2018, at 4:14 p.m. but documented within the progress note that it was a late entry for April 25, 2018.

¹¹⁵ See Administrative Segregation Review, dated April 26, 2018. The form includes a name and signature on the SIEA or equivalent line but both are illegible. SDC was unable to confirm the signatory; therefore, ERAU was unable to interview the individual about the form details.

¹¹⁶ ERAU notes ICE Form I-885 does not include a designated section to document completion of an interview with the detainee, although the ICE PBNDS 2011, *Special Management Units* standard requires documentation of one.

¹¹⁷ ERAU notes there are multiple instances where compliance with the eight-hour healthcare rounds cannot be confirmed due to unknown round times.

¹¹⁸ See eCW Progress Note (b)(6); (b)(7)(C) dated April 26, 2018.

¹¹⁹ ERAU note (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹²⁰ See eCW Progress Note by (b)(6); (b)(7)(C) dated April 26, 2018.

¹²¹ ERAU interview with (b)(6); (b)(7)(C) dated August 14, 2018.

At 6:00 p.m. (b)(6); (b)(7)(C) conducted a suicide watch nursing assessment and documented DE LA ROSA denied homicidal/suicidal ideations or hallucinations.¹²⁴ (b)(6); (b)(7)(C) did not record vital signs.

At 8:55 p.m. (b)(6); (b)(7)(C) conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except an elevated blood pressure of 124/77.¹²⁵ (b)(6); (b)(7)(C) noted DE LA ROSA was cooperative with the examination.

At an unknown time, (b)(6); (b)(7)(C) RN, conducted a nursing assessment.¹²⁴ (b)(6); (b)(7)(C) utilized the segregation evaluation rather than the suicide watch assessment, did not document vital signs, and did not sign her note until July 19, 2018.¹²⁵

At an unknown time, (b)(6); (b)(7)(C) conducted a follow-up suicide risk assessment.¹²⁶ LCSW (b)(6); (b)(7)(C) documented DE LA ROSA did not want to harm himself but believed he would die three horrible deaths. It was also noted that DE LA ROSA denied auditory or visual hallucinations but stated he heard things and did not want to be around others because of that (b)(6); (b)(7)(C) documented assessment findings of delusional disorder and schizophrenia. DE LA ROSA remained on suicide watch.

On this date only, security staff documented 15-minute rounds on the Mental Health Observation Checklist form rather than the Suicide Observation Checklist form.¹²⁷

On April 27, 2018, at 8:51 a.m.,¹²⁸ (b)(6); (b)(7)(C) completed a follow-up suicide risk assessment and documented DE LA ROSA's vital signs were all within normal limits except an elevated blood pressure of 122/71.¹²⁹ (b)(6); (b)(7)(C) noted that although DE LA ROSA continued to deny suicidal ideation, plan, or intent to harm himself, he again stated he would soon die three horrible deaths and be resurrected three times. PMHNP also noted that DE LA ROSA continued to express grandiose beliefs that he was the Antichrist but believed that God was using him as an instrument of change to save the world. According to the assessment, DE LA ROSA reported speaking directly to God and being answered by God and DE LA ROSA continued to refuse

¹²² See eCW Progress Note by (b)(6); (b)(7)(C) dated April 26, 2018.

¹²³ See eCW Progress Note by (b)(6); (b)(7)(C) dated April 26, 2018. According to the AHA, this blood pressure reading indicates an elevated blood pressure; an elevated blood pressure is characterized by a systolic reading of 120 to 129 and a diastolic reading of less than 80.

¹²⁴ See eCW Program Note by (b)(6); (b)(7)(C) dated April 26, 2018.

¹²⁵ ERAU was unable to interview (b)(6); (b)(7)(C) regarding this nursing assessment as she was no longer employed by SDC at the time of the site visit. During interviews of (b)(6); (b)(7)(C) on August 14 and 15, 2018, respectively, they explained nurses who conduct rounds in the RHU have a roster that identifies detainees on mental health observation and suicide watch status.

¹²⁶ See eCW Progress Note by (b)(6); (b)(7)(C) dated April 26, 2018. (b)(6); (b)(7)(C) did not sign her note until April 27, 2018, at 11:00 a.m. but documented within the progress note that it was a late entry for April 26, 2018. There was no confirmatory sign-off by another provider.

¹²⁷ See Mental Health Observation Checklist, dated April 26, 2018. ERAU notes upon comparison, the forms require documentation of the same information.

¹²⁸ ERAU notes (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹²⁹ See eCW Progress Note by (b)(6); (b)(7)(C) dated April 27, 2018.

treatment and stated he did not need medication. (b)(6); (b)(7)(C) determined DE LA ROSA was a danger to himself and potentially to others. (b)(6); (b)(7)(C) discussed the case with (b)(6); (b)(7)(C) and determined medical staff would refer DE LA ROSA to CRCC for inpatient hospitalization.¹³⁰ (b)(6); (b)(7)(C) documented confirmatory sign-off and concurrence with the plan on May 2, 2018.

At 9:30 a.m., (b)(6); (b)(7)(C) RN, conducted a suicide watch nursing assessment and documented DE LA ROSA denied hallucinations or homicidal/suicidal ideations.¹³¹ RN (b)(6); (b)(7)(C) did not record vital signs or sign the note until July 19, 2018, nine days after DE LA ROSA's death.

At 12:40 p.m.,¹³² (b)(6); (b)(7)(C) conducted a suicide watch nursing assessment and documented DE LA ROSA's vitals were all within normal limits except for an elevated blood pressure of 148/90.¹³³ (b)(6); (b)(7)(C) noted DE LA ROSA was asymptomatic relative to his elevated blood pressure and that she made (b)(6); (b)(7)(C) aware.

At 2:39 p.m.,¹³⁴ (b)(6); (b)(7)(C) conducted a mental health observation assessment.¹³⁵ Dr. (b)(6); (b)(7)(C) documented DE LA ROSA's vitals were all within normal limits except for an elevated blood pressure of 148/90. (b)(6); (b)(7)(C) noted DE LA ROSA was generally unchanged in overall presentation, and medical staff would continue to follow up with mental health until medical staff determined proper placement.

At 10:30 p.m. (b)(6); (b)(7)(C) RN, conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 146/86.¹³⁶ (b)(6); (b)(7)(C) noted DE LA ROSA was sitting on his bed, alert, and fully oriented and not experiencing auditory or visual hallucinations.

On April 28, 2018, at 8:40 a.m.,¹³⁷ (b)(6); (b)(7)(C) conducted a mental health observation assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 124/80.¹³⁸

¹³⁰ During interview with ERAU on August 14, 2018, HSA (b)(6); (b)(7)(C) informed ERAU that ICE has a contract with CRCC for care of detainees who require psychiatric services outside the facility's scope. SDC transfers detainees once a bed becomes available at CRCC.

¹³¹ See eCW Progress Note by (b)(6); (b)(7)(C), dated April 27, 2018, electronically signed July 19, 2018.

¹³² ERAU notes (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when RN (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹³³ See eCW Progress Note by (b)(6); (b)(7)(C), dated April 27, 2018, electronically signed April 27, 2018.

¹³⁴ ERAU notes (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹³⁵ See eCW Progress Note by (b)(6); (b)(7)(C), dated April 27, 2018.

¹³⁶ See eCW Progress Note by (b)(6); (b)(7)(C), dated April 27, 2018.

¹³⁷ ERAU notes (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹³⁸ See eCW Progress Note by (b)(6); (b)(7)(C), dated April 28, 2018. ERAU notes medical conducted the last healthcare round more than 10 hours earlier.

At 8:45 a.m., (b)(6); (b)(7)(C) RN, conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 124/80.¹³⁹ (b)(6); (b)(7)(C) noted that DE LA ROSA denied suicidal/homicidal ideations or hallucinations.

At 4:39 p.m., (b)(6); (b)(7)(C) conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 124/76.¹⁴⁰

On April 29, 2018, at 12:50 a.m., (b)(6); (b)(7)(C) RN, conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits.¹⁴¹

At 7:11 a.m.,¹⁴² (b)(6); (b)(7)(C) NP, conducted a mental health observation assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 139/88.¹⁴³ (b)(6); (b)(7)(C) noted that DE LA ROSA denied suicidal/homicidal ideations or hallucinations.

At 8:15 a.m., (b)(6); (b)(7)(C) conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 139/88.¹⁴⁴

At 2:29 p.m., (b)(6); (b)(7)(C) conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 125/86.¹⁴⁵ (b)(6); (b)(7)(C) noted that DE LA ROSA continued to deny suicidal and homicidal ideations or hallucinations.

On April 30, 2018, at 12:30 a.m., (b)(6); (b)(7)(C) conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 145/88.¹⁴⁶

At 8:25 a.m., (b)(6); (b)(7)(C) conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 152/92.¹⁴⁷ (b)(6); (b)(7)(C) noted that DE LA ROSA denied suicidal/homicidal ideations or hallucinations.

¹³⁹ See eCW Progress Note by (b)(6); (b)(7)(C), dated April 28, 2018 at 8:45 a.m.

¹⁴⁰ See eCW Progress Note by (b)(6); (b)(7)(C), dated April 28, 2018 at 4:39 p.m.

¹⁴¹ See eCW Progress Note by (b)(6); (b)(7)(C), dated April 29, 2018.

¹⁴² ERAU notes (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when NP (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹⁴³ See eCW Progress Note by (b)(6); (b)(7)(C), dated April 29, 2018.

¹⁴⁴ See eCW Progress Note by (b)(6); (b)(7)(C), dated April 29, 2018.

¹⁴⁵ See eCW Progress Note by (b)(6); (b)(7)(C), dated April 29, 2018.

¹⁴⁶ See eCW Progress Note by (b)(6); (b)(7)(C), dated April 30, 2018.

¹⁴⁷ See eCW Progress Note by (b)(6); (b)(7)(C), dated April 30, 2018.

At 12:29 p.m., (b)(6); (b)(7)(C) conducted a mental health observation assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 142/80.¹⁴⁹ (b)(6); (b)(7)(C) noted that DE LA ROSA denied suicidal/homicidal ideations or hallucinations.

At an unknown time, LCSW (b)(6); (b)(7)(C) conducted a follow-up suicide risk assessment and documented DE LA ROSA continued to present with fixed delusions and consistently declined medication.¹⁵⁰ LCSW (b)(6); (b)(7)(C) further described DE LA ROSA's appearance and affect as odd. LCSW (b)(6); (b)(7)(C) believed DE LA ROSA was at risk of being a danger to himself and others and he remained focused on the concept of death. DE LA ROSA again declined to be treated with medication. As of this date, referral to CRCC remained pending.

On May 1, 2018, at 8:43 am., (b)(6); (b)(7)(C) conducted a suicide risk nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 139/81.¹⁵¹ (b)(6); (b)(7)(C) noted that DE LA ROSA voiced no suicidal/homicidal ideations.

At 12:09 p.m.,¹⁵² (b)(6); (b)(7)(C) conducted a mental health observation assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 139/81.¹⁵³ (b)(6); (b)(7)(C) noted that DE LA ROSA denied suicidal/homicidal ideations or physical complaints.

At 3:37 p.m., LCSW (b)(6); (b)(7)(C) signed off on a wellness check and noted DE LA ROSA continued to present with fixed delusions and focused on concepts of death.¹⁵⁴ LCSW (b)(6); (b)(7)(C) noted DE LA ROSA felt hopeless, helpless, and like he was a burden to others. In response to further questioning on these risk factors, DE LA ROSA stated he sometimes felt bad because he was in jail and he was a burden to others because he was the Antichrist and rejected Jesus Christ. LCSW (b)(6); (b)(7)(C) noted CRCC accepted DE LA ROSA and travel arrangements were pending. There was no confirmatory sign-off by another provider.

At 4:00 p.m., (b)(6); (b)(7)(C) RN, conducted a suicide risk nursing assessment but did not record vital signs.¹⁵⁵ (b)(6); (b)(7)(C) documented DE LA ROSA denied suicidal/homicidal ideations or hallucinations.

¹⁴⁸ ERAU note (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹⁴⁹ See eCW Progress Note by (b)(6); (b)(7)(C) dated April 30, 2018.

¹⁵⁰ See eCW Progress Note by (b)(6); (b)(7)(C) dated April 30, 2018. (b)(6); (b)(7)(C) did not sign her note until May 1, 2018 at 3:11 p.m. but documented within the progress note that it was a late entry for April 30, 2018. There was no confirmatory sign-off by another provider.

¹⁵¹ See eCW Progress Note by (b)(6); (b)(7)(C) dated May 1, 2018.

¹⁵² ERAU notes (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹⁵³ See eCW Progress Note by (b)(6); (b)(7)(C) dated May 1, 2018.

¹⁵⁴ See eCW Progress Note by (b)(6); (b)(7)(C) dated May 1, 2018.

¹⁵⁵ See eCW Progress Note by (b)(6); (b)(7)(C) dated May 1, 2018.

On May 2, 2018, at 8:45 a.m., (b)(6); (b)(7)(C) conducted a mental health observation assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 137/89.¹⁵⁷

At 9:03 a.m.,¹⁵⁸ (b)(6); (b)(7)(C) conducted a suicide risk nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 128/88.¹⁵⁹

At 9:30 p.m. (b)(6); (b)(7)(C) RN, conducted a suicide risk nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 137/89.¹⁶⁰ When RN (b)(6); (b)(7)(C) asked DE LA ROSA how he was doing, he responded everything was fine.

At an unknown time, (b)(6); (b)(7)(C) conducted a follow-up suicide risk assessment.¹⁶¹ LCSW noted DE LA ROSA continued to present with inappropriate laughter and believed he would die three terrible deaths soon. When asked about suicidal ideations, DE LA ROSA smiled while replying, "No, not right now." At this time, DE LA ROSA's transfer to CRCC remained pending. There was no confirmatory sign-off by another provider.

On May 3, 2018, at 9:57 a.m.,¹⁶² (b)(6); (b)(7)(C) conducted a mental health observation assessment and document DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 141/101.¹⁶³

At 12:40 p.m., an SIEA, or equivalent, conducted an Administrative Segregation Review (ICE Form I-885) of DE LA ROSA.¹⁶⁴ Findings were identical to the April 26, 2018, segregation review, but this time the reviewer recommended DE LA ROSA remain in protective custody. Once again, the reviewer did not document an interview of DE LA ROSA on the ICE Form I-885 or elsewhere in the detention file. On the same date, the Field Office Director, or representative, checked the "Continue Status" box and signed the form.

¹⁵⁶ ERAU notes (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹⁵⁷ See eCW Progress Note by (b)(6); (b)(7)(C) dated May 2, 2018.

¹⁵⁸ ERAU notes R (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when RN Shepherd documented DE LA ROSA's vital signs.

¹⁵⁹ See eCW Progress Note by (b)(6); (b)(7)(C), dated May 2, 2018.

¹⁶⁰ See eCW Progress Note by (b)(6); (b)(7)(C) dated May 2, 2018.

¹⁶¹ See eCW Progress Note by LCSW (b)(6); (b)(7)(C), dated May 2, 2018. LCSW (b)(6); (b)(7)(C) did not sign her note until May 3, 2018, at 7:33 a.m. but documented within the progress note that it was a late entry for May 2, 2018. There was no confirmatory sign-off by another provider.

¹⁶² ERAU notes (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹⁶³ See eCW Progress Note (b)(6); (b)(7)(C) dated May 3, 2018.

¹⁶⁴ See Administrative Segregation Review, dated May 3, 2018. The form includes a name and signature on the SIEA or equivalent line but both are illegible. SDC was unable to confirm the signatory; therefore, ERAU was unable to interview the individual about the form details.

At 3:19 p.m., (b)(6); (b)(7)(C) RN, conducted a suicide risk nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 121/89 and an elevated pulse rate of 104.¹⁶⁶ (b)(6); (b)(7)(C) noted that DE LA ROSA denied any pain.

At 3:54 p.m., (b)(6); (b)(7)(C) signed off on a follow-up suicide risk assessment and documented similar findings to the previous day's encounter.¹⁶⁷ When asked about suicidal ideations, DE LA ROSA replied, "I already told you." There was no confirmatory sign-off by another provider and the transfer to CRCC remained pending.

At 9:40 p.m., (b)(6); (b)(7)(C) conducted a suicide risk nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 137/89.¹⁶⁸ (b)(6); (b)(7)(C) noted that DE LA ROSA denied any suicidal/homicidal ideations or hallucinations.

On May 4, 2018, at 12:57 a.m., (b)(6); (b)(7)(C) RN, signed off on DE LA ROSA's transfer summary to CRCC and documented a diagnosis of schizophrenia, delusional disorder, and suicidal ideations.¹⁶⁹ (b)(6); (b)(7)(C) cleared DE LA ROSA for travel.

At an unknown time, (b)(6); (b)(7)(C) conducted a mental health observation assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 135/80.¹⁷⁰ (b)(6); (b)(7)(C) noted that DE LA ROSA appeared calm and cooperative with the exam and denied any physical complaints. (b)(6); (b)(7)(C) also noted CRCC would admit DE LA ROSA on this date.

Prior to DE LA ROSA's departure from SDC, Officer (b)(6); (b)(7)(C) attempted to obtain DE LA ROSA's signature on the Release section of the Detainee Forwarding Address Form¹⁷¹ and Discharge Checklist section of the Receiving & Discharge Checklist,¹⁷² but DE LA ROSA refused to sign the forms.

At approximately 7:32 a.m., SDC released DE LA ROSA into the care of CRCC for mental health treatment, where he remained until June 12, 2018.¹⁷³

¹⁶⁵ ERAU notes (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹⁶⁶ See eCW Progress Note by (b)(6); (b)(7)(C) dated May 3, 2018.

¹⁶⁷ See eCW Progress Note by (b)(6); (b)(7)(C) dated May 3, 2018.

¹⁶⁸ See eCW Progress Note by (b)(6); (b)(7)(C) dated May 3, 2018.

¹⁶⁹ See eCW Progress Note by (b)(6); (b)(7)(C) dated May 4, 2018.

¹⁷⁰ See eCW Progress Note by (b)(6); (b)(7)(C) dated May 4, 2018. Although (b)(6); (b)(7)(C) recorded vital signs at 9:44 a.m., the SDC Cellmate Housing History and CoreCivic Offender Management System information support DE LA ROSA departed SDC for CRCC around 7:32 a.m.; therefore, the exact time of the assessment is unknown.

¹⁷¹ See Detainee Forwarding Address Form, dated May 4, 2018.

¹⁷² See SDC Receiving & Discharge Checklist, dated May 4, 2018.

¹⁷³ See SDC Cellmate Housing History, dated March 13, 2018 – May 4, 2018. SDC did not provide documentation related to DE LA ROSA's transport to CRCC.

At 2:00 p.m., DE LA ROSA signed a Treatment Agreement and Consent form in Spanish.¹⁷⁴

At 2:29 p.m. (b)(6); (b)(7)(C) CRCC RN, signed off on DE LA ROSA's Nursing Assessment.¹⁷⁵ RN (b)(6); (b)(7)(C) documented DE LA ROSA was able to read and speak English but that his primary language was Spanish and that his vital signs were all within normal limits except for an elevated blood pressure of 160/97. (b)(6); (b)(7)(C) noted that DE LA ROSA stated he did not know why he was being admitted to the hospital other than people thinking he was crazy. (b)(6); (b)(7)(C) also noted his behavior was cooperative, friendly, and that he demonstrated appropriate interaction. (b)(6); (b)(7)(C) further documented DE LA ROSA's thought process appeared within normal limits. In addition to an admitting diagnosis of schizophrenia,¹⁷⁶ (b)(6); (b)(7)(C) checked the boxes beside "Depression with Suicidal Ideations" and "Psychosis" in the assessment form.

At approximately 3:48 p.m., CRCC placed DE LA ROSA under suicide precautions for 24 hours, which included suicide apparel and restricted movement at the facility.¹⁷⁷

On May 5, 2018, at 7:58 a.m., (b)(6); (b)(7)(C) (first name unknown), CRCC RN, documented DE LA ROSA had an elevated blood pressure. (b)(6); (b)(7)(C) did not document any other concerns but further noted an MD directed nursing staff to observe DE LA ROSA's blood pressure and notify the MD if his blood pressure remained high.

At approximately 9:45 a.m., (b)(6); (b)(7)(C) conducted a Suicide Shift Assessment form in which she documented DE LA ROSA denied suicidal or homicidal ideations or hearing voices commanding he hurt himself.¹⁷⁸

At 11:33 a.m., DE LA ROSA signed a Neuroleptic (Antipsychotic) Medication Consent Form in English.¹⁷⁹ According to the CRCC Order Record History, medical staff prescribed DE LA ROSA the antipsychotic medications Haldol and Zyprexa while hospitalized at CRCC.¹⁸⁰

At approximately 4:46 p.m., CRCC staff discontinued DE LA ROSA's suicide precautions.¹⁸¹

On May 7, 2018, at 12:29 p.m. (b)(6); (b)(7)(C) psychiatrist, signed off on DE LA ROSA's initial psychiatric evaluation.¹⁸² According to the notes, DE LA ROSA stated while in prison, he was previously diagnosed with schizophrenia because he told staff he heard the voice of God. He further stated he refused to take medication at SDC because he believed there was nothing wrong with him. (b)(6); (b)(7)(C) noted DE LA ROSA believed God spoke to him regularly, as do many other religious individuals. As such, (b)(6); (b)(7)(C) noted CRCC staff would need to continue observation of DE LA ROSA to determine if signs and symptoms of schizophrenia

¹⁷⁴ See CRCC Treatment Agreement and Consent form, dated May 4, 2018.

¹⁷⁵ See CRCC Nursing Assessment, dated May 4, 2018.

¹⁷⁶ See CRCC Provider Treatment Order, dated May 3, 2018.

¹⁷⁷ See CRCC Provider Treatment Order – Verbal/Telephone, dated May 4, 2018.

¹⁷⁸ See CRCC Suicide Shift Assessment, dated May 5, 2018.

¹⁷⁹ See CRCC Neuroleptic (Antipsychotic) Medication Consent Form, dated May 5, 2018.

¹⁸⁰ See CRCC Order Record History, dated May – July, 2018.

¹⁸¹ See CRCC Provider Treatment Order – Verbal/Telephone, dated May 5, 2018.

¹⁸² See CRCC Initial Psychiatric Evaluation, dated May 7, 2018.

were present. (b)(6); (b)(7)(C) documented DE LA ROSA's thought form and content were coherent and appropriate, respectively.

On May 9, 2018, at 9:16 a.m. (b)(6); (b)(7)(C) Social Worker, signed off on DE LA ROSA's initial psychosocial assessment and documented DE LA ROSA had a history of hypertension.¹⁸³

On May 12, 2018, at 12:08 p.m. (b)(6); (b)(7)(C) psychiatrist, documented DE LA ROSA had told staff he was the Antichrist and would die in three days. (b)(6); (b)(7)(C) noted that DE LA ROSA stated God spoke with him on a daily basis, using the voice of his own father, and communicated with him through the television. DE LA ROSA stated he would be killed by someone soon in a horrible way but could not tell (b)(6); (b)(7)(C) when. DE LA ROSA added he would be resurrected and then used by God to rid the world of everything else evil. Dr.

(b)(6); (b)(7)(C) also noted that DE LA ROSA said he had previously been killed and resurrected but would not go into additional detail. DE LA ROSA claimed to look forward to death but did not intend to harm himself because God would take care of that by having someone else kill him.

May 20, 2018, at 2:53 p.m. (b)(6); (b)(7)(C) noted DE LA ROSA continued to believe he was the Antichrist and that he would be killed and resurrected.¹⁸⁵ According to (b)(6); (b)(7)(C) notes, DE LA ROSA stated he knew the date this would occur but could not share that information with (b)(6); (b)(7)(C). DE LA ROSA also reported hearing the voice of God, who told him good and bad things, but denied having suicidal or homicidal thoughts.

On June 5, 2018, at 11:49 a.m., (b)(6); (b)(7)(C) noted DE LA ROSA had shown significant improvement and was compliant with his psychotropic medication, even though DE LA ROSA did not think it was necessary.¹⁸⁶ (b)(6); (b)(7)(C) noted DE LA ROSA continued to express he was the Antichrist and that at some point he would be killed and then resurrected. (b)(6); (b)(7)(C) also noted DE LA ROSA steadfastly maintained he was not suicidal and had no thoughts of harming himself or others. (b)(6); (b)(7)(C) further documented DE LA ROSA had reached the maximum benefit of being at CRCC but recommended continued psychiatric treatment upon discharge.

On June 10, 2018, at 4:15 p.m., (b)(6); (b)(7)(C) documented that although DE LA ROSA continued to have the delusion that he was the Antichrist and that he would be killed and resurrected, he was not suicidal.¹⁸⁷ (b)(6); (b)(7)(C) again noted DE LA ROSA had reached the maximum benefit of being at CRCC and recommended continued psychiatric treatment upon discharge; she further commented that CRCC completed DE LA ROSA's discharge summary.

CRCC's psychiatric discharge summary of DE LA ROSA's care documented the following:¹⁸⁸

¹⁸³ See CRCC Psychosocial Initial Assessment, dated May 9, 2018.

¹⁸⁴ See CRCC Psychiatrist Progress Note, dated May 12, 2018.

¹⁸⁵ See CRCC Psychiatrist Progress Note, dated May 20, 2018.

¹⁸⁶ See CRCC Psychiatrist Progress Note, dated June 5, 2018.

¹⁸⁷ See CRCC Psychiatrist Progress Note, dated June 10, 2018.

¹⁸⁸ See CRCC Psychiatric Discharge Summary, dated June 5, 2018. Although the date of service notes June 5, 2018, the provider signed off on the document on July 13, 2018 at 5:12 p.m., three days after DE LA ROSA's death. It is unclear if SDC received the discharge summary prior to DE LA ROSA's death.

- On admission to CRCC, DE LA ROSA reported he was able to hear the voice of God. Medical staff initially thought the patient's beliefs about communicating with God could have been part of his religious belief system, rather than evidence of psychosis. However, as DE LA ROSA became more comfortable discussing his experiences, it became clear the patient had delusions. DE LA ROSA also believed he was the Antichrist and that he had been killed twice before and arisen from the dead. He also said he believed he would be killed again shortly but commented he was not permitted by God to disclose when that would happen.
- DE LA ROSA denied suicidal thoughts while at CRCC, and there was no evidence he was suicidal while hospitalized.
- DE LA ROSA was initially resistant to taking medication but by the time of discharge he was compliant.
- Although (b)(6); (b)(7)(C) prescribed DE LA ROSA Haldol¹⁸⁹ and Zyprexa,¹⁹⁰ he continued to be delusional but was less guarded and interacted better with other patients; he also participated in group activities.
- DE LA ROSA stated he would consider taking medication after discharge although he did not feel he needed it.
- DE LA ROSA's insight and judgment were chronically impaired.
- Laboratory tests performed were non-contributory and his condition was stable for discharge, having reached the maximum hospital benefit.
- CRCC listed DE LA ROSA's discharge medications as Zyprexa (20 mg) and Haldol (5 mg).

Although not reflected in the CRCC discharge summary, the CRCC medical record documents medical staff ordered DE LA ROSA amlodipine in response to his elevated blood pressure.¹⁹¹ Additionally, the Medication Reconciliation for Discharge/Transfer lists Norvasc,¹⁹² along with Zyprexa and Haldol, as discharge medications.¹⁹³

On June 11, 2018, prior to DE LA ROSA's return to SDC, (b)(6); (b)(7)(C) completed DE LA ROSA's ICE Custody Classification Worksheet.¹⁹⁴ Officer (b)(6); (b)(7)(C) assigned a custody level of high, and a supervisor approved the rating on June 13, 2018.¹⁹⁵

On June 12, 2018, at 2:20 a.m. (b)(6); (b)(7)(C) CRCC RN, added a nursing progress note stating DE LA ROSA was with the security officer for discharge.¹⁹⁶ At 8:30 a.m., upon DE LA ROSA's return from CRCC to SDC, (b)(6); (b)(7)(C) conducted DE LA ROSA's medical pre-screening.¹⁹⁷ (b)(6); (b)(7)(C) documented receipt of a medical transfer summary from CRCC. At

¹⁸⁹ Haldol is an antipsychotic medication used to treat mental disorders, including schizophrenia.

¹⁹⁰ Zyprexa is an antipsychotic medication used to treat mental disorders, including schizophrenia.

¹⁹¹ See CRCC Order Record History – Medication Orders, dated May – June 2018.

¹⁹² Norvasc is a brand name for amlodipine, which is an antihypertensive medication.

¹⁹³ See CRCC Medication Reconciliation for Discharge/Transfer List, dated July 8, 2018.

¹⁹⁴ See ICE Custody Classification Worksheet, dated June 11, 2018. ERAU notes the special vulnerabilities section omitted mention of any serious mental illness.

¹⁹⁵ ERAU notes both the officer's and supervisor's signatures were illegible.

¹⁹⁶ See CRCC Nursing Progress note, dated June 12, 2018.

¹⁹⁷ See eCW Progress Note by (b)(6); (b)(7)(C) dated June 12, 2018.

9:00 a.m., (b)(6); (b)(7)(C) conducted DE LA ROSA's medical intake screening and documented the following:¹⁹⁸

- DE LA ROSA's vital signs were all within normal limits.
- DE LA ROSA reported a history of schizophrenia, hypertension, and alcohol abuse.
- DE LA ROSA was taking the medications Haldol (5 mg), Norvasc (10 mg), and Zyprexa (20 mg).

(b)(6); (b)(7)(C) cleared DE LA ROSA for custody but designated the intake screening as abnormal and referred him to a provider. DE LA ROSA also signed an IHSC Medical Consent Form for general treatment.¹⁹⁹

At 9:44 a.m., (b)(6); (b)(7)(C) booked DE LA ROSA into SDC.²⁰⁰ At 10:17 a.m., SDC assigned him to general population unit 7, pod B, cell 104.²⁰¹

At an unknown time, LCSW (b)(6); (b)(7)(C) conducted a mental health assessment due to DE LA ROSA's return from CRCC.²⁰² LCSW (b)(6); (b)(7)(C) documented that DE LA ROSA stated he was given medication at CRCC, taking his last dose the prior evening, but did not feel it helped. DE LA ROSA also mentioned he did not want to continue to take his medication as he did not need them. Although he again discussed his future deaths and resurrections, DE LA ROSA stated he would not harm himself. LCSW (b)(6); (b)(7)(C) noted she discussed medication compliance and reoccurrence of symptoms with DE LA ROSA.

At 3:09 p.m., (b)(6); (b)(7)(C) submitted a telephone order for amlodipine (10 mg) in the morning and olanzapine²⁰³ (20 mg) and haloperidol²⁰⁴ (5 mg), both in the evening, for DE LA ROSA to keep-on-person (KOP).²⁰⁵ ERAU notes there were no signed consent forms for the two psychotropic medications, olanzapine and haloperidol.

On June 13, 2018, at 9:00 a.m., (b)(6); (b)(7)(C) NP, conducted an abbreviated physical examination as medical staff last examined DE LA ROSA at SDC on March 15, 2018.²⁰⁶ The examination revealed that DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 123/77. Additionally, DE LA ROSA denied any pain. (b)(6); (b)(7)(C) completed an Abnormal Involuntary Movement Scale (AIMS) test to determine if DE LA ROSA

¹⁹⁸ See eCW Progress Note by (b)(6); (b)(7)(C) dated June 12, 2018.

¹⁹⁹ See IHSC Medical Consent Form, dated June 12, 2018.

²⁰⁰ See Commitment Summary, dated June 12, 2018.

²⁰¹ See Cellmate Housing History Report, dated June 12, 2018 – July 10, 2018.

²⁰² See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated June 12, 2018. LCSW (b)(6); (b)(7)(C) did not sign her note until July 11, 2018, at 2:41 p.m. but documented within the progress note that it was a late entry for June 12, 2018 and that the note was locked on July 11, 2018. There was no confirmatory sign-off by another provider.

²⁰³ Olanzapine is generic Zyprexa.

²⁰⁴ Haloperidol is generic Haldol.

²⁰⁵ See Telephone Encounter by (b)(6); (b)(7)(C) dated June 12, 2018. Although (b)(6); (b)(7)(C) ordered these three medications on this date, per the MAR, medical did not start them until June 14, 2018. The cause of the delay is unknown.

²⁰⁶ See eCW Progress Note by (b)(6); (b)(7)(C), dated June 13, 2018.

was experiencing side effects from psychotropic medications; the score was zero. [REDACTED] noted a follow-up would occur in two weeks.²⁰⁷

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

On June 14, 2018, at an unknown time [REDACTED] completed the remainder of DE LA ROSA's intake process back into SDC.²⁰⁸ At 1:36 p.m., SDC moved DE LA ROSA to general population unit 5, pod A, cell 213.²⁰⁹

On this date, SDC medical staff began attempts to administer the medication [REDACTED] had ordered for DE LA ROSA on June 12, 2018.²¹⁰ DE LA ROSA refused all medications up to and including the day of his suicide; documentation and follow-up by medical staff related to his refusals were limited. Although there were many occasions medical staff documented on his Medication Administration Record (MAR) that DE LA ROSA did not present for pill call, medical staff did not document any efforts to account for DE LA ROSA to confirm if his failure to report for pill call constituted a refusal of his medications. As such, medical staff could have educated him on the associated risks and had him sign a refusal form. Furthermore, as discussed later in the report, security staff placed DE LA ROSA in segregation again, during which time medical staff repeatedly documented DE LA ROSA did not present for pill call, although medical staff administered medications directly to the detainee through their cell door while in segregation. Additionally, medical staff did not consistently notify providers DE LA ROSA was not taking his prescribed medications and, when notified, a provider did not follow up consistently. Exhibit 2 details specifics related to refusals, referrals to providers, and provider follow-ups, unless a significant event tied to medication administration occurred.²¹¹

On June 15, 2018, at 2:38 p.m. [REDACTED] Licensed Practical Nurse (LPN), notified NP [REDACTED] that DE LA ROSA refused his morning amlodipine dose.²¹² Three days later, in the Action Taken section, [REDACTED] documented "noted." This is the first of 17 telephone encounters nurses sent [REDACTED] notifying her of DE LA ROSA's refusals.²¹³ At no time after DE LA ROSA's return from CRCC on June 12, 2018, did [REDACTED] see him [REDACTED] stated she conferred with mental health personnel and reviewed DE LA ROSA's chart, and medical staff scheduled him for follow-up appointments.²¹⁴ [REDACTED] added that medical staff rescheduled these follow-up appointments due to staffing issues. Except for an encounter on June 19, 2018, there was no documentation provided to confirm medical staff scheduled or postponed the appointments. [REDACTED] advised that the Mortality Review Committee

²⁰⁷ ERAU notes there is no documentation a medical provider followed up within two weeks.

²⁰⁸ See SDC Intake Documents, dated June 14, 2018. ERAU notes DE LA ROSA signed all intake processing documents on this date. It is unknown why security did not complete the remainder of DE LA ROSA's intake process until two days later.

²⁰⁹ See Cellmate Housing History Report, dated June 12, 2018 – July 10, 2018.

²¹⁰ See MAR.

²¹¹ See Exhibit 2: Creative Corrections Detainee Death Review Healthcare and Security Analysis.

²¹² See Telephone Encounter by LPN [REDACTED] dated June 15, 2018.

²¹³ As mentioned above, specifics regarding all 17 refusals of medication and subsequent referrals to providers by way of telephone encounters are detailed in Exhibit 2 and are not further discussed within the report unless a significant event occurred related to it.

²¹⁴ ERAU interview with [REDACTED] dated August 14, 2018.

identified this issue and recommended providers document why appointments are not carried out in the future.²¹⁵

On June 18, 2018, at approximately 4:51 a.m., (b)(6); (b)(7)(C) Licensed Vocational Nurse (LVN), notified (b)(6); (b)(7)(C) and LCSW (b)(6); (b)(7)(C) that DE LA ROSA refused his previous night's Haldol and Zyprexa doses.²¹⁶ (b)(6); (b)(7)(C) responded that the mental health provider was informed and LCSW (b)(6); (b)(7)(C) responded that medical staff scheduled an appointment with DE LA ROSA for June 19, 2018.

On June 19, 2018, at 10:55 a.m., LCSW (b)(6); (b)(7)(C) signed off on her assessment of DE LA ROSA in response to his medication refusals.²¹⁷ She documented DE LA ROSA stated he did not need medication but still believed he was the Antichrist. LCSW (b)(6); (b)(7)(C) also documented that DE LA ROSA denied any thoughts of self-harm or hearing any voices. LCSW (b)(6); (b)(7)(C) provided medication education, explained the importance of compliance, and instructed DE LA ROSA to report to staff immediately should he begin to have thoughts of self-harm or command auditory hallucinations. (b)(6); (b)(7)(C) psychologist, reviewed and concurred with LCSW (b)(6); (b)(7)(C) encounter note seven days later. He further noted the BHU would continue to monitor DE LA ROSA's continuity of care needs and mental status examination in consult with the mental health team and (b)(6); (b)(7)(C) HSC's Chief Psychiatrist. (b)(6); (b)(7)(C) also directed staff to notify BHU if a higher level of care became necessary.

At 4:52 p.m., (b)(6); (b)(7)(C) documented an incident with DE LA ROSA and cited him for the prohibited act of making a sexual proposal.²¹⁸

At 5:10 p.m., (b)(6); (b)(7)(C) RN, completed DE LA ROSA's segregation clearance assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 132/86.²¹⁹ (b)(6); (b)(7)(C) noted DE LA ROSA was in no acute distress and within normal limits of behavior, affect and cognitive functioning and cleared him for segregation.²²⁰

At 6:05 p.m., Officer (b)(6); (b)(7)(C) ordered DE LA ROSA's placement in disciplinary segregation²²¹ and security moved DE LA ROSA to RHU unit 7, pod A, cell 107.²²²

²¹⁵ ERAU interview with HSA (b)(6); (b)(7)(C) dated August 14, 2018.

²¹⁶ See Telephone Encounters by (b)(6); (b)(7)(C) dated June 17, 2018; see also MAR. Medical staff notified LCSW (b)(6); (b)(7)(C) of DE LA ROSA's medication refusals and follow-up telephone encounter sent to (b)(6); (b)(7)(C) on one other occasion, June 29, 2019. All other notifications by medical staff regarding DE LA ROSA's medication refusals were routed only to (b)(6); (b)(7)(C). Creative Corrections further advised that although medical staff notified LCSW (b)(6); (b)(7)(C) of DE LA ROSA's medication refusal on these two occasions, she was not a prescribing provider; therefore, (b)(6); (b)(7)(C) could have been the provider to take action.

²¹⁷ See eCW Progress Note by (b)(6); (b)(7)(C), dated June 19, 2018.

²¹⁸ See Incident of Prohibited Acts and Notice of Charges, dated June 19, 2018.

²¹⁹ See Progress Note by (b)(6); (b)(7)(C), dated June 19, 2018.

²²⁰ (b)(6); (b)(7)(C) was no longer employed at SDC during the time of the site visit; therefore, ERAU was unable to confirm if (b)(6); (b)(7)(C) reviewed DE LA ROSA's medical record or was aware of his ongoing issues related to mental illness and medication refusals.

²²¹ See Confinement Record, dated June 19, 2018.

²²² See Cellmate Housing History Report, dated June 12, 2018 – July 10, 2018.

At 6:43 p.m., Case Counselor (b)(6); (b)(7)(C) initiated an investigation related to DE LA ROSA's offense.²²³ Case Counselor (b)(6); (b)(7)(C) documented DE LA ROSA was very calm and admitted to approaching the officer. Case Counselor (b)(6); (b)(7)(C) subsequently referred the incident to the IDP and issued DE LA ROSA his Detainee Rights at the IDP Hearing.²²⁴

On June 20, 2018, at 12:31 p.m., security moved DE LA ROSA to RHU unit 7, pod B, cell 105, where he remained until his death.²²⁵

At 4:13 p.m., LCSW (b)(6); (b)(7)(C) signed off on a mental health assessment.²²⁶ LCSW (b)(6); (b)(7)(C) discussed DE LA ROSA's placement in segregation with him and, when questioned about his behavior, DE LA ROSA stated the officer was beautiful, and he liked her. LCSW (b)(6); (b)(7)(C) documented DE LA ROSA continued to deny the need for medication. DE LA ROSA indicated he did not have any concerns related to housing in segregation or thoughts of self-harm. LCSW (b)(6); (b)(7)(C) noted DE LA ROSA met SMI criteria due to "one or more psychiatric symptoms, presently taking psychiatric medications and still presenting active moderate to severe symptoms. Serious limitations in mental functioning." She also noted that he would benefit from a higher level of care. Contradictory to this statement, however, LCSW (b)(6); (b)(7)(C) documented a "No" answer in response to the questions, "Does the detainee present any active symptoms" and "Is the detainee compliant with his/her treatment?" She provided no explanation for the conflicting information.

During her interview, LCSW (b)(6); (b)(7)(C) stated she advised IHSC Headquarters via e-mail that SDC was not an appropriate placement for DE LA ROSA, but neither she nor HSA (b)(6); (b)(7)(C) produced a copy of the e-mail.²²⁷ Furthermore, LCSW (b)(6); (b)(7)(C) documented completion of an IHSC Form 883, but one was not located in DE LA ROSA's medical file or provided during the on-site review.²²⁸ (b)(6); (b)(7)(C) concurred with LCSW (b)(6); (b)(7)(C) encounter note and entered the same narrative as the June 19, 2018 encounter.

At an unknown time, SDC informed DE LA ROSA his disciplinary hearing would occur on June 21, 2018, at 10:10 a.m.²²⁹ The form documented DE LA ROSA did not request staff representation or witnesses present at the hearing.

²²³ See Investigation Report, dated June 19, 2018.

²²⁴ See Detainee Rights at the IDP Hearing, dated June 19, 2018.

²²⁵ See Cellmate Housing History Report, dated June 12, 2018 – July 10, 2018. Warden Peterson explained security moved all detainees from RHU Pod A to 7B, due to an air conditioner malfunction.

²²⁶ See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated June 20, 2018.

²²⁷ ERAU interview with LCSW (b)(6); (b)(7)(C) dated August 14, 2018. Per IHSC Directive 07-05, "Once a detainee is identified as having significant psychiatric impairment utilizing the SMI criteria, the BHP will immediately notify the HSA and document the following into the Patient Report spreadsheet which he or she submits to BHU at IHSC headquarters on a weekly basis: (a) Name, (b) Alien #, (c) Facility, (d) Status (e.g., hospitalized, medical housing unit, general population, etc.), (e) Diagnosis, (f) Current Symptoms, and (g) Updates/Treatment Plan." Furthermore, the BHP must complete a Mental Health Review Form (IHSC Form 883) for every patient on the Patient Report spreadsheet at the inclusion of the patient on the list and once a month thereafter as long as the detainee remains on the list which is determined by the evaluation completed by the mental health care provider."

²²⁸ See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated June 20, 2018.

²²⁹ See Notice of IDP Hearing, dated June 20, 2018.

On June 21, 2018, at 10:55 a.m., the IDP conducted a disciplinary hearing for DE LA ROSA's violation.²³⁰ The hearing officer, Assistant Shift Supervisor (b)(6); (b)(7)(C) documented DE LA ROSA admitted to the charges. A supervisor reviewed and concurred with the findings the following day. Assistant Shift Supervisor (b)(6); (b)(7)(C) sentenced DE LA ROSA to 30 days' segregation.²³¹

On June 22, 2018, at 10:00 a.m., an SIEA, or equivalent, completed an ICE Form I-887.²³² The ICE Form I-887 documented "Yes" answers to multiple factors, which required DE LA ROSA to continue his segregation status, unless the OIC determined otherwise. Again, the reviewer did not document an interview of DE LA ROSA on the ICE Form I-887 or elsewhere in the detention file.²³³ The SIEA recommended DE LA ROSA remain in disciplinary segregation and the (Acting) Assistant Field Office Director (AFOD) agreed to continue the status.

At an unknown time, Assistant Shift Supervisor (b)(6); (b)(7)(C) delivered a copy of the IDP Report to DE LA ROSA.²³⁴

On June 27, 2018, at 4:11 p.m., PMHNP (b)(6); (b)(7)(C) signed off on a mental health assessment and documented DE LA ROSA had no active symptoms and did not meet SMI criteria.²³⁵ PMHNP (b)(6); (b)(7)(C) reported DE LA ROSA's mood was happy, his affect was appropriate, his behavior pleasant and cooperative, and his judgment was insightful. PMHNP (b)(6); (b)(7)(C) noted DE LA ROSA was receiving psychotropic medications and talk therapy for treatment, and that he was compliant with his medication. When asked to elaborate on the latter, PMHNP (b)(6); (b)(7)(C) explained that DE LA ROSA reported he was taking his medication, and he assumed DE LA ROSA was being truthful since he seemed much better.²³⁶ Additionally, PMHNP (b)(6); (b)(7)(C) noted that DE LA ROSA continued to deny thoughts of self-harm. (b)(6); (b)(7)(C) concurred with PMHNP (b)(6); (b)(7)(C) encounter note two days later and entered the same narrative as previous encounters.

According to the MAR, (b)(6); (b)(7)(C) RN, administered night doses of Haldol and olanzapine and DE LA ROSA complied.²³⁷ ERAU was unable to discuss either this medication administration or two additional administrations of night medications on June 28 and 29, 2018, with RN (b)(6); (b)(7)(C), as her employer, InGenesis, separated her from service at SDC on August 10, 2018.²³⁸ HSA (b)(6); (b)(7)(C) explained that InGenesis separated RN (b)(6); (b)(7)(C) from service after they discovered she falsified a July 10, 2018, entry on DE LA ROSA's MAR.²³⁹ HSA (b)(6); (b)(7)(C)

²³⁰ See IDP Report, dated June 21, 2018.

²³¹ See Disciplinary Segregation Order, dated June 21, 2018.

²³² See Disciplinary Segregation Review, dated June 22, 2018. All signatures on this form were illegible.

²³³ Similar to the ICE Form I-885, it does not include a designated section to document completion of an interview with the detainee.

²³⁴ See IDP Report, dated June 22, 2018.

²³⁵ See eCW Progress Note by PMHNP (b)(6); (b)(7)(C) dated June 27, 2018.

²³⁶ ERAU interview with PMHNP (b)(6); (b)(7)(C) dated August 15, 2018.

²³⁷ See MAR.

²³⁸ ERAU interview with HSA (b)(6); (b)(7)(C), dated August 14, 2018; See email from (b)(6); (b)(7)(C) at Prestige Staffing, dated August 10, 2018.

²³⁹ ERAU interview with HSA (b)(6); (b)(7)(C) dated August 14, 2018. In this instance, RN (b)(6); (b)(7)(C) documented DE LA ROSA refused his medication but analysis of video footage revealed she did not approach his cell.

concluded, considering this information and DE LA ROSA's consistent non-compliance with medication treatment, these successful entries were highly unlikely.

A Confinement Review Committee reviewed DE LA ROSA's placement in SMU and determined that he should remain removed from the general population for disciplinary reasons.²⁴⁰ Other than an EARM entry, there was no other documentation provided to support this review occurred.

On July 2, 2018, SDC staff notified ERO Atlanta of DE LA ROSA's scheduled return to general population on July 18, 2018.²⁴¹

On July 3, 2018, at 9:32 a.m., Security Chief (b)(6); (b)(7)(C) completed an ICE Form I-887.²⁴² He concluded the reason for DE LA ROSA's placement remained valid but proceeded to check the box to recommend DE LA ROSA's removal from disciplinary segregation. Security Chief (b)(6); (b)(7)(C) did not document an interview of DE LA ROSA on the ICE Form I-887 or elsewhere in the detention file. The Field Office Director, or representative, signed the same day but did not document their determination of DE LA ROSA's segregation status. DE LA ROSA remained in segregation.

SDC was unable to produce a CWL for this date.

On July 4, 2018, at 12:24 p.m., (b)(6); (b)(7)(C) signed off on a mental health assessment and documented the same findings as his previous assessment, to include DE LA ROSA's compliance with medication.²⁴³ Again (b)(6); (b)(7)(C) concurred with PMHN (b)(6); (b)(7)(C) encounter note and entered the same narrative as previous encounters.

July 10, 2018 – Day of Death

At 1:04 p.m., LCSW (b)(6); (b)(7)(C) signed off on a mental health assessment and again documented DE LA ROSA met SMI criteria.²⁴⁴ LCSW (b)(6); (b)(7)(C) stated DE LA ROSA presented as pleasantly delusional and the content of his delusions were spiritual in nature. LCSW (b)(6); (b)(7)(C) noted that DE LA ROSA denied hearing any voices or thoughts of self-harm and expressed no desire to take medications as he did not believe he needed them. LCSW (b)(6); (b)(7)(C) reminded DE LA ROSA of the benefits of medication compliance, but DE LA ROSA smiled and stated, "I don't need them." LCSW (b)(6); (b)(7)(C) confirmed she conducted the assessment in her office and reported the encounter was normal.²⁴⁵ LCSW (b)(6); (b)(7)(C) documented completion of an IHSC Form 883 again, but one was not located in DE LA ROSA's medical file or provided during the on-site review.

²⁴⁰ See EARM entry for DE LA ROSA, dated July 2, 2018.

²⁴¹ See EARM entry for DE LA ROSA, dated July 2, 2018.

²⁴² See Disciplinary Segregation Review, dated July 3, 2018.

²⁴³ See eCW Progress Note by PMHN (b)(6); (b)(7)(C) dated July 4, 2018.

²⁴⁴ See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated July 10, 2018.

²⁴⁵ ERAU interview with LCSW (b)(6); (b)(7)(C) dated August 14, 2018.

(b)(6); (b)(7)(C) concurred with LCSW (b)(6); (b)(7)(C)'s note and entered the same narrative as previous encounters.²⁴⁶

At 8:40 p.m., Officer (b)(6); (b)(7)(C) conducted a security round and looked into DE LA ROSA's cell.²⁴⁷ At 9:12 p.m., 9:41 p.m., and 10:04 p.m., Officer (b)(6); (b)(7)(C) logged conducting additional rounds on a clipboard outside of DE LA ROSA's cell; however, video surveillance footage confirmed Officer (b)(6); (b)(7)(C) did not look in DE LA ROSA's cell at these times.²⁴⁸

At 10:05 p.m., Officer (b)(6); (b)(7)(C) entered Pod 7B to assume the 3rd shift post.²⁴⁹ At 10:08 p.m., Officer (b)(6); (b)(7)(C) escorted a nurse to a cell on the opposite side of the room from DE LA ROSA. At 10:13 p.m., Officer (b)(6); (b)(7)(C) assigned to Pod 7A, entered 7B, looked through paperwork at the officer's desk, and then left the pod. At 10:15 p.m., Officer (b)(6); (b)(7)(C) returned to the center of the unit and at 10:17 p.m., moved to his desk. Officer (b)(6); (b)(7)(C) stated when he assumed post, he started to fill out the detainee information on each CAR and CWL for the following day because at midnight, he would need to post the new ones on their clipboards.²⁵⁰ Officer (b)(6); (b)(7)(C) added that while escorting a nurse to another detainee's cell, he noticed the last recorded security round conducted by Officer (b)(6); (b)(7)(C) was at 10:04 p.m.; therefore, he believed he had time before the next required security round to start paperwork needed for the following day during his shift.

At 10:33 p.m., Officer (b)(6); (b)(7)(C) conducted his first security round.²⁵¹ He approached DE LA ROSA's cell, looked in, moved to record his round, and then looked in the cell again after he observed DE LA ROSA standing by the bunk with his chin down.²⁵² Officer (b)(6); (b)(7)(C) knocked on the cell door several times, and after he received no response, called for medical emergency by radio. Officer (b)(6); (b)(7)(C) noted he saw multiple socks wrapped around the top bunk rail.²⁵³ Officer (b)(6); (b)(7)(C) explained he did not open the door and enter the cell himself as he was trained not to do so alone.²⁵⁴

At 10:34 p.m., Officer (b)(6); (b)(7)(C) assigned to Pod 7A, responded to the medical emergency.²⁵⁵ Officer (b)(6); (b)(7)(C) approached DE LA ROSA's cell, looked in, and spoke into his radio. Officer (b)(6); (b)(7)(C)

²⁴⁶ See Progress Note by LCSW (b)(6); (b)(7)(C) dated July 10, 2018. ERAU notes (b)(6); (b)(7)(C) confirmatory signed off on July 11, 2018, the day after DE LA ROSA expired.

²⁴⁷ See Pod 7B video surveillance footage, dated July 10, 2018. On this date, Officer (b)(6); (b)(7)(C) was 2nd Shift Officer (2:00 p.m. – 10:00 p.m.), assigned to Pod 7B.

²⁴⁸ See CWL, dated July 10, 2018; see also Pod 7B video surveillance footage, dated July 10, 2018. ERAU was unable to interview Officer (b)(6); (b)(7)(C) as SDC terminated Officer (b)(6); (b)(7)(C) on July 26, 2018 for failing to properly observe DE LA ROSA while conducting his rounds.

²⁴⁹ At SDC, 3rd Shift times are 10:00 p.m. – 6:00 a.m.

²⁵⁰ ERAU interview with Officer (b)(6); (b)(7)(C) dated August 14, 2018.

²⁵¹ See Pod 7B video surveillance footage, dated July 10, 2018.

²⁵² ERAU interview with Officer (b)(6); (b)(7)(C) dated August 14, 2018.

²⁵³ See Incident Report by Officer (b)(6); (b)(7)(C), dated July 10, 2018.

²⁵⁴ ERAU interview with Officer (b)(6); (b)(7)(C) dated August 14, 2018.

²⁵⁵ See Pod 7B video surveillance footage, dated July 10, 2018.

stated he called for a possible hanging over the radio then immediately went to the RHU Control Center to retrieve the cut-down tool.²⁵⁶

Officer (b)(6); (b)(7)(C) assigned to the RHU Control Center, stated she heard the medical emergency call and saw Officer (b)(6); (b)(7)(C) standing at DE LA ROSA's cell; then Officer (b)(6); (b)(7)(C) pounded on the window and asked for the cut-down tool.²⁵⁷ Officer (b)(6); (b)(7)(C) took the tool from its storage box on the wall, removed it from its pouch, and placed the tool in the pass-through box for Officer (b)(6); (b)(7)(C).

At 10:35 p.m., Officer (b)(6); (b)(7)(C) returned to DE LA ROSA's cell, accompanied by (b)(6); (b)(7)(C). (b)(6); (b)(7)(C) opened the cell door.²⁵⁸ (b)(6); (b)(7)(C) stepped upon entry into the cell, he noticed DE LA ROSA's feet were flat on the floor and that he was drooling.²⁵⁹ Officer (b)(6); (b)(7)(C) proceeded to lift DE LA ROSA upward, while Officer (b)(6); (b)(7)(C) cut through the socks tied around his neck.

At 10:36 p.m., the officers placed DE LA ROSA on the floor, and Officer (b)(6); (b)(7)(C) immediately began cardio pulmonary resuscitation (CPR); Captain (b)(6); (b)(7)(C) arrived on the scene shortly after.²⁶⁰

At 10:37 p.m., security turned the dayroom lights on, and Officer (b)(6); (b)(7)(C) arrived with a handheld camera.²⁶¹ Officer (b)(6); (b)(7)(C) stated she was in Central Control when she heard the medical emergency call, located the handheld camera, and then ran to Pod 7B.²⁶² Unless otherwise noted, the following events are based on a review of the handheld video footage²⁶³ captured by (b)(6); (b)(7)(C) gave DE LA ROSA one rescue breath.

²⁵⁶ ERAU interview with Officer (b)(6); (b)(7)(C) dated August 16, 2018. Officer (b)(6); (b)(7)(C) acknowledged he should not have left his post without proper relief and that he made a judgment call to retrieve the cut-down tool versus breaching the cell as he was unsure how close the other responders were to the pod.

²⁵⁷ ERAU interview with Officer (b)(6); (b)(7)(C) dated August 14, 2018.

²⁵⁸ See Pod 7B video surveillance footage, dated July 10, 2018. ERAU notes two minutes and four seconds elapsed from the time when Officer (b)(6); (b)(7)(C) stepped into DE LA ROSA's cell to when the officers opened the cell door.

²⁵⁹ ERAU interview with (b)(6); (b)(7)(C) dated August 14, 2018.

²⁶⁰ *Id.*; See also Incident Statement by Officer (b)(6); (b)(7)(C) dated July 10, 2018. Officer (b)(6); (b)(7)(C) performed chest compressions without a breathing mask or CPR mouth shield. During interview, Officer (b)(6); (b)(7)(C) pointed out a CPR mask pouch on his belt and stated he forgot about it during the emergency.

²⁶¹ See Pod 7B video surveillance footage, dated July 10, 2018.

²⁶² ERAU interview with Officer (b)(6); (b)(7)(C) dated August 14, 2018. Officer (b)(6); (b)(7)(C) is a member of the SDC Emergency Response Team (ERT).

²⁶³ The time stamp shown in the right-hand corner of the handheld camera footage is approximately an hour and three minutes behind the time stamp shown in SDC's Milestone video surveillance. For instance, the handheld camera footage shows (b)(6); (b)(7)(C) entered DE LA ROSA's cell at 9:36:37 p.m. In the pod 7B video surveillance footage, it shows (b)(6); (b)(7)(C) entered DE LA ROSA's cell at 10:39:28 p.m. As such, any event documented in the handheld video camera footage has been adjusted to add one hour and three minutes in this report.

At 10:38 p.m., (b)(6); (b)(7)(C) took over chest compressions for (b)(6); (b)(7)(C) and another nurse arrived in Pod 7B with a gurney, backboard, and two emergency bags. RN (b)(6); (b)(7)(C) looked into DE LA ROSA's cell, returned to the emergency bags, and asked where the automatic external defibrillator (AED) was. (b)(6); (b)(7)(C) then entered the cell with the backboard. In the approximate two minutes of video footage preceding (b)(6); (b)(7)(C) arrival and subsequent ambu bag²⁶⁵ placement, officers gave DE LA ROSA only one rescue breath.

At 10:39 p.m., (b)(6); (b)(7)(C) stated she needed an oxygen tank, a crash cart, and for someone to call Emergency Medical Services (EMS).²⁶⁶ At this time, Stewart County Fire & EMS dispatched responders to SDC.²⁶⁷ (b)(6); (b)(7)(C) took over CPR and (b)(6); (b)(7)(C) again stated she needed an oxygen tank, an AED, additional nurses from Intake, and a crash cart.

At 10:41 p.m., (b)(6); (b)(7)(C) entered the cell with an AED. Two other nurses arrived moments later.²⁶⁸ (b)(6); (b)(7)(C) applied the AED pads, and another SDC nurse took over CPR.

At 10:42 p.m., (b)(6); (b)(7)(C) arrived at DE LA ROSA's cell with an oxygen tank.

Between 10:42 p.m. and 10:47 p.m., three nurses coordinated CPR efforts; the AED never advised shock.²⁶⁹ At 10:43 p.m., (b)(6); (b)(7)(C) tilted²⁷⁰ DE LA ROSA's head back during CPR for the first time.

At 10:48 p.m., an EMS responder entered DE LA ROSA's cell. The EMS responder removed the AED pads from DE LA ROSA's body, then he and an SDC nurse pulled DE LA ROSA into the 7B dayroom. At 10:50 p.m., an EMS responder re-applied AED pads to DE LA ROSA and another then intubated him. At 10:55 p.m., EMS responders lifted DE LA ROSA onto their gurney and a minute later, wheeled him out of the unit. At 10:57 p.m., an EMS responder can be

²⁶⁴ (b)(6); (b)(7)(C) initially performed chest compressions correctly; however, at one point his hand position moved downward, off DE LA ROSA's chest. In the minute and 24 seconds (b)(6); (b)(7)(C) performed CPR before RN (b)(6); (b)(7)(C) arrival and subsequent oxygen mask placement, he never gave DE LA ROSA a rescue breath. While (b)(6); (b)(7)(C) performed chest compressions, (b)(6); (b)(7)(C) attempted to place a CPR mask on DE LA ROSA but a voice stated, "back up a little bit." (b)(6); (b)(7)(C) proceeded to step back, and (b)(6); (b)(7)(C) arrived to DE LA ROSA's cell within seconds. (b)(6); (b)(7)(C) moved out of (b)(6); (b)(7)(C)'s way and did not place the mask on DE LA ROSA.

²⁶⁵ An ambu bag is a hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately.

²⁶⁶ An oxygen tank was present on the gurney; however, it was nonfunctional due to a disconnected regulator.

²⁶⁷ During his interview, (b)(6); (b)(7)(C) advised that the regulator was in the bag, but during the emergency, RN (b)(6); (b)(7)(C) could not locate it.

²⁶⁸ See Stewart County Fire & EMS Prehospital Care Report, dated July 10, 2018.

²⁶⁹ See Pod 7B video surveillance footage, dated July 10, 2018. ERAU was only able to confirm the identity of one nurse in the video footage as many of the medical staff's incident statements, interviews, and actions in the video footage contradicted one another.

²⁷⁰ See (b)(6); (b)(7)(C)'s Detainee Death e-mail, dated July 11, 2018.

²⁷⁰ Creative Corrections advised that the head tilt method of opening the airway is effective, provided the emergency responder properly places his or her hands in performance of the tilt. During (b)(6); (b)(7)(C) After-Action Review with medical staff, he identified that the jaw thrust method would have been preferred, as it effectively and more simply, opens an airway without having to rely on proper hand placement at the neck as one would need to do with the head tilt method.

heard stating DE LA ROSA was clinically dead as they placed him into the ambulance, but that they were going to do everything they could to reverse that. The handheld video footage ends.

At 11:06 p.m., the ambulance left SDC for SGRMC.²⁷¹

(b)(6); (b)(7)(C) assigned Officers (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) to the hospital detail.²⁷² Officer (b)(6); (b)(7)(C) rode in the front seat of the ambulance with DE LA ROSA, while Officer (b)(6); (b)(7)(C) followed in the chase vehicle.²⁷³

Officer (b)(6); (b)(7)(C) reported the ambulance immediately activated its lights and siren, and she observed EMS responders performing CPR through the rear windows of the ambulance.²⁷⁴ While en route to the hospital, EMS requested to terminate CPR as DE LA ROSA was not responding, his skin was cool to the touch, and his pupils were fixed and unresponsive; an SGRMC Emergency Room NP (unnamed) denied the request, therefore EMS continued CPR efforts.²⁷⁵

At 11:25 p.m., EMS arrived to SGRMC.²⁷⁶ Officer (b)(6); (b)(7)(C) stated hospital staff took DE LA ROSA to a curtained area and continued to perform CPR.²⁷⁷ At 11:27 p.m., SGRMC RN (b)(6); (b)(7)(C) noted that upon arrival, DE LA ROSA was in full cardiac and respiratory arrest with EMS staff performing bag/mask ventilations; no signs of life were present.²⁷⁸

At 11:29 p.m., SGRMC (b)(6); (b)(7)(C) pronounced DE LA ROSA dead.²⁷⁹

At 11:35 p.m., RN (b)(6); (b)(7)(C) contacted Captain (b)(6); (b)(7)(C) to inform him of DE LA ROSA's death.²⁸⁰

At 11:50 p.m., Captain (b)(6); (b)(7)(C) called (b)(6); (b)(7)(C) back and advised her to call the coroner.

On July 11, 2018, at 12:27 a.m., HSA (b)(6); (b)(7)(C) called (b)(6); (b)(7)(C) and notified her an autopsy would be required.²⁸¹

At 1:24 a.m., Deputy Coroner (b)(6); (b)(7)(C) arrived at the hospital. Officer (b)(6); (b)(7)(C) and Coleman remained with DE LA ROSA until Deputy (b)(6); (b)(7)(C) arrived to SGRMC.

At 1:46 a.m., Deputy (b)(6); (b)(7)(C) left the hospital with DE LA ROSA.²⁸² At 1:49 a.m., (b)(6); (b)(7)(C) departed SGRMC, and at 2:16 a.m., they returned to SDC.

²⁷¹ See Stewart County Fire & EMS Prehospital Care Report, dated July 10, 2018.

²⁷² ERAU interview with (b)(6); (b)(7)(C) dated August 14, 2018.

²⁷³ ERAU interview with Officer (b)(6); (b)(7)(C) dated August 15, 2018.

²⁷⁴ ERAU interview with Officer (b)(6); (b)(7)(C) dated August 15, 2018.

²⁷⁵ See Stewart County Fire & EMS Prehospital Care Report, dated July 10, 2018.

²⁷⁶ *Id.*

²⁷⁷ ERAU interview with Officer (b)(6); (b)(7)(C), dated August 15, 2018.

²⁷⁸ See SGRMC Emergency Department (ED) Summary Nursing Notes, dated July 10, 2018.

²⁷⁹ See SGRMC ED Visit Note Report, dated July 11, 2018.

²⁸⁰ See SGRMC ED Summary Nursing Notes, dated July 10, 2018. Officer (b)(6); (b)(7)(C) advised ERAU that she informed Captain (b)(6); (b)(7)(C) by telephone of DE LA ROSA's death but was unable to provide documentation to support this.

²⁸¹ *Id.*

²⁸² See Hospital Logbook, dated July 10, 2018.

Post-Death Events

- SDC collected incident reports from all involved staff immediately following the medical emergency. On July 10, 2018, Officer (b)(6); (b)(7)(C) initially wrote only a two-line incident report but, per instruction by (b)(6); (b)(7)(C) Facility Investigator, she wrote a second, detailed report on July 23, 2018.²⁸³ Officer (b)(6); (b)(7)(C) plained that she did not realize a detailed report was necessary, as she had never been involved in a response to a hanging before.
- Captain (b)(6); (b)(7)(C) stated that after DE LA ROSA's death, Warden (b)(6); (b)(7)(C) instructed him to notify the Sheriff's Department. Sheriff (b)(6); (b)(7)(C) arrived to SDC at 12:30 a.m. on July 11, 2018.²⁸⁴ (b)(6); (b)(7)(C) stated he spoke with the Warden and then interviewed Officer (b)(6); (b)(7)(C). Following the interview, he contacted the GBI and noted that GBI arrived on the scene at 1:15 a.m. Captain (b)(6); (b)(7)(C) informed the review team that he escorted one of the GBI agents to DE LA ROSA's cell. When told he would be awhile, he left the agent with an officer.
- On July 11, 2018, SDC inventoried DE LA ROSA's property and turned it over to ERO staff, along with the \$0.31 remaining in DE LA ROSA's account.²⁸⁵ At the time of the site visit, ERO had not returned DE LA ROSA's property to his next of kin, as there was an ongoing investigation.
- On July 11, 2018, Ward (b)(6); (b)(7)(C) assigned Facility Investigator (b)(6); (b)(7)(C) to review the events surrounding DE LA ROSA's suicide. She submitted a written report to the Warden on August 6, 2018.²⁸⁶ Facility Investigator (b)(6); (b)(7)(C) informed ERAU that her investigation involved a review of written reports, interviews with security and medical staff, and extensive review of video footage. Her review did not include analysis of actions taken by medical personnel.
- HSA (b)(6); (b)(7)(C) conducted an After-Action Review with IHSC and CoreCivic medical staff.²⁸⁷

MEDICAL CARE AND SECURITY REVIEW

ERAU reviewed the medical care SDC provided DE LA ROSA, as well as the facility's efforts to ensure he was safe and secure while detained at the facility. ERAU found deficiencies in SDC's compliance with certain requirements of the ICE PBNDS 2011 (as revised in 2016).

²⁸³ See Incident Statements by Officer (b)(6); (b)(7)(C) dated July 10, 2018, and July 23, 2018.

²⁸⁴ See Stewart County Sheriff's Office Incident Report, dated July 10, 2018.

²⁸⁵ See Disposition of Non-Allowable Property and Inmate Account Summary, both dated July 11, 2018.

²⁸⁶ See CoreCivic General Counsel Office of Investigations, Investigative Report Form by Facility Investigator (b)(6); (b)(7)(C), dated August 6, 2018.

²⁸⁷ HSA (b)(6); (b)(7)(C) did not advise ERAU of the After-Action Review date.

1. ICE PBNDS 2011, *Medical Care*, Section (V)(U)(4) states, “Distribution of medication (including over the counter) shall be performed in accordance with specific instructions and procedures established by the HSA in consultation with the CMA. Written records of all prescribed medication given to or refused by detainees shall be maintained... All prescribed medications and medically necessary treatments shall be provided to detainees on schedule and without interruption, absent exigent circumstances.”
 - Video evidence showed an (b)(6); (b)(7)(C) recorded refusal of psychiatric medications on the night of DE LA ROSA’s suicide, July 10, 2018.
 - ERAU was unable to confirm if the June 14, and 17, 2018, amlodipine administrations were given or refused due to illegible entries on the MAR.
2. ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(1) states, “Upon admission at the facility, documented informed consent shall be obtained for the provision of health care services.”
 - DE LA ROSA did not sign a general consent for treatment form when first admitted to SDC.
3. ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(4) states, “Prior to the administration of psychotropic medications, a separate documented informed consent, that includes a description of the medication’s side effects, shall be obtained.”
 - There is no documentation that medical staff requested DE LA ROSA sign a separate consent form for the psychotropic medications haloperidol and olanzapine when ordered on June 12, 2018.
4. ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(9) states, “Medical staff shall explain the medical risks if treatment is declined and shall document their treatment efforts and refusal of treatment in the detainee’s medical record. Detainees will be asked to sign a translated form that indicates that they have refused treatments.”
 - Medical staff documented DE LA ROSA refused his medications 29 times between June 15 and July 10, 2018, but medical staff completed refusal forms for only 21 of the 29 refusals.
 - Medical staff entered “No-Show” on the MAR 20 times between June 14 and 26, 2018. Fifteen of the 20 no-shows occurred after security placed DE LA ROSA in segregation; therefore, he could not voluntarily report to receive medications. Entries of “No-Show”, especially in segregation, do not constitute affirmative documentation that the detainee refused medications as required by the standard. There is no documentation medical staff confirmed the detainee was refusing medications on these 15 occasions, that they explained the risks associated with these refusals, or that they completed refusal forms.

5. ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(10) states, “The clinical medical authority and facility administrator shall look into refusals of treatment to ensure that such refusals are not the result of miscommunication or misunderstanding.”
 - Medical staff did not notify the Clinical Director that DE LA ROSA was refusing medications; therefore, the Clinical Director was unaware of this issue. However, nurses sent 17 telephone encounters to (b)(6); (b)(7)(C) the mid-level provider responsible for following-up on medication refusals/no-shows. The NP did not see DE LA ROSA, claiming medical staff postponed scheduled appointments; medical staff were unable to produce documentation supporting scheduling occurred at all.
6. ICE PBNDS 2011, *Significant Self-harm and Suicide Prevention and Intervention*, Section (V)(F) states, “All suicidal detainees placed in an isolated confinement setting will receive continuous one-to-one monitoring, welfare checks at least every eight hours conducted by clinical staff, and daily mental health treatment by a qualified clinician.”
 - Medical staff did not meet the eight-hour timeframe on at least three occasions. On April 25, 2018, there was an 8 hour and 45-minute gap between a healthcare round at 1:00 a.m. and the next round at 9:45 a.m. On April 27, 2018, there was a 10 hour and 10-minute gap between a healthcare round at 10:30 p.m. and the next round at 8:40 a.m. on April 28, 2018. On April 29, 2018, there was a 10 hour and 1-minute gap between a round at 2:29 p.m. and the next round at 12:30 a.m. on April 30, 2018. ERAU was unable to positively identify other occasions when medical staff may have exceeded the eight-hour timeframe, as numerous staff members did not enter the exact time of the encounter. Timing of vital signs and medical staff sign-offs suggest there may have been multiple other instances of welfare checks exceeding the eight-hour timeframe, particularly when a round was due on the night shift.
7. ICE PBNDS 2011, *Significant Self-harm and Suicide Prevention and Intervention*, Section (V)(K) states, “A critical incident debriefing following a suicide or serious suicide attempt shall be offered to all affected staff and detainees within 24 to 72 hours after the critical incident.”
 - Although other officers involved in the incident reported getting one, Officer (b)(6); (b)(7)(C), who rode in the ambulance with DE LA ROSA, was not offered a critical incident debriefing or supportive counseling services by SDC.
8. ICE PBNDS 2011, *Custody Classification System*, Section (V)(H)(3) states, “Special Reclassification Assessments: Staff shall complete a special reclassification within 24 hours before a detainee leaves the SMU, following an incident of abuse or victimization, and at any other time when warranted based upon the receipt of additional, relevant information, such as after a criminal act, or if a detainee wins a criminal appeal, is pardoned or new criminal information comes to light.”
 - A reclassification review factoring DE LA ROSA’s disciplinary conviction was conducted on April 10, 2018, following his IDP disciplinary hearing and sentencing

on April 6, 2018. However, security staff did not complete a reclassification review within the 24 hours preceding DE LA ROSA's release from disciplinary segregation on April 18, 2018.

9. ICE PBNDS 2011, *Disciplinary System*, Section (V)(A)(6-8) states, "When a detainee has a diagnosed mental illness or mental disability, or demonstrates symptoms of mental illness or mental disability, a mental health professional, preferably the treating clinician, shall be consulted to provide input as to the detainee's competence to participate in the disciplinary hearing, any impact the detainee's mental illness may have had on his or her responsibility for the charged behavior, and information about any known mitigating factors in regard to the behavior... If a detainee has a mental disability or mental illness but is competent, the disciplinary process shall consider whether the detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. A mental health professional should also be consulted as to whether certain types of sanctions (e.g., placement in disciplinary segregation, loss of visits, or loss of phone calls) may be inappropriate because they would interfere with supports that are a part of the detainee's treatment or recovery plan."
 - There is no documentation that security staff consulted a mental health professional prior to disciplinary hearings on April 6 and June 21, 2018, or that the hearing officer considered the degree to which DE LA ROSA's mental illness may have contributed to his behavior. ERAU acknowledges that DE LA ROSA's mental illness was likely not known to security personnel at the time of the hearings as patient diagnoses are confidential and, per the medical record, he was asymptomatic. Ultimately, ERAU recommends that healthcare and security personnel review the standard and consider ways they can accomplish this without violating patient confidentiality.
10. ICE PBNDS 2011, *Disciplinary System*, Section (V)(H) states, "The detainee in IDP proceedings shall have the right to due process, which includes the rights to... have an IDP hearing within 48 hours after the conclusion of the investigation or the conclusion of the Unit Disciplinary Committee (UDC) hearing... The IDP shall conduct the hearing within 48 hours after the investigation or the conclusion of the UDC hearing, unless the detainee requests more time to gather evidence or otherwise prepare a defense. In cases where a hearing is delayed, the reason(s) must be documented (e.g., a continuing investigation of facts, unavailability of one or more essential witnesses, etc.) and, unless the detainee has requested the delay, approved by the facility administrator. If the detainee is being held in segregation, the delay shall not exceed 72 hours, barring an emergency."
 - On April 4, 2018, at 10:52 a.m. (b)(6); (b)(7)(C) completed the investigation for the April 3, 2018, disciplinary incident. The IDP hearing commenced at 12:42 p.m. on April 6, 2018, more than 48 hours after the conclusion of the investigation. The hearing officer did not document the reason for the delay.
11. ICE PBNDS 2011, *Searches of Detainees*, Section (V)(D)(2)(b) states, "Officers must obtain supervisory approval before conducting strip searches. Staff may conduct a strip

search where there is reasonable suspicion that contraband may be concealed on the person. ‘Reasonable suspicion’ means suspicion based on specific and articulable facts that would lead a reasonable officer to believe that a specific detainee is in possession of contraband. It is a more permissive (lower) standard than probable cause, but it is more than a mere hunch. It must be based on specific and articulable facts—along with reasonable inferences that may be drawn from those facts—that the officer shall document in Form G-1025 or equivalent.”

- The form documenting the strip search of DE LA ROSA on April 24, 2018 states, “Suicide Watch” and does not document the specific facts that led the officer to believe DE LA ROSA was in possession of contraband.

This practice also violates *SDC RHU Post Orders*, Section (III)(C)(1)(b), which states, “ICE detainees will not be strip searched unless there is a ‘reasonable suspicion’ that the detainee is concealing a weapon or contraband. A frisk search shall be performed in lieu of a strip search.”

12. ICE PBNDS 2011, *Special Management Units*, Section (V)(A)(3)(a-b) states, “All facilities shall implement written procedures for the regular review of all detainees held in administrative segregation, consistent with the procedures specified below. A supervisor shall conduct a review within 72 hours of the detainee’s placement in administrative segregation to determine whether segregation is still warranted... The review shall include an interview with the detainee... A supervisor shall conduct an identical review after the detainee has spent seven days in administrative segregation and every week thereafter for the first 30 days and every 10 days thereafter, at a minimum.”

- There is no documentation ICE or security staff interviewed DE LA ROSA during administrative segregation status reviews on April 26, 2018, and May 3, 2018.
- The May 3, 2018 status review was delinquent, as it was due on May 1, 2018, seven days after DE LA ROSA’s initial placement in segregation.

13. ICE PBNDS 2011, *Special Management Units*, Section (V)(B) states, “A detainee may be placed in disciplinary segregation only by order of the IDP, or its equivalent, after a hearing in which the detainee has been found to have committed a prohibited act and only when alternative dispositions may inadequately regulate the detainee’s behavior.”

- Security staff ordered DE LA ROSA’s placement in disciplinary segregation on April 3, 2018, and June 19, 2018, although the charges were not adjudicated until April 6, 2018, and June 21, 2018, respectively.

14. ICE PBNDS 2011, *Special Management Units*, Section (V)(B)(3) states, “All facilities shall implement written procedures for the regular review of all disciplinary segregation cases, consistent with the following procedures: A security supervisor shall interview the detainee and review his/her status in disciplinary segregation every seven days to determine whether the detainee: Abides by all rules and regulations; and, Is provided showers, meals, recreation and other basic living standards, as required by this detention

standard... The supervisor shall document his/her findings after every review, by completing a disciplinary segregation review (Form I-887). The supervisor may recommend the detainee's early release from the SMU upon finding time in disciplinary segregation is no longer necessary to regulate the detainee's behavior. An early-release recommendation must have the facility administrator's approval before the detainee may be returned to the general population. In conducting this review, the facility administrator will consider any request by the detainee to present written evidence or available witnesses. The review shall take into account the detainee's views."

- There is no documentation security staff reviewed DE LA ROSA's placement status in disciplinary segregation from April 6 to April 18, 2018.
- The July 3, 2018, status review was delinquent, as it was due on June 29, 2018, seven days after the June 22, 2018, status review. Although an EARM entry noted that on June 27, 2019, a Confinement Review Committee reviewed DE LA ROSA's segregation status and advised he remain in segregation, there was no additional documentation to support this review occurred. Furthermore, there is no documentation security staff interviewed DE LA ROSA during the disciplinary segregation status reviews on June 22, 2018, and July 3, 2018.
- On April 18, 2018, Security Chief (b)(6); (b)(7)(C) directed DE LA ROSA's release to the general population after he served only 15 days of the first 30-day disciplinary segregation sanction. Security Chief (b)(6); (b)(7)(C) did not complete a status review documenting an interview of the detainee and a recommendation for early release based on a determination that disciplinary segregation was no longer necessary. Security Chief (b)(6); (b)(7)(C) documented the early release only on the Confinement Record, without rationale, and did not obtain approval from the facility administrator.²⁸⁸

15. ICE PBNDS 2011, *Special Management Units*, Section (V)(D)(1) states, "A permanent log shall be maintained in the SMU to record all activities concerning SMU detainees (e.g., meals served, recreational time, visitors, etc.)."

- There was no record of whether the lunch meal was served or refused on April 5, April 6, April 29, and June 22, 2018.

16. ICE PBNDS 2011, *Special Management Units*, Section (V)(M) states, "Detainees in SMU shall be personally observed and logged at least every 30 minutes on an irregular schedule."

- SDC was unable to produce CWLs for April 4, April 17, and July 3, 2018; therefore, ERAU could not verify completion of 30-minute security rounds.
- On July 10, 2018, Officer (b)(6); (b)(7)(C) logged security rounds at 9:13 p.m., 9:39 p.m., and 10:04 p.m. Video surveillance footage showed Officer (b)(6); (b)(7)(C) signing documents on

²⁸⁸ The ICE detention standards do not address suspension of the balance of a disciplinary segregation sanction outside the status review process.

the clipboard next to the detainee's cell, but he did not look in the cell to personally observe DE LA ROSA.

These issues also violate *SDC RHU Post Orders*, Section (III)(B)(1)(i), which states, "Detainees in SMU shall be personally observed and logged at least every thirty (30) minutes on an irregular schedule... Observation will include looking in each cell to ensure that no unusual or unauthorized activities are occurring."

ERAU noted the following additional violations of SDC-specific policy below:

1. *SDC RHU Post Orders*, Section (III)(L)(5) states, "Inmates/residents will be offered the opportunity to shower and shave at least three (3) times per week. In the event an inmate/resident refuses to shower for an entire one (1) week period, notify the Shift Supervisor/Unit Manager."
 - Confinement Activity Records document security staff offered DE LA ROSA showers only twice during the week of April 8, 2018 (April 9 and 11, 2018) and twice during the week of July 1, 2018 (July 4 and 6, 2018).
 - There is no documentation that security staff notified a supervisor when DE LA ROSA did not shower during the period from April 3 to 18, 2018.
2. *SDC Policy 9-13, Count Principles and Procedures* states, "At shift change, the oncoming *Correctional Officer* will conduct an informal count of all inmates in his/her area of responsibility;" and *SDC RHU Post Orders*, Section (II)(G), Start of Shift states, "Verify that all cell doors and food tray slots are secure."
 - On July 10, 2018, Officer [REDACTED] (b)(6); (b)(7)(C) did not conduct a count or make a round to verify all cell doors and food tray slots were secure until he had been on the post for 28 minutes. Officer [REDACTED] (b)(6); (b)(7)(C) informed ERAU that he timed his first security round based on Officer [REDACTED] (b)(6); last documented security round, which was not appropriately conducted according to video surveillance footage. Conducting security rounds in accordance with the standard and facility policy—specifically, verifying detainee welfare through direct observation at least every 30 minutes on an irregular schedule—serves a fundamental and critical safety and security purpose in restricted housing.
3. *SDC RHU Post Orders*, Section (IV) states, "Never leave your post for any reason unless properly relieved by an assigned officer or the Shift Supervisor."
 - On July 10, 2019, Officer [REDACTED] (b)(6); (b)(7)(C) left his post, 7A, on two occasions, at 10:13 p.m. and 10:34 p.m.

Areas of Concern

ERAU also noted the following concerns regarding DE LA ROSA's medical care:

- Nurses used template language programmed in eCW to document segregation rounds while DE LA ROSA was in the RHU for disciplinary reasons. All notes are virtually identical and did not include subjective information reflecting DE LA ROSA's answers in response to queries. In DE LA ROSA's case, nurses' findings that there was no evidence of hallucinatory and delusional thoughts would have been far better supported had they documented subjective information. Including this information helps to ensure that segregation rounds serve the intended purpose of verifying detainee health and welfare.
- On April 30, 2018, medical staff did not follow-up on or report DE LA ROSA's elevated blood pressure reading of 152/92 to a provider to determine possible monitoring and treatment needs. DE LA ROSA's blood pressure was within AHA parameters for elevated blood pressure six times, Stage One hypertension 21 times, and Stage Two hypertension eight times. Despite these readings, SDC medical staff only prescribed DE LA ROSA blood pressure medication after receiving the Medication Reconciliation for Discharge/Transfer List from CRCC. Furthermore, DE LA ROSA's medical record documents his last blood pressure reading was on June 19, 2018, 21 days before his death. Whether or not the detainee's refusal of medications impacted either his physical or mental health, (b)(6); (b)(7)(C), as a prescribing provider, was obliged to act upon nurses' referrals, including educating the detainee on the risks.
- During interview, HSA (b)(6); (b)(7)(C) stated he informed nurses after DE LA ROSA's death that they are expected to follow the blood pressure guidelines within IHSC Directive 03-10, *Intake Screening and Intake Reviews*, which details what action should be taken when a detainee's blood pressure is elevated. (b)(6); (b)(7)(C) was unable to provide ERAU with documentation to support that he informed medical staff to follow these guidelines outside of the intake screening and intake reviews process.
- On July 10, 2018, (b)(6); (b)(7)(C) the first medical responder to arrive at DE LA ROSA's cell, brought emergency equipment with her; however, the AED was not present and the oxygen tank was disconnected from the regulator. (b)(6); (b)(7)(C) explained that medical staff did not replenish emergency equipment, to include the AED, following a medical emergency earlier in the day. Ensuring necessary emergency equipment is available and operable is critical to an effective medical emergency response.

ERAU also noted the following concerns with security:

- On April 21, 2018, DE LA ROSA submitted an incident statement in which he asked security to move him to segregation because his cellmate threatened his life. Although the Cellmate History Housing record documented DE LA ROSA's cellmate was moved on April 23, 2018, there is no documentation of when security received the statement or what specific action security took pursuant to the claim. Within the detention file, a memorandum dated April 24, 2018, documented security placed DE LA ROSA on administration segregation status pending investigation for protective custody. Following a mental health assessment, medical staff placed DE LA ROSA on suicide watch, which continued until he was transferred to CRCC. Although placement on protective custody apparently overlapped with suicide watch, documentation related to protective custody was limited.
- After Officer (b)(6); (b)(7)(C) found DE LA ROSA hanging and called a medical emergency, he did not enter the cell until other officers arrived. Officer (b)(6); (b)(7)(C) stated SDC trained him not to open a cell door in the RHU unless another officer was present; however, SDC policy does not prohibit an officer from opening a cell door without another officer present. In fact, video surveillance footage of Pod 7B showed the officer on the previous shift opened cell doors without another officer present to allow detainees out for showers.
- The Classification Supervisor did not review and approve the detainee's initial classification, completed March 13, 2018, until March 29, 2018, 16 days after it was applied. The ICE PBNDS 2011 Standards do not set a specific timeframe for supervisory review but do state that the purpose of the review is to check "for accuracy and completeness and ensure that each detainee is assigned to the appropriate housing unit." Although in this case, DE LA ROSA's classification and housing assignment were appropriate, the purpose of supervisory review cannot be achieved if review of the classification decision is not timely.
- There were multiple illegible signatures with no accompanying printed names on documents in the detention file. Absent legible names, there is no way to account for actions and decisions.

APPENDIX 1

CONFINEMENT ACTIVITY RECORDS

The table below shows the activities refused by DE LA ROSA and undocumented meals by security staff while DE LA ROSA was in segregation.

Disciplinary Segregation from April 3, 2018, 8:52 p.m. to April 18, 2018, 6:10 p.m.		
Date	Activity Refused	Undocumented Meals
April 4, 2018	Shower	--
April 5, 2018	Recreation	Lunch
April 6, 2018	--	Lunch
April 8, 2018	Recreation	--
April 9, 2018	Shower	--
April 11, 2018	Shower & Recreation	--
April 12, 2018	Recreation	--
April 13, 2018	Recreation	--
April 14, 2018	Recreation	--
April 16, 2018	Recreation	--
Suicide Watch from April 24, 2018, 4:45 p.m. to May 4, 2018, 7:32 a.m.		
Date	Activity Refused	Undocumented Meals
April 29, 2018	--	Lunch
May 1, 2018	Recreation	--
May 2, 2018	Recreation	--
May 3, 2018	No activities logged	--
May 4, 2018	No activities logged	--
Disciplinary Segregation from June 19, 2018, 6:05 p.m. to July 10, 2018, 11:06 p.m.		
Date	Activity Refused	Undocumented Meals
June 22, 2018	--	Lunch

EXHIBITS

1. Georgia Bureau of Investigation, Division of Forensic Sciences Autopsy, Official Report, dated October 2, 2018.
2. Creative Corrections Detainee Death Review Healthcare and Security Analysis.



U.S. Immigration
and Customs
Enforcement

JUL 24 2019

MEMORANDUM FOR: Nathalie Asher
Executive Associate Director
Office of Enforcement and Removal Operations

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

FROM: Acting Assistant Director

SUBJECT: Findings – Death of ICE Detainee
Efrain DE LA ROSA (JICMS (b)(6); (b)(7)(C); (b)(7)(E))

The U.S. Immigration and Customs Enforcement (ICE) Office of Professional Responsibility, External Reviews and Analysis Unit (ERAU) has completed its review of the facts and circumstances regarding the death of ICE detainee Efrain DE LA ROSA, who died on July 10, 2018, at the Southwest Georgia Regional Medical Center (SGRMC) in Cuthbert, Georgia (GA), while in the custody of ICE. The Georgia Bureau of Investigations, Associate Medical Examiner, documented DE LA ROSA's cause of death as suicide by hanging.

On February 9, 2018, a designated immigration officer from the Wake County 287(g) program encountered DE LA ROSA at the Wake County Detention Center (WCDC) in Raleigh, North Carolina, and lodged an Immigration Detainer – Notice of Action with the WCDC. On March 12, 2018, WCDC released DE LA ROSA into ICE's custody, and the following day, ICE transported DE LA ROSA to the Stewart Detention Center (SDC) in Lumpkin, GA.

On March 13, 2018, at 1:07 p.m., SDC admitted DE LA ROSA. At 10:55 p.m., a registered nurse (RN) completed DE LA ROSA's pre-screening and documented that DE LA ROSA denied having any current health problems or taking any medications.

On March 14, 2018, at 2:45 a.m., an RN completed DE LA ROSA's medical and mental health screening and documented that his vital signs were within normal limits except for an elevated blood pressure of 119/80.¹ DE LA ROSA reported that while previously

¹ According to the American Heart Association, this blood pressure reading indicates stage one hypertension. Stage one hypertension is characterized by a systolic reading of 130 to 139 or a diastolic

incarcerated by the Virginia Department of Corrections, Marion Correctional Treatment Center (MCTC), MCTC treated him for schizophrenia. DE LA ROSA also reported taking eight different medications but ceased use approximately three months prior to his arrival at SDC because he could not sleep. The RN documented an abnormal intake screening and referred DE LA ROSA to a medical provider.

On March 15, 2018, a nurse practitioner (NP) conducted DE LA ROSA's initial physical assessment and documented DE LA ROSA's vital signs were within normal limits except for an elevated blood pressure of 113/80. DE LA ROSA reported a history of schizophrenia and hospitalization for the disease in 2004 and 2010 but could not recall the names of his past medications. DE LA ROSA also denied any current homicidal or suicidal ideations. The NP further documented DE LA ROSA was not currently exhibiting symptoms of a serious mental disorder or cognitive impairment but referred him to a mental health provider.

On March 16, 2018, a psychologist conducted a mental health assessment and determined there were no active symptoms of serious mental disorder or condition but listed treatment planning and supportive psychotherapy intervention within the note. Medical staff scheduled DE LA ROSA for a psychiatry evaluation and mental health follow-up and DE LA ROSA consented to receiving tele-psychiatry services.

On April 3, 2018, security staff placed DE LA ROSA into the restricted housing unit (RHU) for a disciplinary infraction. Three days later, the Institution Disciplinary Panel (IDP) sentenced him to 30 days segregation. While in segregation, medical staff was responsible for conducting daily segregation rounds and weekly mental health segregation rounds. Security staff was simultaneously responsible for documenting daily activities and security rounds. DE LA ROSA remained in disciplinary segregation until April 18, 2018. Security staff placed DE LA ROSA in general population post release from disciplinary segregation.

On April 21, 2018, DE LA ROSA submitted an incident statement requesting transfer to another cell as he alleged his cellmate told him he was going to kill him. On April 24, 2018, SDC re-assigned DE LA ROSA to the RHU pending investigation for protective custody. On this same date, a Psychiatric Mental Health Nurse Practitioner (PMHNP) conducted a mental health assessment and documented DE LA ROSA's vital signs were within normal limits except for an elevated blood pressure of 135/88. During the assessment, DE LA ROSA declined medication treatment. The PMHNP completed an initial suicide risk assessment² and determined DE LA ROSA was at "Moderate Acute Risk"³ for suicide; the PMHNP ordered one-on-one suicide watch and scheduled a mental health follow-up for the next day. Prior to placement in the RHU for suicide watch, two security officers conducted a strip search of DE LA ROSA.

reading of 80 to 89.

² The suicide risk assessment includes risk and protective factors and mental status examination elements.

³ Consideration for moderate acute risk includes, but is not limited to, the presence of suicidal ideation with vague plan and/or intent in the presence of multiple risk factors and high acute distress.

On April 27, 2018, during a follow-up suicide risk assessment, mental health providers determined DE LA ROSA required a higher level of care and therefore referred him to Columbia Regional Care Center (CRCC) for in-patient hospitalization.

On May 4, 2018, SDC transported DE LA ROSA to CRCC for mental health treatment, where he remained until June 12, 2018. While receiving treatment at CRCC, medical staff prescribed DE LA ROSA with Norsavc⁴ for hypertension and psychotropic medications Haldol⁵ and Zyprexa⁶ for schizophrenia. The CRCC medical record indicated he was generally compliant with treatment.

On June 12, 2018, upon DE LA ROSA's return to SDC, a prescribing provider ordered amlodipine, haloperidol, and olanzapine. DE LA ROSA did not sign a consent form for the two psychotropic medications, haloperidol and olanzapine

On June 14, 2018, medical staff began attempts to administer the medication ordered on June 12, 2018, to DE LA ROSA. Although the Medication Administration Record (MAR) documents DE LA ROSA only took his psychiatric medications on three occasions, surveillance footage proved one entry false and the Health Services Administrator (HSA) believed the other two were highly unlikely considering DE LA ROSA refused all other medication administrations up to and including the day of his suicide. While nurses notified an NP on 17 occasions that DE LA ROSA refused his medications, the NP never saw him, and medical staff never informed the Clinical Director. Furthermore, medical staff did not check DE LA ROSA's blood pressure from June 20, 2018, through July 10, 2018, despite that DE LA ROSA refused to take his hypertension medication, as well. Overall, documentation of DE LA ROSA's medication refusals were limited and notifications to a provider concerning DE LA ROSA's refusals were inconsistent.

On June 19, 2018, security staff placed DE LA ROSA into the RHU for another disciplinary infraction, for which the IDP later sentenced him to 30 days segregation, where he remained until his death on July 10, 2018. Behavioral health providers (BHPs) assessed DE LA ROSA on four occasions during this period of segregation. In two of those instances, on June 20 and July 10, 2018, the BHP documented that he met the criteria for having a serious mental illness (SMI). However, there was no documentation to support that the BHP completed the required SMI criteria follow-up actions.

On July 10, 2018, at 10:33 p.m., one hour and 53 minutes after security staff last conducted a security round, an officer discovered DE LA ROSA standing by the bunk in his cell with socks wrapped around his neck and tied to the top bunk rail. The officer immediately called a medical emergency via radio. At 10:35 p.m., officers entered DE LA ROSA's cell, utilized a cut-down tool to remove the socks from DE LA ROSA's neck, and within a minute, initiated cardio pulmonary resuscitation (CPR). Other security and medical staff responded without delay; however, a review of the video

⁴ Norvasc is a brand name for amlodipine.

⁵ Haldol is a brand name for haloperidol.

⁶ Zyprexa is a brand name for olanzapine.

footage and documentation identified multiple issues, including the absence of devices needed for the emergency response and improper administration of CPR by multiple staff members. Six minutes after the officer initiated the medical emergency, a nurse requested Emergency Medical Services (EMS). SDC security immediately called EMS, who arrived on scene within nine minutes of being called. At 11:06 p.m., EMS departed SDC and arrived to SGRMC at 11:25 p.m. SGRMC hospital staff immediately performed CPR on DE LA ROSA but were unable to revive him. At 11:29 p.m., a SGRMC physician pronounced DE LA ROSA dead.

MEDICAL CARE AND SECURITY REVIEW

ERAU reviewed the medical care SDC provided DE LA ROSA, as well as the facility's efforts to ensure he was safe and secure while detained at the facility. ERAU found deficiencies in SDC's compliance with certain requirements of the ICE Performance-Based National Detention Standards (PBNDS) 2011.

1. ICE PBNDS 2011, *Medical Care*, Section (V)(U)(4), requires the distribution of medication be performed in accordance with specific instructions and procedures established by the HSA in consultation with the Clinical Medical Authority (CMA). Medical staff should maintain all written records of prescribed medication given to or refused by detainees and provide these medications on schedule and without interruption, absent exigent circumstances. Video evidence showed an RN falsely recorded the refusal of psychiatric medications on the night of DE LA ROSA's suicide, July 10, 2018. Furthermore, ERAU was unable to confirm if the June 14 and June 17, 2018 amlodipine administrations were given or refused due to illegible entries on the MAR.
2. DE LA ROSA did not sign a general consent for treatment form when first admitted to SDC, in contravention of the ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(1), which requires that documented informed consent be obtained for health care services upon admission to the facility.
3. There is no documentation medical staff requested DE LA ROSA sign a separate consent form for the psychotropic medications, haloperidol and olanzapine, when ordered on June 12, 2018, in contravention of the ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(4), which requires a separate documented informed consent for psychotropic medications, to include a description of the medication's side effects, prior to administration.
4. ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(9), requires that medical staff shall explain the medical risks if treatment is declined and shall document their treatment efforts and refusal of treatment in the detainee's medical record. Detainees will be asked to sign a translated form that indicates that they have refused treatments. Medical staff documented DE LA ROSA refused his medications on the MAR 29 times between June 15 - July 10, 2018 but completed refusal forms for only 21 of the 29 refusals. Furthermore, medical staff documented "No-Show" on the MAR 20 times between June 14 - 26, 2018. Fifteen of the 20 "No-Shows" occurred

after security placed DE LA ROSA in segregation; therefore, DE LA ROSA could not voluntarily report to receive medications. There is no documentation medical staff confirmed the detainee was refusing medications on these 15 occasions, that they explained the risks associated with these refusals, or that they completed refusal forms.

5. ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(10), requires the CMA and facility administrator to look into refusals of treatment to ensure that such refusals are not the result of miscommunication or misunderstanding. Medical staff did not notify the Clinical Director that DE LA ROSA was refusing medications; therefore, the Clinical Director was unaware of this issue. However, nurses sent 17 telephone encounters to an NP, the mid-level provider responsible for following up on medication refusals or “No-Shows.” The NP indicated that she did not see DE LA ROSA because medical postponed scheduled appointments, but medical staff were unable to produce documentation supporting scheduling occurred at all.
6. ICE PBNDS 2011, *Significant Self-harm and Suicide Prevention and Intervention*, Section (V)(F), requires all suicidal detainees placed in an isolated confinement setting to receive welfare checks at least every eight hours conducted by clinical staff. However, medical staff did not meet the eight-hour timeframe on at least three occasions. On April 25, 2018, there was an 8 hour and 45-minute gap between welfare checks; on April 27, 2018, there was a 10 hour and 10-minute gap between welfare checks; and on April 29, 2018, there was a 10 hour and 1-minute gap between welfare checks.
7. Per Officer (b)(6); (b)(7)(C) who rode in the ambulance with DE LA ROSA, SDC did not offer him a critical incident debriefing or supportive counseling services, in contravention of ICE PBNDS 2011, *Significant Self-harm and Suicide Prevention and Intervention*, Section (V)(K), which requires that a critical incident debriefing following a suicide be offered to all affected staff and detainees within 24 to 72 hours after the critical incident.
8. Security staff did not complete a reclassification review within the 24 hours preceding DE LA ROSA’s release from disciplinary segregation on April 18, 2018, in contravention of ICE PBNDS 2011, *Custody Classification System*, Section (V)(H)(3), which requires staff to complete a special reclassification within 24 hours before a detainee leaves the Special Management Unit (SMU).
9. ICE PBNDS 2011, *Disciplinary System*, Section (V)(A)(6) and (8), requires that when a detainee has a diagnosed mental illness, the facility shall consult a mental health professional to provide input as to the detainee’s competence to participate in the disciplinary hearing, if the mental illness had any impact on his or her behavior, and if certain types of sanctions may hinder the detainee’s treatment or recovery plan. There is no documentation that security staff consulted a mental health professional prior to disciplinary hearings on April 6 and June 21, 2018, or that the hearing officer

considered the degree to which DE LA ROSA's mental illness may have contributed to his behavior.

10. ICE PBNDS 2011, *Disciplinary System*, Section (V)(H), requires that a detainee in IDP proceedings shall have the right to due process, which includes the right to have an IDP hearing within 48 hours after the conclusion of the investigation. In cases where a hearing is delayed, the IDP must document the reason and obtain approval from the facility administrator. On April 4, 2018, at 10:52 a.m., Sergeant Haynes completed the investigation for the April 3, 2018, disciplinary incident. The IDP hearing commenced at 12:42 p.m. on April 6, 2018, more than 48 hours after the conclusion of the investigation. The hearing officer did not document the reason for the delay.
11. On April 24, 2018, officers conducted a strip search of DE LA ROSA prior to his placement on suicide watch but did not document the specific facts that led the officers to believe DE LA ROSA was in possession of contraband, in contravention of ICE PBNDS 2011, *Searches of Detainees*, Section (V)(D)(2)(b), which requires staff to have a reasonable suspicion that contraband may be concealed on the person prior to conducting a strip search and document the facts associated to the suspicion.
12. ICE PBNDS 2011, *Special Management Units*, Section (V)(A)(3)(a-b), requires that a supervisor conduct a review, to include an interview with the detainee, within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted. A supervisor is also required to conduct an identical review after the detainee has spent seven days in administrative segregation. There is no documentation security staff interviewed DE LA ROSA during administrative segregation status reviews on April 26, 2018, and May 3, 2018. Furthermore, the May 3, 2018, status review was delinquent, as it was due on May 1, 2018, seven days after DE LA ROSA's initial placement in segregation.
13. ICE PBNDS 2011, *Special Management Units*, Section (V)(B), requires a detainee be placed in disciplinary segregation only by order of the IDP and after a hearing in which the detainee has been found to have committed a prohibited act. Security staff ordered DE LA ROSA's placement in disciplinary segregation on April 3, 2018, and June 19, 2018, although the charges were not adjudicated until April 6, 2018, and June 21, 2018, respectively.
14. ICE PBNDS 2011, *Special Management Units*, Section (V)(B)(3), requires that a supervisor conduct a review, to include an interview with the detainee, of their status in disciplinary segregation every seven days and document those findings after every review. The supervisor may recommend the detainee's early release from the SMU but must have the facility administrator's approval before the detainee may be returned to the general population. First, there is no documentation security staff reviewed DE LA ROSA's placement status in disciplinary segregation from April 6 to April 18, 2018. Second, on April 18, 2018, Security Chief Dethrow directed DE LA ROSA's release to the general population after serving only 15 days of the 30-day

sanction. Security Chief (b)(6); (b)(7)(C) did not document an interview of DE LA ROSA, a recommendation reason for early release, or obtain approval from the facility administrator before the release.⁷ Last, the July 3, 2018, disciplinary segregation status review was delinquent, as it was due on June 29, 2018, seven days after the June 22, 2018, status review; the reviews conducted were also devoid of documentation to support security staff interviewed DE LA ROSA.

15. There was no record of whether the lunch meal was served or refused on April 5, April 6, April 29, and June 22, 2018, in contravention of ICE PBNDS 2011, *Special Management Units*, Section (V)(D)(1), which requires a permanent log be maintained in the SMU to record all activities concerning SMU detainees.

16. ICE PBNDS 2011, *Special Management Units*, Section (V)(M), requires that detainees in SMU be personally observed and logged at least every 30 minutes on an irregular schedule. SDC was unable to produce Confinement Watch Logs for April 4, April 17, and July 3, 2018; therefore, ERAU could not verify completion of 30-minute rounds for those dates. Furthermore, on July 10, 2018, Officer (b)(6); (b)(7)(C) logged security rounds at 9:13 p.m., 9:39 p.m., and 10:04 p.m. Video surveillance footage showed Officer (b)(6); (b)(7)(C) signed documents on the clipboard next to the detainee's cell but did not look in the cell to personally observe DE LA ROSA.

ERAU noted three additional violations of facility-specific policy and seven areas of concern, which are further discussed in the attached report. If you have any questions, please contact me or have a member of your staff contact Acting Unit Chief (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) at (202) 732 (b)(6); (b)(7)(C)

Attachment

cc: Matthew Albence
Tae Johnson
Stewart Smith

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

⁷ The ICE detention standards do not address suspension of the balance of a disciplinary segregation sanction outside the status review process.

Official Report



Division of Forensic Sciences
Georgia Bureau of Investigation
State of Georgia

Headquarters

DOFS Case #: 2018-1017193

Report Date: 10/02/2018

Kathryn P. Lee
Deputy Director

* NAME Accredited *



Requested Service: Autopsy

Agency: Stewart Co. Coroner

Agency Ref#:

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

Case Individuals:

Victim: Efran Romero De La Rosa

Evidence:

2018-1017193-001

DECEDENT

Results and Conclusions:

Evidence Submission: 001

A complete examination was performed on the body of Efran Rosa at the Georgia Bureau of Investigation, Division of Forensic Sciences, in Decatur, Georgia on the 12th day of July 2018 commencing at 0800 hours pursuant to the Georgia Death Investigation Act. The autopsy was performed by (b)(6); (b)(7)(C)

EXTERNAL EXAMINATION:

The body was received in the supine position in a black plastic disaster bag. An identification tag bearing the decedent identifier "Dela-Rosa-Efrain Romero" was attached to the zipper. A white identification band was around the left wrist. A yellow identification tag was attached to the right first toe.

The body was that of an unembalmed, well-developed, well-nourished White Hispanic male who weighed 144 pounds, was 5'6" in height, and appeared compatible with the reported age of 40 years. The body had been refrigerated and was cool to touch. Rigor mortis was present, equal, and broken with difficulty within the extremities. Lividity was present and fixed on the posterior aspects of the body, except in areas exposed to pressure. Injuries to the body will be described below, see "Evidence of Injury."

The body was received clad in:

1. A red short-sleeved shirt
2. White underwear
3. Red pants

Personal effects received with the body included: two white towels and a peach sheet. The clothing was incinerated and personal effects were appropriately disposed.

Evidence of medical therapy:

1. An endotracheal tube was emanating from the oral cavity and was secured by a strap device. Copious amounts of gastric contents were present within the tube.
2. A defibrillator pad was on the upper right side of the chest.
3. An intravascular line was in the radial aspect of the right wrist and was secured with blue adhesive gauze.
4. A needle puncture site was in the left antecubital fossa and was covered with blue adhesive gauze.
5. An intraosseous line was in the left anterior proximal leg.

The head was normocephalic and the face was morphologically unremarkable. The facial bones and mandible were free of palpable fracture. The scalp hair was black, curly, and worn

at a short length (< 2"). The facial hair consisted of a medium length beard and moustache (~1-1/2"). The corneae were clear. The irides were brown. The conjunctivae were tan with no petechial hemorrhages. The sclerae were white. The nasal skeleton was palpably intact. The nose was normally formed and without injury. The earlobes were normally formed and unremarkable. The external auditory canals, external nares, and oral cavity were free of foreign material and abnormal secretions. The lips, teeth, tongue, gums, and buccal mucosa showed no evidence of injury. The teeth were natural and in a good to fair state of repair with the two maxillary central incisors having previously placed yellow metal dental restorations. The external meati, pinnae and mastoid regions were unremarkable. The trachea was within the midline of the atraumatic neck. The neck was neither crepitant nor excessively mobile.

The chest was normally formed, symmetrical and palpably unremarkable. A 1-1/8 x 1" hypopigmented patch was on the anterior aspect of the right shoulder. There was no increase in the anterior-posterior diameter of the chest. The abdomen was flat and soft to palpation. The external genitalia were those of a normal adult uncircumcised male; the testes were bilaterally descended within the scrotal sac. The anus was unremarkable. The posterior torso was normally formed and palpably unremarkable.

The extremities were symmetrical, well-developed, and appropriately hair bearing. The appendicular skeleton was stable to palpation and manipulation. All digits were present. The fingernails were long, soiled, and intact. There was no peripheral edema. Tattoos were not noted. Needle tracks were not observed.

EVIDENCE OF INJURY:

I. Hanging

An 11-3/4" near-circumferential, brown, continuous, ligature furrow was on the skin of the neck. The ligature furrow crossed the superior third of the thyroid cartilage, 11" below the top of the head and then extended superiorly on both sides of the neck, passing 2" below the right ear external auditory meatus, and 3-1/2" below the left ear external auditory meatus. The highest point of the furrow, where the knot was located, was on the upper right side of the back of the neck, located 6-1/2" below the top of the head, and 5-1/2" to the right of the posterior midline. The width of the furrow ranged from 3/16" on the left side to 1/4" on the remaining aspects. The depth of the furrow was up to 1/16". There was a 1-1/2 x 3/4" abraded, dried area on the anterior aspect of the neck, just left of the anterior midline of the neck. The anterior neck dissection showed a 2" area of hemorrhage at the medial aspect of the left mid-sternocleidomastoid muscle and a 1-1/2" area of hemorrhage the lateral aspect of the left mid-sternocleidomastoid muscle.

II. Additional Injuries

A 3/4" x 1/2" crusted wound with erythematous borders was on the anterior aspect of the left proximal arm. A 3/4 x 1/2" red contusion was adjacent to the right elbow. On internal examination, there was a fracture of the sternum at the costochondral junction of the left fourth rib with mild associated soft tissue hemorrhage.

INTERNAL EXAMINATION:

The injuries, having been described above, will not be described below.

BODY CAVITIES:

The body was opened by the usual thoraco-abdominal incision and the chest plate was removed. The subcutaneous fat and musculature were free of injury. No adhesions or abnormal collections of fluid were present in any of the body cavities. In-situ examination of the organs shows normal organ morphology and normal anatomical position. The lungs were expanded bilaterally. The diaphragms were intact. The organs were removed using the Virchow technique. There was no internal evidence of blunt force or penetrating injury to the thoraco-abdominal region.

HEAD AND CENTRAL NERVOUS SYSTEM:

The scalp was reflected and was free of hemorrhage. The calvarium of the skull was removed. The dura mater and falx cerebri were intact and free of discoloration and thickening. There was no epidural, subdural, or subarachnoid hemorrhage present. The leptomeninges were thin and delicate. The cerebral hemispheres were symmetrical. The structures at the base of the brain, including cranial nerves and blood vessels were intact. There was no significant atherosclerosis of the Circle of Willis. Coronal sections through the cerebral hemispheres revealed a normal distribution and development of gyri and sulci. The cortices were tan, uniform, and free of contusion or discoloration. The white matter was homogeneous and symmetric. The deep nuclei were tan, uniform, and symmetric. Transverse sections through the brain stem and sagittal sections through the cerebellum demonstrated the appropriate distribution of gray and white matter. The substantia nigra was normally pigmented. The ventricular system was normally formed and the cerebrospinal fluid was clear. The brain weighed 1340 grams.

NECK:

See "Evidence of Injury."

Examination of the soft tissues of the neck, including strap muscles, thyroid gland and large vessels, revealed no atraumatic abnormalities. The hyoid bone and larynx were intact. The epiglottis was unremarkable. No foreign objects were in the airway.

CARDIOVASCULAR SYSTEM:

The pericardial surfaces were smooth, glistening and unremarkable; the pericardial sac was free of significant fluid or adhesions. The coronary arteries arose normally, followed the usual right dominant distribution and were widely patent, without evidence of significant atherosclerosis or thrombosis. The chambers and valves exhibited the usual size-position relationship and were unremarkable. The epicardium, valve leaflets, chordae tendinae, and endocardium were normally formed. The myocardium was red-brown, firm and unremarkable; the atrial and ventricular septa were intact. The left ventricular free wall thickness was 1.5 cm; the ventricular septum thickness was 1.6 cm; the right ventricular free wall thickness was 0.6 cm. The aorta and its major branches arose normally, followed the usual course and were palpably unremarkable. There was no lipid streaking, tortuosity, widening, or aneurysm of the aorta. The vena cava and its major tributaries returned to the heart in the usual distribution and were palpably unremarkable. The heart weighed 300 grams.

RESPIRATORY SYSTEM:

The upper airway was clear of debris and foreign material; the mucosal surfaces were smooth, yellow-tan and unremarkable. The pleural surfaces were smooth, glistening and unremarkable bilaterally. The pulmonary parenchyma was pink, exuding minimal amounts of bloody fluid; no focal lesions were noted. The pulmonary arteries were normally developed, patent and without thrombus or embolus. The right lung weighed 520 grams; the left 480 grams.

LIVER & BILIARY SYSTEM:

The liver had a smooth, glistening and intact capsule, covering dark red-brown, moderately congested parenchyma with no focal lesions noted. The gallbladder contained < 10 mL of green-brown, mucoid bile; the mucosa was velvety and unremarkable. The extrahepatic biliary tree was patent, without evidence of calculi. The liver weighed 1280 grams.

ALIMENTARY TRACT:

The tongue exhibited no evidence of recent injury. The esophagus was lined by gray-white, smooth mucosa. The gastric mucosa was arranged in the usual rugal folds and the lumen contained 400 mL of thick tan digestate; no tablets, capsules or pill fragments were identified. The small and large bowel serosae were unremarkable. The pancreas had a normal yellow-tan lobulated appearance without calcification and the ducts were clear. The appendix was in the right lower abdominal quadrant.

GENITOURINARY SYSTEM:

The renal capsules were smooth and thin, semi-transparent and stripped with ease from the underlying smooth, red-brown cortical surfaces. The cortices were slightly congested and sharply delineated from the red-purple unremarkable medullary pyramids. The calyces, pelves

and ureters were unremarkable. The urinary bladder contained < 20 mL of cloudy yellow urine; the mucosa was gray-tan and unremarkable. The testes and seminal vesicles were without note. The prostate gland was unremarkable. The right kidney weighed 120 grams; the left 140 grams.

RETICULOENDOTHELIAL SYSTEM:

The spleen had a smooth, intact capsule covering red-purple, moderately firm parenchyma; the lymphoid follicles were unremarkable. The regional lymph nodes appeared normal. The spleen weighed 100 grams.

ENDOCRINE SYSTEM:

The thyroid gland was unremarkable. The adrenal glands were unremarkable.

MUSCULOSKELETAL SYSTEM:

Muscle development was normal. No palpable bone or joint abnormalities were noted.

OTHER PROCEDURES:

1. Documentary photographs were obtained.
2. The organs were returned to the body.
3. Specimens for toxicological analysis: femoral blood and vitreous fluid
4. Serology: one blood-stain card
5. Small portions of the major organs were retained.
6. Evidence: postmortem fingerprints
7. Materials reviewed: investigative report, incident report #2018-2505-087-1

PATHOLOGIC DIAGNOSES

- I. Hanging
 - A. Suspended from top bunk
 - B. Independent cell
 - C. Near-circumferential ligature
- II. Postmortem Toxicology
 - A. Haloperidol: lower than the lowest calibrator of 50 mcg/L
 - B. Ethyl alcohol: negative

OPINION:

This 40 year old, White male, Efran Rosa, died of Hanging. As per investigation, he was seen hanging in his solitary cell from the top bunk bed by two socks during rounds. No note was present. Based on information available at this time the manner of death is certified as suicide.

CAUSE OF DEATH:

Hanging

MANNER OF DEATH:

Suicide

Only those items discussed in the results above were analyzed for this report. The above represents the interpretations/opinions of the undersigned analyst. Evidence analyzed in this report will be returned to the submitting agency. Biological evidence (body fluids and tissues) will be destroyed after one year. This report may not be reproduced except in full without written permission of the laboratory.

Technical notes and data supporting the conclusions and findings in this report are maintained within the laboratory case records.

This case may contain evidence that must be preserved in accordance with O.C.G.A. § 17-5-56.

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

Associate Medical Examiner

404 (b)(6)

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

bi.ga.gov

Related Agencies:

DOC-Criminal Investigations Division
Southwestern Judicial Circuit
GBI-Medical Examiner-HQ DOFS
Stewart Co. District Attorney
GBI-Reg. 03-Americus

ACN: GRANDHI

ACN: 0300080119

End of Official Report

DETAINEE DEATH REVIEW: Efrain DE LA ROSA, A209910301
Healthcare and Security Compliance Analysis
Stewart Detention Center
Lumpkin, Georgia

As requested by the ICE Office of Professional Responsibility, External Review and Analysis Unit (ERAU), Creative Corrections participated in a review of the death of detainee Efrain DE LA ROSA while detained at the Stewart Detention Center (SDC). A site visit was conducted August 14 through 16, 2018 by ERAU personnel (b)(6); (b)(7)(C) Section Chief, an (b)(6); (b)(7)(C) ERAU Management and Program Analyst and team leader; and Creative Corrections contract personnel (b)(6); (b)(7)(C) Security Subject Matter Expert, and (b)(6); (b)(7)(C) registered Nurse, Healthcare Subject Matter Expert. Creative Corrections' participation was requested to determine compliance with the 2011 Performance Based National Detention Standards, 2016 revisions, governing healthcare and security operations.

This report was prepared collaboratively by (b)(6); (b)(7)(C) Creative Corrections contract manager. Included is a case synopsis, description of the facility and its medical services, detention summary, a narrative review of events, and conclusions. DE LA ROSA's vital signs documented by healthcare personnel are appended. The information and findings herein are based on analysis of detainee DE LA ROSA's medical record and detention file, tour of the medical area and restricted housing unit, interviews of staff and detainees, analysis of video footage, and review of policies and incident related documentation.

SYNOPSIS

Detainee DE LA ROSA was 40 years old when admitted to SDC on March 13, 2018. He died by suicide on July 10, 2018. He had no known medical conditions but reported a diagnosis of schizophrenia for which he was treated at a mental health facility while serving a Federal Bureau of Prisons sentence. He was received without medications but reported he was previously on several. He was promptly evaluated and determined asymptomatic for active serious mental illness.

Three weeks following his arrival, DE LA ROSA was charged and based on evidence and his admission, found guilty of making inappropriate remarks of a sexual nature to an officer. He spent 15 days in segregation, during which nurses and mental health providers made required rounds. Two days before the detainee was returned to general population, he was offered and refused evaluation for psychiatric medications following statements he hears voice from God. No suicidal ideation was identified during this or earlier segregation rounds.

DE LA ROSA was in general population only six days when returned to segregation for protective custody and parallel assignment to suicide watch ordered by a mental health provider. The detainee said he is the anti-Christ and speaks with God; also, that he would be dead in three days. Medications were offered and refused. Over the course of the next three days, the detainee continued to voice similar delusions and decline medications. He was referred to Columbia Regional Care Center for advanced care and when a bed became available a week later, was transferred.

DE LA ROSA remained at Columbia Regional Care Center for approximately six weeks, during which psychiatric medications were prescribed for treatment of schizophrenia. An antihypertensive medication was ordered as well. Documentation from the hospital indicates he was usually compliant with treatment. The medications were ordered by the SDC Clinical Director upon DE LA ROSA's return to detention, but the evidence indicates he accepted no prescribed doses prior to his suicide approximately a month later.

Asymptomatic of signs of serious mental illness, the detainee was placed in general population upon return to SDC, but one week later was assigned to segregation for again making inappropriate remarks to an officer. Over the course of the next three weeks, nurses made daily rounds and DE LA ROSA was seen by a mental health provider in required weekly intervals. Active symptoms of mental illness were not identified, up to and including on the morning of his suicide.

Shortly after 10:30 p.m. on July 10, 2018, DE LA ROSA was found hanging from socks tied from the top bunk bed in his cell. A medical emergency was called and staff performed cardiopulmonary resuscitation until Emergency Medical Services arrived and transported him to the hospital. He was never resuscitated. Death was pronounced shortly after arrival.

An autopsy report is not available as of the date of this report.

FACILITY DESCRIPTION

The SDC is privately owned and has been operated by CoreCivic, formerly the Corrections Corporation of America (CCA), since 2006. SDC houses only male detainees. On July 10, 2018, the day of DE LA ROSA's death, the detainee population was 1835.

The facility is double fenced with razor wire along the top and in between the fences. Visitors must place personal items on a belt for screening through an X-ray machine, pass through a metal detector and show identification before being admitted to the facility through a secure door. Video surveillance cameras are used throughout the facility to monitor and record events.

HEALTH CARE SERVICES

Healthcare is provided 24 hours a day, seven days a week by ICE Health Services Corp (IHSC) and contractor InGenesis Medical Staffing. InGenesis subcontracts with STG International, Maxim Healthcare Services, Prestige Healthcare, and Akahi Associates.

The staffing plan authorizes 84 positions, eight of which are designated for commissioned officers of the U.S. Public Health Service serving IHSC. They include the Health Services Administrator (HSA) who is a non-practicing midlevel provider; two assistant HSAs, one of whom is a registered nurse (RN) and the other an information technology specialist; one licensed clinical social worker (LCSW), a nurse manager, RN program manager, dentist, and pharmacist. An IHSC General Schedule (GS) for Federal Pay physician serves as Clinical Director, and the IHSC telepsychiatry program is available as needed. Full time contract positions include two staff physicians, eight advanced practice providers¹, 25 RNs, 11 licensed vocational nurses (LVN), one psychiatrist, one psychiatric nurse practitioner, four behavioral health professionals (BHP), a dentist, two dental assistants, contract coordinator, six medical record technicians, two pharmacy technicians, a radiation technician, and two administrative assistants. As-needed positions include one advanced practice provider, two LVNs, and four RNs.

Captain (b)(6); (b)(7)(C) HSA, informed the review team that CoreCivic will be taking over all healthcare services by end of calendar year 2018. IHSC personnel will be reassigned and employment offers may be offered to current contract staff at the discretion of CoreCivic. HSA (b)(6); (b)(7)(C) stated that the current nursing vacancy rate is 60 percent because many nurses have opted to seek other positions offering job security with comparable pay and benefits. He also stated that only two of the total complement of five behavioral health professional positions were filled during DE LA ROSA's detention and both the providers are soon departing. Pending transition to CoreCivic healthcare services, US Public Health Service temporary duty mental health providers provide coverage and IHSC telepsychiatry services remain available.

Credentials of all providers, nurses, and mental health professionals involved in the care of detainee DE LA ROSA were reviewed and confirmed current and primary-source verified. CoreCivic and IHSC training records document all staff involved in the emergency response are currently certified in CPR and AED.

The National Commission on Correctional Healthcare conducted a reaccreditation survey on January 29 and 30, 2018 and set an August 22, 2018 deadline for submitting evidence of corrective action for deficiencies in five essential standards. None of the cited deficiencies were pertinent to DE LA ROSA's care and death.

¹ Advanced practice providers include nurse practitioners and physician assistants.

SDC's clinic was undergoing expansion and renovation at the time of the site visit. Upon completion, there will be four general use examination rooms, a large physician examination room with laboratory, a two-chair dental clinic, an urgent care room, nurses' station, two mental health offices, and a large medication room with an outside window for medication pass. The number of isolation cells will be doubled from two to four, each with anterooms and negative pressure capability. One of two cells designated for suicide watch is padded, and both are equipped with anti-ligature hardware. The clinic has two holding cells which serve as waiting areas. Offices for administrative personnel, a conference room, and the medical records area are located outside the main clinic. IHSC's electronic medical record system, e-Clinical Works (eCW), is currently used at SDC.

DETENTION SUMMARY

Detainee DE LA ROSA was classified high custody due to a lengthy criminal history that included multiple misdemeanor and felony convictions, including escape. His housing history included approximately three weeks in general population, 15 days in segregation for a disciplinary violation, six days in general population following release from segregation, and placement on protective custody and simultaneous suicide watch for ten days pending transfer to an inpatient mental health facility. Upon his return to SDC approximately six weeks later, DE LA ROSA was in general population for five days, then was moved to segregation following another disciplinary incident. Both disciplinary incidents involved inappropriate comments of a sexual nature to female officers. On the day of his suicide, he was serving a disciplinary segregation sanction for the second incident.

DE LA ROSA had no visitors. Phone logs document he made four phone calls during his stay. The first call was placed on March 18, 2018; the last call was placed on June 24, 2018. It is unknown if any of the calls were completed as the longest duration was three minutes.

Detainee DE LA ROSA had limited funds upon his admission to SDC and spent all but 31 cents a week after his arrival. He submitted no grievances and one incident report alleging he was threatened by his cellmate. The report appears to have resulted in his assignment to protective custody simultaneous with placement on suicide watch.

SUMMARY OF EVENTS

Tuesday, March 13, 2018

The Inmate Housing History Report documents DE LA ROSA's date of admission was March 13, 2018, as does the Inmate Information Sheet which specifies the time of admission was 1:07 p.m.

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

pre-screened DE LA ROSA at 10:55 p.m., documenting he arrived at 10:30 p.m. She entered that she is fluent in the detainee's native language in response to the eCW prompt asking whether interpretation was provided. The language used is not documented. DE LA ROSA denied having any current health problems and taking medication. He was described as alert and normal in appearance and behavior. There were no noticeable restrictions or difficulties in movement or breathing, and there were no skin abnormalities.

Note: The discrepancy in the time of admission documented by (b)(6); (b)(7)(C) and on the Inmate Information Sheet cannot be explained by reviewers.

ICE Form 203, Order to Detain, documents that ERO rated DE LA ROSA high custody based on a criminal history that included Carjacking while Armed. An ICE Custody Classification Worksheet² completed by SDC Officer (b)(6); (b)(7)(C) (first name unknown) reflects DE LA ROSA was appropriately rated high custody based on the severity of the charge/conviction associated with the ERO encounter, his single most serious conviction, and multiple prior misdemeanor and felony convictions that included the offense of escape.

Note: The classification rating was not approved by a supervisor until March 29, 2018.

DE LA ROSA signed a form acknowledging he was given facility orientation and that an orientation video would be shown in housing units daily between 8:00 a.m. and noon. He also signed forms acknowledging that he was issued a radio with batteries and a lock.

Wednesday, March 14, 2018

The Detainee Commitment Summary documents DE LA ROSA was booked into SDC at 1:51 a.m. on this date.

Note: Reviewers cannot reconcile the admission time of 1:07 p.m. documented on the Inmate Admission Sheet and booking almost 12 hours later, at 1:51 a.m.

Note: The SDC detention file does not document DE LA ROSA's primary language or English language proficiency. EARM documentation dated February 9, 2018 indicates his primary language was English and that he declined interpretation assistance during the interview with ICE.

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

conducted medical and mental health intake screening at 2:45 a.m. She entered that she speaks Spanish and that interpretation was not provided because she is fluent in the detainee's language. She also noted that the detainee reported he speaks fluent English. She

² The ICE Custody Classification Worksheet is Appendix 2.2.A of the 2011 PBNDS, revised in 2016, Custody Classification System.

documented that medical information accompanied DE LA ROSA to SDC and stamped her name on each of four pages received from the Wake County Detention Facility (WCDF) in Raleigh, NC.

According to the WCDF Medical Summary dated March 13, 2018, DE LA ROSA was not on medications and a purified protein derivative (PPD) skin test for tuberculosis (TB) was read as negative on February 12, 2018. A one page Wake County Sheriff's Office Report of Physical Examination dated February 13, 2018 includes two illegible notations in the Abnormal Findings section. One appears to reference the Mouth and Teeth and an observation regarding two upper incisor teeth. The second abnormal finding notes a scar on the right hand, with no further description. The WCDF Problem List has seven items, all dated February 13, 2018, most of which are not legible. Legible entries include a scar to the dorsal side of the right hand, prior incarceration in the Virginia Department of Corrections, and schizophrenia³.

Note: The WCDF documentation provides no further information on the diagnosis of schizophrenia and any treatment thereof during the month preceding DE LA ROSA's transfer to SDC.

(b)(6); (b)(7)(C) documented DE LA ROSA reported feeling good and denied pain or medical problems. His vital signs were within normal limits except for a mildly elevated blood pressure of 119/80⁴, his height was 62 inches, and his weight was 137 pounds. He admitted to use of alcohol, tobacco products, and drugs. Regarding alcohol, he reported his last use was in December 2017 and replied, "To get drunk" when asked how much he drank. He last used tobacco a month ago, smoking ten to 12 cigarettes. The detainee estimated he snorted \$20 worth of cocaine and smoked \$40 worth of crack cocaine per week; last use two months earlier. He denied alcohol and drug withdrawal symptoms, symptoms of tuberculosis, and dental problems.

In answer to questions related to his mental health history, DE LA ROSA said he was treated for schizophrenia while incarcerated in a federal prison in Virginia. He was released on September 11, 2017 after serving 14 years. The detainee also reported he was treated at the Marion Correctional Treatment Center in Virginia⁵. He said that while incarcerated, he took eight different medications for schizophrenia and stopped using any medication approximately three months before he arrived at SDC because he could not sleep. Asked if he hears voices others cannot hear, he offered that he "hears God talk to him when detained" and that God still talks to him. Asked if

³ Schizophrenia is a chronic mental health disorder that affects how a person thinks, feels, and behaves, often losing touch with reality. It is characterized by possible auditory and visual hallucinations (apparent perception of something not present), delusions (belief that is firmly maintained despite being contradicted by reality), depression, self-harm and harm to others.

⁴ Blood pressure of 119/80 falls within American Heart Association parameters for stage one hypertension.

⁵ Marion Correctional Treatment Center is a behavioral health unit licensed for acute care, outpatient, and residential mental health services. It houses male offenders determined in need of care outside the scope of services available in prisons. Time spent at the Marion treatment center is part of a federal sentence.

he believes someone can control his mind, he said, "Only God." The mental health screening was negative for suicidal or homicidal ideation. He appeared to have normal physical characteristics and emotional attributes. His speech, comprehension, and focus were normal. A scar near the thumb of his left hand was noted; other observations of physical conditions were normal.

(b)(6); (b)(7)(C) documented access to care was explained, informational brochures were provided, and that the detainee was referred to a provider due to the abnormal intake screening. The note also states, "Tuberculosis and [chest X-ray] explained to patient and process completed with appropriate shielding." DE LA ROSA was cleared for custody.

Note: There is no chest X-ray report in the medical record, and if completed, the reason is unclear. WCDF documents TB clearance by way of PPD one month earlier. The information related to a chest X-ray may be pre-populated on the eCW form and not amended by RN Benavidez.

Note: Detainee DE LA ROSA did not sign general consent for treatment during intake screening. As discussed below, there are two consent forms in the medical record. The first, dated March 16, 2018, gave consent for tele-psychiatry services; the second, completed on June 12, 2018 when the detainee returned from psychiatric hospitalization, was a consent for general treatment.

At 4:50 a.m., Officer (b)(6); (b)(7)(C) completed an Assessment Questionnaire Information form, documenting answers of no for 15 victimization and predatory history/risk screening questions. She stated on interview that DE LA ROSA was cooperative and there was nothing unusual about the intake process. A transaction receipt in his detention file reflects the detainee arrived with a \$14.00 check for which he signed a receipt time stamped 4:52 a.m. His personal property consisted of a wallet, cellphone, one pair each of jeans, socks and underwear, two jackets, and a sweater. Detainee DE LA ROSA signed and was issued a receipt for the property items. He was issued facility clothing, hygiene supplies, linens, and the facility handbook and signed a form acknowledging understanding that his mail and non-legal phone calls would be monitored. The detainee also signed a Prison Rape Elimination Act (PREA) pamphlet and PREA Zero Tolerance Policy.

Per the Housing History Report, DE LA ROSA was assigned to general population housing unit 6, pod A, cell 110 at 10:02 a.m.

Thursday, March 15, 2018

Nurse Practitioner (NP) (b)(6); (b)(7)(C) conducted the initial physical assessment at 9:30 a.m. Vital signs associated with the encounter, entered at 7:00 a.m., were within normal limits except for a mildly elevated blood pressure of 113/80⁶. DE LA ROSA denied a history of any chronic medical

⁶ Blood pressure of 113/80 falls within American Heart Association parameters for stage one hypertension.

conditions and dental problems, and general examination findings were normal. NP (b)(6); (b)(7)(C) wrote that DE LA ROSA reported a history of schizophrenia and said he did not remember the names of any past medications. The detainee said he last took medications three months ago and according to (b)(6); (b)(7)(C) note, "he told the doctor in North Carolina outreach program that the medications make him unable to sleep, so they stopped the medication." DE LA ROSA also said he used to hear voices from God and that he was hospitalized for schizophrenia in 2004 and 2010. He said he believed someone can control his mind and that he hears voices others do not hear, but stated the last time he heard voices was in September 2017. He denied suicidal or homicidal ideations. (b)(6); (b)(7)(C) entered no in answer to the question, "Is the patient exhibiting symptoms of a serious mental disorder or symptoms of cognitive impairment?"

The treatment plan for schizophrenia was to refer DE LA ROSA to mental health. He was advised to continue daily activities even if he did not feel like it, engage in regular exercise, and notify an officer or nurse if he starts having thoughts of harming himself or others or hearing voices. Dr. (b)(6); (b)(7)(C) Clinical Director, co-signed (b)(6); (b)(7)(C) s note on March 17, 2018.

Friday, March 16, 2018

(b)(6); (b)(7)(C) US Public Health Service psychologist on temporary duty assignment, conducted a mental health assessment pursuant to (b)(6); (b)(7)(C) referral. (b)(6); (b)(7)(C) did not document the time of the encounter, but signed her note at 5:25 p.m. In her note, she wrote that the session was chaperoned by an officer observing directly from outside a large office window and that the encounter was conducted in English. DE LA ROSA gave an account of his past treatment consistent with what he reported to (b)(6); (b)(7)(C), adding that he had been sent to a "mental health prison." He stated he had friends to talk to for support and that he speaks to God; also, that he planned to call his brother for support while detained. He denied any obstacles in his developmental years and said he completed high school in Mexico. He discussed his use of crack cocaine in 2001 or 2002 for a period of two years on the weekends, and having snorted cocaine more recently in January and February "almost every day." His alcohol intake consisted of five beers every one to two weeks; most recently, one to six months ago. DE LA ROSA reported he was convicted of driving under the influence of alcohol in 2004 and possibly on one other occasion. He said he went to prison in 2004 and to a mental health prison years later.

DE LA ROSA was described as appearing his stated age, being appropriately dressed, and demonstrating good eye contact. He was cooperative with the interview and appeared to be well focused and able to concentrate. He showed no abnormalities of psychomotor activity or body movement, was fully oriented, and appeared aware of his surroundings. His affect⁸, mood, speech, insight, and judgment were normal. He was goal-directed and logical with no evidence of a delusional thought process. Aggressive behavior was not observed, and he appeared to have

(b)(6); (b)(7)(C) as not available for interview during the site visit.

⁸Affect refers to the emotional tone a person expresses, which can be appropriate or inappropriate in relationship to the situation.

adequate anger and impulse control. He denied suicidal or homicidal ideations, gestures, or plan. The mental status exam concluded there were no current symptoms of a serious mental disorder or condition.

DE LA ROSA was given a brochure addressing progressive muscle relaxation, meditation, and positive thinking. He said he would use the techniques when necessary. He said he was future oriented and looked forward to being released and reunited with his family/parents. (b)(6); (b)(7)(C). A (b)(6) wrote that the detainee stated, "God told me I will go speak in the land of Israel, Iraq and Arabia and 'go to Heaven' in the future." She further wrote that while discussing his past diagnosis of schizophrenia, he adamantly denied any current symptomology or command hallucinations, and explicitly denied suicidal or homicidal ideations. DE LA ROSA agreed to notify staff if he had any issues or felt unsafe with himself. He had no complaints regarding his mental status or safety in general population.

In the treatment section of the eCW encounter note, (b)(6); (b)(7)(C) listed treatment **planning and** supportive psychotherapy as interventions. In the Preventive Medicine section, (b)(6); (b)(7)(C) entered yes answers to pre-populated treatment plan elements. The Preventive Medicine section opens with the following explanation, "Due to the unpredictable nature of the immigration process including length of detention stay, the purpose of psychological intervention will be the stabilization of presenting symptoms, acute crisis intervention, and brief supportive/solution-focused psychotherapy." The plan includes multiple elements focusing on wellness, coping and stress management skills, and direction/understanding that staff are to be notified in the event an urgent need arises to access healthcare staff for mental health services. It also states evaluation by psychiatry was scheduled and that follow-up was scheduled in four weeks. DE LA ROSA agreed with the plan and signed consent for tele-psychiatric services.

Note: The medical record includes an initial psychiatry appointment note on April 18, 2018. The note was blank, suggesting the appointment was not conducted. The note was signed by (b)(6); (b)(7)(C) MD on July 19, 2018, nine days following DE LA ROSA's death. As discussed below, the detainee was seen by a prescribing mental health provider, a Psychiatric Mental Health Nurse Practitioner, on April 24, 2018.

Sunday, March 18, 2018

The Telnate daily telephone call report documents detainee DE LA ROSA attempted a telephone call at 9:34 p.m. The call lasted one minute.

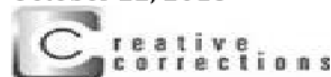
Tuesday, March 20, 2018

The Commissary Summary documents the detainee purchased two 20 ounce bottles of Coke and 25 Chili Ramen noodles. The purchase price was \$13.69 with tax leaving an account balance of \$0.31.

Tuesday, April 3, 2018

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Per written report of Officer (b)(6); (b)(7)(C), at 5:45 p.m. she reported to the case counselor and unit manager that detainee DE LA ROSA stared at her in the housing unit for the entire eight hour shift. He told her that God told him they belonged together and she would get fired soon so they could go to Mexico. He was removed from the pod and told by Unit Manager (b)(6); (b)(7)(C) to stop making these comments to staff. However, when he returned to the pod he told Officer (b)(6); (b)(7)(C) he loved her and did not care that she had told on him. Because DE LA ROSA ignored Unit Manager (b)(6); (b)(7)(C) warning (b)(6); (b)(7)(C) wrote an Incident of Prohibited Acts and Notice of Charges for Making Sexual Proposals or Threats (b)(6); (b)(7)(C) charges were supported by an Incident Statement written by Officer (b)(6); (b)(7)(C) who wrote that detainee DE LA ROSA told her that he had been told by God to tell her that she was going to be his girlfriend and he loved her.

During separate interviews, Officer (b)(6); (b)(7)(C) and Unit Manager (b)(6); (b)(7)(C) were asked for recollections about this incident and about detainee DE LA ROSA in general. Officer (b)(6); (b)(7)(C) recalled that he talked to other detainees and attended meals but he “didn’t like to shower.” She stated that detainee DE LA ROSA paced around the entire shift and frequently went to the faucet by the officer’s station. He constantly stared at her and when she looked at him, he looked away. She said another detainee approached her and commented that detainee DE LA ROSA stared at her for her entire shift and told her she needed to “write him up.” She then spoke with the unit counselor and unit manager. Unit Manager (b)(6); (b)(7)(C) stated that (b)(7)(E) came to her and reported that detainee DE LA ROSA had been inappropriate. She confirmed she spoke to him outside the unit and told him he cannot speak to officers that way and needed to stop. She stated he said OK but “went right back and did it again.” She instructed the officer to write a report and reviewed it for accuracy. Shift Supervisor (b)(6); (b)(7)(C) (first name unknown) ordered DE LA ROSA’s placement in disciplinary segregation for a disciplinary infraction. The placement order was documented on a Confinement Record, a CoreCivic form used for assigning detainees to segregation, administrative review within 72 hours, and release from the status.

Note: The detainee had yet to be found guilty of the rule violation; therefore, assignment he should have been assigned to administrative segregation pending disciplinary hearing. Inexplicably, a copy of the Confinement Record form reflecting release from segregation on April 20, 2018 (see below) shows initial assignment to administrative rather than disciplinary segregation as appears on the original order.

(b)(6); (b)(7)(C) assessed DE LA ROSA for segregation clearance at 8:20 p.m. Associated vital signs, entered at 7:26 p.m., were within normal limits except for a mildly elevated blood pressure of 128/89⁹. DE LA ROSA denied current thoughts of suicide and had no medical complaints. He denied suicidal and homicidal ideation and visual and auditory hallucinations. His speech was spontaneous and he answered questions appropriately. He was well developed, well-nourished, in

⁹ A blood pressure of 128/89 falls within American Heart Association parameters for stage one hypertension.

no acute distress, and appeared to be within normal limits of behavior, affect, and cognitive functioning. He did not appear to have any acute or unresolved medical conditions which might worsen in segregation, and no active psychosis, mania, suicidal ideations, or homicidal ideations. He was educated on how to access medical, mental health, and dental care while in segregation. (b)(6); (b)(7)(C) entry also documents, "A telephone encounter sent to mental health. Detainee has previous mental health encounter with diagnosis of schizophrenia in [eCW]. Detainee is on no medications." DE LA ROSA was cleared for housing in segregation.

Note: The referenced telephone encounter was timed 10:15 p.m. As detailed below, DE LA ROSA was seen by mental health staff the next day, April 4, 2018.

According to a Confinement Activity Record (see discussion of the purpose of the form, below), the detainee was placed in Restricted Housing Unit (RHU)¹⁰, cell 205, at 8:29 p.m. A written notation on the Incident of Prohibited Acts and Notice of Charges form documents a copy was provided to detainee DE LA ROSA at 10:48 a.m. on April 4, 2018.

As detailed below, detainee DE LA ROSA's assignment to segregation for this incident continued until April 19, 2018. He returned to segregation for a second disciplinary incident on June 19, 2018, remaining on segregation status until his suicide on July 10, 2018. The following information is offered to provide a foundation for the reader's understanding of expectations with respect to healthcare and security personnel rounds for detainees in segregation for non-medical or mental health reasons.

- Per SDC RHU Post Orders and the ICE Special Management Units detention standard, officers are to make and document rounds at least every 30 minutes on an irregular schedule. The SDC Post Order further specifies that officers are to look in cells during rounds to observe detainees and confirm their welfare. SDC does not have an electronic system for recording rounds; instead, officers manually record the time of their rounds on a Confinement Watch Log posted on a clipboard outside each cell. Each entry is signed. Also on the clipboard is a Confinement Activity Record on which meals, recreation, visits, and other activities are documented. Although the names are very similar, the Confinement Activity Record and Confinement Record used to order placement and release from segregation are different forms.
- IHSC Directive 03-06, Health Evaluation of Detainees in Special Management Units (SMU), requires daily face-to-face rounds by RNs or medical providers. Rounds are to include querying detainees regarding medical, dental, and behavioral health concerns or requests, with particular consideration given to possible suicidal ideations. Rounds are to be documented in the medical record in SOAP (Subjective-Objective-Assessment-Plan) format and summarize the patient's disposition, to include whether the patient is stable.

¹⁰ SDC's RHU is a special management unit as defined in the ICE detention standards.

The directive also requires documentation of rounds in the SMU Log Book. At SDC, RNs record the time of their round, with signature, on the Confinement Watch Log and sign the Confinement Activity Record. The Confinement Watch Log also has a "Medications Dispensed" section nurses are to sign documenting morning, noon, and/or evening delivery of medication, when applicable.

- Per the same IHSC directive, behavioral health or medical providers are to conduct weekly face-to-face visits with detainees in the SMU to assess behavioral health needs. The visits are to be documented in the medical record and in the SMU log. Assessment of detainees with active psychiatric symptoms are to be conducted on a daily basis.

Officers' entries to the DE LA ROSA's Confinement Watch Logs and Confinement Activity Records are addressed in the below narrative describing DE LA ROSA's first segregation period on an exception basis; i.e., refusals to participate in offered activities and missing entries. Entries for his stay on suicide watch and second segregation period are provided in total. Rounds by healthcare staff are described based on medical record entries.

Wednesday, April 4, 2018

(b)(6); (b)(7)(C) (first name unknown) documented in a written report that he conducted an investigation into the disciplinary charges filed the day before. He wrote that the detainee admitted he told (b)(6); (b)(7)(C) that he loved her and wanted her to go to Mexico with him. Sergeant Haynes wrote, "Detainee was smiling and said he didn't do anything wrong. He do love her [sic]." The sergeant advised DE LA ROSA of his rights and referred the charges to the Institution Disciplinary Panel (IDP). The detainee acknowledged in writing that he was notified of his rights. The report documents the investigation was started at 10:43 a.m. and concluded at 10:52 a.m.

The initial segregation nursing round was conducted at 11:27 a.m. by RN (b)(6); (b)(7)(C) RN (b)(6); entered answers of no to pre-populated questions on the form related to thoughts of suicide, medical complaints or requests, and referral for health care services. In the Examination section, the following template language appears: "Detainee has spontaneous speech and answers questions appropriately, in no acute distress, well developed, well nourished. Detainee appears to be within normal limits of behavior, affect, and cognitive functioning. Detainee does not appear to have any acute or unresolved medical conditions that may worsen in segregation. Detainee does not appear to have active psychosis, mania, suicidal ideations, or homicidal ideations." RN (b)(6); (b)(7)(C) electronically signed the note five days later, at 8:23 a.m. on April 9, 2018.

Note: The eCW template language is not in SOAP note format, and (b)(6); (b)(7)(C) did not add subjective findings reflecting individualized assessment of detainee DE LA ROSA. RNs who conducted subsequent segregation nursing rounds used the same template language with no supplemental information reflecting individualized assessment.

Note: (b)(6); (b)(7)(C) was not interviewed regarding the delay in signing his note. During interview of (b)(6); (b)(7)(C) she said nurses hand write their notes during rounds and enter them in eCW following return to the clinic. She said that although nurses are expected to make all entries prior to the end of their shift, occasionally, some are missed.

The medical record documents LCSW (b)(6); (b)(7)(C) conducted a clinical segregation assessment this date, presumably pursuant to (b)(6); (b)(7)(C) referral. LCSW (b)(6); (b)(7)(C) did not note the time of the encounter but electronically signed her note at 3:17 p.m. In the data checklist section of the eCW form, she entered DE LA ROSA's diagnosis of schizophrenia, that he did not meet serious mental illness (SMI) criteria, had no active symptoms, and that he was receiving mental health treatment by way of talk therapy¹¹. He denied thoughts of suicide and was described as well groomed, happy, pleasant, and cooperative. His affect was appropriate, his judgment insightful, and his thought process was logical and presented in an organized fashion. He did not exhibit paranoid thought content, and there was no evidence of current suicidal or homicidal potential. He stated he was fine and adjusting well to being in segregation. He presented as psychiatrically stable and able to remain in segregation. Mental health providers were to follow up on a weekly basis, and the detainee was instructed to request mental health services if he had any issues. Staff were to continue to monitor and report any changes to mental health or a medical provider. He was reminded of the process for obtaining additional services should the need arise. LCSW (b)(6); (b)(7)(C) note was co-signed 15 days later, April 19, 2018, by LCD (b)(6); (b)(7)(C) LCSW, IHSC Eastern Regional Mental Health. She concurred that DE LA ROSA did not meet SMI criteria and the restricted housing assignment was adequate to address his mental health needs. She recommended continuity of care needs as medically indicated to address coordination of chronic care management.

As referenced above, the programmed data checklist on the eCW clinical segregation assessment form includes a question asking if the detainee meets SMI criteria. IHSC Directive 07-05, Serious Mental Disorders or Conditions, states, "SMI determination is based on significant psychiatric impairment of the detainee. The detainee must meet **one or more** of the following criteria based on the evaluation completed by the mental health care provider:

- a. "One or more active psychiatric symptoms: disorganization of thought or behavior, active hallucinations or delusions, catatonia¹², severe depressive symptoms, suicidal ideation, homicidal ideation, severe exacerbation of manic¹³ symptoms and marked anxiety and impulsivity;

¹¹ Talk therapy, also referred to as psychotherapy involves an encounter by a mental health professional to help patients cope with their feelings, problem solve, and change behavior patterns which might contribute to their symptoms.

¹² Catatonia refers to abnormality of movement and behavior arising from a disturbed mental health state.

¹³ Manic episodes refers to a mood swings involving extreme elation.

- b. History of more than two psychiatric hospitalization in the past three months and still presenting moderate to severe symptoms;
- c. Presently taking psychiatric medications and still presenting active moderate to severe symptoms;
- d. Continues to display harm to self or others in spite of psychiatric treatment and/or psychiatric hospitalizations; and,
- e. Serious limitations in mental functioning (communicating, taking care of activities of daily living, social skill, etc.) due to mental disability or severe medical conditions impairing mental function i.e. dementia or traumatic brain injury.”

The directive requires that upon identification of a detainee as having significant psychiatric impairment based on SMI criteria, the behavioral health provider (BHP) must immediately notify the HSA and enter specified information in a spreadsheet submitted to IHSC headquarters on a weekly basis. As noted, LCSW (b)(6); (b)(7)(C) determined DE LA ROSA did not meet SMI criteria during her assessment.

Note: During the course of the detention period, there were two encounters in which a provider determined SMI criteria was met; however, the detainee was not exhibiting active psychiatric symptoms so no action was taken (see June 20, 2018 and July 10, 2018). In all other mental health encounters in which SMI was specifically addressed, providers found the criteria were not met.

No Confinement Watch Log was produced for this date. The Confinement Activity Record documents DE LA ROSA refused a shower. Entries were made for all three meals; however, the documented times breakfast and lunch were served appear incorrect. The log documents breakfast was served at 06:54 a.m. and lunch two minutes earlier at 06:52 a.m.

Thursday, April 5, 2018

(b)(6); (b)(7)(C) completed a segregation round at 10:21 a.m. His medical record entry consisted of the template language quoted above.

Detainee DE LA ROSA was provided with notice the IDP hearing would be held the following day at noon.

The Confinement Activity Record documents the detainee received breakfast and dinner and refused recreation. There was no entry for the lunch meal.

Friday, April 6, 2018

R (b)(6); (b)(7)(C) documented completion of a segregation round at 9:26 a.m. using template language.

Per report of the IDP, a hearing was held at 12:42 p.m., more than 48 hours after the conclusion of the investigation. The signature of the hearing officer is illegible. DE LA ROSA waived his right to a staff representative and declined to call any witnesses. He stated that he told the officer he loves her and they will go to Mexico together. He added that she loves him too and "God put her here to use her. It was the will of God." The detainee was found guilty of the charge based on the officer's incident report and the detainee's admission and received a sanction of 30 days disciplinary segregation. The sanction was approved by a supervisor (signature illegible) on the same date. The detainee was provided with a copy of the report on April 9, 2018 by Assistant Shift Supervisor (b)(6); (b)(7)(C) (first name unknown). A Disciplinary Segregation Order form was also completed.

The Confinement Activity Record documents that the detainee received breakfast and dinner. There was no entry for the lunch meal.

Saturday, April 7 to Tuesday, April 10, 2018

(b)(6); (b)(7)(C) and English documented daily segregation rounds using template language in their medical record entries.

The Confinement Activity Record for the period documents DE LA ROSA refused recreation on April 8, 2018 and a shower on April 9, 2018.

A special reclassification review was completed by (b)(6); (b)(7)(C) (first name unknown) on April 10, 2018 using the ICE Custody Classification Sheet. Two additional points were added for the disciplinary infraction, and the classification of high was continued. A supervisor (signature illegible) approved the classification on April 11, 2018.

Wednesday, April 11, 2018

Lieutenant (b)(6); (b)(7)(C) LCSW, conducted the weekly mental health segregation round, noting no deterioration in DE LA ROSA's condition while in segregation. She did not note the time of the encounter but signed her medical record entry at 11:36 a.m. In the Data Checklist, LCSW (b)(6); (b)(7)(C) noted DE LA ROSA did not meet SMI criteria. She wrote that DE LA ROSA was lying in bed when approached and indicated he did not have any issues at that time. He presented in a calm manner and there were no signs of ineffective coping or acute emotional distress. He was friendly, cooperative and appropriate in speech, and no suicidal or homicidal potential was observed. LCSW (b)(6); (b)(7)(C) note was co-signed by LCDR (b)(6); (b)(7)(C) eight days later, April 19, 2018. She concurred that the patient does not meet current SMI criteria.

Note: Asked where segregation mental health assessments are conducted, LCSW (b)(6); (b)(7)(C) stated during interview that they are sometimes conducted through the cell door rather than in an area which more reliably assures patient confidentiality. She stated she believes that during rounds conducted at the cell, DE LA ROSA spoke as openly as he would have in an office.

The daily nursing segregation round was conducted by (b)(6); (b)(7)(C) at 9:41 a.m. Template language was used in the medical record entry.

Per the Confinement Activity Record, DE LA ROSA refused both recreation and a shower.

Thursday, April 12 to Sunday, April 15, 2018

(b)(6); (b)(7)(C) conducted daily segregation rounds using template language.

The Confinement Activity Record documents DE LA ROSA refused recreation on April 12, 13, and 14, 2018. Recreation was not offered on April 15, 2018 due to rain.

Note: A seven day review of the detainee's status in disciplinary segregation was due on April 13, 2018. No record of the review was present in the detention file.

Monday, April 16, 2018

(b)(6); (b)(7)(C) documented completion of a segregation round at 11:00 using template language. She did not specify a.m. or p.m.; however, the Confinement Watch Log entry reflects the round was conducted at 11:00 a.m.

In a late entry signed April 17, 2018, LCSW (b)(6); (b)(7)(C) documented completion of a mental health follow up encounter this date. She did not specify the time. She wrote DE LA ROSA reported that he was in segregation "because I told my girl I can't wait for us to be together", referring to a female officer. When asked if he understood the inappropriateness of this behavior, he responded, "Well it was true." Asked about auditory or visual hallucinations, he stated, "I only hear the voice of God." He denied any content that was commanding, threatening, or stressful in nature. He refused when asked if he was willing to be evaluated for medication. He denied any increase in mental health symptoms resulting from segregation, stating, "I don't worry about nothing. I'm in the hands of God" and reported that he hears from God every day. He stated he began to hear the voices while in prison in 2005, and that the voices give him peace because they are there with him. He denied thoughts of self-harm. LCSW (b)(6); (b)(7)(C) determined he was not a danger to himself or others.

Note: LCSW (b)(6); (b)(7)(C) did not use the eCW Clinical Segregation Assessment form; therefore, she did not complete the data checklist that expressly addresses whether the detainee meets SMI criteria. However, her note suggests the criteria were not met.

(b)(6); (b)(7)(C) documented confirmatory sign-off of LCSW (b)(6); (b)(7)(C) note on April 25, 2018, without comment.

A refusal form documents detainee DE LA ROSA refused evaluation for medication because he denied mental health symptoms, including auditory and visual hallucinations, depression, anxiety, thoughts of self-harm, and said that he did not need any medicine. The form was signed by DE LA ROSA and LCSW (b)(6); (b)(7)(C) witnessed by LCSW (b)(6); (b)(7)(C) 12:00 p.m. His signature certified his understanding of possible or probable consequences of his refusal, to include auditory hallucinations or other symptoms which could worsen, causing stress, impairment in functioning, and thoughts of self-harm.

The Confinement Activity Record for this date notes DE LA ROSA refused recreation.

Tuesday, April 17, 2018

(b)(6); (b)(7)(C) conducted a daily segregation round at 9:23 a.m. using template language.

The Confinement Watch Log was not produced for this date.

Wednesday, April 18, 2018

(b)(6); (b)(7)(C) conducted a nursing segregation round at 9:00 a.m. using template language.

(b)(6); (b)(7)(C) conducted a mental health segregation round and completed the Clinical Segregation Data Checklist. She noted DE LA ROSA was lying in bed when approached and indicated he had no issues at that time. He presented in a calm manner and did not present any signs of ineffective coping or acute emotional distress at the time of the encounter. He did not meet SMI criteria, and there was no change in the assessment or treatment plan. LCSW (b)(6); (b)(7)(C) did not note the time of the encounter but signed her note at 10:58 a.m. No confirmatory sign off by another provider was entered on the note.

The Confinement Record form documents “Release to General Population on 4-18-2018.” The form was signed by Security Chief (b)(6); (b)(7)(C) two days later, April 20, 2018 at 5:53 p.m.

Note: According to the Special Management Units standard, early release may be recommended if the supervisor conducting a status review determines “time in disciplinary segregation is no longer necessary to regulate the detainee’s behavior.” A recommendation for early release must be approved by the facility administrator before the detainee is returned to general population. There is no documentation suspension of the balance of DE LA ROSA’s 30-day disciplinary segregation term resulted from a status review, nor is there documentation of the rationale or approval of the decision.

The Housing History Report documents that DE LA ROSA was moved from the RHU to general population housing unit 7B, cell 113 at 6:10 p.m.

Note: A Special Reclassification Assessment was not completed within 24 hours prior to DE LA ROSA’s transfer from the RHU. As discussed above, a reclassification assessment

which factored the disciplinary conviction was conducted on April 10, 2018; however, the Disciplinary System standard states reclassification assessments must be conducted within 24 hours prior to release from segregation.

Note: There is no documentation DE LA ROSA ever showered during the 15 days he was in the RHU. Per policy, detainees are to be offered the opportunity to shower at least three times a week. Refusals were documented on April 4, 9 and 11, 2018; N, for no, was recorded on all other days. Assuming an entry of N signifies a shower was not offered, DE LA ROSA did not have the opportunity to shower three times per week.

Thursday, April 19, 2018

The housing history report documents detainee DE LA ROSA was moved to unit 5B, cell 212 at 12:41 p.m. He remained in this cell until April 24, 2018 when he was placed on suicide watch and protective custody (see below). DE LA ROSA's cellmate from this date through April 23, 2018, (b)(6); (b)(7)(C) was interviewed but stated he did not recall the detainee.

Saturday, April 21, 2018

CCA (CoreCivic) form 5-1c, "Incident Statement", completed in Spanish was present in the detention file. It is unsigned but lists DE LA ROSA's name at the top. Loosely translated using Google Translate, the message states, "I want to move to the hole because my new cellmate told me he was going to kill me." No response to the statement is noted on the form.

Note: Reviewers cannot explain the incident statement. The form includes questions asking, "Did you receive any injuries?" and, "Were you evaluated by medical?", both of which are blank. Also blank is the section, "to be completed by CCA staff if the civilian/other or inmate/resident refused to complete the 5-1c." If the form is made available to detainees for reporting incidents, and assuming DE LA ROSA submitted the incident statement, date and acknowledgement of receipt is not documented, nor is follow up action.

Tuesday, April 24, 2018

Commander (b)(6); (b)(7)(C) Psychiatric Mental Health Nurse Practitioner¹⁴ (PMHNP) on temporary duty assignment, conducted a mental health assessment. He wrote the reason for the encounter was auditory hallucinations, although there is no documentation of a referral by healthcare or security staff. PMHNP (b)(6); (b)(7)(C) did not note the time although vital signs associated with the encounter were time stamped 10:51 a.m. (pulse and respirations) and 1:33 p.m. (blood pressure). Except for a mildly elevated blood pressure of 135/88¹⁵, DE LA ROSA's vital signs were within normal limits. PMHNP (b)(6); (b)(7)(C) wrote that the detainee spoke English fluently but he encouraged use of a Spanish interpreter as this was DE LA ROSA's primary language. The

¹⁴ Psychiatric Mental Health Nurse Practitioners are authorized to prescribe medication.

¹⁵ Blood pressure of 135/88 falls within American Heart Association parameters for stage one hypertension.

detainee declined. PMHNP (b)(6); (b)(7)(C) documented DE LA ROSA presented to the behavioral health clinic wearing red detention attire with appropriate grooming and hygiene. He was calm and cooperative during the interview, and his speech was clear, coherent, and regular in rate, rhythm, and volume. He reported he had been sleeping through the night. He was fully oriented, his mood was good, and his affect was broad with some noted inappropriateness of laughter¹⁶ at times. His thoughts were largely linear and goal-oriented. There were no loose associations¹⁷ or flight of ideas¹⁸. He stated he was filled with the Holy Spirit and could speak with and be answered by God. He stated that he is the “Anti-Christ” and, “I will be dead within three days. I just want to be alone and relax. I do not want to be with the other people in the dormitory. I don’t want anything to happen. I might die three times.” PMHNP (b)(6); (b)(7)(C) did not observe DE LA ROSA responding to internal stimuli and noted his insight and judgment were limited. The detainee denied suicidal and homicidal ideations, plan, or intent and denied low mood or anxiety.

The encounter note documents LCSW (b)(6); (b)(7)(C) as asked to join the interview because she had been following DE LA ROSA to this point. The detainee was noted to be vague in his responses, and repeated that he was the Anti-Christ and would be dead in three days, possibly dying three times. The providers concluded DE LA ROSA was a potential danger to himself and others in the dormitory. PMHNP (b)(6); (b)(7)(C) ordered one-on-one suicide watch/direct observation with all applicable precautions and daily evaluations. The detainee was offered medication to address his psychosis; however, he declined, stating, “I don’t need medications.”

In a separate encounter note, PMHNP (b)(6); (b)(7)(C) completed a suicide risk assessment documented as a late entry and signed three days later. The eCW suicide risk assessment instrument includes risk and protective factors and mental status examination elements. Information and observations documented in PMHNP (b)(6); (b)(7)(C) earlier note were included in the suicide risk assessment, with the conclusion that DE LA ROSA was at “Moderate Acute Risk” and one-to-one suicide watch was indicated. His unwillingness to begin medication treatment was noted.

A Special Needs Form completed by LCSW (b)(6); (b)(7)(C) and approved by PMHNP (b)(6); (b)(7)(C) 1:45 p.m. directed DE LA ROSA’s placement on suicide watch in a safety cell. A safety smock and blanket were to be issued and the detainee was to receive food with no saran wrap and utensils. Handwritten instructions state, “Security will maintain 1:1 visual. No belongings outside of smock/blanket. Finger foods only.”

An untimed memorandum from Unit Manager Minns to Chief of Unit Management Blackmon (first names unknown) documents that detainee DE LA ROSA was placed in administrative

¹⁶ Inappropriate laughter is laughter that is unexpected due to dissociation from the topic or circumstance. For example, if a patient laughs about dying, this would be inappropriate.

¹⁷ Loose associations occur when a patient’s responses are not relative to the questions being posed to him.

¹⁸ Flight of ideas refers to disconnected rambling or a rapid shifting of ideas with only superficial associated connection between them.

segregation pending investigation for protective custody. The detainee signed the memorandum. A Confinement Record documents assignment to the status at 2:37 p.m. and the reason for placement as, "Separation from general population for the purpose of protection from other inmates/residents for reason of personal safety." The form includes the note, "Per Medical Suicide Watch 1:1."

Note: Reference in the memorandum and Confinement Record protective custody and separation from general population for DE LA ROSA's personal safety cannot be unexplained with certainty. If related to the April 21, 2018 incident statement that DE LA ROSA wanted to move because his cellmate said he wanted to kill him, placement on protective custody occurred three days later. If related to an incident or event that occurred this date, possibly precipitating referral for evaluation for auditory hallucinations by PMHNP (b)(6); (b)(7)(C) no documentation exists.

A Record of Search form documents that DE LA ROSA was strip searched at 2:48 p.m. Shift supervisor (b)(6); (b)(7)(C) proved the search, the reason for which was suicide watch.

Note: Justification for the strip search based on specific reasonable suspicion that the detainee may have been concealing contraband was not documented.

The housing history report documents the detainee's assignment to RHU 7A, cell 201 at 10:23 a.m. At 4:45 p.m. he was assigned to cell 112 for suicide watch.

Note: Reviewers cannot explain the times recorded on the housing history report. It is possible cell 201 was designated when it was determined DE LA ROSA's placement on protective custody was called for; then, the cell assignment was changed to 112 when suicide watch was ordered.

HSA (b)(6); (b)(7)(C) explained that the RHU is used for suicide watch when designated cells in the medical housing unit (MHU) are unavailable. He indicated that when demand exceeds supply, the observation cells in the MHU are used for detainees deemed most acutely ill. Because at the time of DE LA ROSA's detention, renovations in the MHU were underway, availability of observation cells was limited. HSA (b)(6); (b)(7)(C) acknowledged that cells in the RHU are not anti-ligature, but stressed that all detainees placed on suicide watch are on constant, one-on-one observation status.

Officers assigned to suicide watch are stationed immediately outside the cell. Every 15 minutes, the officer must record on the Suicide Observation Checklist the activity in which the detainee is engaged, such as sleeping, walking or standing at door. A Confinement Activity Record is also maintained. Per the Significant Self-Harm and Suicide Prevention and Intervention standard and IHSC Operations Memorandum 16-002, Significant Self-Harm and Suicide Prevention and

Intervention, a qualified clinician/health care provider (RN or higher) must check detainees who are potentially or actively suicidal at least once every eight hours. The eCW form used for documenting suicide watch rounds by RNs is not the same used for segregation rounds. It includes vital signs and SOAP elements.

(b)(6); (b)(7)(C) conducted the first suicide watch nursing assessment at 5:45 p.m., entering vital signs time stamped 6:43 p.m. The vital signs were within normal limits except for a slightly elevated blood pressure of 123/78¹⁹. His note documents DE LA ROSA was placed in segregation cell 7A/MHU overflow, and that nursing services were to include rounds and taking vital signs every shift; also, that daily rounds would be conducted by a mental health provider. DE LA ROSA denied pain, was compliant with the nursing assessment, and denied suicidal and homicidal ideations and auditory and visual hallucinations. (b)(6); (b)(7)(C) wrote that he stated, "God the Almighty is the only one I talk to. He hasn't said anything new though." (b)(6); (b)(7)(C) did not sign his note until 2:23 p.m. the next day, April 25, 2018.

Wednesday, April 25, 2018

(b)(6); (b)(7)(C) conducted the second suicide watch nursing assessment, entering in two places that the time of the round was 1:00 a.m. She documented DE LA ROSA was compliant with the nursing assessment and denied suicidal and homicidal ideations. He also denied auditory and visual hallucinations but stated, "God talks to me. We have conversations. He tells me that there are a lot of things that are going to happen to me." He denied pain and except for a mildly elevated blood pressure of 132/87²⁰, his vital signs, time stamped 6:24 a.m., were all within normal limits.

Note: Discrepancies in the manually entered encounter time for this and subsequent nursing encounters and associated vital signs may be explained by delayed entry of information from handwritten notes in eCW. Nurses do not have access to computers during rounds for real-time entry.

The next sequential medical record entry was made by LCSW (b)(6); (b)(7)(C) who wrote in her note that DE LA ROSA was seen for follow up suicide risk assessment. She did not note the time of the encounter, and did not sign her note until 4:14 p.m. the next day. The note documents DE LA ROSA stated he did not want to keep repeating himself as he had already told "the police yesterday what was going to happen"; also, that God was speaking to him and that he had already died, and if he dies again he will be raised from the dead. He stated he did not need any medications because nothing was wrong with him. He smiled during the assessment, even when questioned about death, dying, and plans that God has given to him. He stated he wanted to return to Mexico and "see females." He reported he does not have any children or family because he was incarcerated for 14 years for robbery. He stated that he does not want to be in general population because he does "not want to fight with people." LCSW (b)(6); (b)(7)(C) assessed his level of insight and judgment as poor.

¹⁹American Heart Association standards categorize a blood pressure of 123/78 as elevated.

²⁰ A blood pressure of 132/87 falls within American Heart Association for stage one hypertension.

(b)(6); (b)(7)(C) co-signed her note on April 30, 2018, documenting concurrence with the assessment and plan.

In the next medical record entry, (b)(6); (b)(7)(C) documented she completed a nursing suicide watch assessment at 9:45 a.m. DE LA ROSA was observed walking out of his cell. His mood was calm, and his speech was clear with no thoughts of self-harm voiced on interview. He reported hearing voices the previous night, stating he felt better since he was able to sleep through the night. Vital signs time stamped 3:56 p.m. were within normal limits with the exception of an elevated blood pressure of 147/83²¹. He was described as alert, well-hydrated, and in no acute distress. The general examination showed good eye contact, good judgment and insight, no auditory or visual hallucinations, thought content without suicidal ideation or delusions, and thought process logical and goal directed.

(b)(6); (b)(7)(C) documented a mental health assessment that included vital signs time stamped 10:09 a.m. The vital signs were the same as those taken by (b)(6); (b)(7)(C) including the elevated blood pressure. (b)(6); (b)(7)(C) wrote that DE LA ROSA denied suicidal or homicidal ideation but stated that God was trying to kill him. The general examination was normal; the assessment was "suicidal ideations"; and the treatment plan was to continue to monitor DE LA ROSA in MHU (b)(6); (b)(7)(C) signed her note at 1:16 p.m.

Note: Compliance with the eight-hour timeframe for healthcare rounds cannot be positively determined. As noted, the medical record documents DE LA ROSA was seen by RNs at 1:00 a.m. and 9:45 a.m. He was also seen by (b)(6); (b)(7)(C) sometime before 1:16 p.m., and by (b)(6); (b)(7)(C) at an unknown time.

Thursday, April 26, 2018

(b)(6); (b)(7)(C) documented completion of a suicide watch nursing assessment at 9:50 a.m. The RN noted DE LA ROSA was alert, verbal, in no distress, calm and pleasant, and made eye contact. No complaints, suicidal or homicidal ideations, or visual and auditory hallucinations were voiced. Associated vital signs, time stamped 9:39 a.m., were within normal limits, with the exception of an elevated blood pressure of 137/88²².

Note: The time of the last healthcare contact cannot be determined; however, it appears a nursing round on midnight shift may have been missed.

The next sequential entry in eCW is a mental health assessment documented by (b)(6); (b)(7)(C). She did not note the time of the encounter, but associated vital signs were time stamped 10:43 a.m. The vital signs were the same as those entered by (b)(6); (b)(7)(C). DE LA ROSA denied suicidal or homicidal ideations and stated no one was trying to kill him. The general examination findings

²¹A blood pressure of 147/83 falls with American Heart Association parameters for stage two hypertension.

²²A blood pressure of 137/88 falls within American Heart Association parameters for stage one hypertension.

were normal and the assessment, treatment, and follow-up plans remained unchanged. The note was signed at 2:02 p.m.

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

conducted the next nursing round but did not note the time and did not enter vital signs. She documented a segregation evaluation using template language used for segregation rather than suicide watch rounds. The note was signed on July 19, 2018.

Note: (b)(6); (b)(7)(C) completion of a standard segregation round indicates she was unaware DE LA ROSA was on suicide watch or she failed to perform required duties. The former is questionable because an officer was stationed outside the cell and the detainee was in suicide garb. If (b)(6); (b)(7)(C) did, in fact, speak with DE LA ROSA it would have been evident he was on suicide watch. (b)(6); (b)(7)(C) was no longer employed at SDC at the time of the site visit; therefore, she could not be questioned on the matter. During interview of (b)(6); (b)(7)(C) they stated nurses who conduct rounds in the RHU have a roster identifying detainees on mental health observation and suicide watch status.

The next sequential medical record entry was made by LCSW (b)(6); (b)(7)(C). She did not note the time. In the narrative, she wrote DE LA ROSA stated he did not want to harm himself; however, he still believed that he was going to die three horrible deaths. He said he does not need any medication because he was "perfectly fine." He denied auditory or visual hallucinations. He stated that God talks to him, although he could not share what God told him that day. LCSW (b)(6); (b)(7)(C) wrote that it started to rain during the assessment. DE LA ROSA began smiling and stated, "See that is God." He smiled throughout the session and continually nodded his head. He was adamant that he was going to die, stating that it was no longer in three days; however, he would die three horrible deaths. He also stated that he hears things and does not want to be around others due to what he is hearing. When asked if he was fearful and to whom he was referring when hearing things, he did not elaborate. He denied that what he was hearing was from hallucinatory voices. He stated that he did not want to be housed in general population.

Risk factors in the suicide risk assessment were absent for current thoughts of suicide, but present for feelings of hopelessness, helplessness, fear for his own safety, uncontrolled mental health symptoms, and non-compliance with medication treatment. Mental status examination findings were poor judgment and insight, focus on the concept of death, thoughts of unreality, and perceptual disorders in the form of auditory hallucinations. His affect was inappropriate and his mood was apathetic. Assessment findings were delusional disorder and schizophrenia. He was to remain on suicide watch due to fixations with death, delusions, and hallucinations. The note was signed at 11:00 a.m. on April 27, 2018 and documented as a late entry. There was no confirmatory sign-off by another provider.

(b)(6); (b)(7)(C) conducted a suicide watch nursing assessment at 6:00 p.m. He wrote DE LA ROSA was lying on his bed and woke up when his name was called. The detainee was alert, verbal, and

in no distress. He was calm and pleasant, made eye contact and voiced no complaints. He reportedly was eating his meals. He denied hallucinations and suicidal or homicidal ideations. He denied pain, and the general examination was normal.

Note: Vital signs were not recorded, although the treatment note specifies vital signs were to be obtained every shift.

(b)(6); (b)(7)(C) documented she completed the next nursing assessment at 8:55 p.m., noting DE LA ROSA was cooperative with the examination and engaged in conversation, using good eye contact. (b)(6); (b)(7)(C) wrote that he had been evaluated by mental health and that he would possibly be released to general population the next day. Vital signs time stamped 12:36 a.m. on April 27, 2018 were within normal limits and he denied pain. The general examination was normal.

Note: Based on mental health provider encounter notes, there is no indication DE LA ROSA's return to general population was contemplated.

ICE form I-855, Administrative Segregation Review, was completed and signed. The signature, which appears in the Supervisory Immigration Enforcement Agent or contract equivalent line, is illegible. The reviewing staff person noted the detainee was on medical segregation status and checked YES for the following questions: "Does the reason for initial placement remain valid?" and, "Is the detainee unwilling or unable to live in the general population?" The reviewer also checked the box recommending removal from protective custody status, presumably in error. The Field Office Director signature line and date are blank, although the box "Continue Status" is checked.

Note: The individual who completed the review did not document interview of the detainee as required by the Special Management Units standard. In fact, the ICE form does not include a section for documenting completion of an interview.

The Confinement Activity Record documents DE LA ROSA went to court at 9:45 a.m. and returned at 9:50 a.m. On this date only, monitoring checks every 15 minutes were documented on a Mental Health Observation Checklist form rather than Suicide Observation Checklist form. The reason is unknown although the forms are identical except for the title.

Friday, April 27, 2018

(b)(6); (b)(7)(C) shepherd conducted a suicide watch nursing assessment at 9:30 a.m., entering the same information appearing in R (b)(6); (b)(7)(C) note the day before.

Note: The last healthcare round was conducted by (b)(6); (b)(7)(C) more than 12 hours earlier, at 8:55 p.m. on April 26, 2018. (b)(6); (b)(7)(C) did not record vital signs, and did not sign her note until July 19, 2018.

PMHN (b)(6); (b)(7)(C) conducted a follow-up suicide risk assessment in the clinic, noting a CoreCivic officer was posted at the door. He did not note the time of the encounter. Associated vital signs time stamped 8:51 a.m. were all within normal limits with the exception of a mildly elevated blood pressure of 122/71²³. PMHN (b)(6); (b)(7)(C) documented that on direct questioning, DE LA ROSA denied suicidal ideation, plan, or intent to cause self-harm. However, he continued to express grandiose beliefs that he was the antichrist and would soon die three horrible deaths and be resurrected three times. He was vague in responding to questions about this. He reported he was an instrument of God and would be used to save the world from itself. He reported speaking directly to God and being answered by God. He stated, "I do not fear death. I am in the hands of God." He reported he was previously worried and cried about dying the three horrible deaths but had accepted this as "the way" and was no longer afraid. He was provided education and encouragement to accept treatment, but he continued to refuse, stating, "I don't need medications. Why would I need them? Don't you believe in the Bible?" He was noted to have fixed delusions and had consistently declined care and medication interventions over the past three days while on suicide observation. PMHN (b)(6); (b)(7)(C) determined the detainee continued to be a danger to himself and potentially to others. The case was discussed with LCSW (b)(6); (b)(7)(C) and plans were made to refer him to Columbia Regional Care Center (CRCC) for inpatient hospitalization. PMHNP (b)(6); (b)(7)(C) signed his note at 1:35 p.m. and LCSW (b)(6); (b)(7)(C) documented confirmatory sign-off concurring with the plan on May 2, 2018.

Note: HSA (b)(6); (b)(7)(C) informed the review team that ICE has a contract with CRCC for care of detainees requiring psychiatric services outside the facility's scope. Detainees are transferred once a bed becomes available. Referrals to CRCC do not require processing through the IHSC Medical Payment Authorization Request system.

(b)(6); (b)(7)(C) conducted a nursing assessment, recording vital signs time stamped 12:40 p.m. within normal limits except for an elevated blood pressure of 148/90²⁴. She did not note the time of the encounter. She wrote that DE LA ROSA was standing at the cell door, smiling. He stated, "I had a good night's sleep. God is speaking to me. No bad dreams. I'm okay." (b)(6); (b)(7)(C) noted DE LA ROSA was asymptomatic relative to the elevated blood pressure and that Dr. (b)(6); (b)(7)(C) was made aware. The general examination was normal.

Detainee DE LA ROSA was seen next by (b)(6); (b)(7)(C) the time of the encounter was not documented, although associated vital signs were time stamped 2:39 p.m. The vital signs were the same as those entered by (b)(6); (b)(7)(C), including blood pressure of 148/90. (b)(6); (b)(7)(C) documented normal general examination findings.

²³ American Heart Association standards categorize a blood pressure of 122/71 as elevated.

²⁴ A blood pressure of 148/90 falls with American Heart Association parameters for stage two hypertension.

At 10:30 p.m. (b)(6); (b)(7)(C) conducted a nursing assessment, noting DE LA ROSA was sitting on his bed, alert and fully oriented. His respirations were non-labored, and the general examination was normal. Vital signs time stamped 2:36 a.m. on April 28, 2018 were within normal limits except for a continued elevated blood pressure of 146/86²⁵.

Note: During interview of (b)(6); (b)(7)(C) he stated nurses are expected to follow guidelines in IHSC Directive 03-10, Intake Screening and Intake Reviews, in determining what if any action is to be taken when a detainee's blood pressure is elevated. The directive states, "If the systolic blood pressure is greater than 139 or the diastolic blood pressure is greater than 89, the screener will schedule the resident for a midlevel provider or physician evaluation." The directive further requires provider notification if the systolic blood pressure is greater than 150, or the diastolic blood pressure is greater than 100. (b)(6); (b)(7)(C) did not refer the detainee to a provider, possibly because when seen earlier in the day by (b)(6); (b)(7)(C) DE LA ROSA's blood pressure was slightly higher than when taken during her round and the provider issued no order. (b)(6); (b)(7)(C) may have also recognized that the detainee was being evaluated by a provider on a daily basis and that his blood pressure would be evaluated the next day.

Saturday, April 28, 2018

(b)(6); (b)(7)(C) conducted a nursing assessment at 8:45 a.m. DE LA ROSA denied pain, and his vital signs time stamped 8:23 a.m. were within normal limits, including a mildly elevated blood pressure of 124/80²⁶. The general examination was normal, and he denied suicidal ideations, hallucinations, or delusions.

Note: The last healthcare round was conducted more than ten hours earlier, at 10:30 p.m. on April 27, 2018.

(b)(6); (b)(7)(C) documented a mental health observation assessment, entering the same vital signs taken by (b)(6); (b)(7)(C). The time of the encounter is not noted, although the vital signs were time stamped 8:40 a.m. DE LA ROSA denied suicidal or homicidal ideations. He stated he felt well and had no significant medical complaints. The general examination was normal. Dr. (b)(6); (b)(7)(C) signed his note at 11:46 a.m.

(b)(6); (b)(7)(C) conducted the next nursing assessment at 4:39 p.m. Vital signs time stamped 2:29 p.m. were within normal limits, except for a slightly elevated blood pressure of 124/76²⁷. The general examination was normal.

²⁵ A blood pressure of 146/86 falls within American Heart Association parameters for stage two hypertension.

²⁶ A blood pressure of 124/80 falls within American Heart Association parameters for stage one hypertension.

²⁷ American Heart Association standards categorize a blood pressure of 124/76 as elevated.

Sunday, April 29, 2018

(b)(6); (b)(7)(C) conducted a nursing assessment at 12:50 a.m. Vital signs time stamped 11:13 p.m. on April 28, 2018 were within normal limits, except for a slightly elevated blood pressure of 124/79²⁸. The general examination was normal.

The next sequential entry in the medical record was made by (b)(6); (b)(7)(C). The time of the encounter was not noted, although associated vital signs were time stamped 7:11 a.m. The detainee's blood pressure was mildly elevated at 139/88²⁹; other vital signs were within normal limits. (b)(6); (b)(7)(C) documented DE LA ROSA denied complaints and suicidal or homicidal ideation. The general examination findings were normal.

(b)(6); (b)(7)(C) documented a nursing assessment at 8:15 a.m. entering the same vital signs as those recorded by (b)(6); (b)(7)(C). The vital signs were time stamped 7:05 a.m.

The next nursing assessment was conducted by (b)(6); (b)(7)(C) at 2:29 p.m. DE LA ROSA continued to deny suicidal or homicidal ideations or hallucinations. Vital signs time stamped 2:03 p.m. were within normal limits except for a mildly elevated blood pressure of 125/86³⁰, and the general examination was normal.

The Confinement Activity Record documents the detainee received breakfast and dinner but there was no entry documenting whether he received or refused lunch.

Monday, April 30, 2018

(b)(6); (b)(7)(C) conducted a nursing assessment at 12:30 a.m. Vital signs time stamped 10:18 p.m. on April 29, 2018 included an elevated blood pressure of 145/88³¹; others were within normal limits. He denied pain. The general examination was normal.

Note: The last healthcare round was conducted ten hours earlier.

Note: As discussed, IHSC Directive 03-10 requires scheduling a detainee with systolic blood pressure above 139 for evaluation by a provider. (b)(6); (b)(7)(C) did not document taking this action; however, as noted above, DE LA ROSA was being evaluated by a provider on a daily basis.

The next nursing assessment was made at 8:25 a.m. by (b)(6); (b)(7)(C). DE LA ROSA denied pain, hallucinations, and suicidal or homicidal ideations. His vital signs, time stamped 12:36 p.m., were

²⁸ American Heart Association standards categorize a blood pressure of 124/79 as elevated.

²⁹ A blood pressure of 139/88 falls within American Heart Association parameters for stage one hypertension.

³⁰ A blood pressure of 125/86 falls within American Heart Association parameters for stage one hypertension.

³¹ A blood pressure of 145/88 falls with American Heart Association parameters for stage two hypertension.

within normal limits except for an elevated blood pressure of 152/92³². Regular rate and rhythm were documented for the heart examination.

Note: (b)(6); (b)(7)(C) did not notify a provider of the elevated blood pressure as required by IHSC Directive 03-10. (b)(6); (b)(7)(C) confirmed during interview that this blood pressure was significantly elevated and a provider should have been notified.

(b)(6); (b)(7)(C) entered a mental health encounter note that included vital signs time stamped 12:29 p.m. The time of the encounter is not documented. Vital signs were all within normal limits, except for an elevated blood pressure of 142/80³³, and the physical examination was normal. DE LA ROSA denied suicidal or homicidal ideations. (b)(6); (b)(7)(C) signed her note at 3:38 p.m.

Note: As detailed above, (b)(6); (b)(7)(C) documented completion of a nursing round at 8:25 a.m. for which associated vital signs were not entered until 12:36 p.m. They included a blood pressure reading of 152/92. Vital signs entered at 12:29 p.m. for (b)(6); (b)(7)(C) encounter included a lower blood pressure of 142/80. Although (b)(6); (b)(7)(C)'s entry of vital signs taken during her round was delayed by four hours, the documentation suggests DE LA ROSA's blood pressure, did, in fact, lower somewhat between 8:25 a.m. and 12:29 p.m.

(b)(6); (b)(7)(C) completed a follow-up suicide risk assessment. She did not note the time of the encounter and did not sign her entry until 3:11 p.m. the next day. In her narrative (b)(6); (b)(7)(C) documented DE LA ROSA continued to present with fixed delusions and consistently declined medication intervention. He presented with thought disorder and was deemed at risk of being a danger to himself and others. The referral for admission to CRCC remained pending. Risk factors noted in the suicide risk assessment included current thoughts of suicide, feelings of hopelessness/helplessness due to continued incarceration, uncontrolled mental health symptoms, as evidenced by his delusional thinking, and non-compliance with mental health treatment based on his refusal to accept medications. His appearance and affect were described as odd. He was friendly, cooperative, and fully oriented. He remained delusional and focused on the concept of death. There was no confirmatory sign-off of (b)(6); (b)(7)(C) note.

Warden Charlie Peterson documented administrative review of DE LA ROSA's status at 3:31 a.m. The review was entered in the section of the Confinement Record form stating administrative review must be completed within 72 hours.

Note: Warden Peterson did not document his administrative review until the sixth day following DE LA ROSA's placement on administrative segregation. However, reviewers

³² A blood pressure of 152/92 falls with American Heart Association parameters for stage two hypertension.

³³ A blood pressure of 142/80 falls with American Heart Association parameters for stage two hypertension.

note the section of the Confinement Record form for documenting administrative review does not appear to be designed to constitute a status review as defined by the Special Management Unit standard. Instructions state the section must be completed for initial placement and includes space only for printed name, title, signature and date of the authority completing the section. It does not include space for documenting determination of whether continued assignment to segregation is justified and the rationale. Based on documentation in DE LA ROSA's detention file, reviewers conclude that status reviews mandated by the standard are not documented on the Confinement Record; rather, they are documented on ICE forms I-885, (Administrative Segregation Review) and I-887 (Disciplinary Segregation Review). As noted above, an initial status review was documented on ICE form I-885 on April 26, 2018 and as discussed below, the next status review was conducted and documented on a second I-885 form on May 3, 2018.

Tuesday, May 1, 2018

RN (b)(6); (b)(7)(C) conducted a nursing assessment at 8:43 a.m. DE LA ROSA was lying on his bunk with covers over his head, but he responded immediately when called. He voiced no hallucinations and no suicidal or homicidal ideations. Vital signs time stamped 9:18 a.m. were within normal limits except for mildly elevated blood pressure of 139/81³⁴.

Note: Because (b)(6); (b)(7)(C) did not note the time of her encounter the day before, positive determination of whether the eight hour timeframe was met is not possible. However, a round may have been missed on midnight shift.

(b)(6); (b)(7)(C) entered a mental health encounter note with the same associated vital signs entered earlier by (b)(6); (b)(7)(C). The vital signs were time stamped 12:09 p.m. The examination was normal. (b)(6); (b)(7)(C) signed her note at 3:11 p.m.

(b)(6); (b)(7)(C) documented a Wellness Check, noting that DE LA ROSA continued to present with fixed delusions and focus on concepts of death. Risk factors included feelings of hopelessness, helplessness and being a burden to others. When asked about his feelings of hopelessness and helplessness, the detainee said "because sometimes I feel like bad because I am in jail." Asked about feeling he was a burden to others, he said, "because I am the antichrist, I reject Jesus-Christ." Agitation was present with description, "Yeah, I want to be with my girlfriends." (b)(6); (b)(7)(C) noted DE LA ROSA was accepted by CRCC and travel arrangements were pending. She signed her note at 3:37 p.m. No confirmatory sign-off was entered.

At 4:00 p.m. (b)(6); (b)(7)(C) conducted a nursing assessment, documenting DE LA ROSA's denial of any suicidal or homicidal ideations or hallucinations. The general examination was normal.

³⁴ A blood pressure of 139/81 falls within American Heart Association parameters for stage one hypertension.

Note: Vital signs were not recorded.

Wednesday, May 2, 2018

(b)(6); (b)(7)(C) documented an assessment with associated vital signs time stamped 8:45 a.m. DE LA ROSA's blood pressure was mildly elevated at 137/89³⁵; other vital signs were within normal limits. The general examination was normal. (b)(6); (b)(7)(C) signed her note at 4:13 p.m.

(b)(6); (b)(7)(C) entered a note documenting a nursing assessment with associated vital signs time stamped 9:03 a.m. She did not note the time of the round. Vital signs were within normal limits except for a mildly elevated blood pressure of 128/88³⁶, and the detainee denied pain or discomfort.

Note: Because (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) did not document the time of their rounds, reviewers cannot determine time elapsed since the last healthcare contact completed at 4:00 p.m. the day before.

(b)(6); (b)(7)(C) conducted a follow up suicide risk assessment, noting DE LA ROSA "continues to present with inappropriate laughter and continues to believe that he will die three terrible deaths soon." When asked about suicidal ideations, he replied, "No, not right now." He continued to present with a thought disorder and was at risk of acting impulsively and inflicting self-harm. (b)(6); (b)(7)(C) again noted DE LA ROSA was pending transfer to CRCC. She did not record the time of the encounter and did not sign her note until 7:33 a.m. the next day. There was no confirmatory sign-off on the note.

(b)(6); (b)(7)(C) conducted a nursing assessment at 9:30 p.m. Vital signs time stamped 9:56 p.m. were unchanged from those recorded at (b)(6); (b)(7)(C) at 8:45 a.m. When asked how he was doing, DE LA ROSA replied, "Everything is fine." The general examination was normal.

Note: Time elapsed since the last healthcare encounter cannot be established.

Thursday, May 3, 2018

(b)(6); (b)(7)(C) conducted a suicide risk assessment documenting no change in findings. She noted transfer for a higher level of care remained pending. She did not document the time of the encounter but signed her note at 3:54 p.m. There was no confirmatory sign-off on the note.

Note: Because LCSW (b)(6); (b)(7)(C) did not document the time of her encounter, reviewers cannot establish time elapsed since (b)(6); (b)(7)(C) nursing assessment the evening before.

³⁵ A blood pressure of 137/89 falls within American Heart Association parameters for stage one hypertension.

³⁶ A blood pressure of 128/88 falls within American Heart Association parameters for stage one hypertension.

(b)(6); (b)(7)(C) conducted an assessment recording vital signs time stamped 9:57 a.m. DE LA ROSA's blood pressure was elevated at 141/101³⁷; other vital signs were within normal limits. The general examination was normal. (b)(6); (b)(7)(C) did not document the time of her encounter but signed her note at 1:08 p.m.

A nursing assessment note entered by (b)(6); (b)(7)(C) documented DE LA ROSA was standing in his cell with no distress observed and no medical complaints voiced. The time was not recorded, although vital signs time stamped 3:19 p.m. were within normal limits except for an elevated pulse rate of 104 and mildly elevated blood pressure of 121/89³⁸. He denied pain and the general examination was normal.

(b)(6); (b)(7)(C) conducted the next nursing assessment at 9:40 p.m., noting DE LA ROSA was resting quietly and in no distress. He denied suicidal or homicidal ideation. The officer reported he had been masturbating earlier in the shift. Vital signs time stamped 9:56 p.m. were all within normal limits, except for a mildly elevated blood pressure of 135/80³⁹. The general examination was normal.

ICE Form I-885, Administrative Segregation Review, was completed this date, documenting the detainee was in special housing for medical segregation. An illegible signature appears in the Supervisory Immigration Enforcement Agent or contract equivalent signature line. YES was checked for the following questions: "Does the reason for initial placement remain valid?" and, "Is the detainee unwilling or unable to live in the general population?" Removal from protective custody status was not recommended. An illegible signature appears on the Field Office Director signature line, with check mark entered for "Continue Status".

Note: The status review was conducted seven days following the first, but ten days following DE LE ROSA's placement on administrative segregation. The Special Management Units standard states a status review is to be conducted within 72 hours of placement and "after the detainee has spent seven days in segregation." Technically, this status review was late.

Note: The form does not document interview of the detainee.

Friday, May 4, 2018

(b)(6); (b)(7)(C) entered a mental health observation encounter note with associated vital signs time stamped 9:44 a.m. The vital signs were normal except for a mildly elevated blood pressure of 135/80. (b)(6); (b)(7)(C) documented DE LA ROSA was calm and cooperative and denied any physical complaints. He further noted the detainee was to be transferred to CRCC that day.

³⁷ A blood pressure of 141/101 is within American Heart Association for stage two hypertension.

³⁸ A blood pressure of 121/89 falls within American Heart Association for stage one hypertension.

³⁹ A blood pressure of 135/80 falls within American Heart Association for stage one hypertension.

Note: Because (b)(6); (b)(7)(C) did not note the time of the encounter, positive determination of time elapsed since (b)(6); (b)(7)(C) conducted a nursing assessment at 9:40 p.m. is not possible. A round on midnight shift may have been missed.

A transfer summary prepared by (b)(6); (b)(7)(C) documents diagnosis of schizophrenia, delusional disorders, and suicidal ideation and that DE LA ROSA was negative for TB and cleared for travel. She listed a suicide smock and suicide blanket as the only personal belongings allowed.

The Confinement Activity Record documents DE LA ROSA received breakfast at 7:20 a.m. and per the Confinement Watch Log, a security round was conducted at 7:30 a.m. The Confinement Record documents the detainee was “Released to Intake” but does not specify the time. The Offender Management System report documents that at 7:32 a.m., DE LA ROSA was permanently released.

Note: Reviewers were not provided with records documenting whether CoreCivic officers transported DE LA ROSA to and from CRCC. Based on available information, custody supervision was turned over to CRCC upon the detainee’s admission.

Records from CRCC document DE LA ROSA was under the care of (b)(6); (b)(7)(C), MD, psychiatrist, from admission on May 4, 2018 until discharge on June 11, 2018. The Psychiatric Discharge Summary documents both the admitting and discharge diagnosis was schizophrenia, and the History of Present Illness section documents DE LA ROSA’s acknowledgement that he refused to take medications at SDC because, “Nothing is wrong with me.” The Hospital Course states the following:

“On admission to CRCC, the patient reported that he was able to hear the voice of God. It was initially thought that the patient’s beliefs could have been part of his religious belief system, rather than evidence of psychosis. However, as the patient became more comfortable discussing his experiences it became clear that the patient had delusions. He disclosed that he is the Anti-Christ and that he has been killed twice before and has arisen from the dead. He said he believed but was less guarded and interacted better with other patients. He was initially resistant to taking medication but he would be killed again shortly but said he was not permitted by god to disclose when that would happen. He denied suicidal thoughts. He was begun on Zyprexa⁴⁰ and Haldol⁴¹. He continued to be delusional, but was less guarded and interacted better with other patients. He was initially resistant to taking medication but by the time of discharge he was compliant. He said he would consider taking medication after discharge although he did not feel he needed it. He

⁴⁰ Zyprexa is an antipsychotic medication used to treat mental disorders including schizophrenia.

⁴¹ Haldol is an antipsychotic medication used to treat mental disorders, including schizophrenia.

continued to deny suicidal thoughts and there was never evidence that he was suicidal while hospitalized. He participated in group activities.”

The Mental Status Exam section of the CRCC discharge summary documents DE LA ROSA’s “auditory hallucinations of the voice of God” and the delusion that he is the anti-Christ continued. His insight and judgment were described as chronically impaired. Laboratory test results were found non-contributory, and his condition was stable for discharge having reached the maximum hospital benefit. Discharge medications were Zyprexa 20 mg and Haldol 5 mg, both at night time. Although not reflected in the discharge summary, the CRCC record documents he was also given antihypertensive medication amlodipine when his blood pressure was found elevated. The Medication Reconciliation for Discharge/Transfer form lists amlodipine along with Zyprexa and Haldol as discharge medications.

Note: CRCC nursing notes reflect that the order for Zyprexa included direction to administer the medication intramuscularly if he refused the medication. The record does not document whether Zyprexa was ever administered involuntarily, but nursing notes state he was “usually” medication compliant.

Monday, June 11, 2018

The day before DE LA ROSA returned to SDC (b)(6); (b)(7)(C) (first name unknown) completed a classification review. The review was documented on an ICE Custody Classification Worksheet. He was again rated high. A supervisor approved the classification two days later, June 13, 2018. The signatures of (b)(6); (b)(7)(C) and the supervisor are illegible.

Tuesday, June 12, 2018

(b)(6); (b)(7)(C) completed medical pre-screening, recording the time of arrival was 8:30 a.m. He conducted the intake screening at 9:00 a.m., entering vital signs time stamped 6:33 a.m. Vital signs were within normal limits, including blood pressure of 115/73. Listed medical problems were schizophrenia, hypertension, and history of alcohol abuse. He arrived with the antipsychotic medications Haldol 5 mg and Zyprexa 20 mg and the antihypertensive medication Norvasc⁴² 10 mg. Although DE LA ROSA denied ever hearing voices that others do not hear and (b)(6); (b)(7)(C) observed no behaviors of concern, the RN appropriately designated the intake screen abnormal and referred the detainee to a provider. DE LA ROSA was cleared for custody.

The Commitment Summary documents DE LA ROSA was booked into SDC at 9:44 a.m. As explained Officer (b)(6); (b)(7)(C) during interview, he was “restored into the system.” At 9:51 a.m., she conducted a PREA Risk Assessment, documenting answers of no to each question. The Housing History Report documents that at 10:17 a.m., the detainee was assigned to cell 104 in pod 7B, a general population unit for detainees classified high and medium high.

⁴² Norvasc is a brand name for amlodipine.

Note: Reviewers assume DE LA ROSA's return was handled as a new intake because his transfer to CRCC was documented as a permanent release.

LCSW (b)(6); (b)(7)(C) conducted a mental health assessment, noting CRCC return as the reason for the appointment. She did not enter the time of the encounter and did not sign her note until July 11, 2018, following DE LA ROSA's death. Her note was locked on that date without confirmatory sign-off. LCSW (b)(6); (b)(7)(C) wrote, "Detainee states he was given medication that he did not feel helped. He states that his life is the same. He states that he still feels that he will suffer three terrible deaths in the future but he will never kill himself. He states that while in Virginia he told his therapist about his first death. He states that he told them in Columbia about his second death and three more in the future and God will raise him from the dead. He states that he will never harm himself. He states that he only hears the voice of God but he must pray to find the answer of what he is saying. He states that he is not in any type of pain. He states that sometimes he sees pictures in his mind that makes him happy when he is feeling sad. He states that he does not know how to explain it but he feels happiness from God. He states he feels okay now. He states that he does not feel that his mind is confused. He could identify the date, the place and time. He was future oriented to go to Mexico to see his family. He states that while in Columbia, CRCC he could call his brother, he states that his brother does not believe in him so he is not sending him money. He states that he must prove to his brother that he is changed. He states that he last had his medication on last night. He states that he does not want to continue to take his medications because he does not need it. Patient and writer discussed medication compliance and reoccurrence of symptoms."

By telephone encounter timed 3:09 p.m., (b)(6); (b)(7)(C) ordered daily administration of amlodipine 10 mg in the morning, and daily administration of olanzapine⁴³ 20 mg and haloperidol⁴⁴ 5 mg, both in the evening.

Note: The medical record does not include a specific consent form for the two psychiatric medications.

Note: The Medication Administration Record (MAR) documents the three medications were ordered this date but not started until June 14, 2018. Reviewers cannot explain the delay, although it is possible (b)(6); (b)(7)(C) order was received after the pharmacy closed on June 12, 2018 and the order for amlodipine was not filled until after morning medication administration hours on June 13, 2018. It is also possible that the psychiatric medications were not in stock and had to be ordered. As detailed below, DE LA ROSA took none of his medications up to and including the day of his suicide.

⁴³ Olanzapine is generic Zyprexa.

⁴⁴ Haloperidol is generic Haldol.

Wednesday, June 13, 2018

N [REDACTED] completed an abbreviated physical examination at 9:00 a.m., noting DE LA ROSA had been examined at SDC within the past 90 days, on March 15, 2018. Except for a slightly elevated blood pressure of 123/77⁴⁵, vital signs time stamped 6:08 a.m. were within normal limits. DE LA ROSA denied any pain. The NP conducted an Abnormal Involuntary Movement Scale (AIMS) test to determine if the detainee was experiencing side effects from psychotropic medications. The score was zero. Follow-up was scheduled for two weeks.

Note: There was no documentation a medical provider followed up in two weeks; however, DE LA ROSA was seen by a mental health provider, PMHNP [REDACTED] for a segregation round on June 27, 2018.

Thursday, June 14, 2018

Additional intake procedures were completed following the same process as when DE LA ROSA was originally admitted on March 14, 2018. In addition to the property listed on the first inventory, chewing gum, shoe laces, keys, canvas shoes and an additional pair of socks were receipted. DE LA ROSA was again issued facility clothing, hygiene supplies, linens, a lock, radio with batteries, a PREA pamphlet, PREA Zero Tolerance Policy and the facility handbook. He signed an agreement for monitoring of his mail and phone calls, and a form acknowledging he received an orientation and that an orientation video would also be shown in the housing unit on a daily basis.

Note: Reviewers cannot explain why these processes were completed two days after DE LA ROSA returned from CRCC.

Per the Housing History Report, the detainee was moved to Pod 5A in cell 213 at 1:36 p.m.

As noted above, medications ordered on June 12, 2018 were started this date. They included antihypertensive medication amlodipine to be given in the morning and psychiatric medications Haldol and Olanzaprine to be given in the evening. Daily medication administration attempts through the day of DE LA ROSA's suicide are summarized in tables, below. As detailed, the MAR documents that on all but three days, prescribed medications were not administered because DE LA ROSA did not report for medication pass or refused to take them. MAR entries documenting successful administration on the three days were, in fact, determined false (see below); therefore, the evidence indicates DE LA ROSA took no doses of ordered psychiatric or antihypertensive medications after he returned to SDC.

The Medical Care standard states that if treatment is refused, medical staff will explain the risks and document their efforts. It also states that refusal forms are to be signed. IHSC Directive 02-08, Refusal of Treatment, states detainees have the right to refuse medical treatment at any time. It also sets more detailed requirements for actions to be taken if treatment is refused. It states that

⁴⁵ American Heart Association standards categorize a blood pressure of 123/77 as elevated.

the healthcare professional must educate the detainee based on the treatment being refused and complete the IHSC Refusal Form in its entirety each time the detainee refuses treatment. The directive also states that if a nurse provides the education, he or she “should refer the refusal documentation to a medical provider, BHP, or dentist, as appropriate, for review. The detainee should be scheduled for a face-to-face visit with the medical provider, BHP or dentist to review the treatment plan and receive follow up education.”

As shown in the below tables, there were multiple occasions NS, for No Show, was entered. On no occasion where NS was entered did nurses document any effort to account for the detainee to confirm that his failure to report constituted refusal of the medications and if so, educate him on associated risks and obtain his signature on a refusal form. Also as shown, providers were not consistently notified DE LA ROSA was not taking ordered medications and when notified, a provider did not consistently follow up.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Illegible	No	No	-
Haldol, Olanzaprine	No Show	-	-	-

Friday, June 15, 2018

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes, detainee refused to sign	Telephone Encounter to NP Sekeithia Austin	No
Haldol, Olanzaprine	No Show	-	-	-

Note: This was the first of 17 telephone encounters nurses sent to (b)(6); (b)(7)(C) notifying her DE LA ROSA was refusing medications. (b)(6); (b)(7)(C) was the provider designated responsibility for following up on medication refusals. At no time did she see the detainee, and only once was his blood pressure checked. As discussed below, his blood pressure was checked and found within normal limits on June 19, 2018 as part of the segregation clearance process. When asked why she did not see DE LA ROSA, (b)(6); (b)(7)(C) stated she conferred with mental health personnel and reviewed the detainee’s chart, but he was rescheduled for following days because, “There were not enough staff to bring him.” Although requested, reviewers were not provided with appointment lists to confirm postponed appointments were rescheduled. According to HSA (b)(6); (b)(7)(C), the Mortality Review Committee recommended that providers document why appointments are not carried out.

Saturday, June 16, 2018

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	No	No	-
Haldol, Olanzaprine	No Show	-	-	-

Sunday, June 17, 2018

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Illegible			
Haldol, Olanzaprine	Refused	Yes	Telephone Encounter to LCSW Harvey	LCSW 6-19-2018

Monday, June 18, 2018

The Telmate daily report documents detainee DE LA ROSA attempted a phone call at 3:39 p.m. logged as incomplete.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	No	No	-
Haldol, Olanzaprine	NS	-	-	-

Tuesday, June 19, 2018

(b)(6); (b)(7)(C) documented an encounter with DE LA ROSA “following reports that detainee had been refusing medications.” She wrote that he stated he does not need medication but still believes he is the anti-Christ. He denied thoughts of wanting to harm himself or hearing any voices. The detainee was provided with medication education and the importance of compliance, and was instructed to report to staff immediately should he begin to have thoughts of self-harm or command auditory hallucinations. LCSW (b)(6); (b)(7)(C) did not record the time of the encounter but signed her note at 10:55 a.m. (b)(6); (b)(7)(C) psychologist, entered confirmatory sign-off on June 26, 2018. He wrote, “Reviewed and concur. [Behavioral Health Unit] will continue to monitor patient’s continuity of care needs and MSE in consult with the [Mental Health] team and (b)(6); (b)(7)(C) if higher level of care becomes necessary, please notify [Behavioral Health Unit] for assistance with care coordination as needed.”

An Incident of Prohibited Acts and Notice of Charges form timed 4:44 p.m. documents DE LA ROSA approached Officer (b)(6); (b)(7)(C) and told her she was beautiful. He also told her she was scared when she took his ID the day before. He rubbed his foot on her foot and acted like he was going to touch her buttocks. He then stated, “You gotta big butt just like I like them.” Officer (b)(6); (b)(7)(C) charged the detainee with the prohibited act of Making Sexual Proposals. On interview, Officer

(b)(6); (b)(7)(C) stated that the incident began the day before. She said she was holding pod doors open and monitoring movement to the dining room when detainee DE LA ROSA walked up close to her and acted inappropriately. She had taken his ID and was going to write a disciplinary report but she got busy and ran out of time. She returned his ID to the unit officer. Officer (b)(6); (b)(7)(C) reported that on this date, June 19, 2018, she was again holding doors open when detainee DE LA ROSA walked up and stepped on her foot. She told him to stop. She then reported his actions to the counselor and unit manager.

(b)(6); (b)(7)(C) cleared DE LA ROSA for segregation at 5:10 p.m. Vital signs inexplicably time stamped 2:30 p.m. were within normal limits, except for a mildly elevated blood pressure of 132/86⁴⁶. DE LA ROSA was in no acute distress and within normal limits of behavior, affect, and cognitive functioning. (b)(6); (b)(7)(C) as no longer employed at SDC at the time of the site visit; therefore, she was not interviewed to determine if she reviewed DE LA ROSA's medical record and was aware of his ongoing delusions and that he was refusing psychiatric medications.

A Confinement Record completed by (b)(6); (b)(7)(C) (first name unknown) at 6:05 p.m. assigned detainee DE LA ROSA to disciplinary segregation.

Note: The detainee had not been found guilty of the violation; therefore, the assignment was incorrect. He should have been assigned to administrative segregation pending disciplinary hearing.

Per the housing history report, DE LA ROSA was moved to cell 107 in RHU Pod 7A at 6:05 p.m.

An Investigative Report by Officer (b)(6); (b)(7)(C) (first name unknown) documents he referred the matter to the IDP after the detainee admitted that he approached the officer. Per the report, the investigation started at 6:43 p.m. and ended at 6:53 p.m.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	No Show	-	-	-
Haldol, Olanzaprine	No Show	-	-	-

Wednesday, June 20, 2018

(b)(6); (b)(7)(C) conducted the first nursing round at 9:00 a.m. using the template verbiage for segregation rounds described previously.

⁴⁶ A blood pressure of 132/86 falls within American Heart Association parameters for stage one hypertension.

(b)(6); (b)(7)(C) conducted the first mental health provider segregation round. In her narrative assessment, she wrote that DE LA ROSA was in segregation for making sexual proposals toward staff. When questioned about his behavior, he said, "She's beautiful and I like her." She noted the detainee had limited mental functioning and was denying the need for any medications. He indicated he did not have any concerns related to being in segregation and said, "I feel good wherever I go." The detainee denied thoughts of self-harm and (b)(6); (b)(7)(C) noted, "He did not present with any signs of ineffective coping or acute emotional distress at the time of the encounter." However, in answer to the question, "Does the detainee meet SMI criteria?" the LCSW entered yes, specifying in the Criteria field, "One or more psychiatric symptoms, Presently taking psychiatric medications and still presenting active moderate to severe symptoms. Serious limitations in mental functioning." In conflict with that entry, (b)(6); (b)(7)(C) entered no in answer to the question, "Does the detainee present any active symptoms?" She noted DE LA ROSA was not compliant with his treatment, and answered yes to the question, "Would the detainee benefit from a higher level of care?" The treatment plan consisted of weekly visits by a BHP or sooner if clinically indicated or he requested. (b)(6); (b)(7)(C) signed her note at 4:13 p.m. (b)(6); (b)(7)(C) documented confirmatory sign-off on June 26, 2018 entering the same narrative he entered for LCSW June 19, 2018 encounter note.

Note: (b)(6); (b)(7)(C) informed the review team that she advised IHSC headquarters via e-mail that SDC was not an appropriate placement for DE LA ROSA. Neither she nor HSA (b)(6); (b)(7)(C) were able to produce a copy of the e-mail. As noted above, IHSC Directive 07-05, Serious Mental Disorders or Conditions, requires immediate notification of the HSA that a detainee meets SMI criteria and listing the detainee on a spreadsheet provided to IHSC headquarters on a weekly basis. Although LCSW (b)(6); (b)(7)(C) encounter note documents DE LA ROSA met SMI criteria and that he would benefit from a higher level of care, she also documented he had no active symptoms.

DE LA ROSA was informed by way of Notice of IDP Hearing form that his hearing would be held the next day. DE LA ROSA did not request staff representation or any witnesses.

Per the housing history report, the detainee was moved to cell 105 in Pod 7B at 12:31 p.m. Warden Peterson explained to the review team that all detainees housed in the RHU were moved to 7B because the air conditioning in Pod 7A was not working properly. At the time of the site visit, Pod 7A was once again functioning as the RHU.

Detainee DE LA ROSA remained in Pod 7B, cell 105 until his suicide on July 10, 2018. Review of minutes from weekly Restricted Housing Unit meetings held with ERO, Core Civic, health services administration, and mental health professionals confirmed DE LA ROSA's case was regularly reviewed while he was in segregation. Participants agreed his status should not change based on the nature of the disciplinary incident.

Pod 7B has two tiers and 40 double occupancy cells, although Warden Peterson stated detainees are housed alone when the pod is used for segregation. There are two staircases, one on each side of the unit. The officer's station is positioned at the front of the pod and consists of two tables with chairs. The dayroom has one stainless steel table with four affixed stools in front of the officer's station. There are four fixed cameras mounted near the ceiling in each corner of the pod. The review team was given video footage from all housing unit cameras, although footage from the front left camera provided an unobstructed view of cell 105 and therefore, was used for this analysis.

Cell 105 is the fifth cell to the right of the officer's desk. The cell door is steel and has viewing windows in the top and bottom portions covered with wire mesh on the inside. A food tray/handcuff port is in the center of the door. The port can be opened from outside the cell, only. Immediately to the left inside the door is a light switch and intercom button. The intercom alerts in RHU control; the light switch operates the brighter light inside the cell. A night light within the light fixture is operated in RHU control. The cell has a metal bunk bed along the back wall with a three rung metal ladder welded on the left side. Metal squares are welded in the center of the top bunk to prevent a fall. On the right wall there are two small tables welded to the wall; on the left wall there is a stainless steel toilet/sink combination fixture. A security mirror is above the sink, to the right of which is a sprinkler head. To the right of the sprinkler is the encased light. The door opens toward the dayroom and is manually opened with a key. The RHU Control Center is between Pods 7A and 7B and has windows allowing direct observation into both. Monitors display views from the cameras within the pods. As discussed above, officers assigned to RHU pods are responsible for conducting and documenting security rounds every 30 minutes on an irregular schedule.

The Confinement Activity Record documents DE LA Rosa was given dinner, showered, and allowed recreation.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	No Show	No	Telephone Encounter to NP Austin	No
Haldol, Olanzaprine	No Show	-	-	-

Note: No Show was entered for amlodipine and the psychiatric medications through June 26, 2018; refusals were entered thereafter. Medications for detainees in segregation must be distributed cell to cell; therefore, entry of No Show is unexplained. If nurses did, in fact, go to DE LA ROSA's cell and he refused the medications, proper entries for refusal should have recorded on the MAR.

Thursday, June 21, 2018

(b)(6); (b)(7)(C) conducted a segregation nursing round at 9:36 a.m. She used template language to document her round.

Per report of the IDP, a hearing was held at 10:55 a.m. on the charge of Making Sexual Proposals. The hearing officer, Assistant Shift Supervisor (b)(6); (b)(7)(C) wrote, "Detainee stated he did everything the officer said he did." DE LA ROSA was found guilty and received a sanction of 30 days disciplinary segregation. A disciplinary segregation order was completed.

The Confinement Activity Record documents DE LA ROSA received all three meals and attended recreation from 8:17 a.m. to 9:17 a.m.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	No Show	-	-	-
Haldol, Olanzaprine	No Show	-	-	-

Friday, June 22, 2018

(b)(6); (b)(7)(C) entered a segregation nursing round using template language.

According to the IDP Report, a copy of the disciplinary hearing findings was delivered to DE LA ROSA by Assistant Shift Supervisor (b)(6); (b)(7)(C).

ICE form I-887, Disciplinary Segregation Review, completed this date resulted in continuation of DE LA ROSA's status. Yes was checked for the following three questions: "Does the reason for initial placement remain valid?"; "Does the detainee pose a threat to others?"; and, "Is the detainee defiant towards authority?" Illegible signatures appear in the Supervisory Immigration Enforcement Agent or contract equivalent and Field Office Director lines. The "Continue Status" box was checked by whomever signed as Field Office Director.

Note: The form does not document that the detainee was interviewed.

Confinement Activity Records document DE LA ROSA received breakfast and dinner; no entry was made for the lunch meal. Recreation, a shower, and use of the telephone were logged, although the Telmate report does not list any calls this date. It is possible DE LA ROSA used another detainee's Personal Identification Number to use the phone.

Note: There are two Confinement Activity Records with different entries dated June 22, and none for June 23, 2018. Given the sequential order of the logs, the reviewer surmises the second was misdated.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	No Show	No	Telephone Encounter to NP Austin	No
Haldol, Olanzaprine	No Show	No	No	-

Saturday, June 23, 2018 through Tuesday, June 26, 2018

(b)(6); (b)(7)(C) documented segregation nursing rounds using template language.

Confinement Activity Records document DE LA ROSA received three meals and recreation each day. A shower was logged on June 25, 2018. The Telmate report documents the detainee attempted an international phone call at 3:43 p.m. on June 24, 2018 which was terminated after two minutes. On June 26, 2018 the detainee went to Court at 12:01 p.m. and returned at 12:23 p.m.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	No Show	No	No	-
Haldol, Olanzaprine	No Show	No	No	-

Wednesday, June 27, 2018

(b)(6); (b)(7)(C) entered a segregation round at 9:25 a.m. using template language.

PMHNP (b)(6); (b)(7)(C) conducted a mental health segregation review answering all programmed questions on the eCW form but offering no free form narrative. He documented DE LA ROSA's diagnosis of schizophrenia, that he had no active symptoms, and did not meet SMI criteria. Mental health treatment in the form of psychotropic medications and talk therapy were noted, and yes was entered in response to the question concerning compliance. Asked to explain, PMHNP (b)(6); (b)(7)(C) informed reviewers that DE LA ROSA reported he was taking his medications and because he seemed so much better, he assumed the detainee was being truthful. PMHNP (b)(6); (b)(7)(C) shared that he was surprised when later told DE LA ROSA refused all his medications.

PMHNP (b)(6); (b)(7)(C) documented the detainee's mood was happy, his affect was appropriate, his behavior was pleasant and cooperative, and his judgment was insightful. He denied thoughts of harming himself and suicide. PMHNP (b)(6); (b)(7)(C) did not document the time of the encounter but signed his note at 4:11 p.m. (b)(6); (b)(7)(C) co-signed the note on June 29, 2018, entering the same narrative note documented in his confirmatory sign-off entries for previous mental health encounters.

The Confinement Activity Record documents DE LA ROSA received all three meals and showered.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes; detainee refused to sign	No	-
Haldol, Olanzaprine	Given	-	-	-

Note: The initials documenting that psychiatric medications were given are RH, identified by (b)(6); (b)(7)(C). During interview, (b)(6); (b)(7)(C) stated (b)(6); (b)(7)(C) was separated from service by her employer, InGenesis, after it was discovered she falsified a July 10, 2018 entry on DE LA ROSA's MAR. Specifically, she entered he refused both psychiatric medications when in fact, analysis of video footage found she did not approach the cell. Given the proven false entry, and based on DE LA ROSA's consistent non-compliance with medication treatment, (b)(6); (b)(7)(C) concluded it is highly unlikely that (b)(6); (b)(7)(C) administered the psychiatric medications on this date, June 28, and June 30, 2018 as documented (see below). Reviewers concur with his conclusion.

Thursday, June 28, 2018

(b)(6); (b)(7)(C) documented completion of a segregation round at 9:50 a.m. using template language.

The Confinement Activity Record documents DE LA ROSA received three meals, recreation, and mail.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	Telephone Encounter t (b)(6); (b)(7)(C)	No
Haldol, Olanzaprine	Given	-	-	-

Note: The entry documenting that the psychiatric medications were given was made by (b)(6); (b)(7)(C) and is assumed false. See June 27, 2018 note.

Friday, June 29, 2018

(b)(6); (b)(7)(C) documented completion of a segregation round at 8:14 a.m. using template language.

The Confinement Activity Record documents DE LA ROSA received three meals and recreation and that he showered and exchanged laundry.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	Telephone Encounter to NP Austin	No
Haldol, Olanzaprine	Refused	Yes	Telephone Encounter to NP Austin	No

Saturday, June 30, 2018

(b)(6); (b)(7)(C) documented completion of a segregation round using template language. She did not specify the time.

The Confinement Activity Record documents DE LA ROSA received three meals and recreation.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	Telephone Encounter to NP Austin	No
Haldol, Olanzaprine	Given	-	-	-

Note: The entry documenting that the psychiatric medications were given was made by (b)(6); (b)(7)(C) and is presumed false. See June 27, 2018 note.

Sunday, July 1, 2018

(b)(6); (b)(7)(C) documented completion of a segregation round at 8:58 a.m. using template language.

The Confinement Activity Record documents DE LA ROSA received three meals and attended recreation.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	No	-
Haldol, Olanzaprine	Refused	No	No	-

Monday, July 2, 2018

(b)(6); (b)(7)(C) documented completion of a segregation round at 11:45 a.m. using template language.

The Confinement Activity Record documents DE LA ROSA received three meals and attended recreation. He was not offered a shower.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	No	No	-
Haldol, Olanzaprine	Refused	No	No	-

Tuesday, July 3, 2018

(b)(6); (b)(7)(C) documented completion of a segregation round at 8:10 a.m. using template language.

Security Chief (b)(6); (b)(7)(C) completed ICE form I-887, Disciplinary Segregation Review, concluding the reason for the initial placement remained valid. He checked the box indicating he recommended the detainee's removal from disciplinary segregation status, apparently in error. The Field Office Director signature, also dated July 3, 2018, is illegible and no box is checked for the three options: concur with recommendation, release or continue status.

Note: This status review was delinquent. Per the Special Management Units standard, a status review is to be conducted every seven days. The previous review was conducted on June 22, 2018. No record of a status review completed on June 29, 2018 was found in the detention file.

Note: Security Chief (b)(6); (b)(7)(C) did not document interview of the detainee.

The Security Chief also signed the Confinement Record form documenting completion of a 72-hour administrative review this date.

Note: As discussed above, completion of the administrative review section of the Confinement Record form appears to be a CoreCivic requirement that is independent of the status review process mandated by the Special Management Units standard. It is nonetheless noted that the section was not completed within 72 hours of the initial assignment as required per the form. When completed, DE LA ROSA had been in segregation for 14 days.

The Confinement Activity Record documents that the detainee received all three meals and attended recreation. His cell was searched, he refused use of the telephone and exchanged laundry. It was also noted he went to Court at 1:26 p.m. and returned at 1:59 p.m.

Note: The Confinement Watch Log for this date was not produced.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	No	No	-
Haldol, Olanzaprine	Refused	No	No	-

Wednesday, July 4, 2018

(b)(6); (b)(7)(C) completed a segregation round at 9:05 a.m. using template language in her medical record entry.

PMHNP (b)(6); (b)(7)(C) entered a mental health segregation round note that exactly matches his entry on June 27, 2018, including that DE LA ROSA did not meet SMI criteria. He provided no free form comments, and documented DE LA ROSA was compliant with mental health treatment. He did not record the time of the encounter but signed his note at 12:43 p.m. The entry was co-signed by (b)(6); (b)(7)(C) on July 9, 2018, who added the same narrative note he entered with earlier confirmatory sign-off entries.

Note: DE LA ROSA's continued refusal of medications was not noted by PMHNP (b)(6); (b)(7)(C). As before, PMHNP (b)(6); (b)(7)(C) may have documented compliance with treatment based on the detainee's self-report.

The Confinement Activity Record documents the detainee received all three meals, attended recreation, showered, and refused the opportunity to use the telephone and library.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes, detainee refused to sign	Telephone Encounter to NP (b)(6); (b)(7)(C)	No
Haldol, Olanzaprine	Refused	Yes	Telephone Encounter to NP (b)(6); (b)(7)(C)	No

Thursday, July 5, 2018

(b)(6); (b)(7)(C) documented completion of a segregation round at 9:30 a.m. using template language.

The Confinement Activity Record documents DE LA ROSA received all three meals, attended recreation and refused the opportunity to go to the library.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	No	-
Haldol, Olanzaprine	Refused	Yes	No	-

Friday, July 6, 2018

(b)(6); (b)(7)(C) documented completion of a segregation round at 8:15 a.m. using template language.

The Confinement Activity Record documents DE LA ROSA received all three meals and attended recreation. He showered and received mail.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	No	-
Haldol, Olanzaprine	Refused	Yes	No	-

Saturday, July 7, 2018

(b)(6); (b)(7)(C) documented completion of a segregation round at 9:04 a.m. using template language.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	Telephone Encounter to NP (b)(6); (b)(7)(C)	No
Haldol, Olanzaprine	Refused	Yes	Telephone Encounter to NP (b)(6); (b)(7)(C)	No

The Confinement Activity Record documents DE LA ROSA received all three meals and attended recreation.

Sunday, July 8, 2018

(b)(6); (b)(7)(C) documented completion of a segregation rounds at 7:56 a.m. using template language.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	Telephone Encounter to NP (b)(6); (b)(7)(C)	No
Haldol, Olanzaprine	Refused	Yes	Telephone Encounter to NP (b)(6); (b)(7)(C)	LCSW 7-10-2018

The Confinement Activity Record documents DE LA ROSA received all three meals and attended recreation.

Monday, July 9, 2018

(b)(6); (b)(7)(C) documented completion of a segregation rounds at 8:12 a.m. using template language.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	Telephone Encounter to NP (b)(6); (b)(7)(C)	No
Haldol, Olanzaprine	Refused	No	Telephone Encounter to NP (b)(6); (b)(7)(C)	LCSW 7-10-2018

The Confinement Activity Record documents DE LA ROSA received all three meals, attended recreation, showered, and exchanged laundry.

The Housing Photo Report documents that at 11:03 a.m., detainee (b)(6); (b)(7)(C) was assigned to cell 104, the cell next to detainee DE LA ROSA's. During interview by the review team he stated DE LA ROSA told him he was in disciplinary segregation for kicking a door. (b)(6); (b)(7)(C) said he did not sound depressed, although they were only housed next to each other for a brief time. He stated they talked through the food port at meal times and recalled that DE LA ROSA did talk about God.

Tuesday, July 10, 2018 – Day of Medical Emergency

(b)(6); (b)(7)(C) entered completion of a nursing round at 8:26 a.m. using template language.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	Telephone Encounter to (b)(6); (b)(7)(C)	No
Haldol, Olanzaprine	Refused	No	No	-

Note: Refusal of the psychiatric medications was documented by (b)(6); (b)(7)(C) As discussed above, (b)(6); (b)(7)(C) review of video footage found she did not go to DE LA ROSA's cell and therefore, concluded she falsified the entry.

LCSW (b)(6); (b)(7)(C) conducted a mental health segregation follow-up, signing her entry at 1:04 p.m. She did not note the time of the encounter, but based on an entry to the Confinement Activity Record documenting DE LA ROSA's departure from the unit for medical, reviewers conclude the encounter was completed between 11:35 a.m. and 11:55 a.m. (b)(6); (b)(7)(C) documented DE LA ROSA met SMI criteria, specifying, "One or more active psychiatric symptoms. Presently taking psychiatric medications and still presenting active moderate to severe symptoms. Serious limitations in mental functioning." In the narrative, (b)(6); (b)(7)(C) wrote, "Detainee presents as pleasantly delusional. Content of delusions are spiritual in nature. Detainee spoke about good and bad spirits and how the holy spirit is in him. Detainee denies hearing any voices or having thoughts

of wanting to hurt himself or believing that he is going to die. Detainee was psychiatrically hospitalized and returned to SDC on June 12. He stated that he has no desire to take medications and does not need them. Detainee appears to be at baseline. BHP reminded detainee of the benefits of being compliant with medication, and he smiled and stated, 'I don't need them'. Detainee did not present as a danger to self or others at the time of the encounter. Detainee aware of the process to obtain additional services should the need arise. BHP will monitor and provide support."

During interview, LCSW (b)(6); (b)(7)(C) confirmed she saw DE LA ROSA in her office this date and commented the encounter was a "normal session." As always, the detainee was "very pleasant and cooperative." She shared that though always appropriate with her, DE LA ROSA told the other social worker that he was going to take her back to Mexico. She said he understood he would be deported.

As detailed below, detainee DE LA ROSA was discovered hanging by socks tied together from the top bunk bed at 10:33 p.m., approximately 11 hours after his encounter with (b)(6); (b)(7)(C). The officer assigned to 7B for the preceding shift, 2:00 p.m. to 10:00 p.m., was (b)(6); (b)(7)(C) the officer who relieved him for the 10:00 p.m. to 6:00 a.m. shift was (b)(6); (b)(7)(C). The following description of events is based on review of video surveillance footage from 8:00 p.m., July 10, 2018, to 12:00 a.m. July 11, 2018, written and verbal reports of staff, and entries to the Confinement Watch Log and Confinement Activity Records. Referenced times from are rounded to the nearest minute until moments prior to discovery of detainee DE LA ROSA's suicide.

Video shows Officer (b)(6); (b)(7)(C) made a round and looked in DE LA ROSA's cell at 8:40 p.m.

Note: This was the last round where Officer (b)(6); (b)(7)(C) is seen looking in the detainee's cell before he was discovered hanging by (b)(6); (b)(7)(C) 113 minutes later.

At 9:13 p.m., 9:39 p.m. and 10:04 p.m. (b)(6); (b)(7)(C) made rounds and marked the clipboard at DE LA ROSA's cell. Video evidence shows he did not look in the cell during any of the three rounds. (b)(6); (b)(7)(C) who was assigned to RHU Control during this shift, stated the night light in DE LA ROSA's cell was on during the rounds and remained on throughout the shift. She also reported DE LA ROSA did not attempt contact via intercom during her shift. She received only one intercom call, from another detainee requesting his property.

At 10:05 p.m., (b)(6); (b)(7)(C) is seen arriving on the unit to assume the post. At 10:08 p.m., (b)(6); (b)(7)(C) escorted a nurse to a cell on the opposite side of the dayroom from DE LA ROSA's.

At 10:13 p.m. (b)(6); (b)(7)(C) who was assigned to Pod 7A, is seen on Pod 7B looking through paperwork on the officer's desk and then left. At 10:15 p.m., Officer (b)(6); (b)(7)(C) turned to the center of the unit and at 10:17 p.m., sat at his desk. During interview, he stated he began entering detainee names on Confinement Watch Log and Confinement Activity Records forms for the next day because at midnight, he would need to post them on the clipboards. He stated that

when he escorted the nurse to the cell across the day room, he noticed the last round was recorded at 10:04 p.m. so he had time before another round was required. Officer (b)(6); (b)(7)(C) conducted the first round of his shift at 10:33 p.m., 28 minutes after he assumed the post.

Note: RHU Post Orders state that at the start of each shift, the officer must, “Verify that all cell doors and food tray slots are secure”; SDC Policy 9-13, Count Principles and Procedures, states, “At shift change, the oncoming Correctional Officer will conduct an informal count of all inmates in his/her area of responsibility.” Video evidence indicates Officer (b)(6); (b)(7)(C) did not check cell doors or conduct an informal count. When asked about the officer waiting 28 minutes to conduct a round, Captain (b)(6); (b)(7)(C) stated that it is his expectation that at the beginning of a shift, an officer ~~should do a round~~ and a count before they do anything else.

Officer (b)(6); (b)(7)(C) stated on interview that he started his security round at cell 101, moving to cells 102, 103 and 104 after observing the occupants and making entries to the logs on the clipboard. He recalled that the detainee in cell 102 was using the portable phone and that he moved to cell 103 without signing the log for cell 102. He returned to cell 102 and signed the log before proceeding to cell 103.

Video footage shows Officer (b)(6); (b)(7)(C) approached DE LA ROSA’s cell, 105, at 10:33:52 p.m. He stated on interview that he looked in, moved to record his round, then looked into the cell again. He observed detainee DE LA ROSA standing by the bunk bed with his chin down. In his written report, Officer (b)(6); (b)(7)(C) wrote the detainee, “was standing against the bed with his head in a strange position.” He knocked on the cell door window several times and receiving no response, called medical emergency by radio. He informed the review team that he did not open the cell door because he was trained not to do so alone because the situation “could be a set up.”

Note: SDC RHU Post Orders do not mandate that (b)(7)(E) be present before a cell door is opened in a special management unit. Instead, they state, “Staff members equal to the number of inmates/residents assigned to the cell will be present prior to opening any occupied cell door.” As allowed by the Post Orders, video shows Officer (b)(6); (b)(7)(C) opened cell doors on the previous shift without a second officer present to allow detainees out for showers. Therefore, consistent with the Post Orders and observed practice, Officer (b)(6); (b)(7)(C) could have entered the cell and lifted DE LA ROSA to relieve pressure on his neck and waited for responding staff to bring the cut down tool.

(b)(6); (b)(7)(C) was first to respond, arriving at 10:34:50 per video footage. He acknowledged during interview that this was the second time he left his post, 7A, without being properly relieved, stating that he “shouldn’t have done that.” The video shows Officer (b)(6); (b)(7)(C) looking in DE LA ROSA’s cell, then speaking into his radio. On interview, he said he called “possible hanging” then immediately went to the RHU Control Center to retrieve the cut down tool.

Note: Although (b)(7)(E) were present, they did not enter DE LA ROSA's cell. Not knowing how close other responders were, (b)(6); (b)(7)(C) made a judgment call to retrieve the cutdown tool from RHU Control and return with it to the cell, an action that took him less than one minute.

(b)(6); (b)(7)(C) stated on interview that she was assigned to RHU Control for the first time this date. When she heard the medical emergency call, she turned to look into 7B and saw Officer (b)(6); (b)(7)(C) standing at cell 105, then (b)(6); (b)(7)(C) pounded on the window and asked for the cut down tool. She took the tool from its storage box on the wall and removed it from its pouch. She then placed the tool in the pass through box for (b)(6); (b)(7)(C).

Note: (b)(6); (b)(7)(C) only pertinent entry in the RHU Control Logbook documents a medical emergency in 7B at 11:03 p.m., 30 minutes after DE LA ROSA was discovered hanging. She did not log the radio call or subsequent events related to the emergency, including the arrival and departure of SDC and Emergency Medical Services (EMS) responders. She informed the review team she has since been told she needs to record all activity on the unit during an emergency. Central Control logged the time of the medical emergency at 10:38 p.m.

Officer (b)(6); (b)(7)(C) returned to cell 105 with the cut down tool, accompanied by Lieutenant (b)(6); (b)(7)(C). The video footage shows the cell door was opened at 10:35:56 p.m., two minutes and four seconds after Officer (b)(6); (b)(7)(C) poked into the cell. The cell light was turned on. Officer (b)(6); (b)(7)(C) stated on interview that he and the lieutenant lifted DE LA ROSA upward while Officer (b)(6); (b)(7)(C) cut through the socks around the detainee's neck. (b)(6); (b)(7)(C) informed the review team that he had been trained in the use of the cut down tool and had no trouble cutting through the socks. At 10:36:16 p.m. the detainee was placed on the floor with his feet by the toilet/sink fixture as another officer entered the unit. (b)(6); (b)(7)(C) stated he immediately began cardio pulmonary resuscitation (CPR), remarking that he "wanted to do something" because he recalled officers did not start CPR when a detainee was discovered hanging a year ago. The dayroom lights were turned on at 10:37:05 p.m.

Lieutenant (b)(6); (b)(7)(C) stated on interview that he knew of DE LA ROSA before the emergency because he had been on suicide watch a few months prior and had made a "flirty comment" to a female officer. He was not far from 7B when he heard the emergency call and he encountered Officer (b)(6); (b)(7)(C) retrieving the (b)(6); (b)(7)(C) tool. They entered the pod together as (b)(6); (b)(7)(C) stood outside the cell. Lieutenant (b)(6); (b)(7)(C) instructed Officer (b)(6); (b)(7)(C) to open the cell door and the three entered. He commented that upon entry, he noticed DE LA ROSA's feet were flat on the floor and that he was drooling. He confirmed (b)(6); (b)(7)(C) held the detainee up while (b)(6); (b)(7)(C) cut through the socks, then they lowered the detainee to the floor and (b)(6); (b)(7)(C) began CPR. Lieutenant (b)(6); (b)(7)(C) stated that he took over CPR for (b)(6); (b)(7)(C) who had relieved Officer (b)(6); (b)(7)(C) when he tired.

The video shows Officer (b)(6); (b)(7)(C) arrived with a handheld camera at 10:37:11 p.m. She stated on interview that she heard the medical emergency call while working in Central Control, then grabbed a camera and ran to 7B. She reported she began filming upon arrival at DE LA ROSA's cell, continuing until EMS responders wheeled the detainee off the unit on a gurney. Video from the handheld camera is 20 minutes and 54 seconds in duration. (b)(6); (b)(7)(C) stated that at one point, she sat on the sink in the cell in order to record activities without getting in the way of responders.

Because video taken by (b)(6); (b)(7)(C) includes audio and provides detailed coverage of actions and events within the cell, the following timeline is based primarily on handheld camera footage, supplemented by information reported by staff and documented in a hard copy Chronological Record of Medical Care written by (b)(6); (b)(7)(C). According to (b)(6); (b)(7)(C) the document was produced because eCW was down following the medical emergency. Central Control Logbook entries and the report of the Stewart County EMS Fire-Rescue are also referenced.

Note: The time stamp from the handheld camera video appears to be two minutes behind the time stamp on video from the fixed dayroom camera. Times reflected below are adjusted to match the timestamp on the stationary camera footage. Even with the adjustments, times from other sources do not always correspond. The discrepancies are minor and deemed inconsequential by reviewers. They may be explained by different timepieces and completion of documentation after the fact.

10:37:14 p.m. The video opens with Officer (b)(6); (b)(7)(C) kneeling next to detainee DE LA ROSA who is prone on the floor. Officer (b)(6); (b)(7)(C) is seen performing chest compressions, then gives one rescue breath mouth to mouth without a breathing mask or CPR mouth shield. Lieutenant (b)(6); (b)(7)(C) is heard asking Officer (b)(6); (b)(7)(C) if he is tired, and Officer (b)(6); (b)(7)(C) replied, "A little bit." Officer (b)(6); (b)(7)(C) then took over chest compressions.

Note: During interview, Officer (b)(6); (b)(7)(C) showed the review team the pouch on his belt containing a CPR mask, stating he forgot about it in the midst of the emergency.

Note: The reviewer observed Officer (b)(6); (b)(7)(C) initially performed chest compressions properly; however, his hand position moved downward, off the chest.

10:37:32 p.m. Nursing staff arrived on the unit pushing a gurney. Atop the gurney was a backboard and two emergency bags, one blue and one orange. (b)(6); (b)(7)(C) is seen looking into the cell, then returned to the emergency bags on the gurney. She stated, "Where is my AED?" Lieutenant (b)(6); (b)(7)(C) entered the cell with the backboard.

The Chronological Record of Medical Care documents (b)(6); (b)(7)(C) arrived at 10:38 p.m. The document states, "Detainee was found lying on cell floor unresponsive and not breathing. Detainee skin was pale and cool to touch. Horizontal bruising was noted to neck area. Core Civic officer (b)(6); (b)(7)(C) was giving chest compressions. Began to place ambu mask to open airway to give rescue breaths. Vomitus/Emesis from mouth noted."

10:38:20 p.m. (b)(6); (b)(7)(C) s heard on video stating, "I need an oxygen tank STAT." She then stated, "Tell them to bring a crash cart down and call EMS now." Another nurse entered the cell 19 seconds later.

Note: An oxygen tank was already present; however, it was not usable because a regulator was disconnected. According to (b)(6); (b)(7)(C) the regulator was in the emergency bag but (b)(6); (b)(7)(C) did not locate it.

The Chronological Record of Medical Care documents, (b)(6); (b)(7)(C) (Core Civic) was told to activate EMS" at 10:39 p.m. The Stewart County EMS Fire-Rescue report documents 10:39 was the time a unit was dispatched. The Central Control Logbook documents the time of EMS activation was 10:42 p.m., three minutes after the EMS report documents a unit was dispatched.

10:39:05 p.m. Lieutenant (b)(6); (b)(7)(C) took over CPR.

10:39:11 p.m. (b)(6); (b)(7)(C) stated, "There was nothing on my cart" and that she needed an automated external defibrillator (AED) and additional nurses to be sent from Intake. She also requested the crash cart from medical.

During interview of (b)(6); (b)(7)(C) he stated he followed Lieutenant (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) in responding to the scene. When he arrived, medical staff were asking for equipment they did not have. He stated he sent one officer to medical to retrieve the AED and then sent a second officer to medical to retrieve an oxygen tank.

10:40:15 p.m. Office (b)(6); (b)(7)(C) entered the cell with an AED, followed within seconds by two nurses. During interview, Office (b)(6); (b)(7)(C) stated she was in intake when medical emergency was announced and was directed by Captain (b)(6); (b)(7)(C) to retrieve AED from medical and bring it to 7B.

The Chronological Record of Medical Care documents the AED and an oxygen tank were brought into the cell by (b)(6); (b)(7)(C) at 10:41 p.m.

Note: The Chronological Record of Medical Care does not address the fact that the AED was not initially brought to the scene, nor was the oxygen tank usable because the regulator had been disconnected and (b)(6); (b)(7)(C) could not find it in the emergency bag (b)(6); (b)(7)(C) informed the review team that there was a medical emergency earlier in the day, after which all necessary emergency equipment, including AED, was not returned to the gurney. The reviewers' analysis of the video footage found discovery of missing items added to a response that appeared somewhat disorganized and chaotic.

10:41:25 p.m. The video shows AED pads were applied to DE LA ROSA. A nurse took over CPR.

The Chronological Record of Medical Care documents placement of the AED pads at 10:42 p.m. "[Oxygen] at 15 liters placed to ambu bag. CPR continues with (b)(6); (b)(7)(C) interchanging chest compressions. AED continues to say 'no shock advised. Continue CPR.'"

10:45:46 p.m. A voice off camera announced, "EMS is here."

Per the EMS Fire-Rescue report, the vehicle arrived at the facility at 10:42 p.m. and the responders were at the patient at 10:47 p.m.

10:47:41 p.m. Video shows EMS responders entering the cell. An EMS staffer stated, "We're about to get an airway." 10:47 p.m. is also the time of arrival documented in the Chronological Record of Medical Care and Central Control logbook.

10:47:52 p.m. An EMS responder is seen removing the SDC's AED pads from DE LA ROSA.

10:48:03 p.m. EMS responders dragged the detainee from the cell and to the dayroom by his arm. The Chronological Record of Medical Care documents, "Detainee pulled from cell" at 10:48 p.m.

10:49:13 p.m. An EMS responder applied AED pads to the detainee.

10:49:40 p.m. An EMS responder laid on his stomach at the head of the detainee to intubate him.

10:50:25 p.m. The EMS responder stated, "I'm in."

The Chronological Record of Medical Care documents the detainee was intubated by EMS at 10:50 p.m. "CPR continues. AED monitor exchanged to EMS cardiac monitor/defibrillator."

10:54:16 p.m. Detainee DE LA ROSA was lifted onto the gurney by EMS responders.

10:55:31 p.m. EMS responders wheeled the gurney off the unit.

10:56:59 p.m. An EMS responder is heard saying, “He’s clinically dead right now. We’re doing everything we can to reverse that.”

10:57:03 p.m. DE LA ROSA is placed in the ambulance. Video from the handheld camera ends.

Per the written incident report of Captain (b)(6); (b)(7)(C) the AFOD and contract monitor were notified of the medical emergency at 10:45 p.m.

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) the chase vehicle. Officer (b)(6); (b)(7)(C) informed the review team that when informed of the assignment, he reported to intake and boarded the ambulance with the logbook. He stated there was no room in the back of the vehicle so he sat in the front seat next to the driver. According to his logbook entry, the ambulance left SDC at 11:05 p.m. The EMS report documents the time of departure was 11:06 p.m. Officer (b)(6); (b)(7)(C) told the review team he was unable to observe what was going on in the back of the ambulance and kept his eyes on the road because the ambulance was traveling at a high rate of speed. Officer (b)(6); (b)(7)(C) reported the ambulance immediately activated lights and siren and she followed it as best she could while maintaining posted speed limits. She stated she could see EMS responders performing CPR through the rear windows of the ambulance. The EMS report states that while in route to the hospital, the responders “called for orders to terminate CPR due to efforts being deemed futile”, noting there was no response from the patient, his skin was cool to the touch, and his pupils were fixed and unreactive. The request was denied by a nurse practitioner (not named) so CPR was continued.

DE LA ROSA was taken to Southwest Georgia Regional Medical Center (SGRMC) in Cuthbert, GA, 22.4 miles from SDC. The time of arrival was 11:25 p.m. per both the EMS report and logbook entry. Officer (b)(6); (b)(7)(C) stated that upon arrival at the emergency room (ER), the detainee was taken to a curtained area and hospital staff performed CPR and used an AED. Physicians then checked him and pronounced death. The time of death entered in the logbook was 11:35 p.m.; however, in a later entry Officer (b)(6); (b)(7)(C) documented that (b)(6); (b)(7)(C) informed him that “due to a misunderstanding”, the time was corrected to 11:29 p.m. Officer (b)(6); (b)(7)(C) who arrived in the ER after CPR was terminated, said she notified Captain (b)(6); (b)(7)(C) by telephone as soon as death was pronounced.

Video footage from the 7B dayroom camera shows that at 11:43 p.m., Lieutenant (b)(6); (b)(7)(C) used black tape to apply a large X on DE LA ROSA’s cell, covering the frame and hinges. At 11:51

p.m., he returned and removed the taped X, replacing it with tape covering only the cell door lock. On interview, (b)(6); (b)(7)(C) stated that after he placed the X on the door, he thought about how it might be perceived and that it might “rile up other detainees”, so he returned and removed it.

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Per hospital logbook entries, Deputy Coroner (b)(6); (b)(7)(C) arrived at 1:30 a.m. and exited with the body at 1:46 a.m. Officers (b)(6); (b)(7)(C) confirmed during interview that they remained in the emergency room with the body until it was removed by the Deputy Coroner. At 1:49 a.m., they left the hospital to return to SDC. They arrived at 2:16 a.m. and wrote their incident statements.

Post-Death Actions

- Incident reports were collected from all involved staff immediately following the medical emergency. Officer (b)(6); (b)(7)(C) initially wrote a two line incident report, explaining that she did not realize a detailed report was necessary because she had never been involved in a hanging. Per instruction of the facility investigator, she wrote a second report on July 23, 2018 providing more detail.
- Officer (b)(6); (b)(7)(C) stated he was never offered employee assistance services. He commented to the review team that the death was “hard to watch” and he has had difficulty getting the images out of his head. Reviewers encouraged him to contact the human resources department or his supervisor. Officer (b)(6); (b)(7)(C) stated he was offered employee assistance services but did not receive a return call after his initial contact.
- Captain (b)(6); (b)(7)(C) stated that upon notification of DE LA ROSA’s death, he spoke with Warden Peterson who instructed him to notify the Sheriff’s Department. Per report of the Stewart County Sheriff’s Office, Sheriff (b)(6); (b)(7)(C) was dispatched to SDC and arrived at 12:30 a.m. on July 11, 2018. He spoke with the Warden and interviewed Officer (b)(6); (b)(7)(C). (b)(6); (b)(7)(C) report states that GBI arrived on the scene at 1:15 a.m. and the investigation was turned over to two agents from the GBI Americus office.

Captain (b)(6); (b)(7)(C) informed the review team that he escorted one of the GBI agents to DE LA ROSA’s cell. When told he would be awhile, he left the agent with an officer. The GBI report was not available at the time of the site visit.

- On July 11, 2018, Warden Peterson assigned facility investigator (b)(6); (b)(7)(C) to review events surrounding detainee DE LA ROSA’s suicide. She submitted a written report to the Warden on August 6, 2018. She informed the review team that her

investigation involved review of written reports, interviews with security and medical staff, and extensive review of video footage. Her review did not include analysis of actions taken by medical personnel. As discussed below (b)(6); (b)(7)(C) conducted an after action review involving CoreCivic and IHSC personnel.

(b)(6); (b)(7)(C) analysis of video footage included use of the zoom feature to better see DE LA ROSA inside his cell on the day of his suicide. Her analysis ended at 8:04 p.m., approximately two and a half hours before he was discovered, when he turned off the light and could no longer be seen in camera footage. According to (b)(6); (b)(7)(C) report, detainee DE LA ROSA climbed onto the toilet three times between 8:20 a.m. and 8:25 a.m. He attended recreation and was observed playing basketball and speaking to other detainees. After he returned to his cell, he again climbed on top of the toilet twice. He later went to medical and after his return again climbed on top of the toilet at 12:34 p.m. After this he received his lunch meal. Rounds were conducted throughout the afternoon and DE LA ROSA again climbed atop the toilet at 7:07 p.m., getting down a minute later when he saw staff approaching his cell. He received dinner at 7:09 p.m., climbed on the toilet at 7:23 p.m. and had his food tray picked up by Officer (b)(6); (b)(7)(C) at 7:36 p.m. At 8:04 p.m., detainee DE LA ROSA was seen with his hand on the cell light switch, then turned the light off. This is the last time detainee DE LA ROSA was viewed from the pod camera until the cell was entered at 10:36 p.m.

During (b)(6); (b)(7)(C) interview of Officer (b)(6); (b)(7)(C), he commented that detainee DE LA ROSA was always smiling and asking for the time and date. He said the detainee spoke about how beautiful the nurses were but he was never disrespectful and (b)(6); (b)(7)(C) told him to keep his comments to himself. Officer (b)(6); (b)(7)(C) reported he made his last round at 10:04 p.m. and although the lights were off in DE LA ROSA's cell, he saw the detainee with his peripheral vision sitting on the bed smiling at him. As noted, the video evidence does not support Officer (b)(6); (b)(7)(C) statement. (b)(6); (b)(7)(C) drew the same conclusion, finding that Officer (b)(6); (b)(7)(C) did not look into cell 105 during rounds conducted after 8:40 p.m. By document titled CoreCivic Facility Employee Problem Solving Notice dated July 26, 2018, Officer (b)(6); (b)(7)(C) was terminated by Warden Peterson for failing "to properly observe the detainee inside of his cell (7B/105) while conducting his rounds..."

- (b)(6); (b)(7)(C) reported an After Action Review was conducted with CoreCivic and IHSC to determine what they missed and lessons to be learned." He acknowledged that the review determined several things were missed "from the get go." The findings he verbally shared included the following:
 - Nurses improperly documented that detainees in RHU were "no shows" for medication administration. (b)(6); (b)(7)(C) stated nurses have been retrained on the requirement to go to each cell and that video footage is now periodically reviewed to ensure compliance.

- The emergency cart was not set back up after the medical emergency earlier in the day.
- Medical responders seemed flustered during the emergency.
- (b)(6); (b)(7)(C) did not offer detainee DE LA ROSA medication even though she documented that she did. She made other errors observed on video such as placing medications in her bare hands, signing the MAR prior to distributing the medication and not identifying detainees prior to giving medications. (b)(6); (b)(7)(C) remarked that in fact, “We couldn’t find anything she did right on the video.” Her employer separated her from service.
- (b)(6); (b)(7)(C) gave rescue breaths without a mask.
- (b)(6); (b)(7)(C) used proper technique when he began CPR, but “walked down the abdomen” and at the end was giving CPR “over the spleen.”
- No one counted chest compressions so the required 30 compressions and two breaths were not consistently applied. In addition, staff did not rotate every two minutes or after five cycles.
- Neither SDC medical staff nor EMS responders did a C Spine immobilization⁴⁷ which should be done after a fall or a hanging. Instead of the head tilt, a jaw thrust should have been used, and EMS dragged the detainee out of the cell and placed him on the gurney without securing his head.

(b)(6); (b)(7)(C) commented that although concerning, none of these issues contributed to DE LA ROSA’s death.

- Photographs of cell 105 taken by the GBI were made available to the review team. Graffiti present on the walls translated from Spanish by ERO staff (b)(6); (b)(7)(C) (title and last name unknown) included a reference to Honduras and “Everyday is more important”. Attribution to detainee DE LA ROSA is not possible, although it is assumed the graffiti referencing Honduras was not his since he was from Mexico.
- Disposition of Property and Inmate Account Summary reports document DE LA ROSA’s property was inventoried on July 11, 2018 and was turned over to ERO staff along with the \$0.31 remaining in the detainee’s account. Photographs of the property were taken by GBI agents and provided to the review team.

⁴⁷ C-spine immobilization refers to procedures and equipment which limit the movement of the vertebrae and prevent serious injury to the spinal column, such as with use of cervical collars and long backboards.

CONCLUSIONS

Healthcare

During intake screening, detainee DE LA ROSA disclosed he was diagnosed with schizophrenia and treated at a mental health facility while serving a federal sentence. He also disclosed that his treatment included psychiatric medications he had stopped taking three months earlier because they affected his sleep. He was appropriately referred for expedited initial physical examination and mental health evaluation during which he again disclosed his mental health history. Because he was asymptomatic, no change to his housing in general population was indicated. DE LA ROSA was scheduled for four-week mental health follow up based on his history but before the appointment, was charged with a disciplinary incident involving inappropriate remarks to a female officer. He was cleared for segregation and referred to a mental health provider due to his history. The provider found DE LA ROSA had no active symptoms and SMI criteria were not met; therefore, his status remained segregation without added mental health observation requirements.

During the detainee's 15 day stay in segregation, nurses documented completion of required daily rounds using template language. Their notes were devoid of subjective information reflecting DE LA ROSA's remarks in response to queries as the SOAP format calls for. LCSWs made two segregation rounds as required, on both occasions documenting SMI criteria were not met. In between the rounds an LCSW conducted a follow up assessment, documenting DE LA ROSA said he hears from God every day and that "voices give him peace because they are there with him." This was the third time the medical record documents the detainee reported hearing from God; the first during intake when he told the nurse God talks to him and can control his mind; the second during the initial mental health assessment when he more vaguely said God speaks to him. The LCSW's offer of evaluation for medication therapy was refused by DE LA ROSA.

Six days following the detainee's return to general population housing, he was evaluated by PMHNP (b)(6); (b)(7)(C) for auditory hallucinations. DE LA ROSA said again that he was able to speak with and was answered by God; also, that he is the anti-Christ and that he would be dead in three days. He was offered and refused medications. PMHNP (b)(6); (b)(7)(C) ordered constant observation suicide watch, which, due to lack of space in the medical housing unit, was effectuated in the RHU. On the third day following DE LA ROSA's placement on suicide watch, PMHNP (b)(6); (b)(7)(C) referred him for hospitalization at CRCC on the basis of continued fixed delusions and continued refusal to accept treatment despite education and encouragement. He was transferred to CRCC when space became available, a week following referral. While on suicide watch pending transfer, DE LA ROSA was seen by providers and nurses an average of four times a day, and nurses documented subjective information reflecting interaction with him. However, there were three occasions when documented healthcare rounds were completed outside the required eight-hour timeframe, and multiple others when positive determination was not possible because providers do not enter the times of their encounters. In addition, on three occasions, nurses did not document vital signs associated with their rounds. DE LA ROSA's blood pressure was occasionally found

elevated, including during seven assessments when the American Heart Association threshold for stage one hypertension was exceeded.

DE LA ROSA was hospitalized at CRCC for approximately six weeks. CRCC records document antihypertensive medication amlodipine was given when his blood pressure was elevated, and that he was started on psychiatric medications Haldol and Zyprexa to treat schizophrenia. The records indicate Zyprexa by injection was authorized if he refused the medication, but do not document whether involuntary administration occurred. The CRCC record indicates he was “generally compliant” with treatment.

A nurse screened DE LA ROSA again when he returned to SDC, to include review of discharge documentation from CRCC. The Clinical Director was notified and ordered the three medications started at CRCC. Their administration was not attempted until the second day after ordered, possibly due to timing of the order vis-à-vis pharmacy hours and availability of the psychiatric medications. MARs reflect DE LA ROSA took his psychiatric medications on three days; however, one of the entries was determined false and the others are highly suspect. In fact, the preponderance of the evidence suggests he took no doses of amlodipine or psychiatric medications. No Show entries were made on the MAR on eight days for amlodipine and 12 days for the psychiatric medication, including seven days when he was in segregation and could not voluntarily report to the medication nurse. At no time did nurses who entered No Show document that they sought the detainee out to confirm he refused his medications and educate him as to the risks. Refusals were documented for all other doses; however, nurses did not complete refusal forms or notify a provider on a consistent basis. Although nurses did refer him to (b)(6); (b)(7)(C) 7 times, the provider never saw him. An LCSW was notified twice and in her encounter notes, documented DE LA ROSA maintained he did not need medication. PMHNP (b)(6); (b)(7)(C) incorrectly documented the detainee was compliant with treatment in his own encounter notes, stating during interview that DE LA ROSA reported that he was taking his medications and because he was doing well, the detainee’s assertion was not questioned. At no time was the Clinical Director informed DE LA ROSA was not taking any of his medications.

Detainee DE LA ROSA’s return to segregation took place six days after he was discharged from CRCC and was the result of making inappropriate remarks to a second female officer. His suicide occurred three weeks after placement in the RHU. He was cleared for segregation and nurses made required rounds, again using only template language in their medical record entries. The detainee was seen by mental health providers four times for segregation rounds, twice by LCSW (b)(6); (b)(7)(C) and twice by PMHNP (b)(6); (b)(7)(C). PMHNP (b)(6); (b)(7)(C) documented SMI criteria were not met; LCSW (b)(6); (b)(7)(C) documented SMI criteria were met but added that the detainee had no active psychiatric symptoms. Her determination that DE LA ROSA met SMI criteria and at the same time, had no active symptoms is contradictory. In her encounter note for the morning of DE LA ROSA’s suicide, she wrote that he presented as “pleasantly delusional” and that the content of the delusions was spiritual in nature. She also wrote that he denied having thoughts of suicide or believing that

he was going to die. She concluded he did not present a danger to himself or others at the time of the encounter.

Approximately 11 hours later, an officer discovered DE LA ROSA hanging and immediately called medical emergency. Responding security personnel started CPR without delay, although one officer appeared to inadvertently move his hands to an improper position during performance of chest compressions. The first nurse arrived within four minutes of the medical emergency announcement and directed that EMS be called; however, because emergency equipment was not returned to its designated location after an emergency earlier in the day, the AED was not initially brought to the scene and the oxygen tank was missing its regulator. Although swift, the response was somewhat chaotic.

In summary, detainee DE LA ROSA was monitored by mental health professionals throughout the detention period and hospitalization at a mental health facility was arranged when providers determined he was suicidal. Psychiatric medications were offered and declined multiple times before his hospitalization at CRCC and upon DE LA ROSA's return, medications were ordered. As is his right, DE LA ROSA refused. The record includes 21 refusal forms documenting he was informed by nurses of risks associated with not taking his medications, and LCSW encounter notes indicate the detainee maintained he did not need medications. The Clinical Director or a prescribing mental health provider were not notified he refused to take medications; however, the midlevel provider responsible for following up on medication refusals was, 17 times, and did not see him. Although she failed to do so, PMHNP (b)(6); (b)(7)(C) saw DE LA ROSA twice during segregation rounds in the weeks preceding his suicide and, unaware the detainee was not taking medications, nonetheless determined he did not meet SMI criteria. The LCSW who also saw DE LA ROSA in the weeks preceding his suicide was aware he was refusing his medications, but up to and including the day of his suicide, determined his continued delusions were of a spiritual nature and did not put him at current risk of harming himself. Mental health encounter notes entered in the weeks before DE LA ROSA's suicide were co-signed by IHSC Behavioral Health Unit professionals who concurred with documented plans to continue monitoring.

Based on the evidence, reviewers conclude providers identified no signs of suicidal ideation or intent following DE LA ROSA's return from CRCC; also, that because he exhibited no active psychiatric symptoms, his refusal of psychiatric medications raised no flags. Assessing provider judgment is beyond the scope of the healthcare reviewer's credentials and the scope of this analysis; therefore, the following findings and concerns relate to process, only.

Compliance Findings

Creative Corrections cites the following deficiencies in the ICE PBNDS 2011, 2016 revisions, governing healthcare.

Medical Care, section (V)(U)(4), which states, “Distribution of medications shall be performed in accordance with specific instructions and procedures established by the HSA in consultation with the CMA. Written records of all prescribed medications given to or refused by detainees shall be maintained. All prescribed medication and medically necessary treatments shall be provided to detainees on schedule and without interruption absent exigent circumstances.”

- Video evidence shows an RN falsely recorded refusal of psychiatric medications on the night of DE LA ROSA’s suicide, July 10, 2018. The RN’s entries documenting successful administration of the medications on June 27, 28, and 30, 2018 are also assumed to be false.
- There were two illegible entries on the MAR for amlodipine (June 14 and 17, 2018); therefore, there is no documentation the medication was either given or refused. In addition, entries of No Show were entered 20 times between June 14 and 26, 2018, including 15 after he was placed in segregation and could not voluntarily report to receive medications. Entries of No Show, especially in segregation, do not constitute affirmative documentation that medications were refused as required by the standard.

Medical Care, section (V)(AA)(1), which states, “Upon admission at the facility, documented informed consent shall be obtained for the provision of health care services.

- A consent form was not signed by the detainee when first admitted to SDC. He signed consent for tele-psychiatry services on March 16, 2018, and general consent for treatment when readmitted after hospitalization on June 12, 2018.

Medical Care, section (V)(AA)(4), which states, “Prior to the administration of psychotropic medications, a separate documented informed consent, that includes a description of the medication’s side effects, shall be obtained.”

- There is no documentation DE LA ROSA was asked to sign a separate consent for Haloperidol and Olanzapine when ordered on June 12, 2018.

Medical Care, section (V)(AA)(9-11), which states, “Medical staff shall explain the medical risks if treatment is declined and shall document their treatment efforts and refusal of treatment in the detainee’s medical record. Detainees will be asked to sign a translated form that indicates that they have refused treatments. The Clinical Medical Authority and facility administrator shall look into refusals of treatment to ensure that such refusals are not the result of miscommunication or misunderstanding. Facilities should make efforts to involve trusted individuals such as clergy or family members should a detainee refuse treatment.”

- The MAR documents DE LA ROSA refused his medications 29 times. No refusal forms were completed for eight of the 29. In addition, as noted in the above deficiency, nurses entered No Show on the MAR 20 times. There is no documentation any effort was made to confirm the detainee was, in fact, refusing medications on these 20 occasions, explain the risks, and complete refusal forms.

- The Clinical Director was not notified the detainee was refusing medications and therefore, did not follow up. Nurses did, however, send 17 telephone encounters to (b)(6); (b)(7)(C) the midlevel provider responsible for following up on medication refusal. The provider did not see DE LA ROSA, claiming scheduled appointments were postponed. No documentation of scheduling was produced.

Significant Self-harm and Suicide Prevention and Intervention, Medical Care, section (V)(E), which states, “All suicidal detainees placed in an isolated confinement setting will receive on-to-one monitoring welfare checks at least every eight hours conducted by a qualified clinician.

- The eight-hour timeframe was not met on at least three occasions. There was a 12 and half hour gap between a healthcare round at 8:55 p.m. on April 26, 2018 and the next round at 9:30 a.m. on April 27, 2018; a ten hour gap between a healthcare round at 10:30 p.m. on April 28, 2018 and the next round at 8:45 a.m. on April 29, 2018; and ten hours between a round at 2:29 p.m. on April 29, 2018 and 12:30 a.m. on April 30, 2018. Because providers do not enter the times they see patients, reviewers were unable to positively identify other occasions when the eight-hour timeframe may have been exceeded. However, timing of vital signs and provider sign-off suggests there may have been multiple, particularly when a round was due on midnight shift.

Significant Self-harm and Suicide Prevention and Intervention, section (V)(K), which states, “A critical incident debriefing shall be offered to all affected staff and detainees within 24 to 72 hours after the critical incident.”

- Office (b)(6); (b)(7)(C) who rode in the ambulance, stated he was not offered a critical incident debriefing or supportive counseling services. In addition, (b)(6); (b)(7)(C) who discovered DE LA ROSA hanging and participated in the emergency response, stated the employee assistance program did not call him back following his request for services.

Areas of Concern

The following expands upon above-cited deficiencies and identifies areas of concern not addressed in the detention standards.

- Nurses used template language programmed in eCW to document segregation rounds when DE LA ROSA was in the RHU for disciplinary reasons. All notes are virtually identical and do not include subjective information reflecting DE LA ROSA’s remarks in answer to queries. Subjective information is the first element in the SOAP note format and fundamentally, supports objective findings. In DE LA ROSA’s case, nurses’ findings that there was no evidence of hallucinatory and delusional thoughts would have been far better supported had they documented subjective information. Reviewers recognize that nurses enter segregation rounds in eCW well after completion and including subjective information would require careful note-taking. However, to assure that segregation rounds

serve the intended purpose of verifying detainee health and welfare, reviewers recommend that nurses be required to include adequate, individualized subjective content in their notes.

- An elevated blood pressure of 152/92 recorded on April 30, 2018 was not followed up or reported to a provider for evaluation to determine possible monitoring and treatment needs. (b)(6); (b)(7)(C) stated nurses are to notify providers of elevated blood pressure readings following thresholds sent in IHSC Directive 03-10, Intake Screening and Intake Reviews. This directive states providers are to be notified if the systolic blood pressure is 150 or higher.
- As noted in the fourth deficiency, nurses sent 17 telephone encounters to (b)(6); (b)(7)(C) notifying her DE LA ROSA was refusing his medications. She never saw him. She stated during interview that she consulted mental health professionals, which, if she did, may have resulted in confirmation that he was stable from a mental health perspective. However, the fact remained that a detainee with diagnosed schizophrenia, previously on suicide watch and hospitalized, was not taking prescribed psychiatric medications. Regarding antihypertensive medication amlodipine, the NP's failure to evaluate DE LA ROSA meant his blood pressure was not checked, except by happenstance when he was cleared for segregation. In fact, his blood pressure fell within American Heart Association parameters for stage one hypertension 21 times and stage two hypertension eight times during the detention period. Whether or not the detainee's refusal of medications was impactful on either his physical or mental health, (b)(6); (b)(7)(C) is a prescribing provider, was obliged to act upon nurses' referrals, including educating the detainee on the risks.
- Also addressed in the deficiency are nurses' No Show entries on the MAR, including on seven consecutive days after DE LA ROSA was placed in segregation. An entry of No Show implies the detainee did not report to the nurse to receive his medications which, in segregation, is not possible. If nurses did, in fact, go to his cell and offer medications, they should have documented refusal, educated him as to risks, and completed refusal forms. Although the evidence suggests that DE LA ROSA would have refused medications if offered at his cell, entries of No Show do not properly document attempts to administer ordered medications.
- (b)(6); (b)(7)(C) the first medical responder to arrive at DE LA ROSA's cell, brought emergency equipment with her; however, an AED was not available and the oxygen tank was missing a regulator. The explanation provided to reviewers was that emergency equipment was not replenished following a medical emergency earlier in the day. Although unlikely to have made a difference in DE LA ROSA's case, ensuring necessary emergency equipment is available and operable is critical to an effective medical emergency response.

Safety and Security

Detainee DE LA ROSA was in general population for approximately three weeks until charged the first time with Making Sexual Proposals to an officer. He was placed in RHU pending disciplinary hearing; however, one copy of the Confinement Record erroneously documented he was assigned to disciplinary segregation status prior to adjudication of the charge. The hearing was held approximately 50 hours after the investigation was completed, two hours later than the mandated 48 hours. The detainee admitted to committing the offense and received a sanction of 30 days disciplinary segregation. Per unilateral order of the Security Chief, DE LA ROSA was returned to general population after 15 days. DE LA ROSA committed the same offense against another officer later during his detention. The Confinement Record placing him in the RHU again erroneously assigned him to disciplinary segregation status before the charge was adjudicated. At his disciplinary hearing he admitted to the offense and was sanctioned with 30 days disciplinary segregation. He was serving the sanction at the time of his suicide.

In between the disciplinary incidents, detainee DE LA ROSA submitted an incident statement in which he alleged he was being threatened by his cellmate. The statement does not document when or by whom it was received. Three days after the date of statement, a memorandum and Confinement Record document the detainee's placement on the status for protective custody. The Confinement Record also documents placement by healthcare staff for constant observation suicide watch. The detainee was strip searched without documentation of specific reasonable suspicion that he was secreting contraband. On the third day of the suicide watch, a mental health provider referred him to a mental health facility for advanced care. He was transferred when a bed became available, a week following referral. The detainee returned to SDC and was in general population for approximately one week before the second infraction for Making Sexual Proposals to an officer. During DE LA ROSA's three periods in segregation, status reviews were sometimes missed or late, and none document that he was interviewed.

At approximately 10:33 p.m. on July 10, 2018, the officer assigned to the RHU, (b)(6); (b)(7)(C) observed DE LA ROSA hanging by socks from the upper bunk bed in his cell. (b)(6); (b)(7)(C) made the discovery during his first security round, 28 minutes after he assumed the post. The detainee was presumably last seen alive at 8:40 p.m. by the officer on the previous shift, Officer (b)(6); (b)(7)(C). Although Officer (b)(6); (b)(7)(C) recorded security rounds at 9:13 p.m., 9:39 p.m. and 10:04 p.m., video evidence does not corroborate that he looked into the cell to personally observe detainee DE LA ROSA during any of these rounds.

Officer (b)(6); (b)(7)(C) immediately called a medical emergency when he observed detainee DE LA ROSA hanging. He did not enter the cell pending the arrival of additional security personnel, although facility policy allowed him to do so. (b)(6); (b)(7)(C) was first to respond, leaving his post without being properly relieved, then retrieved a cut down tool from the RHU control center. Approximately two minutes after (b)(6); (b)(7)(C) discovered detainee DE LA ROSA hanging, he

and two responding officers entered the cell, cut the detainee down, and (b)(6); (b)(7)(C) began chest compressions.

The first nurse arrived in less than four minutes of the medical emergency call, although without AED, and immediately directed calling EMS. Other nurses and security staff rotated performance of chest compressions and once brought to the scene, the AED was applied and advised no shock. EMS responders arrived approximately eight minutes after DE LA ROSA's suicide was discovered, took over care, and transported him to a hospital 22 miles away. Detainee DE LA ROSA was pronounced dead at 11:29 p.m.

Incident reports were collected from all involved staff. Employee assistance services were offered to (b)(6); (b)(7)(C) but not to the officer who was in the ambulance and present when death was pronounced. (b)(6); (b)(7)(C) stated he contacted the employee assistance program but did not receive a return call.

Compliance Findings

Creative Corrections cites the following deficiencies in relevant components of the ICE PBNDS 2011, 2016 revisions, governing safety and security.

Custody Classification System, section (V)(H)(3), which states, "Special Reclassification Assessments "Staff shall complete a special reclassification within 24 hours before a detainee leaves the Special Management Unit (SMU), following an incident of abuse or victimization, and at any other time when warranted based upon the receipt of additional, relevant information, such as after a criminal act, or if a detainee wins a criminal appeal, is pardoned or new criminal information comes to light."

- A reclassification review was not completed within the 24 hours preceding DE LA ROSA's release from disciplinary segregation on April 18, 2018. A reclassification review factoring the disciplinary conviction was, however, conducted eight days earlier.

Disciplinary System, section (V)(A)(6), which states, "When a detainee has a diagnosed mental illness or mental disability, or demonstrates symptoms of mental illness or mental disability, a mental health professional, preferably the treating clinician, shall be consulted to provide input as to the detainee's competence to participate in the disciplinary hearing, any impact the detainee's mental illness may have had on his or her responsibility for the charged behavior, and information about any known mitigating factors in regard to the behavior." Also, **Section (V)(A)(8)**, which states, "If a detainee has a mental disability or mental illness but is competent, the disciplinary process shall consider whether the detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. A mental health professional should also be consulted as to whether certain types of sanctions, (e.g.,

placement in disciplinary segregation, loss of visits, or loss of phone calls) may be inappropriate because they would interfere with supports that are a part of the detainee's treatment or recovery plan."

- There is no documentation that a mental health professional was consulted prior to disciplinary hearings on April 6 and June 21, 2018, or that the hearing officer considered the degree to which DE LA ROSA's mental illness may have contributed to his behavior.

Disciplinary System, section (V)(H)(2), which states detainees in IDP proceedings have the right to due process which includes the right to "have an IDP hearing within 48 hours after the conclusion of the investigation or the conclusion of the UDC hearing." Also, section **(V)(H)(4)**, setting requirements for the IDP. The component states, "In cases where a hearing is delayed, the reason(s) must be documented (e.g., a continuing investigation of facts, unavailability of one or more essential witnesses, etc.) and, unless the detainee has requested the delay, approved by the facility administrator."

- The investigation for the April 3, 2018 disciplinary incident was concluded at 10:52 a.m. on April 4, 2018. The IDP hearing commenced at 12:42 p.m. on April 6, 2018, more than 48 hours after the conclusion of the investigation. The hearing officer did not document the reason for the delay.

Searches of Detainees, section (V)(D)(2)(b), which states, "Staff may conduct a strip search where there is reasonable suspicion that contraband may be concealed on the person. 'Reasonable suspicion' means suspicion based on specific and articulable facts that would lead a reasonable officer to believe that a specific detainee is in possession of contraband. It is a more permissive (lower) standard than probable cause, but it is more than a mere hunch. It must be based on specific and articulable facts—along with reasonable inferences that may be drawn from those facts—that the officer shall document in Form G-1025 or equivalent."

- The form documenting the strip search of DE LA ROSA on April 24, 2018 states "Suicide Watch" and does not document the specific facts that led the officer to believe that detainee DE LA ROSA was in possession of contraband.

This also violates SDC RHU Post Orders, Section (III)(C)(1)(b), which states, "ICE detainees will not be strip searched unless there is 'reasonable suspicion' that the detainee is concealing a weapon or contraband, A frisk search shall be performed in lieu of a strip search."

Special Management Units, section (V)(A)(3)(a)(1) which states, "All facilities shall implement written procedures for the regular review of all detainees held in administrative segregation, consistent with the procedures specified below. A supervisor shall conduct a review within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted. The review shall include an interview with the detainee." Also, section **(V)(A)(3)(b)**, which states, "A supervisor shall conduct an identical review after the detainee has

spent seven days in administrative segregation and every week thereafter for the first 30 days and every 10 days thereafter, at a minimum.”

- There is no documentation DE LA ROSA was interviewed during administrative segregation status reviews on April 26, 2018 and May 3, 2018.
- The May 3, 2018 status review was delinquent. Per the standard, it was due on May 1, 2018 after DE LA ROSA had been in segregation for seven days.

Special Management Units, section (V)(B), which states, “A detainee may be placed in disciplinary segregation only by order of the IDP, or its equivalent, after a hearing in which the detainee has been found to have committed a prohibited act and only when alternative dispositions may inadequately regulate the detainee’s behavior.”

- The orders placing DE LA ROSA in segregation on April 3 and June 19, 2018 documented his status was disciplinary segregation. The charges had not been adjudicated.

Special Management Units, section (V)(B)(3)(a), which states, “All facilities shall implement written procedures for the regular review of all disciplinary segregation cases, consistent with the following procedures: A security supervisor, or the equivalent, shall interview the detainee and review his/her status in disciplinary segregation every seven days to determine whether the detainee: 1) Abides by all rules and regulations; and, 2) Is provided showers, meals, recreation and other basic living standards, as required by this detention standard. b. The supervisor shall document his/her findings after every review, by completing a disciplinary segregation review (Form I-887).

- There is no documentation DE LA ROSA was interviewed or reviewed during his placement in disciplinary segregation from April 6 to April 18, 2018.
- There is no documentation DE LA ROSA was interviewed during disciplinary segregation status reviews on June 22 and July 3, 2018.
- The July 3, 2018 status review was delinquent. Per the standard, it was due on June 29, 2018, seven days after the previous status review completed on June 22, 2018.

Special Management Units, section (V)(B)(3)(b)(1) and (2), which state, “All facilities shall implement written procedures for the regular review of all disciplinary segregation cases, consistent with the following procedures: The supervisor may recommend the detainee’s early release from the SMU upon finding time in disciplinary segregation in no longer necessary to regulate the detainee’s behavior. An early-release recommendation must have the facility administrator’s approval before the detainee be returned to the general population.

- On April 18, 2018, Security Chief (b)(6); (b)(7)(C) directed DE LA ROSA’s release to general population after he served 15 days of the first 30 day disciplinary segregation sanction. The early release is noted on the Confinement Record only, without documented rationale. Chief (b)(6); (b)(7)(C) did not complete a status review documenting interview of the detainee and a recommendation for early release based on determination disciplinary segregation was no longer necessary. In addition, facility administrator approval was not obtained. The

ICE detention standards do not address suspension of the balance of a disciplinary segregation sanction outside the status review process.

Special Management Units, section (V)(M), which states, “Detainees in SMU shall be personally observed and logged at least every 30 minutes on an irregular schedule.”

- Because logs were not available for April 4, April 17 or July 3, 2018, completion of 30 minute rounds could not be verified.
- On July 10, 2018, the day of the detainee’s suicide (b)(6); (b)(7)(C) logged security rounds at 9:13 p.m., 9:39 p.m. and 10:04 p.m. While the video footage shows him signing documents on the clipboard next to the detainee’s cell, he did not look in the cell to personally observe DE LA ROSA.

This also violates **SDC Restricted Housing Unit Post Orders, section (III)(B)(1)**, which states, “Detainees in SMU shall be personally observed and logged at least every thirty (30) minutes on an irregular schedule”; and, **SDC Restricted Housing Unit Post Orders, section (III)(B)(1)(i)** which requires the observation of detainees during rounds to include, “looking in each cell to ensure that no unusual or unauthorized activities are occurring.”

Special Management Units, section (V)(D)(1), which states, “A permanent log shall be maintained in the SMU to record all activities concerning SMU detainees (e.g., meals served, recreational time, visitors, etc.).”

- There was no record of whether the lunch meal was served or refused on April 5, April 6, April 29, and June 22, 2018.

Special Management Units, section (V)(R), which states, “In accordance with standard “4.5 Personal Hygiene,” detainees in SMU may shave and shower at least three times weekly.”

- Confinement Activity Records document the detainee was not offered showers three times weekly during the weeks of April 1, April 8, April 15, and July 1, 2018.

This also violates SDC RHU Post Orders, section (III)(L)(5), which states, “Inmates/residents will be offered the opportunity to shower and shave at least three (3) times per week. In the event an inmate/resident refuses to shower for an entire one (1) week period, notify the Shift Supervisor/Unit Manager.”

- There is no documentation that a supervisor was notified when detainee DE LA ROSA did not shower during the period from April 3 to April 18, 2018.

The following additional violations of SDC policy are cited:

SDC Policy 9-13, Count Principles and Procedures, which states, “At shift change, the oncoming Correctional Officer will conduct an informal count of all inmates in his/her area of

responsibility”; and, **SDC RHU Post Orders, section (II)(G), Start of Shift** which states, “Verify that all cell doors and food tray slots are secure.”

- (b)(6); (b)(7)(C) did not conduct a count or make a round to verify all cell doors and food tray slots were secure at the start of his shift at 10:00 p.m. on July 10, 2018. He did not make his first round until he had been on the post for 28 minutes.

SDC RHU Post Orders, Section (IV), which states, “Never leave your post for any reason unless properly relieved by an assigned officer or the Shift Supervisor.”

- (b)(6); (b)(7)(C) left his post on two occasions between the hours of 10:00 p.m. and 10:40 p.m. on July 10, 2018.

Areas of Concern

The following expands upon above-cited deficiencies and identifies areas of concern not addressed in the detention standards.

- As noted in the above Disciplinary System deficiency, a mental health provider was not consulted prior to disciplinary hearings on April 6 and June 21, 2018. Reviewers acknowledge that DE LA ROSA’s mental illness was likely not known to security personnel at the time of the first hearing because patient diagnoses are confidential and per the medical record, he was asymptomatic. DE LA ROSA’s second hearing was conducted nine days following his return from psychiatric hospitalization, prior to which he was on suicide watch for ten days. If this information was known to the hearing officer, consultation with health care staff before proceeding with the disciplinary hearing was called for. Available evidence indicates DE LA ROSA was not, however, exhibiting signs of active mental illness after he returned from CRCC. If the hearing officer was unaware the detainee was on suicide watch for ten days and hospitalized at CRCC, the requirement to consult healthcare staff may not have been considered. Reviewers recommend that healthcare and security personnel review the standard and consider ways it may be met without violating patient confidentiality.
- DE LA ROSA submitted an incident statement dated April 21, 2018 in which he asked to be moved to segregation because his life was threatened by his cellmate. There is no documentation indicating when the statement was received or what action was taken pursuant to the claim. Absent a record of when DE LA ROSA’s statement was received, the date of submission must be assumed to be accurate. No action was taken for three days when a memorandum documents the detainee was placed on administration segregation status pending investigation for protective custody. The segregation order references both protective custody and placement on suicide watch per direction of healthcare staff, the latter status continuing until he was transferred to CRCC. Although placement on protective custody apparently overlapped with suicide watch, documentation relating to

protective custody was poor, including information explaining the three days delay following DE LA ROSA's request. If the detainee accurately dated his incident statement, three days to respond to the allegation that his life was threatened by his cellmate is excessive and put the detainee at risk. Reviewers recommend implementation of procedures that include documenting when requests are received, by whom, and actions taken. Reviewers also recommend prompt action when detainees allege they are at risk.

- As noted in above deficiencies, segregation reviews did not document interview of DE LA ROSA. While document review to assess the basis for continued segregation assignment and provision of mandated basic living conditions is important, so too is interviewing the detainee. Interviews are an additional welfare check, and allow the detainee the opportunity to confirm or refute that basic services are being provided. If the latter is alleged, further review of documentation would be called for. In DE LA ROSA's case, available evidence indicates he preferred to be segregated and except for showers and some meals, documentation reflects he was provided with mandated services.
- DE LA ROSA was last observed almost two hours before his suicide was discovered. As recognized by CoreCivic in terminating (b)(6); (b)(7)(C) employment, failing to make security rounds is an egregious dereliction of duty, compounded by his false entries to the log. Officer (b)(6); (b)(7)(C) also failed to make a security round when he first assumed the post and instead, timed his first round based on Officer (b)(6); (b)(7)(C) last false entry before leaving. Conducting rounds in accordance with the standard and facility policy, specifically, verifying detainee welfare through direct observation at least every 30 minutes on an irregular schedule, serves a fundamental and critical safety and security purpose in restricted housing. Reviewers recommend retraining officers in conducting security rounds and periodic checks of video by supervisors to verify that officers are conducting rounds properly.
- After finding DE LA ROSA hanging and calling medical emergency, Officer (b)(6); (b)(7)(C) did not enter the cell until other officers arrived. As the reason, he said he was trained to not open a cell door in the RHU unless another officer is present. However, SDC policy does not mandate that at least (b)(7)(E) be present before cells are opened. In fact, the officer on the previous shift is seen on video opening cell doors without another officer present to allow cell occupants out for showers. Reviewers recommend review of the policy and retraining officers as to expectations.
- The Classification Supervisor did not review and approve the detainee's initial classification until 16 days after it was applied. The ICE detention standard does not set a specific timeframe for supervisory review, but does state that the purpose of the review is to check "for accuracy and completeness and ensure that each detainee is assigned to the appropriate housing unit." Although in this case, detainee DE LA ROSA's classification

and housing assignment were appropriate, the purpose of supervisory review cannot be achieved if review of classification decisions is not timely.

- There were multiple illegible signatures with no accompanying printed names on documents in the detention file. Absent legible names, accountability for actions and decisions cannot be ascribed. Reviewers recommend that persons who sign forms be required to also print their names and titles.

APPENDIX 1

Medical staff documented the following vital signs in DE LA ROSA's medical record. Per American Heart Association parameters, systolic blood pressure of 120 to 129 and diastolic blood pressure less than 80 signifies **Elevated blood pressure**; systolic blood pressure of 130 to 139 or diastolic blood pressure of 80 to 89 signifies **Stage One hypertension**; and systolic blood pressure of at least 140 or diastolic of at least 90 is **Stage Two hypertension**. Detainee DE LA ROSA's blood pressure was within parameters for Elevated blood pressure on six occasions, Stage One Hypertension on 21 occasions, and Stage Two on eight occasions.

DATE	TEMPERATURE	PULSE	RESPIRATIONS	BLOOD PRESSURE	WEIGHT
March 14, 2018	98.5	80	18	119/80	137
March 15, 2018	98.3	71	18	113/80	138
April 3, 2018	98.8	89	18	128/89	136
April 24, 2018	98.1	88	16	135/88	130
	98.6	92	18	123/78	130
April 25, 2018	98.7	85	16	132/87	130
	98.4	96	16	147/83	131
April 26, 2018	98.3	87	18	124/77	135
	98.2	88	18	137/88	135
	98.2	88	18	137/88	135
April 27, 2018	98.1	81	16	122/71	135
	98.6	97	18	148/90	135
	98.6	97	18	148/90	
	98.6	71	18	146/86	135
April 28, 2018	98.4	89	18	124/80	135
	98.4	89	18	124/80	135
	99.1	95	18	124/76	
April 29, 2018	98.6	100	16	124/79	135
	98.8	86	17	139/88	135
	98.8	90	17	139/88	135
	98.6	98	18	125/86	
April 30, 2018	97.8	83	16	145/88	135
	98.0	69	16	142/80	
	98.4	73	16	152/92	
May 1, 2018	98.4	81	18	139/81	135
	98.6	81	18	139/81	135
May 2, 2018	98.6	77	18	137/89	
	98.6	77	18	137/89	135
	98.8	98	16	128/88	
May 3, 2018	98.9	86	18	137/89	
	98.3	66	18	141/101	135

	98.3	104	18	121/89	135
May 4, 2018	98.6	80	18	135/80	135
June 12, 2018	98.9	94	16	115/73	140
June 13, 2018	98.5	85	18	123/77	140
June 19, 2018	98.7	92	20	132/86	144

 DEPARTMENT OF HOMELAND SECURITY Immigration and Customs Enforcement REPORT OF INVESTIGATION		1. CASE NUMBER (b)(6); (b)(7)(C)	
		PREPARED BY (b)(6); (b)(7)(C)	
		2. REPORT NUMBER 001	
3. TITLE De La Rosa, Efrain/Non-Employee/0107 Death-Detainee/Alien (Suicide)/LUMPKIN, STEWART, GA			
4. FINAL RESOLUTION			
5. STATUS Initial Report	6. TYPE OF REPORT Allegation	7. RELATED CASES	
8. TOPIC Detainee Death at the Stewart Detention Center, Lumpkin, Georgia			
9. SYNOPSIS On July 11, 2018, the U.S. Immigration and Customs Enforcement (ICE) Office of Professional Responsibility (OPR), Atlanta, Georgia (OPR/Atlanta), received information from Assistant Field Office Director (AFOD) (b)(6); (b)(7)(C) Enforcement and Removal Operations (ERO), Atlanta, Georgia (ERO/Atlanta) who reported a possible suicide by ICE detainee Efran Romero De La Rosa while in custody at the Stewart Detention Center (SDC) in Lumpkin, Georgia. This report will detail the information received from AFOD (b)(6); (b)(7)(C)			
10. CASE OFFICER (Print Name & Title) (b)(6); (b)(7)(C) - ICE-OPR Special Agent	11. COMPLETION DATE 11-JUL-2018	14. ORIGIN OFFICE ICE OPR RAC Atlanta	
12. APPROVED BY (Print Name & Title) (b)(6); (b)(7)(C) E-OPR Special Agent	13. APPROVED DATE 11-JUL-2018	15. TELEPHONE NUMBER No Phone Number	
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DEPARTMENT OF HOMELAND SECURITY

REPORT OF INVESTIGATION
CONTINUATION

1. CASE NUMBER

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

PREPARED BY

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

2. REPORT NUMBER

001

10. NARRATIVE

DETAILS OF INVESTIGATION:

On July 11, 2018, OPR/Atlanta received information from AFOD (b)(6); (b)(7)(C) who reported that on July 10, 2018, at approximately 11:38 a.m., a medical emergency was called involving detainee Efran Romero De La Rosa (A#209910301), who was being housed in the SDC segregation unit. It was suspected that Detainee De La Rosa committed suicide by hanging.

According to AFOD (b)(6); (b)(7)(C) the medical providers had a hard time performing CPR due to detainee De La Rosa's jaw being tightly clamped closed. Detainee De La Rosa was also very pale in color and cold to the touch.

Detainee De La Rosa was transported to the hospital where he was pronounced deceased at 11:29 p.m.

The Georgia Bureau of Investigation (GBI) responded to SDC and has initiated an investigation.

 DEPARTMENT OF HOMELAND SECURITY REPORT OF INVESTIGATION Exhibit List	1. CASE NUMBER (b)(6); (b)(7)(C)
	PREPARED BY (b)(6); (b)(7)(C)
	2. REPORT NUMBER 001
	None

From: (b)(6); (b)(7)(C)
Sent: 11 Jul 2018 04:54:15 +0000
To: (b)(6); (b)(7)(C)
Subject: FW: Detainee Attempted Suicide

FYSA

From: (b)(6); (b)(7)(C)
Sent: Tuesday, July 10, 2018 11:58 PM
To: (b)(6); (b)(7)(C) <(b)(6); (b)(7)(C)> <(b)(6); (b)(7)(C)> <(b)(6); (b)(7)(C)>
Subject: Detainee Attempted Suicide

On 10 July 2018, at approximately 2238 a medical emergency was called to 7-B, segregation unit. When the medical team arrived on scene they noted CPR being performed on detainee De La Rosa, Efran Romero (A# 209910301). The medical team continued CPR and 911 was activated. The medical providers indicated they had a difficult time opening the airway due to the detainee's jaws being tightly clamped closed. The indicated the detainee was cold to the touch and very pale in color. CPR was continued with no shockable rhythm noted on AED. Ambulance team arrived and immediately intubated the detainee and transported him to the hospital.

Based on the nurses report, I do not believe the resuscitative efforts will be successful.

eCW is currently down, thus I am not able to provide a more detailed description of the detainee's medical history. Based on (b)(6); (b)(7)(C) statements the detainee had been at Columbia Care for over a month and arrived back at SDC early to middle of last month (June) as Columbia Care. The detainee was evaluated by (b)(6); (b)(7)(C) today and no signs of suicidality were noted.

I will provide more information as it becomes known.

(b)(6); (b)(7)(C) RN, C-APN
CAPT, U.S. Public Health Service
ICE Health Services Corps
Health Services Administrator
Stewart Detention Center
146 CCA Road
P.O. Box 248
Lumpkin, GA 31815
Cell: (202) 321-(b)(6); (b)(7)(C)
Fax: (866) 381-0255
(b)(6); (b)(7)(C) ice.dhs.gov

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JOINT INTAKE CENTER – TELEPHONE WORKSHEET

Reset Form

Date 07/10/2018	Time 10:53 PM CST	Duty Agent Campbell Phone # 972 261-7011
Time Sensitive? ☒ Yes ☐ No		Arrests, assaults (physical/sexual), bribes, death, discharge of weapon, medical, media, serious injuries, suicide, workplace violence, e.g.

Caller Data	
☐ Anonymous ☐ Detainee ☒ Source ☐ Subject ☐ Victim ☐ Witness	
Name Bretz, John	Phone Number 229 529 (b)(6); (b)(7)(C)
Language Spoken English	City, State Lumpkin, GA
A# 209 910 301	Facility Name Stewart Detention Center

Information	
☐ Allegation	☐ Management Issue ☒ Detainee Issue ☐ Incident ☐ Other
Briefly Describe (Who/What/Where/When/Why)	
U.S. Immigration and Customs Enforcement (ICE) Assistant Field Office Director (AFOD) (b)(6); (b)(7)(C) Enforcement and Removal Operations, Lumpkin, Georgia (ERO Lumpkin), reported the death of an ICE detainee. AFOD (b)(6); (b)(7)(C) stated detainee Efron De La Rosa (A209 910 301) committed suicide by hanging at the Stewart Detention Center. AFOD (b)(6); (b)(7)(C) said he will forward additional details and reports to the JIC as they become available.	
☐ CBP ☒ ERO ☐ HSI ☐ Other	

Action Taken	
☐ JICMS File #	☐ JIC Log #
ICE Senior Special Agent (SSA) (b)(6); (b)(7)(C) Office of Professional Responsibility, Atlanta, Georgia (OPR Atlanta) was notified at 11:16 PM CST.	
Referred To	
☐ OIG Duty Agent ☒ OPR Duty Agent ☐ CBP IA Duty ☐ Local ERO ☐ ERO CDH	
☐ ERO JIC Email ☐ Other Agency	
Helpful Numbers	
Community and Detainee Helpline (CDH) - (888) 351-4024 (M-F 0800 – 1700) DOJ EOIR - (800) 898-7180 (immigration court dates, status of hearings) CIS NCSC - (800) 375-5283 (M-F 0800 – 1800, Case Status, Benefits, etc) LESC - (855) 448-6903 Detainee locator - www.ice.gov/locator	

From: Bretz, John C
Sent: 11 Jul 2018 03:57:10 +0000
To: JOINT INTAKE
Cc: (b)(6); (b)(7)(C)
Subject: FW: detainee possible Suicide in unit 7 B

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

As per our discussion, De La Rosa was pronounced dead at 2329.
Thanks

From: (b)(6); (b)(7)(C) @corecivic.com]
Sent: Tuesday, July 10, 2018 11:25 PM
To: Bretz, John C (b)(6); (b)(7)(C) @ice.dhs.gov> (b)(6); (b)(7)(C) @corecivic.com>
Subject: Fwd: detainee possible Suicide in unit 7 B

Detainee info.

Sent from my iPhone

Begin forwarded message:

From: (b)(6); (b)(7)(C) @corecivic.com>
Date: July 10, 2018 at 11:27 AM EDT
To: (b)(6); (b)(7)(C) @corecivic.com>
Cc: (b)(6); (b)(7)(C) @corecivic.com>
Subject: detainee possible Suicide in unit 7 B

Detainee name is De La Rosa, Efrain # 209910301, he was admitted to segregation on 6/19/2018 1805 hours also he was placed in segregation for making sexual proposal. Detainee Efrain arrived in the facility on 6/12/18 at 0944 hours.

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DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

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

SYNOPSIS

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

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

DETAILS OF REVIEW

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

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

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

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

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

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

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

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

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

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

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

IMMIGRATION AND CRIMINAL HISTORY

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

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

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

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

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

On June 3, 2018, RAMIREZ was transferred to OMDC, pending a credible fear interview.¹⁵

On July 9, 2018, Supervisory Asylum (b)(6); (b)(7)(C) completed a credible fear interview with RAMIREZ.¹⁶

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

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

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

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

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

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

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

¹³ *Id.*

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

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

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

¹⁷ See Record of Negative Credible Fear Finding and Request for Review by IJ (Form I-869), dated July 17, 2018.

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

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

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

NARRATIVE

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

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

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

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

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

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

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

²¹ See ICE Custody Classification Worksheet, dated June 3, 2018.

²² ERAU notes all progress note times are based on the VS times entered within the note, unless otherwise stated.

²³ See eCW Progress Note by (b)(6); (b)(7)(C) dated June 3, 2018. (b)(6); (b)(7)(C) utilized Spanish interpretation services.

²⁴ Normal temperature is 98.6; normal range for pulse is 60 to 100 bpm; normal range for respirations is 12 to 20 breaths per minute; and normal blood pressure is 120/80 or less. According to the American Heart Association, this blood pressure reading indicates stage one hypertension. Stage one hypertension is characterized by a systolic reading of 130 to 139 or a diastolic reading of 80 to 89.

²⁵ See eCW Follow Up Pulse Check, dated June 6, 2018, June 16, 2018, and June 18, 2018. Although (b)(6); (b)(7)(C) noted she scheduled RAMIREZ for two additional pulse checks on June 6 and 16, and a third was scheduled for June 18, 2018. None of the pulse checks were completed due to RAMIREZ being in the hospital on those dates. The appointments are recorded in eCW with no comments.

²⁶ ERAU interview with (b)(6); (b)(7)(C) dated August 28, 2018.

²⁷ See IHSC Medical Consent Form, dated June 3, 2018.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

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

On June 4, 2018, at approximately 3:37 a.m., RAMIREZ entered Alpha Unit.²⁸ OMDC staff assigned RAMIREZ to cell 106, bed E.²⁹

At 8:24 p.m., the OMDC radiology technician completed RAMIREZ's initial TB screening X-ray in the Intake X-ray room.³⁰ (b)(6); (b)(7)(C) OMDC Health Services Administrator (HSA), stated that chest X-rays are the primary TB testing method at OMDC. As there is only one full-time radiology technician, who works Monday through Friday during the evening shift, 3:00 p.m. to 11:30 p.m., detainees that arrive outside this timeframe receive a TB symptom screening only and a follow-up TB screening X-ray when the radiology technician returns.³¹ (b)(6); (b)(7)(C) explained that because RAMIREZ arrived on Sunday, the radiology technician did not complete her chest X-ray until Monday evening. Furthermore, as her intake TB symptom screening was negative, isolation pending a chest X-ray was not deemed necessary.³²

At 8:29 p.m., (b)(6); (b)(7)(C) documented active TB could not be ruled out and did not clear RAMIREZ for general population.³³ At 8:43 p.m., a second chest X-ray was performed.³⁴

At 8:45 p.m., although RAMIREZ was not cleared for general population and the results of her second X-ray were not yet available, she returned to Alpha Unit.³⁵

At 11:06 p.m., (b)(6); (b)(7)(C) notified Physician Assistant (PA) (b)(6); (b)(7)(C); (b)(6); (b)(7)(C); (b)(7)(E) of the two chest X-ray findings, both of which confirmed active TB could not be ruled out.³⁶ As OMDC's negative pressure rooms in the Medical Housing Unit (MHU) were full, PA (b)(6); (b)(7)(C) ordered RAMIREZ's transport to the emergency room by facility van.³⁷

At 11:19 p.m., RAMIREZ, wearing a mask, left Alpha Unit; she entered Intake at 11:22 p.m.³⁸

²⁸ See surveillance video screenshot, Alpha Corridor Camera, dated June 4, 2018.

²⁹ See OMDC Cellmate History, dated August 3, 2018.

³⁰ See Shina Systems Configuration Management screen print, dated June 4, 2018.

³¹ ERAU interview with (b)(6); (b)(7)(C) August 28, 2018.

³² The TB symptom screening consists of asking detainees whether s/he has experienced any of the following symptoms in the last two months for more than two weeks: a cough, coughing up blood, chest pain, fever, chills, or night sweats for an unknown reason, loss of appetite, unexplained weight loss, previous history of TB. ERAU notes RAMIREZ answered no to each question.

³³ See X-Ray Exam Report, dated June 4, 2018.

³⁴ See Shina Systems Configuration Management screen print, dated June 4, 2018.

³⁵ See Alpha Unit Logbook, dated June 4, 2018. ERAU notes that per the PBNDS 2011, *Medical Care*, Section (V)(C)(2), "detainees...with suspected or confirmed active TB disease based on clinical and/or laboratory findings, shall be placed in a functional airborne infection isolation room with negative pressure ventilation and be promptly evaluated for TB disease."

³⁶ See Telephone Encounter by (b)(6); (b)(7)(C) dated June 4, 2018. See also Second X-Ray Exam Report, dated June 4, 2018.

³⁷ *Id.*

³⁸ See surveillance video screenshot, (b)(6); (b)(7)(C) dated June 4, 2018.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

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

On June 5, 2018, at 12:52 a.m., RAMIREZ boarded an OMDC van en route to the hospital.³⁹ At 1:52 a.m., AHMC admitted RAMIREZ into the care of attending physician (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) RAMIREZ remained in the care of AHMC from June 5, 2018 to July 4, 2018, during which time OMDC nurses obtained 12 hospital updates from AHMC.⁴¹ Notable events during RAMIREZ's hospitalization are summarized below.

- On June 6, 2018, AHMC collected three mucous samples and administered a purified protein derivative (PPD) skin test.⁴²
- On June 8, 2018, the PPD skin test and mucous samples were negative for TB, but positive for extended spectrum beta-lactamase (ESBL).⁴³ A chest CT scan showed pneumonia in the bilateral lobes and left upper lobe.
- On June 14, 2018, AHMC initiated rifampin, isoniazid (INH), pyrazinamide, and ethambutol (RIPE) therapy.⁴⁴
- On June 19, 2018, AHMC stopped RIPE therapy due to elevated liver enzymes.
- On June 21, 2018, AHMC re-initiated RIPE therapy with ethambutol only, and initiated intravenous hydration with normal saline⁴⁵ and potassium. Liver enzyme and ova and parasites testing were pending.⁴⁶ AHMC gave RAMIREZ Zofran to relieve nausea and Benadryl to treat insomnia.
- On June 26, 2018, AHMC ordered a cardiology evaluation and cardiac catheterization⁴⁷ after the echocardiogram (ECG)⁴⁸ revealed aortic stenosis.⁴⁹ AHMC gave RAMIREZ Benadryl and Vistaril⁵⁰ to relieve itching.
- On June 27, 2018, AHMC re-initiated RIPE therapy.
- On July 3, 2018, AHMC released RAMIREZ from respiratory isolation and planned to discharge her after completing five days of RIPE therapy. A cardiology evaluation and cardiac catheterization were pending as a possible outpatient procedure.

³⁹ See surveillance video screenshot, Inner Bus Sally Port East, dated June 5, 2018.

⁴⁰ See AHMC Hospital Records, dated June 5, 2018, (b)(6); (b)(7)(C)

⁴¹ During interview with ERAU on August 28, 2018, (b)(6); (b)(7)(C) informed the review team that IHSC expects that when detainees are stable, facility medical staff obtain hospital updates daily and document those results.

⁴² A PPD skin test is a solution injected into the skin to determine whether a person has been infected with TB.

⁴³ ESBL is a bacterium that produces an enzyme, beta lactamase, which can break down commonly used antibiotics and render them noneffective for treatment.

⁴⁴ RIPE therapy is the administration of the four antibiotic drugs used in combination to treat TB. The vitamin pyridoxine (B6) is always included with INH dosing.

⁴⁵ Normal saline is a mixture of sodium chloride (salt) and water, often used as an intravenous solution to keep the intravenous catheter cleared of blockage and bacteria.

⁴⁶ See AHMC Microbiology reports, dated July 4, 2018. A parasite is an organism that lives in or on another organism (host) and benefits by deriving nutrients at the host's expense. Ova are eggs of the parasite. An AHMC laboratory report documented the tests were negative.

⁴⁷ Cardiac catheterization is the insertion of a catheter into a chamber or vessel of the heart for diagnostic and interventional purposes.

⁴⁸ An ECG is a test using ultrasound to make pictures of the heart.

⁴⁹ Aortic stenosis is a condition in which the valve in the large blood vessels branching off the heart (aorta) is abnormally narrowed, preventing the heart valve from fully opening and causing inability of the blood to flow from the heart to the rest of the body.

⁵⁰ Vistaril is a sedative used to treat anxiety, tension, and allergic skin reactions.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

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

On July 4, 2018, at 8:59 a.m.,⁵¹ (b)(6); (b)(7)(C) infectious disease specialist at AHMC, documented an assessment finding of latent TB infection.⁵² (b)(6); (b)(7)(C) noted RAMIREZ was negative on all MTB PCR tests and TB smears. The negative tests indicated tuberculosis bacteria was absent in the lungs, meaning the detainee was not infectious by airborne transmission. Dr. (b)(6); (b)(7)(C) discontinued TB isolation on July 3, 2018 and cleared RAMIREZ for aortic stenosis surgery from an infectious disease standpoint.

At 9:42 p.m., RAMIREZ returned to OMDC from AHMC and went directly to medical.⁵³

At approximately 10:07 p.m.,⁵⁴ (b)(6); (b)(7)(C) assessed RAMIREZ and documented RAMIREZ's VS were within normal limits.⁵⁵ OMDC medical staff admitted RAMIREZ to the MHU pending evaluation by the primary care provider the following day.

On July 5, 2018, at approximately 2:26 p.m., (b)(6); (b)(7)(C) conducted RAMIREZ's hospital discharge exam and initial health assessment (b)(6); (b)(7)(C) documented the following:⁵⁶

- RAMIREZ's VS were within normal limits.
- RAMIREZ's cardiac examination was normal except for a heart murmur of 3/6,⁵⁷ heard at the upper sternal border.⁵⁸ The pulse rate and rhythm were normal.
- While RAMIREZ underwent a TB workup and infectious disease consultation at the hospital, a heart murmur was noted. An ECG showed aortic stenosis, found severe by way of cardiac catheterization.
- On July 3, 2018, an AHMC charge nurse called to request urgent AVR per recommendation of cardiology, for which (b)(6); (b)(7)(C) gave verbal approval.⁵⁹ Upon RAMIREZ's return, given the previous urgent request (b)(6); (b)(7)(C) contacted AHMC and determined that the cardiologist decided the AVR procedure was not emergent and could be arranged on an outpatient basis. (b)(6); (b)(7)(C) further noted RAMIREZ was cleared for surgery, general anesthesia, and proposed cardiac operation; he recommended follow-up with cardiac surgeon (b)(6); (b)(7)(C) to consider outpatient surgery.
- (b)(6); (b)(7)(C) addressed the aortic stenosis diagnosis, as well as TB testing and treatment.

⁵¹ See AHMC Progress Note by (b)(6); (b)(7)(C), dated July 4, 2018.

⁵² Latent TB means there was past disease and that bacteria in the lungs was inactive. Latent TB may become active again and result in infectious pulmonary disease.

⁵³ See surveillance video screenshot, Receiving Sally Port, dated July 4, 2018.

⁵⁴ See surveillance video screenshot, Medical Nurse Station 1, dated July 4, 2018.

⁵⁵ See eCW Progress Note by (b)(6); (b)(7)(C), dated July 4, 2018. ERAU notes (b)(6); (b)(7)(C) did not sign off on the progress note or enter the associated VS until July 6, 2018. Furthermore, as (b)(6); (b)(7)(C) is fluent in Spanish, the use of interpretation services was not necessary.

⁵⁶ See eCW Progress Notes by (b)(6); (b)(7)(C), dated July 5, 2018. As (b)(6); (b)(7)(C) is fluent in Spanish, the use of interpretation services was not necessary.

⁵⁷ Heart murmurs are classified according to how loud the sound is with a stethoscope. A 3/6 murmur means the loudness was on a level three on a scale of one to six.

⁵⁸ Upper sternal border is the area in the middle of the chest, under the collar bone.

⁵⁹ ERAU notes RAMIREZ's medical record did not contain a hospital update on July 3, 2018 from (b)(6); (b)(7)(C) regarding this request.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

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

- RAMIREZ's three sputum smears were negative for TB.⁶⁰
- (b)(6); (b)(7)(C) oped the infectious disease specialist determined RAMIREZ was stable for discharge and clear for travel but recommended continuation of three-drug TB treatment, avoiding pyrazinamide, following up on smear cultures, and retesting liver enzymes.

(b)(6); (b)(7)(C) documented the following assessment findings:⁶¹

- The general adult medical examination was abnormal.
- Encounter for observation for other suspected diseases and conditions was ruled out.
- Non-rheumatic aortic valve stenosis.⁶²
- Pneumonia due to Escherichia coli.⁶³

(b)(6); (b)(7)(C) ordered: RIPE medications, except pyrazinamide, and omeprazole as needed for heartburn; an urgent referral for follow-up with (b)(6); (b)(7)(C) and chronic care follow-up on July 9, 2018,⁶⁴ with OMDC PA (b)(6); (b)(7)(C). Additional treatment orders included Snellen⁶⁶ and Ishihara vision testing⁶⁷ and laboratory tests for human immunodeficiency virus (HIV),⁶⁸ comprehensive metabolic panel (CMP),⁶⁹ thyroid cascade profile,⁷⁰ urinalysis with microscopic examination with reflex culture,⁷¹ and QuantiFERON TB Gold.⁷² Although (b)(6); (b)(7)(C) documented the labs and vision testing were completed on July 6, 2018,⁷³ the labs were not completed until July 18, 2018 and (b)(6); (b)(7)(C) medically cleared RAMIREZ for general population

⁶⁰ See AHMC Microbiology report, dated July 4, 2018. According to the AHMC Microbiology report, AHMC conducted four sputum smears, one of which was still processing at the time of RAMIREZ's hospital discharge.

⁶¹ See eCW Progress Notes by (b)(6); (b)(7)(C) dated July 5, 2018.

⁶² Nonrheumatic aortic valve stenosis means the condition is not caused by a history of rheumatic fever.

⁶³ Escherichia coli (E. Coli) is a type of bacteria that normally lives in the intestines. While E. coli is most often associated with food poisoning, the bacteria can cause pneumonia and urinary tract infections from different strains.

⁶⁴ See eCW Progress Note by (b)(6); (b)(7)(C) dated July 9, 2018. A blank follow-up encounter note by (b)(6); (b)(7)(C) was present in the medical record for this date but (b)(6); (b)(7)(C) did not see RAMIREZ until July 19, 2018. The July 19, 2018, appointment was a follow-up to RAMIREZ's July 10, 2018, appointment with the cardiac surgeon, not for the reason (b)(6); (b)(7)(C) originally scheduled the appointment. (b)(6); (b)(7)(C) stated during the interview with ERAU on August 28, 2018, that she did not know why she did not see RAMIREZ as ordered by (b)(6); (b)(7)(C).

⁶⁵ See eCW Progress Note by (b)(6); (b)(7)(C) dated July 5, 2018.

⁶⁶ A Snellen test is a test to determine visual acuity, using an eye chart.

⁶⁷ The Ishihara test is a color perception test for red-green color deficiencies.

⁶⁸ HIV is a virus that attacks cells that helps the body fight infection.

⁶⁹ A CMP is a series of blood test that provide a snapshot of the body's chemistry and the way it uses energy through metabolism.

⁷⁰ A thyroid cascade profile is a test used to diagnose common thyroid disorders. If the initial test result is normal, further testing (cascading) is deemed unnecessary.

⁷¹ A urinalysis with microscopic examination with reflex culture involves a dipstick urine test to determine the chemical constituents in the urine, a microscopic examination to detect the presence of abnormal urine cells, and culture to identify the organisms causing infection.

⁷² QuantiFERON TB Gold is a whole-blood test for use as an aid in diagnosing Mycobacterium TB infection, including latent TB infection and TB disease.

⁷³ ERAU notes the labs were not drawn until July 18, 2018, and there is no documentation vision testing was completed.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

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

with no respiratory isolation needed.⁷⁴ ERAU notes there is no documentation vision testing was completed.

At approximately 3:29 p.m., (b)(6); (b)(7)(C) signed off on an initial TB monitoring report and documented that they submitted a referral to Cure TB,⁷⁵ placed RAMIREZ on a medical hold, and reported the TB case to the California Health Department in San Diego.⁷⁶

On this same date, RAMIREZ submitted a request in Spanish requesting access to her property so she could retrieve phone numbers for her lawyer and family.⁷⁷ An OMDC staff member⁷⁸ responded on July 11, 2018, documenting that RAMIREZ was given an opportunity to access her property for phone numbers and other items but RAMIREZ refused and stated she only wanted to have her voice reset.⁷⁹ The OMDC staff member further noted that RAMIREZ's voice was reset per her request.

On July 6, 2018, at 11:57 a.m., (b)(6); (b)(7)(C) documented an update to the initial TB monitoring report,⁸⁰ adding the results of the tests completed at the hospital, which stated RAMIREZ was positive for Interferon Gamma Release Assay (IGRA)⁸¹ and HIV negative.

At 9:18 p.m., OMDC staff reassigned RAMIREZ to cell 101,⁸² bed H, a lower bunk on the lower level.⁸³

On July 7, 2018, at 2:49 p.m., RN (b)(6); (b)(7)(C) assessed RAMIREZ and documented the following:⁸⁴

- RAMIREZ's VS were within normal limits.
- RAMIREZ denied pain but complained of itchiness on her arms and legs.
- RAMIREZ was prescribed diphenhydramine HCL⁸⁵ (25 mg), orally every six hours, as needed, for three days.

⁷⁴ See eCW Progress Note by (b)(6); (b)(7)(C) dated July 5, 2018.

⁷⁵ Cure TB is a program promoted by the Center for Disease Control that works to prevent the spread of TB among people who cross international borders.

⁷⁶ See eCW TB Suspect Initial by (b)(6); (b)(7)(C) dated July 5, 2018.

⁷⁷ See Request for Assistance, dated July 5, 2018.

⁷⁸ ERAU was unable to identify the OMDC staff member as the signature was illegible.

⁷⁹ ERAU could not confirm the meaning of voice reset; however, it is believed this meant RAMIREZ needed to reset her pin.

⁸⁰ See eCW Progress Note by (b)(6); (b)(7)(C) dated July 6, 2018.

⁸¹ An IGRA is a whole blood test used to aid in the diagnosis of TB infection. It does not differentiate latent TB from active TB disease. QuantiFERON-TB Gold is a commonly used IGRA.

⁸² See OMDC Cellmate Housing History, dated August 3, 2018.

⁸³ During ERAU's tour of the facility, a Unit Counselor (name unknown), stated RAMIREZ was reassigned to a lower bunk on a lower level at her request citing difficulty climbing the stairs and accessing upper bunks.

⁸⁴ See eCW Progress Note by (b)(6); (b)(7)(C), dated July 7, 2018. (b)(6); (b)(7)(C) utilized Spanish interpretation services.

⁸⁵ Diphenhydramine HCL is the generic name for Benadryl, an antihistamine used to treat allergy, hay fever, and common cold symptoms.

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

On July 9, 2018, at 11:14 a.m., (b)(6); (b)(7)(C) signed off on the TB monitoring report from July 5, 2018, requesting updates with final culture results and a follow-up comparison chest X-ray after six to eight weeks of TB treatment.⁸⁶

On July 10, 2018, at 2:25 p.m., (b)(6); (b)(7)(C) completed an offsite consultation with RAMIREZ.⁸⁷

At 2:34 p.m., (b)(6); (b)(7)(C) assessed RAMIREZ and documented the following:⁸⁸

- RAMIREZ's VS were within normal limits.
- An off-site provider discharge note recommended AVR surgery, which she notified PA Rosenblatt of.
- RN Ednacot scheduled RAMIREZ for a follow-up appointment with a provider on July 11, 2018.⁸⁹
- RAMIREZ was returned to general population in stable condition.

On July 12, 2018, at 9:45 a.m., (b)(6); (b)(7)(C) office faxed a consult report (b)(6); (b)(7)(C)⁹⁰ which indicated that RAMIREZ had no knowledge of cardiovascular disease or a heart murmur prior to the recent hospitalization. (b)(6); (b)(7)(C) detailed events at AHMC, including three negative sputum tests, initiation of RIPE therapy, discontinuation of pyrazinamide upon development of symptoms of pancreatitis, and treatment for pneumonia. (b)(6); (b)(7)(C) detailed identification of the cardiac murmur and diagnosis of rheumatic valvular disease with severe aortic stenosis.⁹¹ (b)(6); (b)(7)(C) determined RAMIREZ was a suitable candidate for surgical valve replacement with low surgical risk and recommended RAMIREZ for AVR. (b)(6); (b)(7)(C) documented that through a translator, the indications, risks and alternatives were explained to RAMIREZ and that she indicated her consent.

On July 17, 2018, at 4:38 p.m., (b)(6); (b)(7)(C) documented he submitted a referral for surgery pursuant to (b)(6); (b)(7)(C) recommendation.⁹²

On July 18, 2018, at 11:39 a.m., (b)(6); (b)(7)(C) saw RAMIREZ pursuant to her complaint of itchy skin and documented the following:⁹³

⁸⁶ See eCW TB Suspect Initial by (b)(6); (b)(7)(C), dated July 5, 2018.

⁸⁷ See "Memorandum re: RAMIREZARREOLA, Agustina," by (b)(6); (b)(7)(C) dated July 10, 2018.

⁸⁸ See eCW Progress Note by (b)(6); (b)(7)(C), dated July 10, 2018. As (b)(6); (b)(7)(C) is fluent in Spanish, the use of interpretation services was not necessary.

⁸⁹ Although (b)(6); (b)(7)(C) scheduled a follow-up for July 11, 2018, (b)(6); (b)(7)(C) did not see RAMIREZ until July 19, 2018. During her interview with ERAU on August 30, 2018, (b)(6); (b)(7)(C) could not recall the reason for the delay.

⁹⁰ See "Memorandum re: RAMIREZARREOLA, Agustina" by (b)(6); (b)(7)(C) dated July 10, 2018. There is no progress note from (b)(6); (b)(7)(C) detailing receipt of this report; however, (b)(6); (b)(7)(C) signed the bottom of the fax coversheet on July 13, 2018.

⁹¹ Rheumatic valvular disease describes a group of short-term and long-term heart disorders that can occur as a result of rheumatic fever. One common result of rheumatic fever is heart valve damage. The damage may lead to a valve disorder such as aortic valve stenosis.

⁹² See eCW Telephone encounter by (b)(6); (b)(7)(C) dated July 17, 2018.

⁹³ See eCW Progress Note by (b)(6); (b)(7)(C) dated July 18, 2018.

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

- RAMIREZ's VS were within normal limits except for an elevated BP of 137/84.
- RAMIREZ's skin was very dry, with a red rash over her left forearm and right upper arm.
- RAMIREZ complained of recurring itchiness all over.

(b)(6); (b)(7)(C) noted a diagnosis of risk for impaired skin integrity and started RAMIREZ on diphenhydramine HCL (25 mg) orally every six hours, as needed, for three days.

At 4:25 p.m., (b)(6); (b)(7)(C) signed off on a progress note documenting completion of RAMIREZ's blood work pursuant to the lab tests ordered on July 5, 2018.⁹⁴

On July 19, 2018, at 2:08 p.m., (b)(6); (b)(7)(C) saw RAMIREZ for a post-cardiology consultation follow-up and documented the following:⁹⁵

- RAMIREZ's VS were within normal limits except for an elevated BP of 134/80.
- RAMIREZ reported that prior to arrival, she had no idea she had the heart problem and that she does get tired easily.
- RAMIREZ indicated that the itching was the most bothersome symptom, possibly from one of her current medications. The general examination found no obvious rash, although RAMIREZ had scratched her skin, which caused welts and erythema.⁹⁶
- PA Rosenblatt heard the systolic murmur.⁹⁷
- RAMIREZ became tearful and was concerned about being alone for surgery.

(b)(6); (b)(7)(C) diagnosed RAMIREZ with nonrheumatic aortic stenosis and pruritus,⁹⁸ unspecified. Per the direction of (b)(6); (b)(7)(C) IHSC Infection Control Specialist, RAMIREZ was started on diphenhydramine HCL (25 mg) orally three times daily, as needed for 30 days, approved as a "keep on person" medication. (b)(6); (b)(7)(C) noted surgery for aortic valve stenosis was scheduled for July 25, 2018. (b)(6); (b)(7)(C) scheduled a provider follow-up for one week as needed post-surgery.

⁹⁴ See eCW Progress Note by (b)(6); (b)(7)(C) dated July 18, 2018. During the interview with ERAU on August 28, 2018, (b)(6); (b)(7)(C) stated he ordered the labs drawn on July 6, 2018, so the results would be available prior to the cardiology consultation; although the labs were drawn later than ordered, the tests were done in time for RAMIREZ's surgery.

⁹⁵ See eCW Progress Note by (b)(6); (b)(7)(C) dated July 19, 2018.

⁹⁶ Erythema is superficial reddening of the skin, usually in patches, as a result of injury or irritation causing dilatation of the blood capillaries.

⁹⁷ A systolic murmur is a heart murmur that begins during or after the first heart sound and ends before or during the second heart sound.

⁹⁸ Pruritis is the medical term for itchiness.

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On July 20, 2018, at an unknown time, (b)(6); (b)(7)(C) received the results of RAMIREZ's laboratory work.⁹⁹ (b)(6); (b)(7)(C) noted the results were normal except for elevated liver enzymes and low blood urea nitrogen (BUN),¹⁰⁰ creatinine,¹⁰¹ BUN/creatinine ratio,¹⁰² and Albumin/Globulin ratio.¹⁰³

On July 24, 2018, at 9:53 a.m., OMD C transferred RAMIREZ to AHMC to prepare RAMIREZ for her surgery; RAMIREZ arrived at the hospital at 10:15 a.m.¹⁰⁴ Officer Mona Joseph, assigned to hospital detail from 2:00 p.m. to 10:00 p.m., stated RAMIREZ was nervous, emotional, and crying during the shift.¹⁰⁵

At 2:03 p.m., (b)(6); (b)(7)(C) documented that AHMC medical staff had prepared RAMIREZ for repair of the aortic stenosis and coronary artery bypass graft (CABG),¹⁰⁶ scheduled for the following day, and that RAMIREZ was currently stable.¹⁰⁷

Day of Death

On July 25, 2018, at 6:38 a.m., (b)(6); (b)(7)(C) documented that RAMIREZ had been anxious and crying the evening before but was better at the time of the update.¹⁰⁸

During the morning hours, RAMIREZ underwent cardiopulmonary bypass (CPB)¹⁰⁹ and AVR surgery.¹¹⁰ Per the Postoperative Report completed by (b)(6); (b)(7)(C) initially, the surgery was completed without trouble but as the right atrium was being repaired, RAMIREZ's BP began to drop. Surgical staff ultimately placed RAMIREZ on extracorporeal membrane oxygenation (ECMO).¹¹¹ RAMIREZ's chest was left open and she was taken to the intensive care unit (ICU). The postoperative report indicates RAMIREZ had significant bleeding over the next several hours which required repeated blood transfusions. Despite the various interventions, which failed to

⁹⁹ See Lab Result Printout, dated August 1, 2018.

¹⁰⁰ BUN is a medical test that measures the amount of urea nitrogen found in blood. The liver produces urea in the urea cycle as a waste product of the digestion of protein.

¹⁰¹ Creatinine is a chemical waste molecule that is generated from muscle metabolism. Creatinine is produced from creatine, a molecule of major importance for energy production in muscles.

¹⁰² BUN/creatinine ratio test is used to detect conditions such as congestive heart failure, gastrointestinal bleeding or severe dehydration in high results, and liver disease or malnutrition in low results.

¹⁰³ A/G ratio is a test used to determine overproduction of globulins, seen in cases of multiple myeloma or autoimmune diseases, or underproduction of albumin, which is seen in cirrhosis, or selective loss of albumin from the circulation, as seen with kidney disease.

¹⁰⁴ See Transportation Trip Ticket, OMD C, dated July 24, 2018.

¹⁰⁵ ERAU interview with Officer (b)(6); (b)(7)(C), dated August 29, 2018.

¹⁰⁶ CABG is a form of bypass surgery to create new routes around the narrowed and blocked coronary arteries, permitting increased blood flow to deliver oxygen and nutrients to the heart muscle.

¹⁰⁷ See eCW Telephone encounter by (b)(6); (b)(7)(C), dated July 24, 2018.

¹⁰⁸ See eCW Progress Note by (b)(6); (b)(7)(C), dated July 25, 2018.

¹⁰⁹ CPB is a technique in which a machine temporarily takes over function of the heart and lungs during surgery, maintaining the circulation of blood and the oxygen content of the patient's body.

¹¹⁰ See Postoperative Report by (b)(6); (b)(7)(C), dated July 25, 2018.

¹¹¹ ECMO is a technique of providing prolonged cardiac and respiratory support, outside the body, to persons whose heart and lungs are inefficient.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

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

increase RAMIREZ's cardiac index,¹¹² AHMC medical staff decided to return RAMIREZ to the operating room. (b)(6); (b)(7)(C) documented that following further interventions during the surgery, RAMIREZ initially looked good, but her condition quickly deteriorated. Despite all efforts, AHMC medical staff could not maintain adequate cardiac output, and (b)(6); (b)(7)(C) made the decision to stop all treatments. RAMIREZ sustained a cardiac rhythm¹¹³ but her BP could not be sustained.

At 10:45 p.m. (b)(6); (b)(7)(C) pronounced RAMIREZ dead.¹¹⁴ (b)(6); (b)(7)(C) recorded RAMIREZ's preliminary cause of death as cardiogenic shock,¹¹⁵ with possible contributing factors of an allergic reaction to protamine¹¹⁶ following the first operation, and a hypertrophied¹¹⁷ noncompliant left ventricle.¹¹⁸

Officer (b)(6); (b)(7)(C) stated she notified (b)(6); (b)(7)(C) of RAMIREZ's death. (b)(6); (b)(7)(C) documented he immediately notified Deportation Officer (DO) (b)(6); (b)(7)(C).

Post-Death Events

On July 26, 2018, at 2:50 a.m., after RAMIREZ's body had been transferred to the hospital morgue, (b)(6); (b)(7)(C) relieved Officers (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) of hospital detail duty.¹²¹

At 6:37 a.m., (b)(6); (b)(7)(C) documented the aortic replacement procedure from the previous day, RAMIREZ's death at 10:45 p.m., and that OMDC staff had notified ICE.¹²²

On July 31, 2018, OMDC security staff processed RAMIREZ's property and funds for release to ICE.¹²³

¹¹² Cardiac index is a measurement of the amount of blood being pumped out of the heart to the body.

¹¹³ A cardiac rhythm refers to the transmission of electrical signals that normally control the heart rate and regularity of beats.

¹¹⁴ See County of San Diego Medical Examiner's Report, dated October 15, 2018.

¹¹⁵ Cardiogenic shock is a fatal condition in which the heart is suddenly unable to pump enough blood to meet the body's needs.

¹¹⁶ Protamine is a medication used to reverse the effect of heparin (an anticoagulant used to prevent blood clotting) during surgery.

¹¹⁷ Hypertrophied means an abnormal enlargement of an organ or tissue.

¹¹⁸ The left ventricle is one of four chambers in the heart, separated by the aortic valve, which pumps blood from the heart to the rest of the body. See Death Summary by (b)(6); (b)(7)(C) dated July 31, 2018.

¹¹⁹ See Incident Report by Officer (b)(6); (b)(7)(C), dated July 26, 2018.

¹²⁰ See Incident Report by (b)(6); (b)(7)(C), dated July 26, 2018.

¹²¹ See Incident Reports by (b)(6); (b)(7)(C) and Stephens, dated July 26, 2018.

¹²² See eCW Progress Note by (b)(6); (b)(7)(C) dated July 26, 2018.

¹²³ See OMDC Trust Account Closing Receipt, dated August 21, 2018.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

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

On August 21, 2018, (b)(6); (b)(7)(C) inventoried and proceeded RAMIREZ's property and funds at the facility.¹²⁴ ICE shipped the property and funds to RAMIREZ's family on this same date.¹²⁵ The package was delivered on August 24, 2018.¹²⁶

On September 20, 2018, the San Diego County Medical Examiner completed RAMIREZ's autopsy and documented an official cause of death of rheumatic heart disease, with coronary artery disease, pneumonia, and tuberculosis as contributing.¹²⁷

MEDICAL CARE AND SECURITY REVIEW

ERAU reviewed the medical care OMDC provided RAMIREZ, as well as the facility's efforts to ensure that she was safe and secure while detained at the facility. ERAU found deficiencies in OMDC's compliance with certain requirements of the ICE PBNDS 2011.

1. ICE PBNDS 2011, *Medical Care*, Section (V)(C)(2) states, "Detainees with symptoms suggestive of TB, or with suspected or confirmed active TB disease based on clinical and/or laboratory findings, shall be placed in a functional airborne infection isolation room with negative pressure ventilation and be promptly evaluated for TB disease. Patients with suspected active TB shall remain in airborne infection isolation until determined by a qualified provider to be noncontagious in accordance with CDC guidelines." The CDC TB Guidelines, *Prevention and Control of Tuberculosis in Correctional and Detention Facilities*, further state, "Persons who have radiographs suggestive of TB should be isolated immediately and evaluated further."
 - On June 4, 2018, although RAMIREZ's initial chest X-ray identified possible TB, OMDC allowed RAMIREZ to return to general population. RAMIREZ was in the unit for approximately two and one-half hours before results of a second chest X-ray were available. The second chest X-ray confirmed results of the first and, after notification to a provider, the provider ordered RAMIREZ's transfer to the hospital for isolation, testing, and treatment.
2. ICE PBNDS 2011, *Terminal Illness, Advanced Directives and Death*, Section (III)(V)(F) states, "Facilities shall turn over the property of the decedent to ICE/ERO within one week for processing and disposition. Unless property of a decedent is being held as part of an investigation into the circumstances of death, that property should be returned to the decedent's next of kin, if known, within two weeks."
 - OMDC processed RAMIREZ's property on July 31, 2018, 5 days after her death; however, ERO did not retrieve the property or funds from OMDC until August 21, 2018, 27 days after her death. ERO shipped the property and funds to RAMIREZ's family on that same date.

¹²⁴ *Id.*

¹²⁵ See Property Tracking, dated August 21, 2018.

¹²⁶ See Proof of Delivery, dated August 29, 2018.

¹²⁷ See Exhibit 1: San Diego County Medical Examiner Department, dated September 20, 2018.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

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

Areas of Concern

Although not reflective of any violation of the requirements of the detention standards, ERAU noted the following general concerns regarding RAMIREZ's medical care:

- On July 5, 2018, (b)(6); (b)(7)(C) ordered laboratory samples and vision testing for July 6, 2018. Nurses did not draw the laboratory samples until July 18, 2018, and there is no documentation vision testing was ever completed.
- On July 5, 2018, (b)(6); (b)(7)(C) orders included direction for a chronic care follow-up assessment by (b)(6); (b)(7)(C) on July 9, 2018. (b)(6); (b)(7)(C) did not see RAMIREZ on this date or at any other time for a chronic care follow-up. Also, on July 10, 2018, RN (b)(6); (b)(7)(C) noted she scheduled a cardiology consultation follow-up with P (b)(6); (b)(7)(C) for July 11, 2018. (b)(6); (b)(7)(C) did not assess RAMIREZ for the cardiology consultation follow-up until July 19, 2018.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

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

EXHIBITS

1. San Diego County Medical Examiner Department, dated September 20, 2018.
2. Creative Corrections Healthcare and Security Compliance Analysis.



U.S. Immigration
and Customs
Enforcement

AUG 13 2019

MEMORANDUM FOR: Timothy S. Robbins
Acting Executive Associate Director
Office of Enforcement and Removal Operations
(b)(6); (b)(7)(C)

THROUGH:

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

SUBJECT: Findings for the Death of ICE Detainee
Agustina RAMIREZ-Arreola (b)(6); (b)(7)(C); (b)(7)(E)

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

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

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

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

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

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

States at the San Ysidro POE, (b)(6); (b)(7)(C); (b)(7)(E) A CBP officer interviewed RAMIREZ and determined she was inadmissible to the United States pursuant to section 212(a)(7)(A)(i)(I) of the INA and RAMIREZ was processed for expedited removal pending review of credible fear claim. On May 24, 2018, CBP determined RAMIREZ would remain in CBP custody at the San Ysidro POE until bed space became available with ICE. On June 3, 2018, RAMIREZ was transferred to Otay Mesa Detention Center (OMDC).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

¹¹ Pruritis is the medical term for itchiness.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ERAU also noted two areas of concern, which are discussed in the attached report. If you have any questions, please contact me or have a member of your staff contact Acting Unit Chief (b)(6); (b)(7)(C) at (202) 732 (b)(6); (b)(7)(C)

Attachment

cc: Derek Benner
Tae Johnson
Stewart Smith

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



County of San Diego

GLENN N. WAGNER, D.O.
CHIEF MEDICAL EXAMINER
(858) 694-2895

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

STEVEN C. CAMPMAN, M.D.
CHIEF DEPUTY MEDICAL EXAMINER
(858) 694-2895

CALL INFO	NAME OF DECEASED RAMIREZ-ARREOLA, Agustina		AKA	HIO ☐	CASE NUMBER 2018-01819	
	INVESTIGATOR Christopher Burton	REPORTED BY Alvarado OR	REPORT NG AGENCY Alvarado Hospital		PREVIOUS WAIVE #	
	CALL DATE AND TIME 7/25/2018 2255	ARRIVAL DATE AND TIME		RETURN DATE AND TIME		
DECEDENT	DATE AND TIME OF DEATH 7/25/2018 2245		DATE OF BIRTH 5/30/1956	AGE 62 Years	GENDER Female	RACE Hispanic Mexican
	RESIDENCE (STREET, CITY, STATE, ZIP) San Diego, California, 92101			COUNTY San Diego		LAST SEEN ALIVE
	COUNTRY OF RESIDENCE San Diego		OCCUPATION Homemaker		PA D AUTOPSY ☐	
	LOCATION OF DEATH Alvarado Hospital					
DEATH	TYPE OF PLACE Hospital					
	ADDRESS (STREET, CITY, STATE, ZIP) 6655 Alvarado Road, San Diego, CA, 92120					
	SUMMARY The decedent was a married, 62 year old Hispanic female who was currently in custody with the Immigration and Customs Enforcement (ICE). After developing sudden weakness, she was sent to Alvarado Hospital on June 08, 2018 and was found to have significant cardiac disease. On July 04, 2018, she underwent a cardiac catheterization and was released back into custody. On July 24, 2018 she was re-admitted to undergo a cardiac valve replacement. On the morning of July 25, 2018, her surgery began and was completed without any known complications. While in the recovery room, staff were unable to stabilize her vital signs and she was taken back to the operating room where she continued to decline. Despite aggressive efforts, staff were unable to regain a spontaneous heart rate and her death was pronounced. Medical Examiner's jurisdiction invoked according to the California Government Code 27491: Deaths in prison or while under sentence.					
	INCIDENT PLACE TYPE AT WORK ☐ AT RESIDENCE ☐					
INCIDENT	LOCATION OF INCIDENT		ADDRESS (STREET, CITY, STATE, ZIP)			
	DATE AND TIME OF INCIDENT		INVESTIGATING AGENCY	OFFICER	BADGE #	REPORT #
	DECEDENT WAS	BELTED No	HELMETED ☐ YES ☒ NO	POSITION	ON PRIVATE PROPERTY ☐ YES ☐ NO	
	VEHICLE		LICENSE NUMBER		STATE	
	IDENTIFIED BY		METHOD Hospital Identification		DATE AND TIME 07/25/2018 2331	
NOTIFICATION	FUNERAL HOME		PROPERTY ☐ YES ☒ NO	PUBLIC ADMINISTRATOR ☐ YES ☒ NO		TYPE OF EXAM External Exam
	NAME OF NOK OR OTHER Homeland Security		RELATIONSHIP Legal		DATE NOTIFIED 7/25/2018	NOTIFIED BY Hospital Staff

DHS-20-0638-D-000352

San Diego Medical Examiner
5570 Overland Avenue, Suite#101
San Diego, CA 92123-1206
(858) 694-1234 (b)(6);

Case Number 2018-01819
Investigator (b)(6); (b)(7)(C)
Date of Death : 07/25/2018
Date Today : 10/15/2018

INVESTIGATIVE NARRATIVE

Decedent: RAMIREZ-ARREOLA, Agustina

Antemortem Events:

On July 25, 2018 I learned the following information through medical staff from Alvarado Hospital and supplemented with medical records. The decedent had been a detainee in custody of the Immigration and Customs Enforcement (ICE) at their downtown San Diego facility. While in custody, in June of 2018, she began to develop weakness and was taken to Alvarado Hospital for an evaluation. At the time, tests showed that she had significant pre-existing cardiac disease and was admitted. On July 03, 2018, she was scheduled for and underwent a cardiac catheterization and was released back to the facility the following day pending follow up surgery at a later date.

On July 24, 2018, she was brought back to Alvarado Hospital to undergo the surgery, which was relayed as a valve replacement procedure. On the morning of July 25, 2018, the surgery began and was completed without reported complications and she was brought into the recovery room to stabilize her. During this time, medical personnel were unable to normalize her vital signs and she was ultimately taken back to the operating room in an attempt to find the reason. Despite lengthy efforts by staff to regain spontaneous heart rate, they were unable to and on July 25, 2018 at 2045 hours, her death was pronounced. At 2255 hours, hospital staff called the San Diego County Medical Examiner's Office to report the death and secured her body for transportation.

Past Medical, Surgical, and Social History:

According to medical records from Alvarado Hospital, the decedent was described as a poor historian and her past medical history prior to being detained was unknown. While in custody, she was diagnosed with coronary artery disease, pneumonia and tuberculosis.

Scene Description:

The decedent was pronounced dead while in the operating room of Alvarado Hospital located at 6655 Alvarado Road in the city of San Diego. On July 25, 2018 at 2331 hours, I arrived at the facility where I found the decedent atop a gurney in a hallway of the OR. There was nothing remarkable regarding the scene.

Body Description:

The body was only briefly viewed lying supine inside a hospital issued pouch. Blue tamper-evident seal number 0071325, along with an identification band was placed on top of the decedent's body for the transportation company.

Special Requests:

None.

Identification:

The decedent was visually identified to me upon my arrival by Alvarado Hospital staff.

Antemortem Specimens:

I did not collect antemortem samples.

Public Administrator:

No referral is needed as the decedent's next of kin are aware of her death.

Other Important Factors:

None.

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

Signed:

September 20, 2018

Medical Examiner Investigator

Approved by:

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

CAUSE OF DEATH WORKSHEET

San Diego County Medical Examiner Department

☐ Autopsy

☐ Fetal death

San Diego County Medical Examiner

2018-01819

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

7/27/2018

RAMIREZ-ARREOLA, Agustina

☒ External

☐ Possible SIDS

☒ Not Dictated

☐ Family Paid

☐ Body not coming to office

CAUSE OF DEATH: (PENDING)

Time interval

Complications of aortic valve replacement hours

Due To: Rheumatic Heart Disease years

Due To: _____

Due To: _____

CONTRIBUTING: Coronary artery Disease, Pneumonia;
Tuberculosis (TB).

MANNER: () Pending (☒) Natural () Accident () Suicide () Homicide () Undetermined

**Use reverse side for manner type in non-pending cases

HOW OCCURRED: _____

DATE and TIME of INJURY:

LOCATION:

SURGERIES and DATES:

Aortic valve replacement, 7/25/18.

7/29/18

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

() Yes

(☒) No

(☒) Unknown

Supervising Pathologist

Date: 7/27/18

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

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Manner Types and SubTypes

(check one)

NATURAL

- ☐ AIDS Related
- ☐ Alcohol Related
- ☐ Anaphylactic Reaction
- ☐ Autoimmune/Systemic
- ☐ Cancer
- ☒ Cardiovascular
- ☐ Central Nervous System
- ☐ Chronic Drug Abuse
- ☐ Diabetes Related
- ☐ Endocrine
- ☐ Family Paid
- ☐ Gastrointestinal
- ☐ Hematologic
- ☐ Infant/Perinatal (not SIDS)
- ☐ Infectious
 - ☐ Viral
 - ☐ Bacterial
 - ☐ Other
- ☐ Intrauterine/Stillborn
- ☐ Liver disease
- ☐ Obesity Related
- ☐ Other
- ☐ Pregnancy Related
- ☐ Psychiatric Related
- ☐ Pulmonary
- ☐ Renal
- ☐ Seizures
- ☐ SIDS
- ☐ Undetermined

ACCIDENT

- ☐ Aircraft
- ☐ Alcohol Related
- ☐ Anaphylactic Reaction
- ☐ Animal Related
- ☐ Asphyxia
 - ☐ Airway Obstruction
 - ☐ Autoerotic
 - ☐ Other
 - ☐ Positional
 - ☐ Strangulation
 - ☐ Suffocation
 - ☐ Traumatic
- ☐ Bicycle
- ☐ Blunt Force (other)
- ☐ Boating
- ☐ Carbon Monoxide
- ☐ Chemical/Poison
- ☐ Cutting/Stabbing
- ☐ Drowning
- ☐ Drug - Medication
 - ☐ Drug and Alcohol
 - ☐ Drug and Meds
 - ☐ Drug, meds & alcohol
 - ☐ Drugs of Abuse
 - ☐ Medication
 - ☐ Meds & Alcohol

ACCIDENT (cont.)

- ☐ Electrocution
- ☐ Explosion
- ☐ Exposure
- ☐ Fall
 - ☐ Blunt head trauma
 - ☐ Fracture, other
 - ☐ Hip/Femur fracture
 - ☐ Multiple injuries
 - ☐ Other
 - ☐ Spinal fracture
 - ☐ Subdural hematoma
- ☐ Fire
- ☐ Firearm
- ☐ Hanging
- ☐ Industrial
- ☐ Ingested Foreign Object(s)
- ☐ Inhalation
- ☐ Medical/Therapeutic
- ☐ Motor Vehicle
 - ☐ Auto Rollover (solo)
 - ☐ Auto vs Auto
 - ☐ Auto vs Bicycle
 - ☐ Auto vs Fixed Object
 - ☐ Auto vs Motorcycle
 - ☐ Auto vs Pedestrian
 - ☐ Hit and Run
 - ☐ Motorcycle
 - ☐ Off Road
 - ☐ Other
 - ☐ Unknown
- ☐ Other
- ☐ Restraint Related
- ☐ Scalding
- ☐ Scuba - Diving
- ☐ Spear gun
- ☐ Train
- ☐ Undetermined

SUICIDE

- ☐ Alcohol Related
- ☐ Asphyxia
 - ☐ Strangulation
 - ☐ Suffocation
 - ☐ Other
- ☐ Blunt Force (other)
- ☐ Carbon Monoxide
- ☐ Chemical/Poison
- ☐ Cutting/Stabbing
- ☐ Drowning
- ☐ Drug - Medication
 - ☐ Drug & Alcohol
 - ☐ Drug and Meds
 - ☐ Drug, meds & alcohol
 - ☐ Drugs of Abuse
 - ☐ Medication
 - ☐ Meds & Alcohol
- ☐ Electrocution

SUICIDE (cont.)

- ☐ Explosion
- ☐ Fire
- ☐ Firearm
- ☐ Hanging
- ☐ Inhalation
- ☐ Jumping
- ☐ Motor Vehicle
 - ☐ Auto Rollover (solo)
 - ☐ Auto vs. Fixed Object
 - ☐ Auto vs. Pedestrian
 - ☐ Motorcycle
- ☐ Train
- ☐ Undetermined

HOMICIDE

- ☐ Alcohol Related
- ☐ Asphyxia
 - ☐ Other
 - ☐ Positional
 - ☐ Strangulation
 - ☐ Suffocation
- ☐ Assault
- ☐ Blunt Force
- ☐ Chemical/Poison
- ☐ Child Abuse
- ☐ Cutting/Stabbing
- ☐ Drowning
- ☐ Drug - Medication
- ☐ Elder Abuse
- ☐ Exposure
- ☐ Fire
- ☐ Firearm
- ☐ Homicidal Violence, NOS
- ☐ Intrauterine/Stillborn
- ☐ Motor Vehicle
- ☐ Other
- ☐ Restraint Related
- ☐ Undetermined

UNDETERMINED

- ☐ Alcohol Related
- ☐ Blunt Force
- ☐ Decomposed
- ☐ Drowning
- ☐ Drug - Medication
- ☐ Fire related
- ☐ Firearm
- ☐ Infant/Perinatal (not SIDS)
- ☐ Intrauterine/Stillborn
- ☐ Other
- ☐ Skeletal Remains
- ☐ Undetermined

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DHS-20-0638-D-000356

DETAINEE DEATH REVIEW: Agustina RAMIREZ-Arreola, A206266687
Healthcare and Security Compliance Analysis
Otay Mesa Detention Center
San Diego, California

As requested by the ICE Office of Professional Responsibility, External Reviews and Analysis Unit (ERAU), Creative Corrections participated in a review of the death of detainee Agustina RAMIREZ-Arreola while she was in the custody of the Otay Mesa Detention Center (OMDC), San Diego, California. A site visit was conducted August 28 through 30, 2018 by ERAU staff (b)(6); (b)(7)(C) Management and Program Analyst and team leader, and (b)(6); (b)(7)(C) Inspection and Compliance Specialist, and Creative Corrections contract personnel (b)(6); (b)(7)(C) RN, Healthcare Subject Matter Expert, and (b)(6); (b)(7)(C) Security Subject Matter Expert. Contractor participation was requested to determine compliance with the ICE 2011 Performance Based National Detention Standards (PBNDS), revised 2016, governing medical care and security operations.

This report was prepared collaboratively by (b)(6); (b)(7)(C) Creative Corrections contract manager. Included is a case synopsis, description of the facility and its medical services, a narrative summary of events, and conclusions. The information and findings herein are based on analysis of detainee RAMIREZ's medical record and detention file, tour of the medical clinic, housing unit, and intake area, interviews of staff, and review of policies, video surveillance recordings, hospital and specialist consultation records, and available incident related documentation.

SYNOPSIS

Detainee RAMIREZ was admitted to OMDC on June 3, 2018, 12 days after she was processed by US Customs and Border Patrol. She was 62 years old. RAMIREZ reported no chronic medical conditions during intake and symptom screening for tuberculosis was negative; however, two chest X-rays conducted approximately 17 hours following her admission were positive for possible tuberculosis. RAMIREZ was not isolated following notification the first chest X-ray was positive, pending results of the second. A provider ordered her transport to the hospital when informed the second chest X-ray confirmed the findings of the first. Transfer to the hospital was ordered because the facility's respiratory isolation rooms were occupied.

RAMIREZ was hospitalized for 30 days, during which she was isolated, tested, and treated for tuberculosis. Tests for active pulmonary tuberculosis disease were ultimately found negative; however, during examination by the infectious disease specialist, a heart murmur was identified. Further diagnostic testing found severe aortic stenosis, confirmed during cardiac consultation within a week following RAMIREZ's return to OMDC. Surgery was recommended and

completed 15 days later. During surgery, complications developed. After multiple attempted interventions, death was pronounced at 10:45 p.m. on July 25, 2018.

A death certificate and autopsy were not available as of the date of this report. A summary prepared by the cardiac surgeon states the presumptive cause of death was cardiogenic shock.

FACILITY DESCRIPTION

OMDC is owned and managed by CoreCivic, formerly Corrections Corporation of America. At the time of RAMIREZ's detention, Spectrum Security Services provided security for detainees admitted to hospitals; however, according to Acting Officer in Charge (b)(6); (b)(7)(C) Assistant Field Officer Director, responsibility for hospital details was assumed by CoreCivic starting August 1, 2018.

OMDC houses male and female ICE and US Marshal Service (USMS) detainees. On July 25, 2018, the total population was 1458, including 832 male and 142 female ICE detainees, and 384 male and 100 female USMS detainees.

Visitors to OMDC are issued visitor badges after producing identification. They pass through a metal detector and place personal items through an X-ray machine before being permitted to pass through a secure door into the facility. The facility uses the Milestone System for video surveillance. The team reviewed video showing detainee RAMIREZ's movement within the facility and selected 39 screenshots deemed most pertinent to the compliance analysis. Reviewers note system-generated timestamps from video are not synchronized with times documented by other means.

HEALTHCARE SERVICES

OMDC was accredited by the National Commission on Correctional Health Care (NCCHC) in June 2016. The health services department is staffed 24 hours a day, seven days a week by ICE Health Services Corp (IHSC) and contractor STG International headquartered in Alexandria, Virginia. In addition, one nurse is contracted through Akahi Associates based in Honolulu, Hawaii. The staffing plan authorizes 73 positions, 17 of which are designated for commissioned officers of the US Public Health Service. They include the Clinical Director, Health Services Administrator (HSA), two assistant HSAs, one staff physician, two behavioral health professionals, a dentist, registered dental hygienist, nurse manager, two pharmacists, one program manager, and four registered nurses (RN). There are 51 authorized full-time contract positions

including seven advanced practice providers¹, one psychiatrist, three behavioral health professionals, 13 RNs, seven mental health RNs, nine licensed vocational nurses (LVN), one dental assistant, six medical records technicians, two pharmacy technicians, one radiation technician, and an administrative assistant. As-needed positions include four RNs and one LVN. According to CAPT (b)(6); (b)(7)(C) SA, there were three or four nursing vacancies during detainee RAMIREZ's detention; however, all shifts were covered with temporary duty nurses. There was also a vacancy for an assistant HSA. Review of credential files found all but four contained copies of current licensure. During the site visit, the HSA verified the licenses of the four nurses were active by accessing the California nursing licensure website.

OMDC's clinic has six medical examination rooms, an urgent care/treatment room, nursing triage room, nurses' station, pharmacy, medical records office, four-chair dental suite, large conference room, laboratory draw room, and several offices. The observation area has two nine-person dormitory-style units for mental health patients and six negative pressure rooms for respiratory isolation. Three holding tanks, which serve as waiting rooms, allow separation of genders. Intake screening and radiology rooms are located in the receiving and discharge processing area.

The IHSC e-Clinical Works (eCW) electronic medical record system is used at OMDC. The system does not have mandatory fields for entry of the times patient encounters are conducted, and OMDC healthcare professionals are not required to include the times they see patients in their free-form notes. Therefore, times referenced in this report reflect timestamps of vital sign entries and times healthcare professionals signed their notes.

DETENTION SUMMARY

Detainee RAMIREZ was classified low custody. She had no disciplinary incidents and filed no grievances. Her single request, in Spanish, was answered six days later. The response suggests she asked to obtain phone numbers from her property but then declined the opportunity to access the numbers. The response, in English, indicates her interest was in resetting her voice for the telephone system, which was facilitated. When not hospitalized, RAMIREZ was housed in general population.

SUMMARY OF EVENTS

Sunday, June 3, 2018

Detainee RAMIREZ was medically pre-screened by Lieutenant (b)(6); (b)(7)(C) RN upon arrival at OMDC. (b)(6); (b)(7)(C) documented the time of arrival was 5:48 p.m. and interpretation assistance was not provided. The RN also noted the detainee was not transferred from another facility.

¹ Advanced Practice Providers include nurse practitioners and physician assistants.

RAMIREZ acknowledged a current, illness or health problem (b)(6); (b)(7)(C) did not specify on the pre-screening form, and denied being on medication. The detainee's appearance, behavior, skin and breathing were all described as normal, she was alert, and there were no noticeable restrictions or difficulties in her ease of movement. (b)(6); (b)(7)(C) did not designate RAMIREZ for priority intake screening. The note was electronically signed at 8:07 p.m.

Note: According to (b)(6); (b)(7)(C) pre-screening involves RNs boarding the transport bus and asking arriving detainees simple, routine health questions in Spanish, whether or not the nurses themselves speak the language fluently. If detainees want to elaborate on their responses, they are designated priority one status and brought into the facility for full screening using interpretation assistance as needed. (b)(6); (b)(7)(C) was reassigned to another duty station prior to the review team's site visit and therefore, was not available for interview.

Note: Documentation provided to reviewers indicates that consistent with (b)(6); (b)(7)(C) note, RAMIREZ was not transferred from another ICE detention facility. However, Form I-213, Record of Deportable/Inadmissible Alien, documents she entered the US on May 21, 2018 and was processed by US Customs and Border Patrol (CBP) 12 days before arrival at OMDC, May 22, 2018. Reviewers do not know when custody of RAMIREZ was transferred from CBP to ICE Enforcement and Removal Operations (ERO).

A screenshot from the Receiving Sally Port camera shows detainee RAMIREZ entered Intake at 5:45 p.m. The Inmate/Detainee Commitment Summary documents she was booked into OMDC at 5:55 p.m.

Medical and mental health intake screening was conducted by RN (b)(6); (b)(7)(C) using a telephonic service for Spanish interpretation. Vital signs entered at 7:55 p.m. were as follows: temperature normal at 97.2, blood pressure slightly elevated at 130/85, respirations normal at 18, and pulse rapid at 126. RAMIREZ's height was four feet, nine inches and she weighed 185 pounds. Because her pulse was elevated when first taken, it was retaken after ten minutes of rest and found slightly lower at 116. She was scheduled for two additional pulse checks.

Note: The pulse checks, scheduled in eCW for June 6 and 16, 2018, were not completed. (b)(6); (b)(7)(C) stated during interview that she did not know they were not done, and could not offer an explanation.

(b)(6); (b)(7)(C) wrote RAMIREZ stated she felt good and was not in any pain. She denied medical problems, except for having a cough and sore throat for three days. She was not taking medication on a regular basis and when asked if she had ever been treated by a doctor for a medical condition, she stated she had eye surgery ten years earlier to remove a piece of flesh. RAMIREZ denied use of tobacco, alcohol, or drugs, and the mental health screening was normal. A pregnancy test was negative. All questions related to tuberculosis symptoms were answered in the negative, including experiencing a prolonged cough, and she denied a history of tuberculosis infection. During

interview (b)(6); (b)(7)(C) stated that because RAMIREZ's cough was only three days in duration, she did not consider it prolonged. Therefore, in her medical judgment, the reported cough was not a possible symptom of tuberculosis.

The intake screening was designated normal. Education was provided to address health, wellness, stress management, and access to medical, dental, and mental health care. Consent for treatment was signed, and RAMIREZ was medically cleared for custody. (b)(6); (b)(7)(C) signed her note at 8:08 p.m.

Officer (b)(6); (b)(7)(C) documented completion of the following admission processing forms: Assessment Questionnaire Information, Free Admission Telephone Call Form, and Custody Classification Worksheet. The Assessment Questionnaire Information form includes questions related to history of sexual assault and abuse, all of which were answered in the negative. Officer (b)(6); (b)(7)(C) was not interviewed; therefore, reviewers do not know whether she posed the questions in Spanish or if interpretation assistance was used. The telephone call form documents detainee RAMIREZ placed a three minute telephone call to her daughter (b)(6); (b)(7)(C). The Custody Classification Worksheet documents the detainee was rated low custody. The rating was approved by a supervisor on June 5, 2018.

June 4, 2018

A Detainee Personal Property Record Form initiated at 1:01 a.m. by (b)(6); (b)(7)(C) (first name unknown) lists the following items: backpack, blouse, bras, cellphone, creams, deodorant, earring bows, eyeglass cleaner, eyeglass pouch, fiber pouches, jacket, jeans, make-up brush, money pouch, phone charger, shoes, socks, sweater, tablet with pen, toothpaste, toothbrush, underwear, vitamins, and wallet. Funds included one US dollar and enumerated Mexican currency. Two tubes of cream, nail polish and cologne were confiscated and destroyed per Disposition of Non-Allowable Property Form 14-6A. Receipts for the property and funds, in English, were initialed by detainee RAMIREZ in lieu of signature. She also initialed receipts for facility clothing, hygiene items, and bedding and linens.

The Offender System housing report documents detainee RAMIREZ was assigned to Alpha Unit cell 106, bed E. Alpha Unit is a two-tier, direct supervision, general population housing unit with eight-person rooms and dayroom. A screenshot from the Alpha Corridor camera shows RAMIREZ entering Alpha Unit at 3:37 a.m. A screenshot from the same camera shows she departed the housing unit at 7:59 p.m. heading towards Intake. The Receiving East camera captured detainee RAMIREZ standing with other detainees in a line near the Intake X-Ray room door at 8:16 p.m. She entered the room at 8:22 p.m.

During interview, HSA (b)(6); (b)(7)(C) explained that chest X-rays are the primary tuberculosis testing method at OMD. She said one full-time radiology technician works the evening shift, 3:00 p.m. to 11:30 p.m. Monday through Friday. Because intake tuberculosis symptom screening was negative, isolation pending chest X-ray was not indicated, and because she arrived on a Sunday,

her chest X-ray was not taken until the evening following her admission. “Public Health Actions for Tuberculosis Care Guide: IHSC-Staffed Medical Clinics”, signed July 11, 2017 by CAPT (b)(6); (b)(7)(C) authorizes the practice followed at OMDC.

Medical record documentation indicates two X-rays were taken. Per the Shina Systems Configuration Management screen print, the first was taken at 8:24 p.m.; the second at 8:43 p.m. The report for the first chest X-ray documents it was positive for active TB disease and, “cannot exclude Active TB; NOT clear for general population.” The X-Ray was read (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) and transcribed by Aloxx Sao at 11:29 p.m. Eastern Standard Time (EST)/8:29 p.m. Pacific Standard Time (PST). The report for the second X-ray confirmed the findings of the first. The second X-ray was read by (b)(6); (b)(7)(C) MD and transcribed by (b)(6); (b)(7)(C) at 2:25 a.m. EST/11:25 a.m. PST. Neither of the radiology reports document the times they were sent to OMDC.

Note: The two radiology reports document procedure times of 11:06 p.m. EST/8:06 p.m. PST and 11:32 p.m. EST/9:32 PST. Other evidence indicates these times are inaccurate. Specifically, as noted, a screenshot from the facility’s security video shows RAMIREZ first entered the X-ray room at 8:22 p.m., and the Shina Systems screen print documents electronic time stamps of 8:24 p.m. and 8:43 p.m. for the two X-rays. When the discrepancies were pointed out to (b)(6); (b)(7)(C) she said she had not noticed them and could offer no explanation.

A screenshot from the camera system shows detainee RAMIREZ approaching the entry door to Alpha Unit with other detainees at 8:45 p.m.

Note: Detainee RAMIREZ was returned to the housing unit despite two chest X-rays which were positive for suspected TB. The results of the second were not known when she returned to Alpha Unit; however, the evidence indicates OMDC medical staff were aware the first was positive and did not direct the detainee’s isolation. While possible the written report for the first chest X-ray was not received prior to completion of the second, the time of its transcription, 8:29 p.m. PST, and the fact that a second X-ray was performed 19 minutes after the first, points to staff’s awareness of the first positive finding, presumably by telephone. Per the above-cited IHSC Tuberculosis Care Guide, “Health staff should obtain a two view [chest X-ray] (PA² and lateral) as an additional verifier for any single view [chest X-ray] with an abnormal impression consistent with suspected TB disease (‘positive’) as soon as possible but no later than 72 hours of the initial abnormal, single view [chest X-ray] result.” The evidence suggests that the second chest X-ray was taken in accordance with these instructions.

² PA in this context stands for posteroanterior, meaning the radiation rays pass through the body from back to front.

As detailed below, after extensive testing, respiratory isolation, and treatment at the Alvarado Hospital Medical Center (AHMC), infectious pulmonary TB was ultimately ruled out. That was not known when RAMIREZ returned to Alpha unit at 8:45 p.m. on June 4, 2018; therefore, other detainees and staff were placed at risk for possible exposure to TB. Available information does not allow attribution of responsibility; nor does it allow determination of whether RAMIREZ was allowed to return to the housing unit due to lack of procedures that ensure detainees with positive chest X-rays are isolated pending results of a second, or staff failure to follow them. CAPT (b)(6); (b)(7)(C) Clinical Director, and OMDC's designated Infection Prevention Officers, Lieutenant Commander (b)(6); (b)(7)(C) RN and Commander (b)(6); (b)(7)(C) RN, stated during interviews that OMDC is a high-risk location for tuberculosis transmission.

A telephone encounter initiated by (b)(6); (b)(7)(C) at 11:06 p.m., documents she notified Physician Assistant (PA) (b)(6); (b)(7)(C) of the results of the two chest X-rays. She wrote that because the negative pressure rooms in the Medical Housing Unit (MHU) were full, the provider ordered RAMIREZ's transport to the emergency room by facility van.

Note: As discussed above, the report for the second chest X-ray documents a transcription time of 11:25 p.m. PST., following (b)(6); (b)(7)(C) notification of PA (b)(6); (b)(7)(C) that both X-rays were positive. Reviewers assume OMDC staff were notified of the results of the second by telephone, before the findings were transcribed.

Note: Documentation of the chest X-ray results and notification of a provider for orders exists in the telephone encounter, only. There is no corresponding progress note. RN (b)(6); (b)(7)(C) informed the review team nurses are required to enter a progress note only if there is a patient encounter.

Screenshots from the camera system show detainee RAMIREZ leaving Alpha unit at 11:19 p.m. and entering intake at 11:22 p.m. She was wearing a mask.

June 5, 2018

A screenshot shows detainee RAMIREZ boarding an OMDC van at 12:52 a.m. She continued to wear a mask. A Transfer of Custody Receipt documents CoreCivic transport officers turned custody of RAMIREZ over to Spectrum Security Services officers at 6:30 a.m.

Note: Security logs documenting the time of arrival at AHMC and events during RAMIREZ's hospitalization were not available.

Detainee RAMIREZ was admitted to AHMC under the care of attending physician (b)(6); (b)(7)(C) MD. She was hospitalized for 30 days, during which OMDC nurses entered only 12 hospital updates, summarized below. Further information on care provided at the hospital is provided below (see July 5, 2018 and July 12, 2018).

Note: HSA Schneider informed the review team that hospital updates are to be obtained daily when detainees are stable. Updates were not recorded for June 5, 7, 10, 12, 13, 15, 18, 19, 20, 22, 25, 26, and 27, and July 1 and 2, 2018.

Date	Update
June 6, 2018	Current diagnosis: rule out tuberculosis; condition stable. Three sputum samples ³ were collected and a purified protein derivative (PPD) skin test was planted.
June 8, 2018	PPD and two sputum samples were negative for TB but positive for extended spectrum beta-lactamase (ESBL) ⁴ . A CT scan of the chest, with contrast, showed pneumonia in the bilateral lobes and left upper lobe. Antibiotics were changed from Levaquin ⁵ to Augmentin ⁶ .
June 11, 2018	Results of the third sputum and the MTB (micro-bacterium tuberculosis) ⁷ VCR ⁸ were pending. An infectious disease consult was also pending.
June 14, 2018	The three sputum samples and MTB were negative. Rifampin, isoniazide (INH), pyrazinamide, and ethambutal (RIPE) therapy ⁹ was initiated on June 12, 2018 and was to be continued for five days.
June 16, 2018	No changes.
June 17, 2018	Day six of RIPE therapy. Discharge was pending clearance by the county public health department.
June 21, 2018	RIPE therapy was stopped on June 19, 2018 due to elevated liver enzymes. RIPE treatment was re-initiated this date, starting with Ethambutol, only. There were no episodes of nausea or vomiting. Liver enzyme lipase was to be retested the next morning. Test results for O&P (ova and parasites) ¹⁰ were pending. The medication

³ Sputum is mucous that must be coughed up from the lungs and tested to determine if the tuberculosis bacteria is present. For accuracy, three sputum samples are collected. If all three smears are negative, the patient is determined not to be actively infectious.

⁴ ESBL is a type of bacteria which produces an enzyme, beta lactamase, which has the ability to break down commonly used antibiotics and render them non-effective for treatment.

⁵ Levaquin is an antibiotic medication used to treat pneumonia, an infection of the lungs.

⁶ Augmentin is an oral antibacterial combination consisting of the antibiotic amoxicillin and the beta lactamase inhibitor clavulanate potassium.

⁷ MTB is another way of saying tuberculosis, caused by a microscopic bacteria.

(b)(6); [redacted] and OMDC's two infection control nurses were unfamiliar with the acronym VCR. Reviewers conclude VCR may be a typographical error and that the RN may have intended to type PCR. MTB PCR is a molecular based test for TB and is, in fact, referred to in a progress note by the infectious disease specialist in a hospital progress note dated July 4, 2018.

⁹ RIPE therapy is the administration of the four antibiotic drugs which are used in combination to treat tuberculosis. The vitamin pyridoxine (B6) is always included with INH dosing.

¹⁰ A parasite is an organism that lives in or on another organism (host) and benefits by deriving nutrients at the host's expense. Ova are eggs of the parasite. An AHMC laboratory report documents the tests were negative.

	Zofran was given the night before to relieve nausea, and Benadryl was given to treat insomnia. Intravenous hydration was started with normal saline ¹¹ and potassium ¹² .
June 26, 2018	RAMIREZ remained in respiratory isolation. An echocardiogram ¹³ revealed aortic stenosis ¹⁴ , and a cardiology evaluation and possible cardiac catheterization ¹⁵ were pending. She was reportedly crying all night because she could not call her family. Ethambutol was discontinued due to continued elevated liver enzymes. Benadryl and Visteril were ordered to be given as needed to relieve itching.
June 28, 2018	Ethambutol and Rifampin were restarted on June 27, 2018. Follow up liver enzyme testing was pending.
June 29, 2018	No treatment changes.
June 30, 2018	No treatment changes.
July 3, 2018	A cardiology evaluation and possible cardiac catheterization were pending, possibly as an outpatient procedure, following RAMIREZ's release from respiratory isolation. Ethambutol, Rifampin, and vitamin B6 had been administered for five days, and it was day three for INH. Discharge was being planned for the next day, following five days of RIPE.

July 4, 2018

A Transfer of Custody Receipt indicates Spectrum Security Services officers turned over custody of detainee RAMIREZ to CoreCivic officers at 9:00 p.m. A screenshot from the video camera system shows she entered the intake area at 9:42 p.m. and went directly to medical.

(b)(6); (b)(7)(C) initiated an encounter note documenting assessment of RAMIREZ following her return from AHMC. The RN wrote she is fluent in the detainee's language and did not use interpretation assistance. Vital signs associated with the encounter were not entered until 8:03 a.m. July 6, 2018, and (b)(6); (b)(7)(C) signed her note two hours later the same date. Vital signs were within normal limits (temperature 97.6, pulse 82, blood pressure 116/71, respirations 14, and pulse oxygen 96 percent). RAMIREZ was in no acute distress, well-developed, and well nourished. RN (b)(6); (b)(7)(C) wrote that the detainee was admitted to the MHU pending evaluation by the primary care provider the following day. A screenshot shows detainee RAMIREZ entering negative pressure room 1468 at 10:20 p.m.

July 5, 2018

¹¹ Normal saline is a mixture of sodium chloride (salt) and water, often used as an intravenous solution to keep the intravenous catheter cleared of blockage and bacteria.

¹² Potassium is an alkaline (pH greater than seven) chemical element.

¹³ An echocardiogram is a diagnostic tool which uses ultrasound (sound waves) to create images of the heart.

¹⁴ Aortic stenosis is a condition in which the valve in the large blood vessels branching off the heart (aorta) is abnormally narrowed, preventing the heart valve from fully opening and causing inability of the blood to flow from the heart to the rest of the body.

¹⁵ Cardiac catheterization is the insertion of a catheter into a chamber or vessel of the heart for diagnostic and interventional purposes.

(b)(6); (b)(7)(C) entered a tuberculosis monitoring report documenting submission of transnational referral to Cure TB¹⁶, RAMIREZ's placement on medical hold, and reporting of the case to the California Health Department in San Diego. Confirmatory sign-off by (b)(6); (b)(7)(C) at 11:14 a.m. on July 9, 2018 requested continued updates with final culture results when available, and a follow up comparison chest X-ray after six to eight weeks of TB treatment.

(b)(6); (b)(7)(C) entered two encounter notes this date. The lengthier note, for which vital signs were entered at 2:26 p.m., was documented as the PE-C, Physical Examination-Complex. At IHSC facilities, PE-C is the designation for the initial health appraisal of detainees with identified medical conditions. Vital signs were within normal limits (temperature 98.6, pulse 90, blood pressure 123/73, respirations 12), and RAMIREZ reported she was in no pain. In the narrative, (b)(6); (b)(7)(C) recounted that mild tachycardia was noted during intake and that the detainee was sent to the emergency room as a result of positive chest X-rays. He also noted that she had no history of pulmonary issues and was asymptomatic. (b)(6); (b)(7)(C) wrote that while RAMIREZ was undergoing TB workup and infectious disease consultation at the hospital, a heart murmur was noted. An ECG showed aortic stenosis, found severe by way of cardiac catheterization. The narrative further documents that on July 3, 2018, charge nurse (b)(6); (b)(7)(C) (first name not specified) called to request urgent aortic valve replacement per recommendation of cardiology. (b)(6); (b)(7)(C) wrote that he gave verbal approval through (b)(6); (b)(7)(C) but for reasons that were unclear, RAMIREZ was returned to OMDC on July 4, 2018. Later in his note, in Examination findings, (b)(6); (b)(7)(C) wrote that he spoke with charge nurse (b)(6); (b)(7)(C) (first name not specified) and was told the cardiologist decided the AVR procedure was not emergent and could be arranged on an outpatient basis. He also recommended follow up with cardiac surgeon (b)(6); (b)(7)(C) consider outpatient surgery, and that RAMIREZ was cleared for surgery for general anesthesia and proposed cardiac operation.

In the Examination and Assessments sections of the encounter note (b)(6); (b)(7)(C) addressed the aortic stenosis diagnosis as well as TB testing and treatment. He wrote, "Overall, suspect [chest X-ray] abnormality likely from pneumonia, not TB." He documented three sputum smears were negative for TB but in narrative notes, documented two were negative and two others, processed at AHMC, were presumably negative. RIPE therapy was started but pyrazinamide was stopped due to hepatitis/pancreatitis which resolved when stopped. (b)(6); (b)(7)(C) noted the infectious disease consultant determined RAMIREZ stable for discharge and clear for travel, but recommended continuation of three-drug TB treatment, avoiding pyrazinamide, and following smear cultures and liver enzymes.

Note: For added context, reviewers note that a progress note in the AHMC record by Dr. (b)(6); (b)(7)(C), infectious disease specialist, documents an assessment finding of latent TB infection. The finding of latent TB means there was past disease and that bacteria in

¹⁶ Cure TB is a program promoted by Center for Disease Control which works to prevent the spread of tuberculosis among people who cross international borders.

the lungs was inactive. Latent TB may become active again and result in infectious pulmonary disease. (b)(6); (b)(7)(C) rogress note also states RAMIREZ was smear negative and negative on all MTB PCRs. The negative tests indicate tuberculosis bacteria was absent in the lungs, meaning the detainee was not infectious by airborne transmission. This finding does not, however, rule out the presence of tuberculosis in other parts of the body.

Per his progress note, (b)(6); (b)(7)(C) rote that he discontinued TB isolation on July 3, 2018, and determined there were no contraindications from an infectious disease standpoint to preclude surgery for aortic stenosis.

The general examination conducted by (b)(6); (b)(7)(C) was normal except for a heart murmur of 3/6¹⁷, heard at the upper sternal border. The pulse rate and rhythm were normal. The assessments were enumerated as follows: encounter for general adult medical examination with abnormal findings; encounter for observation for other suspected diseases and conditions ruled out; non-rheumatic aortic valve stenosis¹⁸; and pneumonia due to Escherichia coli¹⁹.

Treatment orders included RIPE medications except pyrazinamide, and omeprazole as needed for heartburn; an urgent referral for follow up with cardiac surgeon (b)(6); (b)(7)(C); and chronic care follow up on July 9, 2018 with OMDC P (b)(6); (b)(7)(C).

Note: Referrals for outside consultations are not processed through the ICE Medical Payment Authorization Request system at facilities where healthcare services are provided by IHSC. The OMDC medical record does not document the processing of (b)(6); (b)(7)(C) referral but as discussed below, the consultation was, in fact, completed by (b)(6); (b)(7)(C) five days later, July 10, 2018.

Note: (b)(6); (b)(7)(C) did not see RAMIREZ until July 19, 2018. A blank follow up encounter note is present in the medical record for this date, suggesting the appointment was scheduled. (b)(6); (b)(7)(C) stated during interview that she did not know why she did not see detainee RAMIREZ as ordered by (b)(6); (b)(7)(C).

¹⁷ Heart murmurs are classified according to how loud the sound is with a stethoscope. A 3/6 murmur means the loudness was on a level three on a scale of one to six.

¹⁸ Nonrheumatic aortic valve stenosis means the condition is not caused by a history of rheumatic fever.

¹⁹ Escherichia coli is a bacteria that normally lives in the intestines of healthy people and animals, but some strains can cause diarrhea when consuming contaminated food, drink, or fouled water.

Additional treatment orders included Snellen and Ishihara vision testing²⁰ by RNs on July 6, 2018, and laboratory tests for HIV, comprehensive metabolic panel²¹, thyroid cascade²² profile, urinalysis with microscopic examination with reflex culture²³, and QuantiFERON TB Gold. In the Assessments section of his note (b)(6); (b)(7)(C) documented the labs were to be drawn on July 6, 2018; in the Treatment section, he wrote they were ordered for July 5, 2018.

Note: The labs were not drawn until July 18, 2018, and there is no documentation vision testing was completed. The reason (b)(6); (b)(7)(C) orders were not followed is unknown.

The Examination section (b)(6); (b)(7)(C) note documents detainee RAMIREZ was medically cleared for custody, and RN (b)(6); (b)(7)(C) (first name unknown) was advised the patient may locate to general population; no respiratory isolation needed.

In his second encounter note for July 5, 2018 (b)(6); (b)(7)(C) documented the reason for the appointment was 23-hour observation/hospital return. The History of Present Illness and Examination sections refers to the PE-C for full details. Vital signs time-stamped 3:40 p.m. were the same as those entered for the PE-C.

A Telephone Encounter (b)(6); (b)(7)(C) timed 4:30 p.m. documents he discussed dosing of rifampin and ethambutol with the pharmacist. The medication dosages were:

- Isoniazid (INH) 300 mg, one tablet daily in the morning
- Pyridoxine (Vitamin B6) 50 mg, one daily in the morning
- Rifampin 150 mg, three capsules, daily in the morning, after meal
- Ethambutol HCl 400 mg, two tablets daily in the morning
- Omeprazole 20 mg, as needed for heartburn at night

A screenshot from the video camera system shows detainee RAMIREZ exiting negative pressure room 1468 at 2:37 p.m. with linens and pillow in hand. At 2:33 p.m., she entered Alpha Unit. The Offender Management System Log documents RAMIREZ was assigned to cell 103, bed C at 2:37 p.m. Cell 103 is on the lower level of the housing unit; bed C is an upper bunk. Per the log, at 11:12 p.m. detainee RAMIREZ was reassigned to cell 207, bed F, a lower bunk on the upper level.

Detainee RAMIREZ submitted a request in Spanish. By response in English, dated July 11, 2018 a staff member whose signature is not legible notified the detainee she was given the opportunity

²⁰ A Snellen test is a test to determine visual acuity, using an eye chart.

²¹ A comprehensive metabolic panel (CMP) is a series of blood test that provide a snapshot of the body's chemistry and the way it uses energy through metabolism.

²² A thyroid cascade profile is a test used to diagnose common thyroid disorders. If the initial test result is normal, further testing (cascading) is deemed unnecessary.

²³ A urinalysis with microscopic examination with reflex culture involves a dipstick urine test to determine the chemical constituents in the urine, a microscopic examination to detect the presence of abnormal urine cells, and culture to identify the organisms causing infection.

to access her property for phone numbers and other items. She refused, saying she did not need anything, “just wanted to have your voice reset.” The response further notes the detainee’s voice was reset.

Note: Reviewers assume a voice re-set relates to the phone system.

July 6, 2018

The Offender Management System Log documents that at 9:18 p.m., detainee RAMIREZ was reassigned to cell 101, bed H, a lower bunk on the lower level. During tour of the housing unit, unit counselor (name unknown) indicated changes were made to detainee RAMIREZ’s cell and bed assignments pursuant to requests claiming hardship climbing the stairs and to upper bunks.

(b)(6); (b)(7)(C) documented an update to the initial infectious disease monitoring report, adding results of tests completed at the hospital; specifically, the Interferon Gamma Release Assay²⁴ was positive, and the HIV test was negative.

July 7, 2018

(b)(6); (b)(7)(C) conducted a nursing assessment to address RAMIREZ’s complaint of itchiness on her arms and legs. Spanish interpretation assistance was used. The detainee denied pain, and vital signs entered at 2:49 p.m. were within normal limits (temperature 98, pulse 88, blood pressure 125/68, and respirations 16). Risk for impaired skin integrity was the assessment and the plan, per RN Guideline 2008 (title not specified), was to start diphenhydramine HCL²⁵ 25 mg orally every six hours as needed for three days, keep-on-person (KOP). (b)(6); (b)(7)(C) signed her note at 3:00 p.m.

July 10, 2018

(b)(6); (b)(7)(C) entered an encounter note documenting RAMIREZ returned from consultation with cardiac surgeon Howden at 2:25 p.m. Interpretation assistance was not used based on the RN’s documented fluency in the detainee’s language. Vital signs entered at 2:34 p.m. were within normal limits (temperature 98.4, pulse 86, blood pressure 119/70, respirations 16, and pulse oxygen 99). Her weight was 181 pounds. RAMIREZ denied pain and offered no complaints. In the Treatment section of the encounter note, (b)(6); (b)(7)(C) wrote that an offsite provider discharge note was received with recommended treatment plan, “Patient needs aortic valve replacement surgery.”

²⁴ An Interferon Gamma Release Assay (IGRA) is a whole blood test used to aid in the diagnosis of tuberculosis infection. It does not differentiate latent (inactive) tuberculosis from active tuberculosis disease. Quantiferon-TB Gold is a commonly used IGRA.

²⁵ Diphenhydramine HCL is the generic name for Benadryl, an antihistamine used to treat allergy, hay fever, and common cold symptoms.

Note: The referenced discharge note was ~~not found in the~~ medical record; however, as discussed below, a consult report prepared by (b)(6); (b)(7)(C) on July 10, 2018 was faxed to the facility on July 12, 2018.

(b)(6); (b)(7)(C) documented she notified onsite provider (b)(6); (b)(7)(C) and gave her “papers”. RAMIREZ was scheduled to see the PA for follow up on July 11, 2018, and was instructed to notify staff in the event of any shortness of breath, chest pain, or if otherwise needed. Per PA Rosenblatt’s authorization, RAMIREZ was returned to general population in stable condition. RN Endacot signed her note at 2:45 p.m.

Note: PA Rosenblatt did not see detainee RAMIREZ on July 11, 2018. The medical record does not document the reason she did not see RAMIREZ until July 19, 2018.

July 12, 2018

(b)(6); (b)(7)(C) six-page consult report dated July 10, 2018 was faxed to (b)(6); (b)(7)(C) attention at 9:45 a.m. (b)(6); signed the fax coversheet on July 13, 2018. (b)(6); (b)(7)(C) opened the report by noting detainee RAMIREZ spoke Spanish only, and that her history was obtained with the assistance of a translator. He wrote that RAMIREZ had no knowledge of cardiovascular disease or a heart murmur prior to the recent hospitalization. He detailed events at AHMC, including three negative sputum tests, initiation of RIPE therapy, discontinuation of pyrazinamide upon development of symptoms of pancreatitis, and treatment for pneumonia. He detailed identification of the cardiac murmur and diagnosis of rheumatic valvular disease with severe aortic stenosis. In the Impressions section of the report, (b)(6); (b)(7)(C) documented RAMIREZ was a suitable candidate for surgical valve replacement with low surgical risk. He concluded the report with a recommendation for aortic valve replacement and documented that through a translator, the indications, risks and alternatives were explained to RAMIREZ. She indicated her consent.

July 17, 2018

A Telephone Encounter by (b)(6); timed 4:38 p.m. documents a surgery referral was submitted pursuant to (b)(6); (b)(7)(C) recommendation. As detailed below, the surgery was conducted on July 25, 2018.

July 18, 2018

(b)(6); (b)(7)(C) entered a note documenting blood was drawn for lab tests ordered on July 5, 2018. The specimens were drawn without difficulty and the patient tolerated the procedure well.

Note: During interview, (b)(6); (b)(7)(C) said he ordered that the labs be drawn on July 6, 2018 so the results would be available prior to the cardiology consultation. He noted that although the labs were drawn later than ordered, the tests were done in time for RAMIREZ’s surgery.

(b)(6); (b)(7)(C) conducted a nursing assessment to address RAMIREZ's complaint of continued itching. Spanish interpretation assistance was used for this encounter. Vital signs entered at 11:39 a.m. were within normal limits except for a mildly elevated blood pressure (temperature 98.2, pulse 94, respirations 16, pulse oxygen 100, blood pressure 137/84. RAMIREZ complained of recurring itchiness all over, and (b)(6); (b)(7)(C) described the skin as very dry with a red rash over the detainee's left forearm and right upper arm. The skin on her back was intact, with no lesions. Other general examination findings were normal. The treatment plan was to start diphenhydramine HCL 25 mg orally every six hours as needed for three days, keep-on-person. Instructions, per the Nursing Guideline 2008 for allergies, were to increase fluid intake to eight eight-ounce glasses per day, take lukewarm showers, and to return to sick call in three days if symptoms persist or worsen. TN (b)(6); (b)(7)(C) signed her note at 11:55 a.m.

July 19, 2018

PA Rosenblatt conducted a post-cardiology consultation follow up encounter. Vital signs entered at 2:08 p.m. were within normal limits with the exception of a mildly elevated blood pressure (temperature 98.0, pulse 98, respirations 16, and blood pressure 134/80). (b)(6); (b)(7)(C) wrote, "[Patient] has been in Alvarado Hospital for more than one month originally sent for suspect TB, then found the heart problem. (b)(6); (b)(7)(C) has recommended surgery, referral has been placed. [Patient] reports prior to arrival, she had no idea she had the heart problem, reports she did get tired easily. [Patient] reports what bothers her most is the itching, possibly from one of the TB meds, pyrazinamide or ethambutol." The general examination found no obvious rash, although she was constantly scratching at her skin which caused welts and erythema. The systolic murmur was heard. She was diagnosed with nonrheumatic aortic stenosis and pruritus²⁶, unspecified. The treatment plan noted surgery for aortic valve stenosis was scheduled for July 25, 2018. PA (b)(6); (b)(7)(C) documented RAMIREZ became tearful and was concerned "about having surgery alone in the facility," and had no prior knowledge of heart problems. The treatment for pruritis related to tuberculosis medication included a teleconference with (b)(6); (b)(7)(C) IHSC Infection Control Specialist, and to start diphenhydramine HCL 25 mg orally three times daily as needed for 30 days, approved as a KOP medication. Provider follow up was scheduled for one week as needed post-surgery. Patient education was provided, and RAMIREZ was medically cleared for custody (b)(6); (b)(7)(C) ed the note at 2:47 p.m.

Note: This is the last patient encounter note in the medical record. As detailed below, the next entry was five days later, following RAMIREZ's transport to AHMC in advance of the scheduled surgery.

July 24, 2018

A Transfer of Custody Receipt indicates CoreCivic officers turned custody of detainee RAMIREZ over to Spectrum Security Services at 2:00 p.m.

²⁶ Pruritis is the medical term for itchiness.

Note: Spectrum Security Services logs were not provided to reviewers. Interview of five Spectrum officers²⁷ confirmed security supervision was maintained without incident.

(b)(6); (b)(7)(C) signed to the 2:00 p.m. to 10:00 p.m. shift this date, stated RAMIREZ was nervous, emotional and crying during the shift.

(b)(6); (b)(7)(C) documented a hospital update at 2:03 p.m. RAMIREZ was being prepared for repair of the aortic stenosis and CABG (coronary artery bypass graft)²⁸ on July 25, 2018. Her current status was stable, and she was scheduled to be NPO (nothing by mouth) status after midnight.

July 25, 2018 – Day of Death

(b)(6); (b)(7)(C) documented a hospital update at 6:38 a.m. RAMIREZ was anxious and crying the evening before but was better at the time of the update.

(b)(6); (b)(7)(C) were assigned to the 10:00 p.m. to 6:00 a.m. shift. Both officers documented in incident reports that detainee RAMIREZ was returned to surgery when complications developed after the first. Per their reports, death was pronounced in the operating room at 10:45 p.m.

In a Death Summary signed July 31, 2018, (b)(6); (b)(7)(C) documented death was declared at 8:45 p.m. He wrote cardiopulmonary bypass surgery was initially completed without trouble, but as small needle holes in the right atrium were being repaired, RAMIREZ's blood pressure began to drop. After several failed interventions, the decision was made to place her on extracorporeal membrane oxygenation (ECMO)²⁹. The chest was left open and she was taken to the intensive care unit (ICU). Significant bleeding continued over the next several hours, and doctors attempted to keep up with the transfusion demand. Despite various interventions which failed to increase her cardiac index³⁰, it was decided to return RAMIREZ to the operating room. (b)(6); (b)(7)(C) wrote that following further interventions, "she initially looked good, but then would quickly fade." Despite all efforts, an adequate cardiac output could not be maintained to sustain life and the decision was made to stop all treatments. She sustained a rhythm³¹ for a while, but her blood pressure could not be sustained. Eventually she declined and expired. The cause of death was

²⁷ Officers (b)(6); (b)(7)(C) were interviewed.

²⁸ CABG is a form of bypass surgery to create new routes round the narrowed and blocked coronary arteries, permitting increased blood flow to deliver oxygen and nutrients to the heart muscle.

²⁹ ECMO is a technique of providing prolonged cardiac and respiratory support, outside the body, to persons whose heart and lungs are inefficient.

³⁰ Cardiac index is a measurement of the amount of blood being pumped out of the heart to the body. .

³¹ A cardiac rhythm refers to the transmission of electrical signals that normally control the heart rate and regularity of beats.

cardiogenic shock³². A possible contributing factor was an allergic reaction to protamine³³ following the first operation; another possible contributing factor was a very hypertrophied³⁴ noncompliant left ventricle³⁵.

Note: The time of death documented by (b)(6); (b)(7)(C) 8:45 p.m., is likely inaccurate. This conclusion is based on the following: the officers present at the time of death were assigned to the 10:00 p.m. to 6:00 a.m. shift; in their incident reports, the officers documented the time of death was 10:45 p.m.; a medical record entry the next day (see below) also documents the time of death was 10:45 p.m.; and AHMC nursing notes documenting that at 10:00 p.m., RAMIREZ remained in the operating room. A death certificate was not available to confirm the time of death.

During interview of Officer (b)(6); (b)(7)(C) he stated she notified her supervisor, Lieutenant (b)(6); (b)(7)(C) of the death. Spectrum Security Services Lieutenant (b)(6); (b)(7)(C) documented in his incident report that he immediately upon notification of the death by Officer (b)(6); (b)(7)(C) he contacted Supervisory Deportation and Detention Officer (b)(6); (b)(7)(C) (first name unknown).

July 26, 2018

Officers (b)(6); (b)(7)(C) wrote in their incident reports that they were relieved of any further duty at 2:50 a.m.

RN (b)(6); (b)(7)(C) entered a hospital update at 6:37 a.m. documenting the aortic replacement procedure the previous day; however, bleeding was noted and she was returned to the operating room. She died during the procedure at 10:45 p.m. ICE was notified.

(b)(6); (b)(7)(C) was notified of RAMIREZ's death by follow up to the telephone encounter initiated on July 19, 2018 by (b)(6); (b)(7)(C)

Post Death Actions

- A Detainee Property Inventory and the Trust Account Closing Receipt dated July 31, 2018 documents detainee RAMIREZ's property and funds were processed by OMD for release to ICE. The property and US funds totaling \$62.65 was picked up by (b)(6); (b)(7)(C) (title unknown) on August 21, 2018.

³² Cardiogenic shock is a fatal condition in which the heart is suddenly unable to pump enough blood to meet the body's needs.

³³ Protomine is a medication used to reverse the effect of heparin (an anticoagulant used to prevent blood clotting) during surgery.

³⁴ Hypertrophied means an abnormal enlargement of an organ or tissue.

³⁵ The left ventricle is one of four chambers in the heart, separated by the aortic valve, which pumps blood from the heart to the rest of the body.

- (b)(6); (b)(7)(C) entered a tuberculosis-case management update on July 31, 2018. Information added since the July 6, 2018 update included identification of an outside clinic and address verification should RAMIREZ be deported. For contact purposes, RAMIREZ's daughter was identified as A (b)(6); (b)(7)(C) from Modesto, CA. (b)(6); (b)(7)(C) signed her note at 1:21 p.m. Detainee RAMIREZ's death is not mentioned.

CONCLUSIONS

Medical

Detainee RAMIREZ did not report, and intake nurses did not observe, symptoms suggestive of TB. On that basis, she was cleared for general population housing pending chest X-ray. Because RAMIREZ was admitted on a Sunday evening, and as allowed by IHSC guidelines, her screening chest X-ray was not completed for approximately 17 hours following her admission. The X-ray was read promptly and per the radiology report, the detainee was not cleared for general population because active TB could not be ruled out. A second X-ray was conducted 19 minutes after the first to confirm the findings; however, RAMIREZ was sent back to her general population housing unit immediately after the second chest X-ray was taken. She was in the unit for more than two hours before results of the second chest X-ray were available, results which confirmed the initial positive findings. Although RAMIREZ was ultimately determined non-infectious, her return to the housing unit placed other detainees and staff at potential risk for exposure.

Upon notification of chest X-ray results, a provider ordered the detainee's transfer to the hospital to rule out TB. The transport, with respiratory mask, was facilitated quickly. RAMIREZ was hospitalized for 30 days. She was in respiratory isolation until the day before discharge from the hospital when, after testing and treatment for TB and pneumonia, the infectious disease physician documented a diagnosis of latent TB. During RAMIREZ's hospitalization, a heart murmur was incidentally identified and aortic stenosis was diagnosed.

Upon return to OMD, RAMIREZ was assessed by an RN and placed in respiratory isolation pending assessment (b)(6); (b)(7)(C) the next day. (b)(6); (b)(7)(C) documented a detailed summary of the hospital record and comprehensive physical examination. He cleared the detainee for housing in general population and ordered continuation of recommended TB medications. He also ordered vision testing, laboratory studies, follow up by (b)(6); (b)(7)(C) and urgent referral for cardiac consultation. The consultation was completed five days later; however, (b)(6); (b)(7)(C) orders for vision testing, laboratory studies and provider follow up were not completed prior to the consultation as directed.

Detainee RAMIREZ was assessed by an RN when she returned from the cardiac consultation. The RN notified (b)(6); (b)(7)(C) that the cardiologist recommended aortic valve replacement surgery and per authorization of the PA, returned RAMIREZ to the housing unit with direction to notify

staff if she experienced shortness of breath or chest pain. The detainee was scheduled to see PA (b)(6); (b)(7)(C) the next day; however, she was not seen by the provider until nine days later.

Pursuant to the cardiologist's recommendation (b)(6); (b)(7)(C) submitted a referral for aortic valve replacement surgery. The surgery was completed eight days following the documented referral. The surgeon's death summary documents complications developed during surgery, and after multiple unsuccessful interventions over the course of several hours, life-sustaining efforts were discontinued. Official documentation of the time of death is not available.

Compliance Findings

Creative Corrections cites the following deficiency in the ICE PBNDS 2011, Medical Care, revised 2016.

Section (V)(C)(2), which states, "All new arrivals shall receive TB screening within 12 hours of intake and in accordance with [Center for Disease Control] guidelines." Center for Disease Control TB Guidelines, Prevention and Control of Tuberculosis in Correctional and Detention Facilities, state, "Persons who have radiographs suggestive of TB should be isolated immediately and evaluated further."

- Detainee RAMIREZ was allowed to return to her general population housing unit after an initial chest X-ray on June 4, 2018 identified possible TB. She was in the unit for approximately two and a half hours before results of a second chest X-ray were available, resulting in confirmation of results of the first and transfer to the hospital for isolation, testing, and treatment.

Reviewers recognize that the written report for the first chest X-ray, which states, "cannot exclude Active TB; NOT clear for general population", may not have been received when RAMIREZ was allowed to return to the housing unit. However, a second X-ray would not have been performed unless medical personnel were aware that the first was positive. Reviewers recommend review of procedures to ensure detainees are isolated when screening chest X-rays do not exclude active TB.

Areas of Concern

Creative Corrections cites the additional areas of concern for findings not addressed in the ICE detention standards:

- Detainee RAMIREZ's pulse was found elevated when checked twice during intake screening. The RN appropriately scheduled two monitoring checks; however, neither were completed.

- On July 5, 2018, (b)(6); (b)(7)(C) ordered laboratory studies and vision testing for July 6, 2018. Nurses did not draw laboratory samples until July 18, 2018, and there is no documentation vision testing was completed.
- (b)(6); (b)(7)(C) July 5, 2018 orders included direction for follow up assessment by PA Rosenblatt on July 9, 2018. She did not see RAMIREZ that date, nor did she see her on July 11, 2018 pursuant to referral by an RN following RAMIREZ's return from the cardiology consultation. Although the RN's note documents she informed (b)(6); (b)(7)(C) the cardiologist recommended surgery to correct aortic stenosis, (b)(6); (b)(7)(C) did not assess the detainee until July 19, 2018. Reviewers acknowledge the medical record documents RAMIREZ was stable when she returned from the cardiac consultation and continued to be stable when seen for sick call for complaint of itchy skin on July 18 and by (b)(6); (b)(7)(C) on July 19, 2018. However, given the consulting cardiologist's findings, completion of the scheduled July 11, 2018 provider follow up would have been prudent.
- Nurses did not enter daily updates during the detainee's hospitalization. RAMIREZ was transferred to the hospital during the early morning hours of June 5, 2018 and returned to OMDC at approximately 9:30 p.m. on July 4, 2018.

Safety and Security

Compliance Findings

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

JOINT INTAKE

From: (b)(6); (b)(7)(C) <[REDACTED]@ice.dhs.gov>
Sent: Thursday, July 26, 2018 4:50 AM
To: JOINT INTAKE
Cc: (b)(6); (b)(7)(C) <[REDACTED]>
Subject: Detainee Death – San Diego Field Office

JIC,

On July 25, 2018, at approximately 2251 hours, Spectrum Security assigned to Alvarado Hospital in San Diego, California verbally notified ERO San Diego that Augustina RAMIREZ-Arreola, A206 266 687 died on July 25, 2018 at approximately 2245 hours. RAMIREZ was admitted to Alvarado Hospital due to a heart abnormality, had undergone surgery and died from complications of the surgery.

BACKGROUND:

On November 20, 2013, RAMIREZ applied for admission into the United States without proper document at the San Ysidro Port of Entry, CA. RAMIREZ was processed as an Expedited Removal. RAMIREZ claimed no fear of returning to Mexico and was returned to Mexico on November 22, 2013 via the San Ysidro Port of Entry, CA.

On May 21, 2018, RAMIREZ applied for admission into the United States without proper document at San Ysidro Port of Entry, CA. RAMIREZ claimed fear of returning to Mexico and was processed as an Expedited Removal with Credible Fear.

On June 3, 2018, RAMIREZ was transferred to the Otay Mesa Detention Center, CA pending a credible interview with asylum officer.

On July 17, 2018, RAMIREZ was found to have negative credible fear by the asylum officer. RAMIREZ requested a find by an immigration judge.

On July 23, 2018, an immigration judge in San Diego found no credible fear. RAMIREZ was pending removal to Mexico.

Please let me know if you need anything else.

Respectfully,

(b)(6); (b)(7)(C) <[REDACTED]>

Supervisory Detention and Deportation Officer
United States Department of Homeland Security
U.S. Immigration and Customs Enforcement
San Diego Field Office
Otay Mesa Detention Center

7488 Calzada De La Fuente | San Diego, CA 92154 | Office 619-661-(b)(6); Cell 213-200-1-(b)(6) | E-mail (b)(6); (b)(7)(C)@ice.dhs.gov

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DEPARTMENT OF HOMELAND SECURITY
Immigration and Customs Enforcement

REPORT OF INVESTIGATION

1. CASE NUMBER

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

PREPARED BY

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

2. REPORT NUMBER

001

3. TITLE

Ramirez Arreola, Agustina/Non-Employee/0109 Detainee/Alien - Death (Known Cause -Terminal Illness)/SAN DIEGO, SAN DIEGO, CA

4. FINAL RESOLUTION**5. STATUS**Initial
Report**6. TYPE OF REPORT**

Allegation

7. RELATED CASES**8. TOPIC**

Detainee Death

9. SYNOPSIS

On July 26, 2018, the Joint Intake Center (JIC) received information from Immigration and Customs Enforcement (ICE) Supervisory Detention and Deportation Officer (SDDO) (b)(6); (b)(7)(C) Enforcement and Removal Operations, San Diego, CA (ERO San Diego), who reported the death of Augustina Ramirez-Arreola (A206 266 687), a detainee at Otay Mesa Detention Center located in Otay, CA.

10. CASE OFFICER (Print Name & Title)

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

Joint Intake Specialist

(Print Name & Title)

JIC Supervisor

11. COMPLETION DATE

26-JUL-2018

13. APPROVED DATE

26-JUL-2018

14. ORIGIN OFFICE

Joint Intake Center

15. TELEPHONE NUMBER

No Phone Number

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DEPARTMENT OF HOMELAND SECURITY

REPORT OF INVESTIGATION
CONTINUATION

1. CASE NUMBER

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

PREPARED BY

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

2. REPORT NUMBER

001

10. NARRATIVE

On July 26, 2018, the JIC received information from ICE SDDO Sergio Albarran, ERO San Diego, who reported the death of Augustina Ramirez-Arreola (A206 266 687), a detainee at Otay Mesa Detention Center located in Otay, CA.

According to the report, Ramirez-Arreola died on July 25, 2018, at approximately 2245 hours. Ramirez-Arreola was admitted to Alvarado Hospital due to a heart abnormality and undergone surgery, but died from complications of the surgery.

The email is attached to the case file.

End of report.

 DEPARTMENT OF HOMELAND SECURITY REPORT OF INVESTIGATION Exhibit List	1. CASE NUMBER (b)(6); (b)(7)(C)
	PREPARED BY (b)(6); (b)(7)(C)
	2. REPORT NUMBER 001
None	

 DEPARTMENT OF HOMELAND SECURITY Immigration and Customs Enforcement REPORT OF INVESTIGATION		1. CASE NUMBER (b)(6); (b)(7)(C)
		PREPARED BY (b)(6); (b)(7)(C)
		2. REPORT NUMBER 002
3. TITLE Ramirez Arreola, Agustina/Non-Employee/0109 Detainee/Alien - Death (Known Cause -Terminal Illness)/SAN DIEGO, SAN DIEGO, CA		
4. FINAL RESOLUTION		
5. STATUS Interim Report	6. TYPE OF REPORT Investigative Findings	7. RELATED CASES
8. TOPIC Investigative findings.		
9. SYNOPSIS U.S. Immigration and Customs Enforcement (ICE) Otay Mesa Detention Center (OMDC) detainee, Augustina Ramirez-Arreola (A206 266 687) died of complications from surgery on July 25, 2018. The allegation was documented and reported in Significant Incident Report 2018SIR0014560. This report of investigation details investigative findings.		
10. CASE OFFICER (Print Name & Title) (b)(6); (b)(7)(C) E-OPR Special Agent	11. COMPLETION DATE 02-AUG-2018	14. ORIGIN OFFICE ICE OPR RAC San Diego-1
12. APPROVED BY(Print Name & Title) (b)(6); (b)(7)(C) CE-OPR Special Agent Supervisor	13. APPROVED DATE 02-AUG-2018	15. TELEPHONE NUMBER No Phone Number
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 DEPARTMENT OF HOMELAND SECURITY REPORT OF INVESTIGATION CONTINUATION	1. CASE NUMBER (b)(6); (b)(7)(C)
	PREPARED BY (b)(6); (b)(7)(C)
	2. REPORT NUMBER 002
10. NARRATIVE DETAILS OF INVESTIGATION: On July 26, 2018, the Joint Intake Center (JIC) received information from (b)(6); (b)(7)(C) Supervisory Detention and Deportation Officer (SDDO), Enforcement and Removal Operations, San Diego, CA (ERO/San Diego). SDDO (b)(6); (b)(7)(C) reported that on July 25, 2018, at approximately 10:45 pm, Ramirez died at Alvarado Hospital from complications related to heart surgery she underwent. On May 21, 2018, Ramirez applied for admission into the United States at the San Ysidro Port of Entry and requested asylum. Customs and Border Protection (CBP) officers processed Ramirez's request that same date. On May 22, 2018, CBP officers served Ramirez a Notice and Order of Expedited Removal charging inadmissibility pursuant section 212(a)(7)(A)(i)(I), Immigrant Without an Immigrant Visa, of the Immigration and Nationality Act. On June 3, 2018, Ramirez was transferred to the custody of ERO at OMDC. That same day, Ramirez was transported to Alvarado for additional examination following a chest scan that indicated tuberculosis (TB) exposure. Ramirez' exams for active TB were negative, but she was diagnosed with pneumonia and extended-spectrum beta-lactamases and given antibiotics. (b)(6); (b)(7)(C) On June 12, 2018, Alvarado medical staff initiated treatment for TB. On June 19, 2018, Alvarado staff stopped Ramirez' treatment due to side effects from the medication. On June 26, 2018, an echocardiogram revealed Ramirez was suffering from aortic stenosis. Her TB treatment was stopped due to elevated enzymes. On July 3, 2018, a cardiology evaluation and possible outpatient cardiac catheterization was scheduled for when Ramirez was out of respiratory isolation and she returned to OMDC the next day. On July 10, 2018, a cardiac surgeon at Alvarado evaluated Ramirez and recommended aortic valve replacement surgery. Ramirez was screened upon returning to OMDC and cleared for general population.	

 DEPARTMENT OF HOMELAND SECURITY REPORT OF INVESTIGATION CONTINUATION	1. CASE NUMBER (b)(6); (b)(7)(C)
	PREPARED BY (b)(6); (b)(7)(C)
	2. REPORT NUMBER 002
10. NARRATIVE On July 17, 2018, CIS determined Ramirez did not establish a credible fear of persecution in her asylum case and she requested review by an immigration judge (IJ). On July 19, 2018, Ramirez was seen as a follow up to review cardiac surgery recommendations. An aortic stenosis surgery was scheduled for July 25, 2018. (b)(6); (b)(7)(C) On July 24, 2018, Ramirez was transported to Alvarado in preparation for surgery. On July 25, 2018, at approximately 6:20 am, Ramirez underwent surgery for replace her aortic valve. At approximately 2:50 pm, the surgery was complete. Upon recovery from surgery, Alvarado medical staff noticed Ramirez was still bleeding and returned her to surgery at approximately 5:20 pm. At 10:45 pm, Ramirez died during surgery.	

 DEPARTMENT OF HOMELAND SECURITY REPORT OF INVESTIGATION Exhibit List	1. CASE NUMBER (b)(6); (b)(7)(C)
	PREPARED BY (b)(6); (b)(7)(C)
	2. REPORT NUMBER 002

None



STATE OF WASHINGTON DEPARTMENT OF HEALTH



CERTIFICATE OF DEATH



CERTIFICATE NUMBER: **2018-054225**

DATE ISSUED: **02/28/2019**

FEE NUMBER: **2715**

FIRST AND MIDDLE NAME(S): **MERGENSANA DABAEVICH**

LAST NAME(S): **AMAR**

COUNTY OF DEATH: **PIERCE**

DATE OF DEATH: **NOVEMBER 18, 2018**

HOUR OF DEATH: **02:45 PM**

SEX: **MALE**

AGE: **40 YEARS**

SOCIAL SECURITY NUMBER: **UNKNOWN**

HISPANIC ORIGIN: **NO, NOT SPANISH/HISPANIC/LATINO**

RACE: **MONGOLIAN**

BIRTH DATE: **OCTOBER 23, 1978**

BIRTHPLACE: **KHURAMSHA RUSSIA**

MARITAL STATUS: **SINGLE, NEVER MARRIED**

SPOUSE: **NOT APPLICABLE**

OCCUPATION: **ENTREPRENEUR**

INDUSTRY: **BUSINESS**

EDUCATION: **BACHELOR'S DEGREE**

US ARMED FORCES: **NO**

INFORMANT: **(b)(6); (b)(7)(C)**

RELATIONS: **(b)(6); (b)(7)(C)**

ADDRESS: **(b)(6); (b)(7)(C)**

CAUSE OF DEATH:

A: **ANOXIC ENCEPHALOPATHY**

INTERVAL: -

B: **HANGING**

INTERVAL: -

C:

INTERVAL:

D:

INTERVAL:

OTHER CONDITIONS CONTRIBUTING TO DEATH:

DATE OF INJURY: **NOVEMBER 15, 2018**

HOUR OF INJURY: **03:06 PM**

INJURY AT WORK: **NO**

PLACE OF INJURY: **INSIDE CELL AT ICE NORTHWEST DETENTION CENTER**

LOCATION OF INJURY: **1623 EAST J STREET**

CITY, STATE, ZIP: **TACOMA, WASHINGTON 98421-1602**

COUNTY: **PIERCE**

DESCRIBE HOW INJURY OCCURRED: **HANGED HIMSELF WITH BED SHEET**

IF TRANSPORTATION INJURY, SPECIFY: **NOT APPLICABLE**

PLACE OF DEATH: **HOSPITAL**

FACILITY OR ADDRESS: **ST. JOSEPH MEDICAL CENTER**

CITY, STATE, ZIP: **TACOMA, WASHINGTON 98405**

RESIDENCE STREET: **1123 E J STREET**

CITY, STATE, ZIP: **TACOMA, WA 98421**

INSIDE CITY LIMITS: **YES**

COUNTY: **PIERCE**

TRIBAL RESERVATION: **NOT APPLICABLE**

LENGTH OF TIME AT RESIDENCE: **11 YEARS**

FATHER/PARENT: **(b)(6); (b)(7)(C)**

MOTHER/PARENT: **(b)(6); (b)(7)(C)**

METHOD OF DISPOSITION: **CREMATION**

PLACE OF DISPOSITION: **SOUTH SOUND CREMATORY**

CITY, STATE: **LACEY, WASHINGTON**

DISPOSITION DATE: **DECEMBER 11, 2018**

FUNERAL FACILITY: **FUNERAL ALTERNATIVES OF WASHINGTON - FEDERAL WAY**

ADDRESS: **31919 6TH AVE S, STE 200**

CITY, STATE, ZIP: **FEDERAL WAY, WASHINGTON 98003**

FUNERAL DIRECTOR: **DAVID D. MCNEIL**

MANNER OF DEATH: **SUICIDE**

AUTOPSY: **YES**

WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE

CAUSE OF DEATH: **YES**

DID TOBACCO USE CONTRIBUTE TO DEATH: **NO**

PREGNANCY STATUS IF FEMALE: **NO RESPONSE**

CERTIFIER NAME: **THOMAS B. CLARK, III**

TITLE: **CORONER/ME**

CERTIFIER ADDRESS: **3619 PACIFIC AVENUE**

CITY, STATE, ZIP: **TACOMA, WA 984187929**

DATE SIGNED: **NOVEMBER 26, 2018**

CASE REFERRED TO ME/CORONER: **NO**

FILE NUMBER: **18-2308**

ATTENDING PHYSICIAN: **NOT APPLICABLE**

LOCAL DEPUTY REGISTRAR: **CHARA RIM**

DATE RECEIVED: **DECEMBER 11, 2018**



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) #: (b)(6); (b)(7)(C)

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)¹ 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.² 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 encephalopathy³ due to hanging.⁴

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

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

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.⁶

¹ This facility is also known as the Tacoma or Northwest ICE Processing Center.

² See Exhibit 1: Creative Corrections Healthcare and Security Compliance Analysis Report.

³ Anoxic encephalopathy is a condition where the brain tissue is deprived of oxygen and there is a global loss of brain function.

⁴ See Exhibit 2: Pierce County Medical Examiner's Office Postmortem Examination Report, dated November 26, 2018.

⁵ See I-867A, Record of Sworn Statement in Proceedings under Section 235(b)(1) of the Act, dated December 3, 2017.

⁶ See Form I-860, dated December 3, 2017.

On December 5, 2017,⁷ 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, 2017.⁸

On December 19, 2017, ERO San Diego transferred AMAR into the custody of ERO Seattle, who transferred him to NWDC.⁹

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

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.¹¹

On February 25, 2018, ERO Seattle denied AMAR's parole because he lacked community ties and he posed a flight risk.¹²

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.¹³

On October 1, 2018, AMAR filed a notice of appeal with the Board of Immigration Appeals (BIA).¹⁴ On November 2, 2018, the BIA dismissed AMAR's appeal because he did not file the appeal within 30 days.¹⁵

On November 15, 2018, ERO Seattle scheduled AMAR's removal from the United States to Russia for November 28, 2018.¹⁶

CHRONOLOGY OF EVENTS

December 19, 2017

At 11:05 a.m., Officer (b)(6); (b)(7)(C) admitted AMAR into NWDC.¹⁷ and Registered Nurse (b)(6); (b)(7)(C) immediately completed his medical pre-screening in his native language and

⁷ See ENFORCE Alien Removal Module (EARM), dated December 5, 2017.

⁸ See San Luis Detention Center, Booking Report, dated December 7, 2017.

⁹ See EARM, dated December 19, 2017.

¹⁰ See Record of Determination/Credible Fear Worksheet (Form I-870), dated January 3, 2018.

¹¹ See Custody Order of the Immigration Judge, dated February 1, 2018.

¹² See Record of Determination/Parole Determination Worksheet (ICE Form 71-013), dated February 25, 2018.

¹³ See Order of the Immigration Judge, dated August 7, 2018.

¹⁴ See BIA Board's Decision, dated November 2, 2018.

¹⁵ *Id.*

¹⁶ See EARM, dated November 15, 2018.

¹⁷ 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.¹⁸

An unknown officer issued AMAR linens, facility clothing and shoes, hygiene items, a radio, and the facility and the ICE National Detainee Handbook.¹⁹ (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.²⁰

At 8:57 p.m., an unknown officer assigned AMAR to housing unit B1, cell 117.²¹

At 11:32 p.m.,²² (b)(6); (b)(7)(C) completed AMAR's medical and mental health intake assessment using interpretation services and documented the following:²³

- She reviewed the medical transfer summary from SLRDC.²⁴
- AMAR's vital signs were within normal limits.²⁵
- 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 test²⁶ from SLRDC, which was negative for active tuberculosis.²⁷ (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.²⁸ ERAU notes the officer did not identify and enumerate 21 foreign coins.

December 23, 2017

¹⁸ See eCW Progress Note by (b)(6); (b)(7)(C) dated December 19, 2017.

¹⁹ See NWDC Property Receipt, dated December 19, 2017.

²⁰ See Detainee Classification Worksheet, dated December 19, 2017.

²¹ See Housing History, dated November 30, 2018.

²² 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.

²³ See eCW Progress Note by (b)(6); (b)(7)(C) dated December 19, 2017.

²⁴ See SLRDC Medical Transfer Summary, dated December 18, 2017.

²⁵ 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.

²⁶ A PPD skin test occurs when a solution is injected into the skin to determine whether a person has been infected with tuberculosis.

²⁷ See PPD Skin Test Results, dated December 8, 2017.

²⁸ 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.²⁹ (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 maleate³⁰ and 325 mg of acetaminophen³¹ tablets for three days.³²
- 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.³³ 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.³⁴
- 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 G3,³⁵ 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.³⁶

August 17, 2018

At 9:52 a.m., (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:³⁷

- AMAR stated he requested a transfer to housing unit G3 with no success.³⁸

²⁹ See eCW Progress Note by (b)(6); (b)(7)(C) dated December 23, 2017.

³⁰ Chlorpheniramine maleate is a medication used to relieve symptoms of allergy, hay fever, and the common cold.

³¹ Acetaminophen is a medication used to treat minor to moderate pain and reduce fever.

³² See eCW Progress Note by (b)(6); (b)(7)(C) dated January 21, 2018.

³³ See eCW Progress Note by (b)(6); (b)(7)(C), dated April 24, 2018.

³⁴ See eCW Progress Note by (b)(6); (b)(7)(C), dated July 28, 2018.

³⁵ During interview with (b)(6); (b)(7)(C) on December 12, 2018, he stated that housing unit G3 had Russian speaking detainees.

³⁶ See Detainee Classification Worksheet, dated March 8, 2018. An unknown officer completed the June 14, 2018 reassessment on the March 8, 2018 classification worksheet.

³⁷ See eCW Progress Note by (b)(6); (b)(7)(C) dated August 17, 2018.

³⁸ 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.³⁹ (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.⁴⁰

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:⁴¹

- 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.⁴²

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.⁴³ An unsigned Special Needs Form documents AMAR's admission to administrative

³⁹ ERAU interview with (b)(6); (b)(7)(C) dated December 13, 2018.

⁴⁰ See eCW Progress Note by (b)(6); (b)(7)(C) dated August 17, 2018.

⁴¹ 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.

⁴² See eCW Progress Note by (b)(6); (b)(7)(C) dated August 22, 2018.

⁴³ 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.⁴⁴

At 8:32 a.m., Officer (b)(6); (b)(7)(C) transferred AMAR to segregation unit D3 and placed him in cell 103.⁴⁵

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.⁴⁶

(b)(6); (b)(7)(C) completed daily segregation rounds for AMAR.⁴⁷ (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.⁴⁸ 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.⁴⁹ (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:⁵⁰

- 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.

⁴⁴ See Special Needs Form, dated August 22, 2018.

⁴⁵ See Housing History, dated November 30, 2018.

⁴⁶ See Daily Log of Special Housing Detainee, dated August 22, 2018.

⁴⁷ See eCW Progress Notes by (b)(6); (b)(7)(C) dated August 23 and 24, 2018.

⁴⁸ See D3 Logbook, dated August 25, 2018. The officer's initials in the D3 Logbook are illegible.

⁴⁹ See eCW Progress Note by (b)(6); (b)(7)(C) dated August 25, 2018. ERAU notes (b)(6); (b)(7)(C) was not interviewed because she no longer worked at NWDC.

⁵⁰ See eCW Progress Note by (b)(6); (b)(7)(C) dated August 25, 2018.

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

ordered intake and output monitoring,⁵¹ every eight hours, daily weight checks, a dipstick urinalysis,⁵² orthostatic vital signs,⁵³ 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.⁵⁴

At 2:03 p.m., (b)(6); (b)(7)(C) completed AMAR's admission to MHU and documented the following:⁵⁵

- 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.⁵⁶

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

⁵¹ Intake and output are measurements of fluids and nutrients a patient takes in to determine whether there is adequate output of urine and defecation.

⁵² 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.

⁵³ 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.

⁵⁴ See Daily Log of Special Housing Detainee, dated August 22, 2018.

⁵⁵ See eCW Progress Note by (b)(6); (b)(7)(C) dated August 25, 2018.

⁵⁶ 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:⁵⁷

- 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)'s 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.⁵⁸ The motion specifically authorized involuntary hydration through intravenous (IV).⁵⁹ 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) Drew Bostock, and an unknown ICE official discussed the court order with AMAR.⁶⁰ (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 Bostock introduced himself and asked AMAR if he understood the court order, and AMAR acknowledged that he understood and agreed to medical treatment.

⁵⁷ See eCW Progress Note by (b)(6); (b)(7)(C) dated September 4, 2018.

⁵⁸ See U.S. District Court for the Western District of Washington at Tacoma, Emergency Ex Parte Motion, dated September 6, 2018.

⁵⁹ IV is the delivery of fluids directly into a vein.

⁶⁰ See Court Order Reading Video Surveillance, dated September 7, 2018.

At approximately 9:45 a.m.,⁶¹ (b)(6); (b)(7)(C) evaluated AMAR and documented the following:⁶²

- 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 Pedialyte⁶³ but continued to refuse meals.
- AMAR reported pain in his lower body and rated it as a level six on the standardized pain scale.⁶⁴
- 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:⁶⁵

- 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 electrocardiogram⁶⁶ were within normal limits, and he was complying with the court order.

(b)(6); (b)(7)(C) prescribed AMAR a tablet of thiamine⁶⁷ 100 mg twice a day for five days to be given with Boost⁶⁸ 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

⁶¹ See Daily Log for Medical ISO, dated September 7, 2018.

⁶² See eCW Progress Note by (b)(6); (b)(7)(C) dated September 7, 2018.

⁶³ Pedialyte helps prevent dehydration and replaces nutrients and electrolytes.

⁶⁴ The standardized pain scale allows patients to report their pain level from zero to ten, with ten being the worst.

⁶⁵ See eCW Progress Note by (b)(6); (b)(7)(C) dated September 13, 2018.

⁶⁶ An electrocardiogram is a test that measures the electrical activity of the heartbeat.

⁶⁷ Thiamine is vitamin B1 and is found in foods such as whole grains, legumes, and some meats.

⁶⁸ 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.⁶⁹ (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.⁷⁰

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.⁷¹

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.⁷² (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 109.⁷³

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.⁷⁴
- 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.⁷⁵
- 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.⁷⁶ 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).⁷⁷ An officer informed LCSW (b)(6); (b)(7)(C) there were no observed mental health concerns but stated that AMAR

⁶⁹ See eCW Progress Note by (b)(6); (b)(7)(C) dated October 16, 2018.

⁷⁰ ERAU interview with (b)(6); (b)(7)(C), dated December 11, 2018.

⁷¹ See Administrative Detention Order, dated October 16, 2018.

⁷² See eCW Progress Note by (b)(6); (b)(7)(C) dated October 16, 2018.

⁷³ See Housing History, dated November 30, 2018.

⁷⁴ *Id.*

⁷⁵ 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.

⁷⁶ See eCW Progress Note by (b)(6); (b)(7)(C) dated October 22, 2018.

⁷⁷ 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.⁷⁸ (b)(6); (b)(7)(C) recommended retention of administrative segregation status.

October 26, 2018

At 4:00 p.m., while AMAR was at recreation, (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.⁷⁹ He placed the rope in the Lt.'s office and notified the shift supervisor, Sergeant (Sgt. (b)(6); (b)(7)(C))⁸⁰ Officer (b)(6); (b)(7)(C) notified the nurses in the clinic and (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.⁸¹

(b)(6); (b)(7)(C) of her encounter with AMAR and (b)(6); (b)(7)(C) notified (b)(6); (b)(7)(C) a facility psychologist.⁸² (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.⁸³ (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.⁸⁴

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.⁸⁵ (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.⁸⁶

At 7:31 p.m. an officer escorted AMAR to MHU, cell 1.⁸⁷

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.

⁷⁸ See Administrative Detention Review, dated October 25, 2018.

⁷⁹ See Evidence/Search Report, dated October 26, 2018.

⁸⁰ See Information Report by (b)(6); (b)(7)(C) dated October 26, 2018.

⁸¹ ERAU interview with (b)(6); (b)(7)(C) dated December 13, 2018.

⁸² See eCW Progress Note by (b)(6); (b)(7)(C) dated October 26, 2018.

⁸³ ERAU interview with (b)(6); (b)(7)(C) dated December 13, 2018.

⁸⁴ *Id.*

⁸⁵ See eCW Progress Note by (b)(6); (b)(7)(C) dated October 26, 2018.

⁸⁶ ERAU interview with (b)(6); (b)(7)(C) dated December 13, 2018.

⁸⁷ 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.⁸⁸

At 10:46 a.m., (b)(6); (b)(7)(C) facility psychiatrist, completed AMAR's comprehensive suicide risk assessment using an interpreter and documented the following:⁸⁹

- 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.⁹⁰
- 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.⁹¹ 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,⁹² where he remained until his suicide attempt on November 15, 2018.⁹³ AMAR remained on mental health observation until November 5, 2018. During this time, medical staff completed rounds as required⁹⁴ 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

⁸⁸ See eCW Progress Note by (b)(6); (b)(7)(C) dated October 27, 2018.

⁸⁹ See eCW Progress Note by (b)(6); (b)(7)(C) dated October 27, 2018.

⁹⁰ (b)(6); (b)(7)(C) did not mention AMAR's hunger strike or that his food intake was minimal.

⁹¹ See Special Needs Form, dated October 27, 2018.

⁹² 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 (b)(6); (b)(7)(C) dated December 11, 2018.

⁹³ See Housing History, dated November 30, 2018.

⁹⁴ In housing unit H, (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.⁹⁵ (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.⁹⁶

November 4, 2018

At 6:15 p.m.,⁹⁷ AMAR went to recreation and Officer (b)(6); (b)(7)(C) searched his cell and found a sheet torn in thirds and empty milk containers and Pedialyte bottles.⁹⁸ Officer (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.⁹⁹

November 5, 2018

At 1:17 p.m., LCSW (b)(6); (b)(7)(C) evaluated AMAR and documented that he declined the use of an interpreter.¹⁰⁰ 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:¹⁰¹

- 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.¹⁰²

⁹⁵ See Administrative Detention Order, dated October 29, 2018.

⁹⁶ See Daily Log of Special Housing Detainee, dated October 30, 2018 and November 3, 2018.

⁹⁷ See Daily Log of Special Housing Detainee, dated November 4, 2018.

⁹⁸ See Evidence/Search Report, dated November 4, 2018.

⁹⁹ 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.

¹⁰⁰ See eCW Progress Note by (b)(6); (b)(7)(C) dated November 5, 2018.

¹⁰¹ See eCW Progress Note by (b)(6); (b)(7)(C) dated November 5, 2018.

¹⁰² 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:¹⁰³

- 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.,¹⁰⁴ 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.¹⁰⁵ 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.¹⁰⁶
- On November 12, 2018, AMAR began accepting all meals.
- AMAR went to recreation each day.¹⁰⁷
- On November 13, 2018, LCSW (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.¹⁰⁸

November 15, 2018 – Day of the Emergency

¹⁰³ See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated November 5, 2018.

¹⁰⁴ See Daily Log of Special Housing Detainee, dated November 5, 2018.

¹⁰⁵ See Administrative Detention Review, dated November 8, 2018.

¹⁰⁶ The signatures of the warden and ICE Officer in Charge are illegible.

¹⁰⁷ 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.

¹⁰⁸ 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.¹⁰⁹ 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), ERO personnel, and IHSC medical and mental health staff were in attendance.¹¹⁰ AFOD Bostock 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.¹¹¹ 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.¹¹² (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., (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., (b)(6); (b)(7)(C) arrived at housing unit H and proceeded to AMAR's cell.¹¹³ Officers (b)(6); (b)(7)(C) and (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.¹¹⁴ 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) stated that DO (b)(6); (b)(7)(C) did not inform them what the meeting with AMAR was about.¹¹⁵ 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.¹¹⁶

At 1:57 p.m., (b)(6); (b)(7)(C) notified SDDO (b)(6); (b)(7)(C) met with AMAR and asked to be informed when his transfer to housing unit A3 could proceed.¹¹⁷ At 2:17 p.m., SDDO (b)(6); (b)(7)(C)

¹⁰⁹ See Administrative Detention Review, dated November 15, 2018.

¹¹⁰ It is unknown which mental health staff attended the meeting.

¹¹¹ ERAU interview with AFOD (b)(6); (b)(7)(C) dated December 12, 2018.

¹¹² See Email by (b)(6); (b)(7)(C) dated November 15, 2018.

¹¹³ See H3 Video Surveillance, dated November 15, 2018.

¹¹⁴ See Memorandum by (b)(6); (b)(7)(C) dated November 21, 2018.

¹¹⁵ ERAU interviews with Officers (b)(6); (b)(7)(C) dated December 12, 2018 and December 27, 2018, respectively.

¹¹⁶ ERAU interview with (b)(6); (b)(7)(C) dated December 11, 2018.

¹¹⁷ 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.¹¹⁸ 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.¹¹⁹ (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.¹²⁰ At 2:40 p.m., she activated the pipe sensor at AMAR's cell (cell 106) and moved quickly past the cell. (b)(6); (b)(7)(C) stated that she quickly moved past his cell because AMAR was standing up and looking at her.¹²¹ 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). 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.¹²³ 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.¹²⁴ 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.¹²⁵ 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.¹²⁶ and radioed central control to activate the Incident Management System (IMS).¹²⁷ for a detainee engaged in self-harm. At 3:07 p.m., central control activated IMS.¹²⁸ 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.¹²⁹

¹¹⁸ ERAU interview with (b)(6); (b)(7)(C) dated December 12, 2018.

¹¹⁹ See GEOTour Hourly Log, dated November 15, 2018.

¹²⁰ See H3 Video Surveillance, dated November 15, 2018.

¹²¹ ERAU interview with (b)(6); (b)(7)(C) dated December 12, 2018.

¹²² See H3 Video Surveillance, dated November 15, 2018.

¹²³ *Id.*

¹²⁴ See GEOTour Hourly Log, dated November 15, 2018.

¹²⁵ See Information Report by Officer (b)(6); (b)(7)(C) dated November 15, 2018.

¹²⁶ 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.

¹²⁷ 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.

¹²⁸ See Master Control Logbook, dated November 15, 2018.

¹²⁹ 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., Officers (b)(6); (b)(7)(C) returned to cell 106 but did not ask central control to open the cell door.¹³⁰ At 3:07:14 p.m., Officer (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., (b)(6); (b)(7)(C) radioed central control to open the door to cell 106.¹³¹

According to (b)(7)(E) assigned to segregation and the facility policy requires a third officer to be present before a cell door is opened.¹³² 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 (b)(7)(F) 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, (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.¹³³ Officers observed the rope tied around the back-top corner of the bunk bed. (b)(6); (b)(7)(C) lifted AMAR to relieve the pressure on his neck while (b)(6); (b)(7)(C) cut the noose from the bunk bed first, then from around AMAR's neck.¹³⁴ (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.¹³⁵ (b)(6); (b)(7)(C) stated that AMAR's face was blue, and his lips were white when he was cut down.¹³⁶ At 3:07:57 p.m., the officers pulled AMAR outside of the cell and into the dayroom.¹³⁷ (b)(6); (b)(7)(C) used the Life Knife to remove AMAR's sweatshirt and T-shirt. (b)(6); (b)(7)(C) stated he was going to begin cardiopulmonary resuscitation (CPR) when Physician Assistant (PA) (b)(6); (b)(7)(C) arrived.¹³⁸ At 3:08:51 p.m., (b)(6); (b)(7)(C) and RN (b)(6); (b)(7)(C) entered the unit with a wheelchair.¹³⁹

(b)(6); (b)(7)(C) observed AMAR lying unresponsive on the floor and not breathing.¹⁴⁰ (b)(6); (b)(7)(C) checked AMAR's airway for obstruction, a sternum rub elicited no response,¹⁴¹ and he found no pulse. (b)(6); (b)(7)(C) initiated chest compressions. (b)(6); (b)(7)(C) stated that when she arrived on

¹³⁰ See H3 Video Surveillance, dated November 15, 2018.

¹³¹ See H3 Video Surveillance, dated November 15, 2018.

¹³² ERAU interview with Lieutenant (b)(6); (b)(7)(C), dated December 12, 2018.

¹³³ See Information Report by (b)(6); (b)(7)(C), dated November 15, 2018.

¹³⁴ See Information Report by (b)(6); (b)(7)(C), November 15, 2018.

¹³⁵ ERAU interview with (b)(6); (b)(7)(C), dated December 13, 2018.

¹³⁶ ERAU interview with (b)(6); (b)(7)(C), dated December 11, 2018.

¹³⁷ See H3 Video Surveillance, dated November 15, 2018.

¹³⁸ ERAU interview with (b)(6); (b)(7)(C), December 13, 2018.

¹³⁹ See H3 Video Surveillance, dated November 15, 2018.

¹⁴⁰ See eCW Progress Note by (b)(6); (b)(7)(C), dated November 15, 2018.

¹⁴¹ 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.¹⁴² She stated AMAR was still warm but very pale and completely lifeless. (b)(6); (b)(7)(C) attached the automated external defibrillator (AED) pads¹⁴³ on AMAR's chest; the AED did not advise for a shock to be delivered.¹⁴⁴ She then placed the ambu-bag¹⁴⁵ 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.¹⁴⁶ Medical and security staff completed four to five cycles of CPR before Emergency Medical Services (EMS) responders arrived and assumed care.¹⁴⁷

Simultaneously, additional security staff responded to the IMS call; among the staff that responded were (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.¹⁴⁸ At 3:11 p.m.,¹⁴⁹ 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 (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) to escort the detainee to the hospital.¹⁵⁰

At 3:16 p.m., nine EMS and fire department responders arrived and entered the housing unit.¹⁵¹ The fire department responders observed that AMAR was unresponsive, pulseless, and not breathing.¹⁵² 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.¹⁵³ EMS responders intubated AMAR and after approximately four minutes, they removed the airway tube, and placed an ambu-bag over his mouth and nose.¹⁵⁴ 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.¹⁵⁵ 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.¹⁵⁶ (b)(6); (b)(7)(C) accompanied AMAR in the ambulance, and (b)(6); (b)(7)(C) followed in the chase vehicle.

¹⁴² ERAU interview with (b)(6); (b)(7)(C) dated December 13, 2018.

¹⁴³ An AED is a portable electronic device that analyzes the heart rhythm and sends a shock to the heart to restore a normal rhythm.

¹⁴⁴ 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.

¹⁴⁵ An ambu-bag is a handheld device commonly used to provide ventilation to patients who are not breathing or not breathing adequately.

¹⁴⁶ See H3 Video Surveillance, dated November 15, 2018.

¹⁴⁷ See eCW Progress Note by (b)(6); (b)(7)(C) dated November 15, 2018.

¹⁴⁸ ERAU interview with (b)(6); (b)(7)(C), dated December 12, 2018.

¹⁴⁹ See Tacoma Fire Department Report, dated November 15, 2018.

¹⁵⁰ ERAU interview with (b)(6); (b)(7)(C) dated December 13, 2018.

¹⁵¹ See H3 Video Surveillance, dated November 15, 2018.

¹⁵² See Tacoma Fire Department Report, dated November 15, 2018.

¹⁵³ 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.

¹⁵⁴ See Handheld Video Surveillance, dated November 15, 2018.

¹⁵⁵ See H3 Video Surveillance, dated November 15, 2018.

¹⁵⁶ See Master Control Logbook, dated November 15, 2018.

At 3:42 p.m., the ambulance arrived at St. Joseph Medical Center (CHI Franciscan Health).¹⁵⁷ Hospital staff were able to regain a heart rhythm following two rounds of CPR and one dose of epinephrine.¹⁵⁸ 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.¹⁵⁹

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) signed the certification of brain death.¹⁶⁰ 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.¹⁶¹ 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.¹⁶² 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.¹⁶³ At 4:45 p.m., (b)(6); (b)(7)(C) conducted a fourth conference call with AMAR's parents to discuss withdrawal of care.¹⁶⁴

At 5:52 p.m., a nurse removed AMAR from the ventilator.¹⁶⁵ At 6:05 p.m., (b)(6); (b)(7)(C) pronounced AMAR deceased.¹⁶⁶ At 6:11 p.m., the vigil officers notified Sgt. (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.¹⁶⁷ 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.¹⁶⁸

Post-Death Actions

¹⁵⁷ See Transport Logbook, dated November 15, 2018.

¹⁵⁸ See CHI Franciscan Health, ED Notes, dated November 15, 2018.

¹⁵⁹ See Transport Logbook, dated November 15, 2018.

¹⁶⁰ See Brain Death Determination Checklist, dated November 18, 2018.

¹⁶¹ See CHI Franciscan Health Discharge Summary, dated November 24, 2018.

¹⁶² See Transport Logbook, dated November 24, 2018.

¹⁶³ See CHI Franciscan Health Flowsheet, dated November 24, 2018.

¹⁶⁴ See CHI Franciscan Health Discharge Summary, dated November 24, 2018.

¹⁶⁵ See Transport Logbook, dated November 24, 2018.

¹⁶⁶ See CHI Franciscan Health Discharge Summary, dated November 24, 2018.

¹⁶⁷ See Transport Logbook, dated November 24, 2018.

¹⁶⁸ ERAU interview with O (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.¹⁶⁹ Additionally, AMAR's personal property and funds remained in NWDC's custody.

On February 22, 2019, the Pierce County Medical Examiner, [REDACTED] (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.¹⁷⁰

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."

¹⁶⁹ ERAU interview with HSA [REDACTED] (b)(6); (b)(7)(C) dated December 13, 2018.

¹⁷⁰ See Exhibit 3: State of Washington Certificate of Death, dated February 28, 2019.

- (b)(6); (b)(7)(C) and (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); 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, (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, (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.

From: (b)(6); (b)(7)(C)
Sent: 16 Nov 2018 02:03:33 +0000
To: JOINT INTAKE
Subject: Detainee Suicide

Please see the below concerning a detainee suicide at the Northwest Detention Center:

From: (b)(6); (b)(7)(C) <(b)(6); (b)(7)(C)@ice.dhs.gov>
Date: Thursday, Nov 15, 2018, 5:29 PM
To: (b)(6); (b)(7)(C) <(b)(6); (b)(7)(C)@ice.dhs.gov>, (b)(6); (b)(7)(C) <(b)(6); (b)(7)(C)@ice.dhs.gov>
Subject: ***ALERT*** SUICIDE ATTEMPT AND ER UPDATE AT

Alcon,

The below detainee attempted suicide by hanging on 11/15/2018. He was revived on the scene by Tacoma Fire and Rescue. He had a pulse with regular heart rhythm on ECG and was being bagged by paramedics when he left the building at 1535. LCDR (b)(6); (b)(7)(C) received an update.

Name: Amar, Mergensana

A#: 216269802

DOB: 10/23/1978

COB: Russia

DOA: 12/19/2017

Relevant Medical History: Was on Hunger Strike but currently eating three meals a day with liquid nutritional supplements

Reason sent to ER: CPR initiated due to detainee being found unconscious and hanging with no pulse.

Current Status: (b)(6); (b)(7)(C) N: detainee is still non-responsive, has an anoxic brain injury, possible spinal cord injury, pupils fixed and dilated, organ life center notified.

Mode of transportation: ACLS

Name of Transport Company: Tacoma Fire and Rescue

Hospital being sent to: St. Joseph's

All notifications by the Field Office Director have been made per ICE Policy Number 11003.2, Section 4.3

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

Acting Field Office Director

ICE Enforcement & Removal Operations, Seattle, WA

Main: 206-835-(b)(6); / Desk: 206-835-(b)(6); / Cell: 206-(b)(6); (b)(7)(C)



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 DEPARTMENT OF HOMELAND SECURITY Immigration and Customs Enforcement REPORT OF INVESTIGATION		1. CASE NUMBER (b)(6); (b)(7)(C)	
		PREPARED BY (b)(6); (b)(7)(C)	
		2. REPORT NUMBER 001	
3. TITLE Amar, Mergensana/Non-Employee/0615 Detainee/Alien - Suicide Attempt/TACOMA, PIERCE, WA			
4. FINAL RESOLUTION			
5. STATUS Initial Report	6. TYPE OF REPORT Allegation	7. RELATED CASES	
8. TOPIC Detainee Suicide Attempt			
9. SYNOPSIS On November 15, 2018, the Joint Intake Center (JIC) received information from Immigration and Customs Enforcement (ICE) Supervisory Detention and Deportation Officer (SDDO) (b)(6); (b)(7)(C) who reported a suicide attempt involving Mergensana Amar (A216 269 802), a detainee at Northwest Detention Center, located in Tacoma, WA.			
10. CASE OFFICER (Print Name & Title) (b)(6); (b)(7)(C) Joint Intake Specialist	11. COMPLETION DATE 16-NOV-2018	14. ORIGIN OFFICE Joint Intake Center	
12. APPROVED BY (Print Name & Title) (b)(6); (b)(7)(C) OPR Special Agent Supervisor	13. APPROVED DATE 16-NOV-2018	15. TELEPHONE NUMBER No Phone Number	
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DEPARTMENT OF HOMELAND SECURITY

REPORT OF INVESTIGATION
CONTINUATION

1. CASE NUMBER

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

PREPARED BY

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

2. REPORT NUMBER

001

10. NARRATIVE

On November 15, 2018, the JIC received information from ICE SDDO (b)(6); (b)(7)(C), who reported a suicide attempt involving Mergensana Amar (A216 269 802), a detainee at Northwest Detention Center, located in Tacoma, WA.

According to the report, Amar attempted suicide by hanging. He was revived on the scene by Tacoma Fire and Rescue. He had a pulse with regular heart rhythm on ECG and was being bagged by paramedics when he left the building at 1535. Per Resident Nurse (b)(6); (b)(7)(C) detainee is still non-responsive, has an anoxic brain injury, possible spinal cord injury, pupils fixed, and dilated, and organ life center was notified.

The email is attached to the case file.

End of report.

 DEPARTMENT OF HOMELAND SECURITY REPORT OF INVESTIGATION Exhibit List	1. CASE NUMBER (b)(6); (b)(7)(C)
	PREPARED BY (b)(6); (b)(7)(C)
	2. REPORT NUMBER 001
None	

ICE Significant Incident Report

Submitted Date and Time of Report: 11/26/2018 1152 EST

Incident Date: 11/24/2018	Incident Time: 1805	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Field Operations Division	Area: Western Operations
Case Number: No Case Involved	Office: WA - FOD SEATTLE - SEA	Lead Agency: B - DHS / ICE
SEN Incident Number: (b)(7)(E)	Initial/Follow-Up: Initial	Event Status: Routine
Related SEN Number:	Related Case Number: —	SEACATS Number:
Intel Number:	ENFORCE Number:	

Employee	Operational	Security	Other
☐ Shots Fired At Employee	☐ Air/Marine Incidents	☐ National Security Interest	☐ Escape
☐ Shots Fired By Employee	☐ Controlled Delivery	☐ Facility Disturbance	☒ Suicide Attempt
☐ Employee Assaulted	☐ Significant Seizure	☐ Terrorism Related	☐ Hunger Strike
☐ Employee Death	☐ Significant Arrest	☐ Foreign Military/Police Incursion	☒ Media Interest
☐ Employee Injured	☐ IPAS	☐ WMD/HAZMAT	☒ Alien Injury/Death
☐ Employee Arrested	☐ SCR	☐ Demonstrations	☐ Vehicle Incidents
☐ Firearms Discharge to Include Unintentional Discharge	☐ Rescue	☐ JTTF	☐ Other
☐ Use of Baton or other Impact Weapon	☐ Weapon Violations	☐ Bomb Threat	☐ Predator
☐ Use of OC Spray or other Chemical Agents	☐ Other Agency Interest	☐ DHS SAR	☐ Gang Related
☐ Other Use of Force			
☐ Loss or Theft of Firearm or Body Armor			

Principal Subject: Person
Date of Birth: 10/23/1978

Last Name: AMAR
Country of Birth: Russia

First Name: Mergensana
Citizenship: Russia

Alien ID: 216269802

Narrative

Report Title: ERO Seattle Detainee Death (AMAR)

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Mergensana AMAR, A216 269 802.

ISSUE:

On November 24, 2018, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) Seattle reported the death of ICE detainee Mergensana AMAR, A216 269 802, a 40-year-old citizen of Russia, at Saint Joseph's Hospital (SJH) in Tacoma, WA. The medical staff pronounced AMAR deceased on November 24, 2018, at 6:05 p.m. PST. Medical staff identified the preliminary cause of death as asphyxia caused by hanging from the neck.

Consistent with ICE policy, ERO Seattle notified the U.S. Department of Homeland Security, Office of Inspector General, and the ICE Office of Professional Responsibility via the Joint Intake Center. ERO Seattle also provided telephonic message and email notification to the Embassy of the Russian Federation in Washington, DC, of AMAR's death who will, in turn, notify AMAR's next of kin.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On December 2, 2017, AMAR applied for entry into the United States via the pedestrian

(b)(7)(E)

DHS-20-0638-D-000417

2020-ICLI-00057 1496

11/27/2018

lanes at the San Ysidro, CA Port Entry. AMAR presented his valid Russian passport to the primary inspection Customs & Border Protection Officer (CBPO) (b)(6); (b)(7)(C). Customs and Border Protection (CBP) determined AMAR to be inadmissible and served him a Notice and Order of Expedited Removal, Form I-860 charging inadmissibility pursuant to section 212(a)(7)(A)(i)(I) of the Immigration and Naturalization Act (INA), as amended, as an immigrant without immigrant visa.

On December 6, 2017, CBP transferred AMAR to ERO San Diego custody at the San Luis Regional Detention Center.

On December 19, 2017, ERO San Diego transferred AMAR to ERO Seattle at the Northwest Detention Center (NWDC) in Tacoma, WA to await a credible fear interview with United States Citizenship and Immigration Services (USCIS) Asylum office in San Francisco, CA. (b)(7)(E); (b)(3):Unspecified Statute

case and served him a Notice to Appear, Form I-862, alleging inadmissibility pursuant to section 212(a)(7)(A)(i)(I) of the INA, as amended, as an immigrant without immigrant visa.

On February 1, 2018, an immigration judge (IJ) in Tacoma, WA determined the court had no jurisdiction in a custody hearing due to AMAR being an arriving alien.

On February 7, 2018, ERO Seattle served AMAR a Parole Advisal and Scheduling Notification.

On February 26, 2018, ERO Seattle denied AMAR parole due to posing a risk of flight.

On August 7, 2018, an IJ in Salt Lake City, UT, appearing via video teleconferencing (b)(6); (b)(7)(C)

On August 22, 2018, AMAR declared himself to be on hunger strike and ICE Health Service Corps (IHSC) began monitoring his meals.

On August 25, 2018, AMAR declined his ninth consecutive meal and IHSC initiated hunger strike protocols.

On September 6, 2018, IHSC obtained an order to permit involuntary medical monitoring and hydration from a judge with the United States District Court for the Western District of Washington. When presented with the order, Amar began drinking Pedialyte and allowing medical monitoring.

On September 14, 2018, AMAR began drinking Boost nutritional shakes and continued to consume Pedialyte, and occasionally ate pieces of fruit.

On September 19, 2018, ERO Seattle scheduled AMAR for an escorted commercial removal with his valid Russian passport for October 24, 2018.

By September 26, 2018, AMAR regularly consumed liquid nutritional supplements, eating fruit and taking vitamins. He had stopped losing weight and was effectively not on hunger strike. However, AMAR demanded to remain in the medical housing unit (MHU), threatening to stop consuming the nutritional supplements and food items if returned to general population. AMAR was effectively in administrative/protective custody at this time.

On October 1, 2018, AMAR filed an untimely notice of appeal with the Board of Immigration Appeals (BIA). ERO Seattle cancelled AMAR's scheduled removal.

On October 16, 2018, AMAR consumed a full meal and IHSC declared an official end to hunger strike protocols. Although AMAR was moved at his request to administrative segregation, he would continue to skip meals. IHSC made nutritional supplements and Pedialyte available to AMAR three times daily to promote weight gain.

On October 26, 2018, GEO contract staff found a long rope made of bedding hidden under his mattress. AMAR was re-admitted to the MHU on suicide watch as a precaution because they considered this a suicidal gesture, although AMAR denied it.

On October 27, 2018, a psychiatrist evaluated AMAR and determined there was no suicidal ideation, homicidal ideation, or auditory verbal hallucination. AMAR remained on constant-watch.

On October 29, 2018, AMAR was transferred from the MHU to administrative segregation, but he remained on 10-minute irregular mental health observation (MHO) checks.

On November 2, 2018, the BIA dismissed AMAR's appeal as having been filed untimely.

On November 5, 2018, IHSC removed AMAR from MHO checks and released him to NWDC GEO contract staff for a housing determination. AMAR requested to remain in administrative segregation and GEO complied with that request.

On November 8, 2018, ERO Seattle re-scheduled AMAR's removal to Russia for November 28, 2018.

On November 12, 2018, AMAR began regularly eating facility provided meals and consumed a complete lunch and dinner.

On November 14, 2018, IHSC discontinued providing AMAR Boost and Pedialyte following his consistent consumption of the food on his meal trays. AMAR also expressed his desire to leave administrative segregation and return to general population.

On November 15, 2018, at approximately 3:06 p.m. PST, during a health and welfare check, GEO contract staff discovered AMAR hanging from a noose made of bed sheets in his cell in the restricted housing unit. GEO contract staff initiated an Incident Management System (IMS) and loosened the noose around AMAR's neck. Staff used a life knife to cut AMAR down, and placed him on the floor.

At approximately 3:08 p.m. PST, IHSC arrived and began administering cardiopulmonary resuscitation (CPR) to AMAR.

At approximately 3:10 p.m. PST, IHSC contacted emergency medical service (EMS).

At approximately 3:16 p.m. PST, EMS from Tacoma Fire and Rescue arrived on scene and took over the administration of CPR. GEO contract staff notified ERO Seattle that an IMS had been called after detainee AMAR was discovered attempting self-harm by strangulation.

At approximately 3:29 p.m. PST, EMS reported that AMAR had a pulse.

At approximately 3:34 p.m. PST, EMS departed NWDC and transported AMAR to Saint Joseph's Hospital in Tacoma, WA.

At approximately 3:36 p.m. PST, AMAR arrived at Saint Joseph's Hospital.

At approximately 3:42 p.m. PST, ERO Seattle notified ERO HQ Field Operations of AMAR's suicide attempt.

At approximately 5:31 p.m. PST, Saint Joseph's Hospital admitted AMAR. IHSC notified ERO Seattle that staff at St. Joseph's Hospital reported AMAR was non-responsive, had an anoxic brain injury, possible spinal cord injury, and no apparent brain activity.

At approximately 6:03 p.m. PST, ERO Seattle notified the Joint Intake Center of AMAR's suicide attempt.

At approximately 7:58 p.m. PST, IHSC notified ERO Seattle that staff at St. Joseph's Hospital reported AMAR continued to be non-responsive with no brain activity, no corneal response, and had been intubated and moved to the intensive care unit (ICU).

On November 16, 2018, throughout the day, ERO Seattle attempted to identify a next of kin and made efforts to notify the embassy of Russia in Washington, DC without success.

At approximately 6:45 a.m. PST, IHSC notified ERO Seattle that AMAR's status remained unchanged and he was on full life support.

At approximately 2:00 p.m. PST, hospital staff conducted a neurology consult with electroencephalography (EEG).

On November 17, 2018, IHSC notified ERO Seattle that the results of the EEG r showed no brain activity. The St. Joseph's Hospital Ethics Committee reviewed the case and recommended that AMAR be considered a do not resuscitate (DNR) case in the event of sudden cardiac arrest. The committee continued to monitor the case for future recommendations on withdrawal of care.

On November 18, 2018, hospital staff conducted a cerebral blood flow study on AMAR. The results showed no flow to the brain. All testing indicated brain death, so the hospital declared AMAR brain dead at 2:45 p.m. PST and notified ICE that they intended to turn off life support unless next-of-kin could be located, and they request otherwise. Hospital staff granted ERO Seattle additional time to locate next of kin.

On November 19, 2018, the HQERO International Operations Division Assistant Attaché for Removal in Warsaw, Poland provided contact information for AMAR's parents in Russia.

On November 20, 2018, HQERO Removal and International Operations Division advised ERO Seattle that the Russian embassy had contacted the next-of-kin in Russia and that the next of kin were in contact with the hospital concerning the decision to keep or remove AMAR from life support.

From November 20, 2018 through November 24, 2018, the hospital staff had multiple conversations with the parents of AMAR, who, in the afternoon of November 24, 2018, decided to remove life support.

On November 24, 2018, at approximately 6:00 p.m. PST, hospital staff removed all life support from AMAR.

At approximately 6:05 p.m. PST, hospital staff pronounced AMAR's cardiac death.

At approximately 6:30 p.m. PST, IHSC notified ERO Seattle of AMAR's passing.

At approximately 6:31 p.m. PST, ERO Seattle notified ERO Headquarters of AMAR's death.

On November 25, 2018, at 9:30 a.m. PST, ERO Seattle telephonically notified the Joint Intake Center and the Office of Professional Responsibility duty agent of AMAR's death. At approximately 10:15 a.m. and 10:20 a.m. PST, ERO Seattle attempted to contact the Embassy of the Russian Federation in Washington, DC, via telephone to provide notification of AMAR's death.

At approximately 10:51 a.m. PST, ERO Seattle emailed Vice-Consul Nadya Shumova and provided notification of AMAR's death. ERO Seattle will continue to attempt personal communication with embassy staff.

AMAR is the second detainee to pass away in ICE custody in fiscal year 2019.

Violations of Law:**Action Taken:****Other Agencies Notified:**

Name	Agency	Phone	Date	Time
none				

Injuries:	Injuries (Names and Extent of Injury):
Fatalities:	
Damage:	

Locations:

Type	Address	City	State	Zip
Other	St. Joseph Medical Center 1717 S. J St.	Tacoma	Washington	98405

Reported to ICE Operations Center via Phone:**Public Affairs Notified: Yes****Officer Notified:** (b)(6); (b)(7)(C)**Date:** 11/25/2018**Time:** 0714**Comments:****Reported By:** (b)(6); (b)(7)(C)**Phone:** 253-77(b)(6);
(b)(7)(C)**Cell/Pager:** 206-786(b)(6);
(b)(7)(C)**Supervisor:****Phone:** 253-77**Cell/Pager:** 801-473

JOINT INTAKE CENTER – TELEPHONE WORKSHEET

Date 11/25/2018	Time 12:24 pm	Duty Agent (b)(6); (b)(7)(C)	Phone # (404)925-(b)(6);
Time Sensitive? ☒ Yes ☐ No		Arrests, assaults (physical/sexual), bribes, death, discharge of weapon, medical, media, serious injuries, suicide, workplace violence, e.g.	

Caller Data	
☐ Anonymous ☐ Detainee ☒ Source ☐ Subject ☐ Victim ☐ Witness	
Name (A)FOD Bryan Wilcox	Phone Number (206)786-5147
Language Spoken English	City, State Seattle, WA (ERO/Seattle)
A#	Facility Name Northwest Det. Ctr. Seattle WA

Information	
☐ Allegation ☐ Management Issue ☐ Detainee Issue ☐ Incident ☒ Other	
Briefly Describe (Who/What/Where/When/Why)	
Detainee Death: On 11/24/18 at approx. 6:05 pm, detainee Mergensana AMAR (A216 269 802) was taken off life support and died at St. Joseph Hospital, Tacoma WA. Detainee AMAR was being treated after a previous suicide attempt at NW Det. Ctr. (SEN# (b)(6); (b)(7)(C))). No other detainees are related to this incident. POC for NW Det. Ctr. is AFOD (b)(6); (b)(7)(C) (801)473-(b)(6);	
☐ CBP ☒ ERO ☐ HSI ☐ Other	

Action Taken	
☐ JICMS File # _____ ☐ JIC Log # _____	
SEN initiated by ERO/Seattle. (A)FOD Wilcox notified OPR/Seattle RAC Fallah. JIC duty agent follow-up with OPR/Seattle.	
Referred To	
☐ OIG Duty Agent ☐ OPR Duty Agent ☐ CBP IA Duty ☐ Local ERO ☐ ERO CDH ☐ ERO JIC Email ☐ Other Agency _____	
Helpful Numbers	
Community and Detainee Helpline (CDH) - (888) 351-4024 (M-F 0800 – 1700) DOJ EOIR - (800) 898-7180 (immigration court dates, status of hearings) CIS NCSC - (800) 375-5283 (M-F 0800 – 1800, Case Status, Benefits, etc) LESC - (855) 448-6903 Detainee locator - www.ice.gov/locator	



**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)

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)

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)¹ in Tacoma, Washington (WA), while in the custody of ICE. The Pierce County Medical Examiner documented AMAR's cause of death as anoxic encephalopathy² due to hanging.³

Abbreviated Chronology⁴

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

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

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.

¹ Also known as Tacoma ICE Processing Center.

² Anoxic encephalopathy is a condition where the brain tissue is deprived of oxygen and there is a global loss of brain function.

³ See Pierce County Postmortem Examination Report, dated November 26, 2018.

⁴ 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) at (202) 734 (b)(6);

Enclosure

Mergensana Dabaevich AMAR Detainee Death Review Report

DETAINEE DEATH REVIEW: Mergensana AMAR, A216269802
Healthcare and Security Compliance Analysis
Northwest Detention Center
Tacoma, Washington

As requested by the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU), Creative Corrections participated in a review of the death of detainee Mergensana AMAR while in the custody of the Northwest Detention Center in Tacoma, WA. A site visit was conducted December 11-13 2018, by ERAU staff A (b)(6); (b)(7)(C) ERAU Unit Chief, (b)(6); (b)(7)(C) Management and Program Analyst and team leader, and Creative Corrections contract personnel C (b)(6); (b)(7)(C) Security Subject Matter Expert and (b)(6); (b)(7)(C) RN, Healthcare Subject Matter Expert. Contractor participation was requested to assess compliance with the ICE Performance Based National Detention Standards (PBNDS) 2011, revised 2016, governing medical care and security operations.

Included in this report is a case synopsis, description of the facility and its healthcare services, a narrative summary of events, and conclusions. The information and findings herein are based on analysis of detainee AMAR's medical record and detention file; tour of the medical clinic, housing units, and intake area; interviews of staff and a detainee; and review of policies, video surveillance footage, police reports and photographs and available incident related documentation. The report was prepared collaboratively by (b)(6); (b)(7)(C) and Creative Corrections ERAU contract Program Manager (b)(6); (b)(7)(C).

SYNOPSIS

Mergensana AMAR, 39 years old, was admitted to the Northwest Detention Center on December 19, 2017. He reported no medical or mental health issues and none were identified during intake screening and physical examination. He was classified low custody and for the first eight months of his detention, was assigned to general population housing. He had minimal contact with healthcare staff over that period.

In mid-August, 2018, AMAR started refusing meals in protest to what he perceived to be a delay in resolving his immigration status and until notified that he would be allowed to remain in the United States. Hunger strike monitoring in accordance with the applicable ICE detention standard was implemented on August 25, 2018. Because AMAR continued to refuse meals and did not cooperate with medical staff's attempts to monitor his health, a court order was obtained on September 6, 2018 authorizing ICE to take necessary action to save his life. Thereafter, AMAR agreed to health assessments and started eating fruit and drinking nutritional supplements. On October 16, 2018, the Clinical Director discontinued hunger strike monitoring. AMAR did not

resume eating meals until November 12, 2018 but consumed fruit, nutritional supplements, and the contents of snack bags.

When his hunger strike status was discontinued, AMAR was assigned to administrative segregation pursuant to his request for protective custody. On October 26, 2018, he was placed on suicide watch after a rope fabricated from torn linens were found hidden under his mattress. The next day, the psychiatrist discontinued suicide watch and ordered mental health observation. He was on mental health observation status for another nine days, during which AMAR refused to cooperate with healthcare staff's attempts to evaluate him. The status was discontinued on November 5, 2018 when the mental health team decided that there were no evident mental health issues. The team was not told that the day before, an officer found a torn bed sheet hidden beneath AMAR's mattress.

AMAR remained on protective custody following discontinuation of mental health observation. On November 15, 2018, three days after he started eating meals, he informed security personnel that he wished to return to general population. The request was approved but transfer was delayed until ICE personnel notified him his appeal had been denied and that he would be deported. AMAR was found hanging by a rope made of torn bed sheets approximately an hour after he received the notification, and 25 minutes after he was last seen alive. Medical emergency was called and additional security and medical personnel were on scene within two minutes. Cardio pulmonary resuscitation was initiated and continued until Emergency Medical Services responders arrived and took over care, nine minutes after the internal medical emergency was announced. AMAR was transported to the hospital where brain death was determined. He remained in the intensive care unit on life support until November 24, 2018 when, after consultation with his family in Russia, life support was discontinued. Death was pronounced at 6:05 p.m.

According to the Certificate of Death issued by the State of Washington Department of Health, dated February 28, 2019, the date and time of death was November 18, 2018, at ¹, and the cause of death was anoxic encephalopathy² as a result of hanging. An autopsy report from the Pierce County Medical Examiner's Office, signed February 22, 2019, by (b)(6); (b)(7)(C) MD confirmed the death was due to anoxic encephalopathy, secondary to hanging.

FACILITY DESCRIPTION

Northwest Detention Center (NWDC) is operated by the GEO Group, Inc. (GEO) of Boca Raton, FL. NWDC is a dedicated Intergovernmental Service Agreement facility housing both male and

¹ This date and time denote the when the provider determined there was no brain activity following an imaging brain study.

² Anoxic encephalopathy is a process which begins with the cessation of blood flow to brain tissue, causing changes or absence of brain function.

female ICE detainees. The population on the date of detainee AMAR's death was 1310, including 1121 males and 189 females.

Staff and visitors enter NWDC from the main lobby, first placing their belongings through an X-ray machine, then passing through a metal detector. All persons entering the secure section of the facility must display a staff or visitor identification badge. Video surveillance cameras positioned throughout the facility monitor and record events.

The direct supervision model of detainee supervision is in place in general population housing units. NWDC's control center is located off the main entrance and is staffed at all times b (b)(7)(E) (b)(7)(E) Officers assigned to the control center handle radio traffic, maintain the logbook, control doors and monitor cameras. During an emergency, they access video from the closest camera in the area.

GEO officers are members of the United Government Security Officers of America (UGSOA) union, Local 883. The union contract permits officers to bid annually for post assignments which are then awarded by seniority. Shifts are 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m. and 11:00 p.m. to 7:00 a.m. Each shift is overseen by a lieutenant as the shift supervisor and a sergeant as the assistant shift supervisor.

NWDC uses the Incident Management System (IMS) for Emergency Responses. Per NWDC Policy 3.2.3, IMS is a three-tiered response system designed to ensure that the right personnel and equipment are present for an emergency response. The goal is to immediately isolate and contain the incident and return the facility to normal operations as soon as possible. For each level, designated staff respond to the emergency. As an incident escalates or de-escalates, the Incident Commander makes the determination whether to raise or lower the level of the incident. Phase I incidents include medical emergencies involving two or less detainees and require a response by NWDC staff only. At this level, all members of the Emergency Response Team may be called to report to the facility. Phase II incidents include escapes, disturbances involving a group of detainees and a possible hostage situation. Phase III incidents include large scale hostage situations, large scale demonstrations or large scale natural disasters such as an earthquake. For Phase III, outside agencies such as local police and fire personnel as well as all available ICE agents may be called to respond. As discussed herein, IMS/Phase I was activated when detainee AMAR's suicide attempt was discovered.

HEALTHCARE SERVICES

NWDC was last accredited by the National Commission on Correctional Health Care in February 2018. Health care is provided 24 hours a day, seven days a week by ICE Health Service Corps (IHSC), supported by contractor STG International. The 2019 staffing plan allocates 25 IHSC positions, including the Health Services Administrator (HSA), two assistant HSAs, five advanced

practice professionals (APP), one nurse manager, eight registered nurses (RN), two pharmacists, one dentist, a health program manager, registered dental hygienist, and three mental health professionals. A full-time IHSC General Schedule (GS) for Federal Pay physician serves as Clinical Director. STG positions include one staff physician, one full time and one part time psychiatrist, three APPs, 18 RNs, seven Licensed Practical Nurses (LPN), a dentist, dental assistant, two pharmacy technicians, radiation technician, five medical records technicians, one administrative assistant and two mental health professionals. Vacancies at the time of AMAR's death included three APPs, eight RNs, one mental health professional, one dental assistant, and one LPN. According to the HSA, most vacancies resulted from a recent contract change which eliminated all sub-contracts.

NWDC's clinic has seven medical examination rooms, an urgent care room, nurses' station, a two-chair dental operator, pharmacy, pill pass room, laboratory, digital radiology room, and various administrative offices. Two holding cells, each with a capacity of eight, serve as waiting rooms. The medical housing unit has four negative pressure rooms for respiratory isolation, one double and three single occupancy cells for medical observation, a padded cell, and a nurses' station. At the time of the site visit the padded cell was being used for storage because structural updates are needed to place it in operation for its intended use. Detainees who are on constant watch receive a suicide smock and blanket, and the metal bed is removed from the cell and replaced with a tear-proof mat. Camera surveillance is present in the four observation cells.

DETENTION SUMMARY

Detainee AMAR was classified low custody throughout his detention. He was housed in general population for eight months following his admission and thereafter, was segregated for hunger strike monitoring, suicide watch, mental health observation, and per his request, for protective custody. No disciplinary charges were filed against him during the detention period. AMAR filed no grievances and 25 facility requests. He had no non-attorney visits and placed 128 calls. His last call was placed five days before his suicide attempt.

SUMMARY OF EVENTS

December 19, 2017

The Booking/Release Report documents detainee AMAR arrived at NWDC at 11:05 a.m. Medical pre-screening was completed by RN (b)(6); (b)(7)(C) who documented she is fluent in the detainee's native language. There were no findings that called for completion of the full intake screening on a priority basis.

Admission processing was completed by Officer (b)(6); (b)(7)(C) who did not document the detainee's primary language or use of interpretation assistance. During interview, Officer (b)(6); (b)(7)(C) acknowledged he completed the intake documents, but stated he had no recollection of AMAR.

Note: The Record of Deportable/Inadmissible Alien form completed by a Customs and Border Protection Officer on December 2, 2017 documents AMAR stated he speaks Russian, Ukrainian, Mongolian, and "a little English." As detailed throughout this report, many healthcare encounters were completed with Russian interpretation assistance. No security personnel used interpretation assistance in interactions with AMAR.

Detainee AMAR's personal property consisted of the following clothing items: one pair of shoes, shoestrings, a pair of boots, three pairs of pants, three pairs of socks, a jacket, coat, one pair of gloves, a belt, underwear, shorts, four hats, and seven shirts. He also had a cell phone and case, charger, a set of headphones, a micro secure digital (SD) card, a suitcase, bag, eyeglasses, miscellaneous toiletries, cotton swabs, nail clipper, miscellaneous paperwork, 21 foreign coins, and a check for \$1533.35.

Note: The foreign coins were not identified and enumerated as required by the PBNDS 2016, Funds and Personal Property.

AMAR was issued linens, clothing, shoes, hygiene supplies, a radio, and the facility and the ICE National Detention Handbooks. He signed for the property and funds inventories and was issued a copy of all receipts. He also signed acknowledgment he was allowed to make a free five-minute phone call.

A rating of low custody was applied by ICE Enforcement and Removal Operations (ERO) prior to AMAR's admission to NWDC and was reapplied during intake using the NWDC Classification Worksheet. The reviewer determined the rating was correctly applied based on the fact the detainee had no criminal history. A supervisor approved the rating the same day. A Prison Rape Elimination Act (PREA) Risk Assessment resulted in determination that AMAR was not at victimization or predatory risk. Facility orientation was completed and documented on the Orientation Checklist form, including instructions on use of the telephone, access to medical care, the grievance system and PREA information. Detainee AMAR signed confirming he had received this orientation.

Note: With the exception of the property receipt and acknowledgment he was given the opportunity to make a free phone call, all forms completed during the intake process, including those signed by detainee AMAR, were in English. The property receipt and phone call acknowledgement were in English and Spanish. The degree to which the detainee understood the information he was given and signed for cannot be determined.

(b)(6); (b)(7)(C) completed the medical and mental health intake screening using the telephonic interpretation service. She noted AMAR said he speaks Russian and some English, and that he was transferred from another detention facility. A transfer summary, medical, dental, and mental health screening, and the initial physical assessment which accompanied him from the San Luis Regional Detention Center (SLRDC) where the detainee had been held since December 7, 2017 identified no healthcare issues. (b)(6); (b)(7)(C) documented detainee AMAR said he felt good and was experiencing no pain, and he denied any current or past medical problems. The mental health screening and suicide risk assessments were negative. His vital signs, entered at 11:32 p.m., were all within normal limits, as follows: temperature 97.9, pulse 88, respirations 16, and blood pressure 124/79. His height was 66.5 inches and he weighed 172 pounds. Tuberculosis symptom screening was negative, and AMAR was cleared for general population housing. Consent for treatment was signed.

Per the Housing History Grid, detainee AMAR was assigned to low custody housing unit B1, cell 117 at 8:57 p.m. His housing assignment remained the same until August 20, 2018.

December 23, 2017

(b)(6); (b)(7)(C) conducted AMAR's initial physical examination using telephonic interpretation assistance. The vital signs were within normal limits, as follows: temperature 98.1, pulse 62, respirations 16, and blood pressure 120/74. AMAR again denied a history of medical, mental health, and dental problems, and general examination findings were normal. The note was cosigned by Clinical Director (b)(6); (b)(7)(C) the next day.

December 24, 2017 – August 16, 2018

There were no significant medical or security events between these dates. The following summarizes information documented in records provided to reviewers.

- AMAR was seen by healthcare professionals four times. On January 3, 2018 he was assessed by an RN on a routine basis following his "return from borrow out," which reviewers presume refers to return from court. Vital signs and general examination findings were normal, and the detainee was cleared to return to general population. On January 21, 2018, AMAR was seen for complaint of cold symptoms. Per the applicable nursing protocol, RN Guidelines for Upper Respiratory Infection, he was given over-the-counter medications for congestion and pain. On April 24, 2018, AMAR was seen by the dentist for complaint of a broken filling. Upon examination, the dentist recommended extraction of the tooth. The detainee refused the recommended treatment and signed a refusal form. Finally, AMAR was seen by a nurse practitioner (NP) on July 28, 2018 for complaint of pain in his right ear. The NP diagnosed infection and the detainee was given antibiotic ear drops. Vital signs taken during all four encounters were normal. Interpretation assistance was used for all but the first, presumably because it was a routine check involving only rudimentary confirmation of the detainee's wellness.

- AMAR submitted 27 requests over the period, all of which were written and answered in English. As detailed in Appendix 1, they were answered in a timely and responsive manner. Multiple requests were for Russian language books; in many others, the detainee requested access to his property to obtain phone numbers and his credit card number so he could pay his attorney. He also requested release of his cell phone to his attorney. AMAR's requests related to his property and release of his cell phone were honored, and based on available information, facility staff made efforts to provide the detainee with Russian language books.
- AMAR's classification was reviewed on March 8, 2018 and June 14, 2018. His custody level was retained at low.
- A PREA Vulnerability Reassessment completed on April 28, 2018 found AMAR presented no risk.
- The Intimate Call Detail Report documents AMAR made 128 calls on 69 days over the period. 73 were international, 24 were interstate, and 31 were local. They ranged in duration from one to 25 minutes and averaged 6.4 minutes in length.

August 17, 2018

(b)(6); (b)(7)(C) entered an encounter note documenting she conducted a mental health wellness check at 9:52 a.m. She used the telephonic interpretation service. According to the note, AMAR was referred to mental health after he presented to sick call complaining of feeling depressed because there was no one in his dorm who spoke Russian. He claimed he had requested transfer to housing unit G3 on two previous occasions with no success.

Note: The review team was informed G3 housed Russian-speaking detainees. As indicated in Appendix 1, AMAR filed one request for placement in G3 on August 11, 2018. The request was denied on grounds that housing moves are not made based on detainee requests. He was, however, transferred to G3 on August 20, 2018 (see below).

AMAR denied feeling unsafe in his dorm but stated he did not participate in any activities or interactions with other detainees because he had no desire to do so. He denied thoughts of self-harm, suicidal or homicidal ideation, and auditory and visual hallucinations, and reported eating, drinking, and sleeping well. He acknowledged stress related to immigration and legal issues. Vital signs were all within normal limits, as follows: temperature 97.5, pulse 65, respirations 16, and blood pressure 108/66. His weight was 165 pounds, seven pounds less than at intake. The general examination noted he was alert, pleasant, in no acute distress, well hydrated, well nourished, comfortable, calm and relaxed, and cooperative. The psychological examination noted he was oriented with cognitive function intact. He used good eye contact, his judgment and insight were good, mood and affect were full ranged, speech was clear, and his thought process was logical

and goal directed. The assessment finding was readiness for enhanced resilience³, and AMAR was advised to send a grievance if he did not hear back from custody regarding the housing change. He was advised to continue his daily activities even if he did not feel like it, and was encouraged to engage in a regular exercise program and participate in activities to help with his depression. He was also advised to eat something at every meal, even if just a little bit. Asked if this instruction was based on information that AMAR was not eating, (b)(6); (b)(7)(C) stated it was not, explaining that it is a component of the standardized plan called for depression. She said AMAR did not specifically use the words depressed or depression during the encounter, but based on the reason he presented for sick call, she followed the RN Guidelines applicable to stress and depression. The encounter note documents that at the end of the session, AMAR stated he did not need mental health services. Commander (CDR (b)(6); (b)(7)(C) Doctor of Psychology, documented she reviewed (b)(6); (b)(7)(C) note and staffed the case the same day. She concurred with the findings and noted no mental health appointment was indicated at the time.

August 20, 2018

Per the Housing History Grid, detainee AMAR was assigned to general population unit G3 at 8:39 a.m.

August 22, 2018

At 7:25 a.m. CDR (b)(6); (b)(7)(C) nurse practitioner (NP), entered an encounter note, documenting the reason for the appointment was dietary issues. He used the telephonic language interpretation service. (b)(6); (b)(7)(C) wrote that AMAR announced he had no intentions of eating from that point on, stating he was protesting the length of time it was taking the immigration system to decide his asylum case. He wanted to be released and allowed to remain in the United States. He denied suicidal and homicidal ideation. His vital signs were all within normal limits, as follows: temperature 97.9, pulse 62, respirations 16, and blood pressure 113/73. His weight was 163 pounds, nine pounds less than at intake. The general examination findings were normal, including general appearance observations that AMAR was in no acute distress, well developed, and well nourished. The treatment plan was to place the detainee in the segregation unit and begin meal count. (b)(6); (b)(7)(C) wrote that he discussed the process for monitoring missed meals, and if prolonged and medically necessary, the possibility a court order may be pursued for involuntary feeding. He explained these steps were not meant to be punitive; rather they were intended to prevent deterioration of the detainee's health. AMAR voiced his understanding and agreement. An unsigned Special Needs Form documents orders for admission to administrative segregation, single cell housing, no commissary food or beverages in his cell, and documentation of all food and beverage intake.

Note: Although not provided with records documenting any communications between security and medical staff that may have led to this encounter, reviewers conclude it

³ This nursing diagnosis refers to a pattern of positive responses to an adverse situation or crisis can be strengthened to optimize human potential.

resulted from notification that AMAR was refusing meals. Beginning this date, August 22, 2018, officers were expected to complete Information Reports noting what, if anything, the detainee consumed. See Appendix 2 for detail.

At 7:30 a.m., (b)(6); (b)(7)(C) cleared AMAR for segregation for the purpose of meal monitoring. She used the telephonic language interpretation service to complete the encounter. The detainee's weight was 163 pounds and his vital signs were within normal limits, as follows: temperature 97.9, pulse 62, respirations 16, and blood pressure 113/73. The examination found he had spontaneous speech and answered questions appropriately, he appeared to be within normal limits of behavior, affect, and cognitive functioning, and did not appear to have any acute or unresolved medical conditions which might worsen in segregation. No active psychosis, mania, suicidal ideations or homicidal ideations were noted.

An Administrative Segregation Order was prepared documenting AMAR's placement on the status for medical observation for hunger strike. A copy was provided to AMAR at 8:00 a.m. His property was inventoried and he refused to sign the receipt. Per the Housing History Grid, detainee AMAR was assigned to Unit D3, a Restricted Housing Unit (RHU)⁴ at 8:32 a.m.

Unit D3 is used for general segregation purposes and is the designated RHU for medical housing overflow. It is a two story housing unit with ten double occupancy cells on each tier. Cell 106 on the bottom tier has been decommissioned for housing and is used as a janitor's closet, making the current capacity of the unit 38. There are showers and an enclosed indoor recreation area on each level.

August 23 and 24, 2018

AMAR remained in D3 for meal monitoring. Officers maintained a daily log of his activities documenting he attended recreation on August 24, 2018 but refused other recreation opportunities as well as showers and all meals. (b)(6); (b)(7)(C) made required daily segregation rounds documenting in the notes AMAR's continued refusal of meals. (b)(6); (b)(7)(C) did not use interpretation assistance.

August 25, 2018

At 9:19 a.m., (b)(6); (b)(7)(C) signed a segregation round encounter note in which she documented custody staff informed her AMAR refused his ninth meal. She documented the detainee spoke English fluently. His speech was spontaneous and he answered questions appropriately. He did not appear to have active psychosis, mania, suicidal or homicidal ideation.

In an encounter note reflecting this date but not signed until the next day, (b)(6); (b)(7)(C) documented she saw the detainee "due to declaration of a Hunger strike." The reason for the appointment was Medical Housing Unit (MHU) admission.

⁴ RHUs at NWDC are special management units as defined in the ICE detention standards.

Note: Although not documented by (b)(6); (b)(7)(C) reviewers conclude she referred AMAR for provider assessment in accordance with the Hunger Strikes standard which requires referral of any detainee who has not eaten in 72 hours.

(b)(6); (b)(7)(C) wrote, “He was at meal 9 as of this morning breakfast. He states that the cause of this hunger strike is because he wants to be released. He states that he is experiencing dizziness and lightheadness [*sic*] as a result of his hunger strike.” AMAR stated that the symptoms had been present for two days and were getting worse; also, that the last time he had something to drink was two days prior to the encounter. (b)(6); (b)(7)(C) ordered intake and output monitoring every eight hours, daily weights, urinalysis and orthostatic vital signs⁵, laboratory tests, and medications once ordered. She noted detainee AMAR refused examination and refused to have his vital signs taken.

(b)(6); (b)(7)(C) entered another encounter note, signed 2:33 p.m., noting the reason for the appointment was, “MHU nursing admit note (hunger strike monitoring)”.

Note: Although (b)(6); (b)(7)(C) note appears before (b)(6); (b)(7)(C) in the medical record, reviewers conclude this was the first nursing encounter after (b)(6); (b)(7)(C) evaluated AMAR and admitted him to the MHU. This conclusion is based on the fact that authority to admit detainees to the MHU lies with providers, and (b)(6); (b)(7)(C) treatment notes, detailed below, reflect (b)(6); (b)(7)(C) orders. (b)(6); (b)(7)(C) likely entered this note before (b)(6); (b)(7)(C) entered hers, out of sequence.

As she had in her earlier note, (b)(6); (b)(7)(C) documented AMAR spoke English fluently. She wrote the following in her narrative: “English-speaking male detainee states ‘I refuse (vital signs check), I refuse (to give a urine specimen). Last time I drank was three days ago. Last time I ate food was five days ago. I refuse, take that (plastic urine specimen container) away. I refuse (to sign a Refusal Form). I eat when I go to the outside’. Patient is considered to be on official hunger strike and will be isolated from other detainees for close supervision, observation, and monitoring.” In the treatment section of her note, (b)(6); (b)(7)(C) wrote that AMAR was instructed on the potential health problems (dizziness, lightheadedness, possible permanent organ damage and death) he may experience as a result of continued refusal of food and fluids. She also wrote the detainee did not verbalize understanding but non-verbally indicated his agreement. In treatment notes, RN (b)(6); (b)(7)(C) entered the following:

1. “Continue with vital signs every shift; Intake and Output Monitoring⁶ every shift; Daily weights; Daily orthostatic vital signs.
2. An adequate supply of drinking water and other beverages are available to the patient at all times.
3. Three meals per day are delivered to the patient and delivery of meals is documented.
4. All food not authorized by CD/Physician is removed from the patient’s room.

⁵ Orthostatic vital signs are a series of vital signs of a patient taken while the patient is reclines and then again while standing.

⁶ Intake and output is measurement of fluid a patient takes and how much is lost through urine and other routes.

5. Patient is not allowed to purchase food from commissary/vending machine while on hunger strike.
6. Patient will only be release from hunger strike treatment/monitoring by CD or physician order
7. Patient counseled regarding the medical risks of continuing the hunger strike.
8. Encouraged to terminate the hunger strike and eat/drink as normal.”

Note: The enumerated elements reflect N (b)(6); (b)(7)(C) orders and hunger strike protocol requirements.

(b)(6); (b)(7)(C) completed a standardized Care Plan for Weight Loss to address the nursing diagnosis of Alteration in Nutrition: Less than Body Requirements. The expected outcome was maintenance of adequate hydration, as evidenced by good skin turgor⁷, urine output greater than 30 milliliters per hour, and moist mucous membranes; also, that AMAR would resume eating without complications of dehydration or malnutrition. Interventions included obtaining a baseline weight and daily weights; record vital signs once daily; assess hydration status, skin turgor, mucous membranes, intake and output, blood pressure, and heart rate; encourage patient to eat and drink, perform urine dipsticks, as ordered by the medical provider; discuss with patient possible need for enteral or parenteral nutrition; encourage patient to verbalize feelings; and provide psychological, spiritual, or psychosocial assistance, as ordered.

A Special Needs Form documents detainee AMAR was admitted to the MHU for hunger strike monitoring. Property confiscated when he was transferred from general population unit G-3 to the RHU D-3 on August 22, 2018 was returned to him. Again, he refused to sign the receipt.

Per the Housing History Grid, detainee AMAR was assigned to the MHU at 11:12 a.m. The Daily Log for the unit documents detainee AMAR was assigned to cell 4 until August 30, 2018; however, reviewers confirmed with MHU security staff that he was assigned to cell 2. The door to the cell 2 is solid steel and has a window on the upper half. Inside the door is an anteroom with a sink and table and a large window for viewing from the corridor. The cell itself has a bed on wheels, a small moveable table, shower stall, and stainless steel toilet and sink. A call button alerts in the nurse’s station and activates a strobe light outside the cell that remains lit until staff respond.

August 26, 2018 to October 15, 2018

Detainee AMAR’s hunger strike status continued for this period. With the exception of eight hours on September 22, 2018 when moved to D3 for MHU overflow, he was housed in MHU cell 2.

RNs consistently documented attempts to follow the nursing care plan, including taking vital signs and weights, and monitoring input and output every shift. Medical providers, including the

⁷ Skin turgor refers to the skin’s elasticity, which can be tested by pinching the skin to see if it returns to normal.

Clinical Director, saw him almost daily, and a mental health professional saw him on a bi-weekly basis. Use of interpretation assistance was variable. Some healthcare staff used the telephonic interpretation service; some documented an interpreter was not available; and some documented AMAR spoke English fluently or on a limited basis, sufficient to conduct the encounter. On other occasions, R (b)(6); (b)(7)(C) who speaks Russian, interpreted. In repeated encounters over the period, AMAR stated his hunger strike was a protest that he would not end until allowed to remain in the United States.

Through September 6, 2018, AMAR declined to cooperate with healthcare staff, often simply stating “refuse” when staff asked to take his vital signs and otherwise assess him. He did, however, periodically answer questions about pain and other symptoms, reporting dizziness, weakness, feeling lightheaded, and pain primarily in his lower body. AMAR refused pain medication and all medications ordered per protocol. As for intake of food and fluids, officers documented he ate nothing (see Appendix 2), also reflected by nurses in encounter notes. Monitoring of fluid intake was not possible because he refused to drink from the pitcher of water provided. He was occasionally observed covertly drinking from the sink while washing his face or brushing his teeth, but output could not be monitored because he refused to use collection cups for measurement, urinating in the commode.

By Order dated September 6, 2018 of the US District Court for the Western District of Washington at Tacoma, ICE was authorized to undertake necessary medical treatment and testing to save AMAR’s life and prevent injury to him. The order specifically authorized involuntary hydration through intravenous (IV) fluids, physical examination with daily weight assessments and frequent vital sign checks, and laboratory testing every 48 to 72 hours. Two days earlier, (b)(6); (b)(7)(C) had entered an encounter note stating, “[Patient] with symptoms of dehydration. We are unable to tell his full condition due to no labs, vital signs or weight. We will request forced monitoring, feeding and/or IV hydration from the court.”

Reviewers were provided with a video-recording showing that on September 7, 2018, (b)(6); (b)(7)(C) Assistant Field Office Director (AFOD) Drew Bostock, and another ICE official (name unknown), discussed the court order with detainee AMAR. The video shows Dr. (b)(6); (b)(7)(C) accessed the telephonic interpretation service for the meeting. Detainee AMAR was laying on his back in his cell covered with a blanket. His eyes were open at all times. During the 40 minute video, (b)(6); (b)(7)(C) explained through the Russian interpreter that being on a hunger strike had been detrimental to the detainee’s health. She explained it was essential for medical staff to obtain his weight, and to check his blood pressure and other vital signs. She also explained why she had asked the Court to allow her to give him hydration and that the Court had granted that permission. When she asked if he would cooperate, he refused until he heard the Court Order. He then refused to sign a refusal form.

The ICE official then read the Court Order, which was translated into Russian by the interpreter. AMAR was then given and appeared to read a copy of the Order. Reviewers do not know if it was

translated into Russian. After the detainee placed the document on the table, AFOD (b)(6); (b)(7)(C) introduced himself as the ICE officer in charge and asked him if he understood the Order. AMAR replied yes. AFOD Bostock informed him officers were available to force him to submit to medical testing but asked if he would voluntarily submit. The detainee agreed to do so (b)(6); (b)(7)(C) then explained that medical staff would take his blood pressure, heart rate and weight. They would also draw three tubes of blood and ask that the detainee drink a fluid which would replace the need for IV hydration. Detainee AMAR agreed to comply.

In her medical record entry (b)(6); (b)(7)(C) documented labs were drawn without force and a urine sample, vital signs and weight were taken. The nutritional evaluation studies for phosphorus⁸, creatine kinase⁹, magnesium¹⁰, and prealbumin¹¹ were all within normal limits. She noted there were marked orthostatic changes in the detainee's blood pressure, which was 88/61, as well as a significant weight loss of 21 pounds since the beginning of the hunger strike. Although AMAR reported pain he rated six on the standardized pain scale¹², he declined any pain medication. He drank the oral electrolyte solution so an IV line was not placed. (b)(6); (b)(7)(C) ordered Pedialyte, a beverage which helps prevent dehydration and replace nutrients and electrolytes lost through vomiting and diarrhea.

Detainee AMAR's cooperation with healthcare staff generally improved in the days after the court order was served. He allowed his vital signs to be taken, drank Pedialyte, and was observed drinking water, but continued to refuse meals. **On September 13, 2018**, Dr (b)(6); (b)(7)(C) completed a hunger strike assessment, documenting AMAR's concerns about his heart pain. Vital signs were documented as follows: temperature 97.4, pulse 46, respirations 16, and blood pressure 91/53, all within normal range except for a low pulse rate and low blood pressure, which in some persons can indicate heart disease. (b)(6); (b)(7)(C) documented the normal dipstick urinalysis results and an electrocardiogram were within normal limits, but also noted that while he was in compliance with the court's order for monitoring, his refusal to eat may necessitate court-ordered feeding. She ordered Boost, a liquid nutritional supplement and Thiamine¹³ 100mg twice daily for five days.

AMAR continued to accept Pedialyte and surreptitiously, drink water. He also accepted Boost on most days, but continued to refuse food. Starting September 30, 2018, he ate one to two pieces of fruit per day. On October 9, 2018, (b)(6); (b)(7)(C) documented the detainee was getting about 1800 calories a day and not losing weight, but was eating only fruit off his tray. She offered to return AMAR to general population, but he stated he did not wish to end his hunger strike.

⁸ Phosphorus is a mineral naturally found in the body.

⁹ Creatine kinase is an enzyme expressed by various tissues and cell in the body.

¹⁰ Magnesium is a mineral found in the bones and muscles of the body.

¹¹ Prealbumin is a protein made by the liver.

¹² The standardized pain scale rates the level patient's report of pain from zero to ten, with ten being worst.

¹³ Thiamine is a Vitamin B supplement.

On October 15, 2018, (b)(6); (b)(7)(C) documented AMAR was well-hydrated and his mental health was fine. She noted he continued to refuse meal trays and was eating only whole fruit. She also noted there was no need to compel collection of lab samples, which he had refused since the court ordered studies on September 7, 2018.

October 16, 2018

Dr. (b)(6); (b)(7)(C) discontinued AMAR's hunger strike status. Her medical record entry documents his vital signs were within normal limits with the exception of a slightly low blood pressure of 91/55. His weight was 142 pounds. She wrote the following: "[Patient] has continued to drink boost and pedialyte. After refusing lunch tray he then ate complete lunch snack. [Patient] would not admit to giving up his hunger strike but could not explain why he was eating the snack. He is wanting to be able to eat/drink adequate calories and stay on hunger strike. He is told he does not need to be housed in MHU for any medical reason and was asked about his preference in housing after discharge. He has asked to be moved to D3 segregation rather than go to general population for undisclosed reasons." (b)(6); (b)(7)(C) wrote in her treatment notes that GEO was contacted concerning AMAR's request to be housed in D3 and that medication and supplement orders would not change. Her encounter note also documents his refusal to have labs drawn and that given past normal results, there was no need to force them.

During interview, (b)(6); (b)(7)(C) was asked why she did not discontinue AMAR's hunger strike status once he began consuming Pedialyte, Boost, and fruit. She stated it was hoped that as long as he believed his hunger strike was recognized, he would continue to consume the items, gain weight and maintain hydration. Asked about the sack lunch, she explained it was given in an attempt "to try different things to get him to eat." She further stated facility meals are considered unpalatable by some detainees and that a sandwich may be preferred over a meal.

A Special Needs Form documents discontinuation of hunger strike monitoring and discharge from MHU. An Administrative Segregation Order completed by Lieutenant (b)(6); (b)(7)(C) documents the following: "Detainee was released from medical and stated he wanted to [protective custody]. Detainee refused to give any further statement other than he did not want to go to general population." The form notes the detainee did not request a hearing and that a copy of the order was delivered to the detainee at 3:28 p.m.

Per Investigative Report filed by Sergeant (b)(6); (b)(7)(C) AMAR stated upon interview that he wanted protective custody and did not want to go to general population. The detainee stated he did not want to leave medical and he would continue his hunger strike.

(b)(6); (b)(7)(C) entered encounter notes documenting AMAR's discharge from MHU at 4:30 p.m. and clearance for segregation. The detainee refused to have his vital signs taken. He was spontaneous in his speech and answered questions appropriately; appeared to be in normal limits of appearance, behavior, affect and cognitive functioning; did not appear to have any acute or unresolved medical conditions that might worsen in segregation; and did not appear to have acute

psychosis, mania, suicide or homicidal ideations (b)(6); (b)(7)(C) electronically signed a Special Needs Form documenting segregation clearance.

Per the Housing History Grid, detainee AMAR was assigned to D3 segregation at 6:47 p.m.

October 17, 2018

RN (b)(6); (b)(7)(C) conducted the first segregation nursing round, noting AMAR was able to express medical needs adequately, in English.

RNs are required to make rounds in segregation on a daily basis to confirm detainee wellness by way of subjective information gathering and examination focused on health factors particularly pertinent in a segregated setting. Taking vital signs is not required during a segregation round. To document their rounds, nurses use the standardized eCW RN Daily Segregation Rounds note which includes a question related to thoughts of self-harm, and an inquiry as to any medical complaints or concerns. The following template language is pre-populated in the Examination section: "Patient has spontaneous speech and answers questions appropriately. In no acute distress, well developed, well nourished. Patient appears to be within normal limits of behavior, affect, and cognitive functioning. Patient does not appear to have any acute or unresolved medical conditions that may worsen in segregation. Patient does not appear to have active psychosis, mania, suicidal ideations or homicidal ideations." The standardized Assessment is, "Health Maintenance Related to Segregation Placement", and when completed, the Preventive Medicine and patient education sections routinely addressed access to medical, mental health, and dental care while in segregation. It could not be determined if nurses were, in fact thorough in their observations and interactive information-gathering to determine accuracy of the standardized findings.

For this and all subsequent segregation rounds while AMAR was on protective custody, RNs entered No in response to the two questions and did not modify the template language for the examination. No segregation rounds were missed. Because the encounter notes were largely redundant, the reviewer did not provide a daily summary of their content in the below chronology. Where individualized, the notes reflected that he continued to refuse meals, periodically ate fruit, and inconsistently drank the prescribed supplements.

Lieutenant (b)(6); (b)(7)(C) conducted a 24-hour review of AMAR's placement on administrative segregation. The staff member noted the detainee was unwilling to live in general population and recommended the status be continued. The recommendation was approved by the Warden Stephen Langford on October 19, 2018.

Per the Housing History Grid, at 12:38 p.m. detainee AMAR was assigned to H Segregation, cell 106 at 12:38 p.m.

Note: As detailed below, he was assigned to this cell until October 26, 2018 when moved to the MHU. He was reassigned to the cell on October 28, 2018, remaining until this death.

A full description of H Segregation and cell 106 is provided in discussion of October 28, 2018 events, below.

October 18, 2018

On an Administrative Detention Review form, Lieutenant (b)(6); (b)(7)(C) documented he interviewed detainee AMAR regarding his placement in protective custody. He did not address use of language interpretation assistance, or whether AMAR's English language proficiency was adequate to complete the interview. The lieutenant wrote, "Detainee stated he would not live in general population and signed for protective custody. Detainee was released from medical holding after eating. Prior to eating detainee was on hunger strike for multiple weeks." Lieutenant (b)(6); (b)(7)(C) recommended retention of the status. The recommendation was approved by the Warden and ICE Officer in Charge (signature illegible) on the same date. A copy of the form was delivered to the detainee.

October 19, 2018

Detainee AMAR was seen by (b)(6); (b)(7)(C) DDS for complaint that his tooth was sensitive to chewing. Interpretation assistance was used. The detainee agreed to have his vital signs taken, all of which were within normal limits. His weight was 147 pounds, representing a five pound weight gain since hunger strike monitoring was discontinued. The assessment finding was secondary canal infection, broken tooth, and an appointment was made for its extraction.

October 22, 2018

(b)(6); (b)(7)(C) saw detainee AMAR in H Segregation after he refused to go to medical for evaluation. She did not use interpretation assistance. She wrote, "He has not been consistent in drinking his Boost and is now refusing to drink it in front of the nurse. [Patient] states he is feeling ok but with some dry mouth." AMAR was told he was in H Segregation for protective custody, because D3 was closed. He refused to be weighed and have his blood pressure checked. Dr. (b)(6); (b)(7)(C) noted AMAR had been taking fresh fruit off the trays to eat, so it appeared he was following the same pattern of eating and drinking as he did in the MHU. The treatment plan was to continue checking the Medication Administration Record (MAR) for acceptance of Boost and Pedialyte; follow up in three to four days.

Note: As shown in Appendix 2, officers documented that through lunch this date, AMAR had eaten only two apples since the hunger strike was discontinued. If he more regularly ate fruit on trays, as (b)(6); (b)(7)(C) apparently believed to be the case, the information is not documented.

October 24, 2018

(b)(6); (b)(7)(C) again completed the daily segregation round. In addition, RNs documented three shift rounds that did not include standardized segregation template language but included free-form narrative, suggesting AMAR was on medical observation status. The notes document the detainee refused assessment, including vital signs.

Note: Reviewers were not provided with documentation indicating medical observation status was ordered before these three nursing rounds. If RN May 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) also 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, Officer (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.

Officer S (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, RN (b)(6); (b)(7)(C) documented the admitting provider was Shirley Shen, PhD psychologist. (b)(6); (b)(7)(C) did not make her own encounter entry and did not co-sign (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 to 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), (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., Sergeant Shepp 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

LCSW (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 LCSW (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), 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) noting 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: Lieutenant (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 Lieutenant (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., LCSW (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. LCSW (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), DDS, 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) note 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) recommendation 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

LCSW (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. LCSW (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 (b)(6); (b)(7)(C) 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 LCSW (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) cosigned 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

CDR (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 Riach 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". Lieutenant (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 (b)(6); (b)(7)(C), 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. Lieutenant (b)(6); (b)(7)(C) recalled 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., (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 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 Bostock's 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, DO (b)(6); (b)(7)(C) documented he first heard from SDDO (b)(6); (b)(7)(C) by email timed 11:17 a.m. DO (b)(6); (b)(7)(C) replied that he had not yet disclosed AMAR's removal date to him. During interview, DO (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 DO (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 DO (b)(6); (b)(7)(C). During interview, he stated he used the telephonic interpretation service during the meeting. DO (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 arrangement. (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.

Officers (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, Officer (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., Lieutenant (b)(6); (b)(7)(C) notified (b)(6); (b)(7)(C) that (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 (b)(6); (b)(7)(C) look more time at other cells, carefully looking through the windows. Given the

totality of the evidence, the reviewer concludes that (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 (b)(6); (b)(7)(C) would leave as soon as the first relief officer arrived. Officer (b)(6); (b)(7)(C) briefed (b)(6); (b)(7)(C) and at 3:04 p.m., Officer (b)(6); (b)(7)(C) arrived on the unit. (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 Knife¹⁴. 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 shield¹⁵. 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, Officer (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.

¹⁴ 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.

¹⁵ 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 Order (b)(6); (b)(7)(C) 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:

(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 (b)(6); (b)(7)(C) 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 (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). Sergeant (b)(6); (b)(7)(C) stated during interview that he instructed (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) inability 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 (b)(7)(E) 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 epinephrine¹⁶ 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 intubated¹⁷ 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) and (b)(6); (b)(7)(C) were assigned to the hospital detail, Officer (b)(6); (b)(7)(C) the ambulance and Officer (b)(6); (b)(7)(C) giving 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

¹⁶ Epinephrine is a hormone which supports heart function in the event of an emergency.

¹⁷ 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.

Officer (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) 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 epinephrine¹⁸ 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) is 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).

¹⁸ 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 (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. Sergeant (b)(6); (b)(7)(C) and Officers (b)(6); (b)(7)(C) did not submit reports. Officer (b)(6); (b)(7)(C) 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); (b)(7)(C) as not aware (b)(6); (b)(7)(C) 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, (b)(6); (b)(7)(C) 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) logged, "[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:

- Officer (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) 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 (b)(6); (b)(7)(C). 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 (b)(6); (b)(7)(C) home country. (b)(6); (b)(7)(C) 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 (b)(6); (b)(7)(C) 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 (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 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."

- 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 b (b)(6); (b)(7)(C) that he would be deported b (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 than two officers 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/ Disposition 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, (b)(6); (b)(7)(C) 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.	"St. Joe's medical staff will not conduct CPR due to detainee Amar #802 condition being futile. St. Joe's 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) said 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) in 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 ¹⁹ for detainee AMAR.
6:05 p.m.	Buddhist Minister in to perform Last Rites for detainee AMAR.

¹⁹ 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.

**Pierce County**

Medical Examiner's Office

3619 Pacific Avenue
Tacoma, Washington 98418
(253) 798-6494 • FAX (253) 798-2893

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PER RCW 68.50.105**

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

Associate Medical Examiner

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

Medical Examiner Services Manager

POSTMORTEM EXAMINATION REPORT

MEDICAL EXAMINER CASE #:

18-2308

NAME OF DECEASED:

Mergensana Dabaevich Amar

DATE OF EXAMINATION:

November 26, 2018

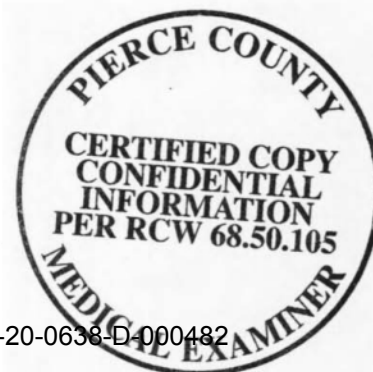
LAW ENFORCEMENT AGENCY AND CASE #:

**Tacoma Police Department
18-319-01418**

CAUSE OF DEATH:

Anoxic encephalopathy due to hanging

MANNER OF DEATH:

Suicide

DHS-20-0638-D-000482

FINAL DIAGNOSES:

Abrasion of the neck.
Respirator brain.
Acute bronchopneumonia and bronchitis, widespread.
Fatty change of the liver, severe.

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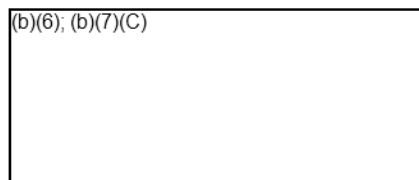
OPINION:

This 40-year-old man was found hanging in his locked cell at the Northwest Detention Center. He was resuscitated, and regained circulation, but never showed any neurologic response. He was pronounced brain dead on the third hospital day, and extubated.

Autopsy examination shows an abrasion of the neck consistent with the history. Anatomic findings include brain autolysis consistent with prolonging circulation following brain death, fatty change of the liver, and widespread pneumonia, likely the result of aspiration. Toxicology testing is negative for alcohol and other drugs.

Death is due to anoxic encephalopathy secondary to hanging.

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



22 Feb 2019
Date

Medical Examiner



EXTERNAL EXAMINATION:

The decedent is received in a body bag clothed only in a hospital gown. He is 66 in. tall and weighs 160 lbs. The hair is brown. The eyes are brown with jaundiced sclera. The teeth are natural. Rigor is not detectable. Livor is purple and posterior. The body is cold.

There is evidence of medical intervention. There is a two-lumen central line in the right arm. A foley catheter is present. There are punctures and bruising in the left antecubital fossa. There is a purple bruise on the posterior left forearm consistent with an attempted vascular access.

There are multiple healing rounded lesions on the anterior abdomen, right side greater than left. There is a scar on the left knee.

Injuries:

There is a band of brown discoloration around the front and both sides of the neck. It is faint, approximately 1/4-in. in average width. It cants upward on both sides of the neck as it proceeds backward. The discoloration is more prominent on the left than the right side of the neck.

There is no internal injury of the neck.

There is faint discoloration of the right periorbital region, possibly representing a bruise.

INTERNAL EXAMINATION:**Body Cavities:**

The serosal surfaces are smooth and glistening. Approximately 600 cc of blood-tinged fluid are present in the right chest cavity. Approximately 100 cc of blood-tinged fluid are present in the left chest cavity. The abdominal cavity contains approximately 50 cc of clear, straw-colored fluid.

Head:

The scalp does not have evidence of injury. The skull is intact. The brain weighs 1640 g. The meninges are thin and delicate, with no evidence of inflammation or hemorrhage. The brain itself is soft and discolored consistent with respirator brain.

Neck:

The hyoid bone is not fused but not fractured. There is no associated hemorrhage. There is no hemorrhage of the strap muscles. The larynx is clear. The thyroid gland is of the usual size and configuration.

Cardiovascular System:

The heart weighs 390 g. The coronary arteries arise in the usual locations. There is a short 10% concentric lesion of the left anterior descending artery and no other significant atherosclerotic disease. Serial sections of myocardium do not show evidence of acute nor old infarction. The valves are normally formed. The descending aorta is intact and does not have significant atherosclerotic disease.

Respiratory System:

The right lung weighs 1120 g, left lung weighs 1290 g. The lungs are firm and noncompliant with diffuse patchy light discoloration. Sections of both lungs sink when placed into formalin.

Liver, Gallbladder, Pancreas:

The liver weighs 1920 g. It is light in color. The gallbladder contains liquid green bile. The pancreas is unremarkable.

Spleen and Lymph Nodes:

The spleen weighs 260 g and is unremarkable. There are no prominent lymph nodes.

Genitourinary System:

The right kidney weighs 200 g, left kidney weighs 220 g. The kidneys are normally formed and do not have focal lesions. The bladder contains 6 cc of urine. The bladder mucosa has multiple punctate hemorrhagic lesions consistent with a foley catheter. The prostate is unremarkable.

Endocrine System:

The adrenal glands are autolyzed.

Digestive System:

The gastrointestinal tract is intact. The stomach contains 70 cc of liquid. An appendix is present and unremarkable.

Musculoskeletal System:

There is a sternal fracture consistent with resuscitative efforts.

Toxicology: Specimens are submitted for toxicologic analysis. A separate report will be issued.

Histopathology: Sections are submitted for microscopic analysis.

Block 1 contains: heart and right lung.

Block 2 contains: left lung and liver.

Block 3 contains: kidney and brain.

MICROSCOPIC EXAMINATION:

Heart: There is no evidence of acute nor old infarction.

Lung: Sections of lung show diffuse alveolar damage with widespread acute bronchitis and bronchopneumonia.

Liver: There is a severe degree of fatty change.

Kidney: No pathologic diagnosis.

Brain: Autolyzed.

TBC: aa

Dictated: 11/26/2018

Transcribed: 11/26/2018

Finalized: 02/20/2019

RETENTION:

Blood, body fluids, tissues, and physical/trace materials that may be collected (the exact samples vary by case) during the examination are routinely held in accordance with our retention policy prior to biohazard disposal, unless transferred to a laboratory or other agency by the Medical Examiner's Office, or otherwise released by special arrangement.

Detainee Death Review: Guerman VOLKOV, A209879518

Healthcare and Security Compliance Analysis

Baker County Detention Center

Macclenny, Florida

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 Guerman VOLKOV while in the custody of the Baker County Detention Center in Macclenny, FL. A site visit was conducted February 5-7, 2018, by ERAU staff C(b)(6); (b)(7)(C) ERAU Section Chief, (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) RN, Healthcare Subject Matter Expert. Contractor participation was requested to assess compliance with the ICE 2000 National Detention Standards governing medical care and security operations.

Included in this report are the facility description and staffing, an Executive Summary, the medical summary with findings and the security summary with findings. The information and findings are based on analysis of detainee VOLKOV's medical record and detention file; tour of the medical clinic, housing units, and intake area; interviews of staff; and review of policies, video surveillance footage and available incident related documentation.

FACILITY DESCRIPTION & STAFFING

Baker County Detention Center (BCDC) opened in 2009 and is operated by the Baker County Sheriff's Office. BCDC is an Intergovernmental Service Agreement facility housing county inmates, U.S. Marshall detainees and both male and female ICE detainees. The total facility population on the date of detainee VOLKOV's death was 450. The ICE population was 244, including 226 males and 18 females. All persons entering the secure section of the facility must display a staff or visitor identification badge. There are 96 video surveillance cameras positioned throughout the facility to monitor and record events.

BCDC's medical clinic is small but adequate and well-equipped. There are two examination/treatment rooms offering adequate privacy and containing emergency equipment, a patient restroom and shower, offices for the HSA, administrative assistant, and medical providers, and a nurses' station behind which the pharmacy and medical records room are located. A waiting area, accommodating 16 detainees is located immediately inside the clinic area with the officer's station at the front of the room. To the right of the officer's station is a hallway with a treatment room on the right followed by cells one through four. Two of these four medical observation

DETAINEE DEATH REVIEW: Guerman VOLKOV

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Healthcare and Security Compliance Analysis

March 2019

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DHS-20-0638-D-000487

2020-ICLI-00057 1566

rooms provide negative pressure air flow for airborne isolation. Aside from cell one, the cells have a camera inside which shows a view of the cell, not including the toilet area or the lower bunk. Cell four, which is padded and camera-monitored, is used for suicide watch. A second padded cell, which does not currently have a camera, is located in the segregation unit, and a cell in Booking is commonly used for overflow of medical or mental health observation. Medical Observation cell two, where detainee VOLKOV was housed, has a steel bunk bed on the left as you enter the cell and a toilet/sink combination on the right.

To assist detainees with limited English proficiency, Lionbridge Language Line is available at BCDC. It was noted, however, that the language line was not used during medical, security or deportation officer encounters with VOLKOV, with the exception of one instance when the detainee was pending a transfer to Krome. Staff stated when interviewed that detainee VOLKOV was able to speak some English, but it was fragmented, and he was not likely able to express or understand medical concepts. Multiple staff stated they did not use interpretation services while also acknowledging there was a language barrier with the detainee. Per medical staff interviewed, VOLKOV expressed frustration with the inaccurate dialect of the interpretation line and at times, emphatically voiced preference to speak English. With the exception of a handful of medical staff, he most often chose not to converse at all.

BCDC does not currently have electronic medical records; however, according to (b)(6); (b)(7)(C) Health Services Administrator (HSA), plans are to install the system this year. While standard nursing protocol forms are available, they were not used throughout VOLKOV's detention period. Nurses documented progress notes in narrative form, failing to use the SOAPE¹ note format, in accordance with general nursing practice and directive of Armor Policy J-H-01, Health Record Format and Content. Documentation and signatures were often illegible, with nurses seldom using name stamps or printing their names and credentials.

Medical services at BCDC are provided by Armor Correctional Health Services, Inc. (ACHS), based in Miami, Florida. The clinic is open 24 hours a day, seven days a week. HS (b)(6); (b)(7)(C) a registered nurse (RN) who has been in her position for one year. Her administrative duties are supported by Director of Nurses (DON) (b)(6); (b)(7)(C) who was hired within the past year. At the time of detainee VOLKOV's death, (b)(6); (b)(7)(C) supervised four full-time registered nurses (RN), three PRN (as needed) RNs, seven full time licensed practical nurses (LPN), and three PRN LPNs. Administrative support positions include one full time, one part time, and two PRN medical records technicians, and one administrative assistant. Dental services are provided by an off-site private practice.

¹ SOAPE is a format for documentation which includes Subjective, Objective, Assessment, Plan of treatment, and Education.

A significant turn-over of nursing staff was noted during the time VOLKOV was detained. According to HSA White, this was primarily a result of the previous HSA's departure and her own arrival and leadership. Many nurses and mental health staff who had direct encounters with the detainee were no longer employed by BCDC, and due to illegibility of signatures and the inability of current staff to identify them, some nurses' identities remain unknown throughout the following summary of care.

Full-time physician (b)(6); (b)(7)(C) who has worked at BCDC for four years, provides clinical oversight and 24-hour on-call services. He obtained his education in Puerto Rico and holds a temporary two-year restricted license through the State of Florida, authorizing him to practice only in critical need locations. According to the Florida Board of Medicine, applicants for a temporary license in an "Area of Critical Need" must "only practice in certain designated, approved facilities located in communities of Florida where there is a critical need for physicians". The list of approved facilities includes Baker County Health Department, but BCDC is not specifically named for inclusion. (b)(6); (b)(7)(C)'s license, number ACN210, is current, and on repeated requests for a copy of the National Practitioner Data Bank Query, it was not provided by HSA (b)(6); (b)(7)(C) or (b)(6); (b)(7)(C). There are no advanced practice providers to support clinical duties at BCDC.

Part-time Psychiatric services are provided by (b)(6); (b)(7)(C) MD who has worked for BCDC for two years, providing onsite services on Tuesdays and Thursdays. He also holds a temporary two-year certification to practice only in critical need locations within the State of Florida. Full time mental health services are provided by (b)(6); (b)(7)(C) Licensed Mental Health Counselor (LMHC), who has been with the facility for about six months. Both the psychiatrist and LMHC are available on-call 24 hours a day, seven days a week.

NOTE: The issue regarding licensure was referred to IHSC leadership who followed up on the concern and found that both (b)(6); (b)(7)(C) met state licensure requirements.

Per the Florida Department of Law Enforcement website, corrections deputies are certified by the State of Florida after successful completion of the 10 and a half week Florida Basic Recruit Training Program as well as receiving a passing score on the State Officer Certification Exam. At BCDC, a Lieutenant oversees the jail operations and sergeants and corporals run the daily shifts. In addition, a sergeant is assigned supervision over Booking and Housing. Officers work 12 hour shifts. The Central Control is operated 24 hours a day by a corrections deputy. Two elevated pod controls located within the housing units are staffed by civilian employees who receive basic security training. Central Control can override the satellite pod controls at any time.

General population housing units are located on Bravo unit and consist of dorms numbered one through eight. An officer is assigned to the unit, along with a rover who assists as needed. As noted, the pod control officer is in an enclosed elevated station with both visual and camera views into the dorms. The cells in the dorms accommodate either two or four men and have bunk beds as well as a shower and toilet in each cell. Kiosks are used for sending requests or grievances. All meals are served on the unit. The recreation unit is adjacent to the pods and has a mesh screen to allow for fresh air and sunlight. There are TV's as well as exercise bikes in the recreation area.

In addition to the dorms on Bravo unit, there is a female ICE unit located in A5, and a 31 bed segregation unit located in A7. There is a shower in each segregation cell. There are also available beds in Booking and Medical, none of which have a shower. A correctional deputy is assigned to the Medical, Booking and segregation units at all times.

Vehicle entry to the facility is through an enclosed sallyport, with garage doors on each end. A door from the sallyport enters into the Booking area. The Booking area has multiple holding cells and one suicide prevention cell.

EXECUTIVE SUMMARY

Detainee VOLKOV was housed at BCDC for over 17 months. He arrived on June 26, 2017, with limited personal property and no funds. A PPD skin test for tuberculosis clearance was not done at the time of intake. This was a cited deficiency following the last ODO oversight inspection. During his detention, detainee VOLKOV made four requests for assistance: one for forms, one for glasses and two for attorney calls. The request for glasses was never appropriately responded to by staff. Detainee VOLKOV filed no grievances.

While initially housed in general population, he requested placement in Protective Confinement (PC) stating he was afraid to be around other detainees. He was housed in PC from September 16 to November 14, 2017, and from November 16, 2017, to November 28, 2018, with the exception of times he was placed on suicide watch or psych watch. He was housed on the segregation unit, the medical unit or in the booking area. There is no documentation confirming that recreation and showers were offered as required when he was housed in Medical or Booking. He was housed alone for his entire detention period.

Most staff described the detainee as cooperative and quiet. However, he once had to be placed in a restraint chair due to continually banging his fist on the cell door and refusing to stop and once

had to be physically removed from his cell due to his refusal to relocate. He was placed on suicide watch on four occasions for between one and 25 days. Mental health rounds were often not conducted on weekends when he was on suicide watch or mental health observation. Ativan, an anti-anxiety medication ordered by the psychiatrist, was administered via intramuscular injection on October 27, 2017, in the absence of emergency need or court order.

A borderline EKG, dated June 29, 2017, indicated a possible history of heart disease, but it was not included on the problem list and was never repeated. Laboratory tests dated July 2, 2017, indicating possible anemia and/or internal bleeding, were not followed up on by the physician. A hernia belt approved by the physician on September 12, 2017, to provide comfort was never issued to the detainee. Additionally, prescribed studies ordered over seven months later in February 2018, to include a complete blood count and prescription drug levels, were never completed. Chronic care assessments to address unstable hypertension, seizure disorder, inguinal hernia, and abnormal diagnostic findings were not conducted every three months, with the last being in September 2017. Informed consent for the administration of high-risk psychotropic medication was not signed by the detainee. Medical record documentation was often illegible and lacked thorough subjective and objective information, essential in verifying quality patient care was provided.

Detainee VOLKOV sometimes refused medical care, most notably when hospitalized on November 28, 2018. He signed himself out of the hospital that date despite hospital staff informing him he was in a life and death situation. He was placed on suicide watch when he was returned to BCDC. Video surveillance footage confirms that rounds were not made as required and were falsified by the assigned unit deputy.

On November 30, 2018, Detainee VOLKOV was no longer on suicide watch but he remained housed in medical on 15 minute checks. The deputy assigned to the medical unit falsified numerous rounds, electronically recording that he had personally observed the detainee when he had not.

Detainee VOLKOV was returned to the hospital that date and vomited feces and blood while being wheeled to a treatment room. Hospital staff worked on the detainee for over 45 minutes before pronouncing his death at 1:59 p.m. The Inspection Report from the Office of the Medical Examiner, dated January 24, 2019, noted the diagnoses of 1) Abrasions of lower legs and dorsal right foot, and 2) Clinical history of small bowel obstruction and gastrointestinal hemorrhage². The cause of death was natural as a result of a small bowel obstruction, with gastrointestinal hemorrhage.

² Gastrointestinal hemorrhage refers to bleeding in in the stomach and/or intestines.

MEDICAL SUMMARY OF CARE AND FINDINGS

June 27, 2017

The medical record document (b)(6); (b)(7)(C) LPN conducted the intake screening at 1:00 a.m., recording vital signs as follows: temperature 98.0, pulse 84, respirations 14, and blood pressure 136/90, all within normal limits, except for the blood pressure reading at stage one hypertension, in accordance with the American Heart Association's (AHA) 2017 Guidelines (*Appendix I*). At six feet in height, VOLKOV weighed 204 pounds. The transfer summary from Pasco County Jail, Land O' Lakes, Florida, dated June 25, 2017, listed the medications he had been receiving, to include Lisinopril, 20 mg every morning to treat hypertension; metoprolol, 25 mg every morning to treat hypertension and heart failure; and Keppra (*levetiracetam*), 500 mg twice daily to treat his seizure disorder. The transfer summary also indicated a diagnosis of conversion disorder³, with seizures or convulsion, as confirmed by an unnamed hospital, where he was being treated with Keppra. A transfer summary from the Pinellas County Sheriff's Office, also dated June 25, 2017, noted a subjective history of seizures for which Tegretol (*carbamazepine*) 200 mg every 12 hours for 30 days. Medications, including Keppra, which he had already been receiving for seizures while at the Pasco County Jail were not listed. (b)(6); (b)(7)(C) who had earned her RN degree in July 2018, stated during interview that the entry, "2 months ago" was erroneously documented

³ Conversion disorder is a mental condition such as stress or depression, in which a person has seizures, blindness, paralysis, or other symptoms related to the nervous system that cannot be explained by medical evaluation.

beside the entry of diabetes, intending to reference the last seizure. When questioned if she determined a language of preference or need for interpretation services, (b)(6); (b)(7)(C) stated that VOLKOV conversed with her in English.

Detainee VOLKOV's appearance, behavior, state of consciousness, breathing, skin, and ease of movement were all found to be within normal limits, with no evidence of disability or suicidal presentation. The mental health assessment was normal. VOLKOV denied having been in the hospital or emergency room within the prior three months and reported his last health care visit was a "few weeks ago". He denied symptoms of tuberculosis infection, and (b)(6); (b)(7)(C) noted his last tuberculosis test was negative on June 10, 2017. Of note, detainee VOLKOV was not in ICE custody on the date of June 10, 2017, and because the skin test measured four millimeters, need for a PPD or a chest x-ray was indicated at the time of arrival.

VOLKOV denied a history of alcohol or drug use, sexual assault, or symptoms of dengue infection or influenza. His dental assessment noted broken and missing teeth. The disposition was clearance for general population, with placement in chronic care clinic and assignment to a low bunk. A telephone order was obtained from (b)(6); (b)(7)(C) for a cardiac diet, rewrites of lisinopril, metoprolol, Keppra, and carbamazepine 200 mg twice daily. A consent for medical treatment was signed, and (b)(6); (b)(7)(C) signed as reviewer of the intake screening on the same day. A Problem List was initiated on this date to include hypertension and seizures. On September 13, 2017, "No Diagnostic Impression"⁴ for mental health was added, and "Suicide Watch" for the dates of September 12-13, 2017, October 10-11, 2017, and October 15 to November 9, 2017, were also added. Questioned why a dental referral was not documented, RN (b)(6); (b)(7)(C) stated such a referral would have been forwarded, as needed, at the time of the initial assessment.

June 29, 2017

(b)(6); (b)(7)(C) conducted the initial chronic care assessment at 10:45 a.m., noting VOLKOV's history of hypertension and seizure disorder. There was no documentation noting the language of preference or use of an interpretation service; yet, during interview (b)(6); (b)(7)(C) stated that it was difficult for them to communicate due to a language barrier. Questioned if the standardized Chronic Care form was to be used for documenting the assessment, he replied yes; however, his initial chronic care assessment was somewhat illegibly written as a narrative in the Progress Note. Normal vital signs were recorded as follows: temperature 98.3, pulse 72, and respiration 16. His blood pressure was erroneously documented 155/192, and when asked to decipher that read, (b)(6); (b)(7)(C) believed it was meant to be 155/92. Nonetheless, the read was at a stage two

⁴ No diagnostic impression means following assessment, there was no evidence of a mental health diagnosis.

hypertension level. VOLKOV was described as “asymptomatic⁵” and in no acute distress. He appeared to be in good physical condition, and his physical examination was found to be “unremarkable”. The assessment findings were seizure disorder and hypertension. A stat EKG⁶ per (b)(6); (b)(7)(C) order, showed a slow sinus rhythm, indicating a possible septal infarct⁷ and borderline EKG⁸. Of note, the EKG was never repeated prior to VOKLOV’s death. Laboratory studies were to be drawn on July 3, 2017, to include a complete blood count (CBC)⁹ with differential, comprehensive metabolic panel (CMP), lipid profile, carbamazepine level, and a urinalysis (UA). Additional orders included aspirin (ASA), 81 mg daily¹⁰, discontinue cardiac diet, give clonidine 0.3 mg and recheck blood pressure in one half hour. Blood pressure checks were to be done once daily. At 11:35 a.m. (b)(6); (b)(7)(C) documented the normal blood pressure recheck of 105/75. The medications remained otherwise unchanged. During interview, Dr. (b)(6); (b)(7)(C) stated he had not been clear in his order to discontinue the cardiac diet, stating it was likely based on VOLKOV’s request. (b)(6); (b)(7)(C) stated during interview that he was unaware of the history of the two previous heart attacks which were first reported during the ensuing initial mental health assessment, and along with the abnormal EKG finding, this critical information was never included on the problem list, nor was it followed up on during VOLKOV’s detention period. Because the initial blood pressure results on the Vital Signs Flow Sheets provided to the review team were all dated after October 21, 2017, it cannot be established if VOLKOV’s blood pressures were obtained on a daily basis per order and remained at a normal level. Medication compliance was good.

July 2, 2017

⁵ Asymptomatic means there were no symptoms. According to the American Heart Association, however, “High blood pressure is a largely symptomless ‘silent killer’.

⁶ An EKG, or electrocardiogram, is the process of recording the electrical activity of the heart over a period of time using electrodes placed over the skin.

⁷ A septal infarct is a patch of dead, dying, or decaying tissue on the wall of tissue that separates the right ventricle of the heart from the left ventricle. Septal infarct is usually caused by an inadequate blood supply during a heart attack. The EKG finding of septal infarct means the patient possibly had a heart attack at an undetermined time in the past.

⁸ A borderline EKG means the findings are in a range that while not precisely normal, are not significantly abnormal.

⁹ A complete blood count (CBC) with differential is a blood test that measures the number of red blood cells, white blood cells, and platelets in the blood, along with a breakdown of the various types of white blood cells. This test is used to help diagnose and monitor many different conditions, including anemia and infection.

¹⁰ Low dose aspirin (81 mg) is a common addition for patients with cardiac disease, as it thins the blood and prevents strokes or heart attacks related to blood clotting.

At 2:00 a.m. (b)(6); (b)(7)(C) documented laboratory studies were completed. The results received the following day showed the microscopic urinalysis, comprehensive metabolic profile, and carbamazepine levels to be within normal limits. The complete blood count, however, recorded red blood cells to be low at 4.07 (Reference range 4.70-6.10, hemoglobin low at 13.0 (Reference Range 14.0-18.0), hematocrit low at 39.0 (Reference range 42.0-52.0), and MCV slightly high at 95.9 (Reference Range 80.0-95.0). The lipid panel showed a normal cholesterol and triglyceride level, but his LDL was high at 109 (Reference range 0.00-99.0), VLDL was high at 46.0 (Reference range 8.00-39.00), and his HDL was low at 28.0 (Reference range 40.0-60.0). The reports were signed by (b)(6); (b)(7)(C) eight days later on July 10, 2017, suggesting he was aware of the abnormal results. When questioned during interview if these specific hemoglobin and hematocrit levels were of concern, (b)(6); (b)(7)(C) replied yes, that it could be a sign of internal bleeding or anemia. When asked why the problem had not been addressed in a treatment plan, he replied he perhaps did not consider it a serious problem at that time.

July 7, 2017

A Refusal of Treatment form was completed by an unidentified RN at 2:00 p.m., documenting VOLKOV's refusal of his initial physical assessment. There is no progress note documentation to address this refusal, nor is there an action plan to reoffer the physical assessment, which while not required by the standard, would have been a prudent nursing action.

July 20, 2017

A response was documented to VOLKOV's request for glasses, as he was unable to see small letters. (b)(6); (b)(7)(C), whose position is unknown, returned the request with the question to him, "What focus do you need?" There is no evidence this question was responded to, nor were reading glasses found in his property following his death. The Temporary Problems section of the Problem List included "vision problems", but a corresponding entry in the progress notes to suggest an eye chart test was done was nonexistent. The reviewer finds the management of this request unacceptable, as the detainee would unlikely be aware of the strength needed for visual correction.

July 22, 2017

At 7:00 a.m. VOLKOV submitted a sick call request to address his sleep difficulty, specifying he was getting one to two hours of sleep per night. The request was received the same day and triaged the following day, July 23, 2017. The illegible signature of the triage nurse could not be identified by medical staff. He was referred to the health care provider to be seen 20 days later on August 11, 2017. A Refusal of Treatment form, dated July 23, 2017, noted he refused the sick call appointment, as he did not want to wait that long to be seen. During medication pass at 9:00 p.m. on August 11, 2017, (b)(6); (b)(7)(C) documented her notification to the MD that VOLKOV's medications were expiring. New orders were received via telephone order, renewing the

medications for 180 days. (b)(6); (b)(7)(C) signed the order three days later on August 14, 2017. The next chronic care clinic was September 12, 2017, a period of one month following renewal of medication.

September 10, 2017

Detainee VOLKOV submitted a sick call request to see the doctor for “pains around my thighs”. Receipt of the request was the same day, and the triage note by (b)(6); (b)(7)(C) RN two days later recorded the following vital signs: temperature 99, pulse 65, respirations 16, and blood pressure 131/89, all within normal limits, with the exception of the elevated blood pressure at stage one hypertension. His weight was 197 pounds. It was documented on the request that he was seen by the MD on September 12, 2017. (b)(6); (b)(7)(C) is no longer employed at BCDC and therefore was unavailable for interview.

September 12, 2017 (Suicide Watch #1 Initiated)

At 10:00 a.m. (b)(6); (b)(7)(C) conducted a chronic care assessment, using ACHS’s standardized form. The language of preference and use of interpretation services were not documented. He noted VOLKOV’s history of hypertension and seizure disorder, and subjectively listed the complaint of “Painful left inguinal hernia¹¹”. His current medications were listed as aspirin 81 mg, lisinopril 20 mg, metoprolol 25 mg, carbamazepine 200 mg, and Keppra 500 mg. Vital signs were recorded as follows: temperature 99.0, pulse 65, respirations 16, blood pressure 131/89, all within normal limits, except for the elevated blood pressure at stage one hypertension. In the Objective section of the SOAPE note, (b)(6); (b)(7)(C) addressed the abdominal hernia but otherwise documented normal assessment findings, adding VOLKOV “appeared to be in good physical condition” and having a good degree of control in his hypertensive and seizure disorder management. The results of the laboratory studies completed July 2, 2017, were listed but not otherwise mentioned in the treatment plan. There were no changes in the medication regimen, he was not to receive a restricted diet, and there were no follow-up laboratory studies ordered. A hernia belt¹² was approved, with a special needs form filed in the record; however, there is no evidence the belt was ever issued to him. On review of his personal property, the belt was not present. The next chronic care clinic was to be scheduled in three months. During interview Dr. (b)(6); (b)(7)(C) stated that he evaluates chronic care patients at least once every three months, unless a detainee’s condition is stabilized, such as with controlled asthma, and can be scheduled out longer.

¹¹ An inguinal hernia is a condition in which soft tissue bulges through a weak point in the abdominal muscles. When left untreated or not surgically repaired, as needed, an inguinal hernia can lead to life-threatening complications, such as **bowel obstruction**.

¹² A hernia belt is a supportive undergarment for men, designed to keep protruding tissue in place and relieve discomfort.

A review of the logs of the clinic assessments indicate they were frequently refused by VOLKOV, in the absence of properly completed refusal forms:

Date	Chronic Care Clinic Appointment	Refusal Form Completed
6/29/17	Initial Assessment Completed	Not applicable
9/12/17	3-Month Follow-up Completed	Not applicable
12/7/17	Refused	Yes, on 12/10/17
3/8/18	Refused	None, not in progress note.
6/5/18	Refused	Yes, not in progress note.
9/6/18	Refused	No signature, no witness.

Note: The December 7, 2017, refusal did not include a correlating progress note.

Considering the importance of follow-up chronic care assessment for detainees who are being pharmaceutically treated for unstable and high-risk conditions, such as those of detainee VOLKOV, the reviewer recognizes inadequate effort in encouraging acceptance and cooperation of these assessments prior to renewal of prescription medication. Progress note documentation fails to outline such efforts; nor does it address (b)(6); (b)(7)(C) review of progress notes and diagnostic studies since the last clinics or a follow-up treatment plan.

At 4:20 p.m. (b)(6); (b)(7)(C) LPN, who is no longer employed at BCDC, documented a phone call received from (b)(6); (b)(7)(C)s, reporting VOLKOV's statement, "If I can't go home, then I just want to kill myself." He was placed on suicide watch in Unit A7, by (b)(6); (b)(7)(C) and notification was made to (b)(6); (b)(7)(C) LMHC, who also is no longer employed at this facility. A Confinement/Restraint Clearance was completed by an unidentified person. At 4:20 p.m., LMHC Douglas completed the Mental Health Protocols Order Sheet, requiring continuous visual observation for active suicidal ideations; suicide tray with paper products only; suicide smock and suicide blanket only; no sharp objects, bedding, utensils, pencils, etc. and placement in medical housing. A Restricted Diet Order Form was completed by (b)(6); (b)(7)(C) ordering a suicide management diet with no utensils or bones. Additionally, the same nurse completed a Special Needs Communication/Relocation form for suicide watch. Of note, ACHS's standardized forms did not include questions related to language of preference or use of an interpreter. The reviewer recommends revisions to include this information. Additionally, because signatures were frequently difficult or impossible to identify, credential stamps should have been provided and utilized for legal record-keeping. HSA White advised the team that all regular and PRN staff currently have stamps for authentication.

September 13, 2017 (Suicide Watch #1 Discontinued)

DETAINEE DEATH REVIEW: Guerman VOLKOV
Healthcare and Security Compliance Analysis
March 2019

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An Initial Mental Health Evaluation written at 3:57 p.m. by LMHC Douglas documents, “55-year old Russian male placed on suicide watch because of a language barrier. He showed officers the sign of cross (Medical Red Cross sign). He stated he was needing medical attention. Patient denied any suicidal/homicidal ideation. No mental health history except in DUI classes in 1999. No family mental health treatment.” VOLKOV denied current, past, or pre-incarceration psychotropic treatment. He admitted to drinking beer after work to relax, having last consumed on April 17, 2017. His occupation was a painter. He reported having been hospitalized for two heart attacks and for injuries related to a car accident. He suffered a head injury two years ago when he was hit while driving. His last seizure was in May 2017. VOKLOV signed an Informed Consent to Mental Health Treatment. His mental status examination was all within normal limits, and there was no diagnostic impression. He was released from suicide watch with no restriction on clothing, bedding, or utensils. He was to have a mental health follow up in one to two weeks, which occurred on September 20, 2017. LMHC (b)(6); (b)(7)(C) made no reference to language preference, language barrier, or use of an interpreter.

A Special Needs Communication/Relocation form was completed by LMHC Douglas at 4:30 p.m. which noted release from suicide watch, notification to Officer (b)(6); (b)(7)(C) (first name unknown) and (b)(6); (b)(7)(C) LPN and no restrictions on clothing, bedding, or utensils. She also completed a Behavioral Health Individual Treatment Plan noting no diagnostic impression, no psychotropic medications, and no history of mental health problems, except for DUI classes in 1999. The treatment plan otherwise mirrored the Special Needs form.

September 14, 2017

At 11:15 a.m. (b)(6); (b)(7)(C) documented a progress note stating detainee VOLKOV was brought to the clinic for complaint of “losing my brain,” explaining that he was not getting along with another inmate in his housing unit and couldn’t tolerate him anymore. He denied abuse or suicidal and homicidal ideation. RN (b)(6); (b)(7)(C) documented, “Medical officer was made aware”, but there was no other action documented. AS RN (b)(6); (b)(7)(C) is no longer employed by BCDC, undocumented action could not be determined.

September 20, 2017

At 3:07 p.m., LMHC (b)(6); (b)(7)(C) documented a follow-up assessment from the September 13, 2017, suicide watch. VOLKOV was alert and cooperative, well groomed, and fully oriented. He offered good eye contact but presented with an anxious mood, and his speech was rapid with possible delusional thinking. He denied suicidal thinking or intent, stating, “I love life”. He stated he felt unsafe because he believed there was a hit placed on him by President Trump and he was afraid he would be raped in the night. Reassurance was offered by custody that his safety would be ensured, and 15 minutes checks were explained. Follow-up was to be done on September 22, 2017; however, there are no records available for the nine days following this encounter.

September 29, 2017

A Post Use-of-Force assessment was completed at 8:00 a.m. by LPN (b)(6); (b)(7)(C). The assessment was completed in Booking, as VOLKOV was being placed in the restraint chair. A Medical Restraint Log was filed in the absence of documentation to justify this action. Between the hours of 8:00 a.m. and 9:50 a.m., the log shows he was restrained in a chair, with calm behavior following the initial 15-minute period when he was described as agitated. Vital signs were all within normal limits as follows: temperature 98.2, pulse 69, respirations 18, blood pressure 115/87, and oxygen 98. He was alert, oriented, and cooperative. There were no injuries observed, and he offered no complaints. A 24-hour follow-up was not documented using SOAPE format and did not include a neurological check as directed by ACHS policy.

October 10, 2017 (Suicide Watch #2 Initiated)

At 2:35 p.m., (b)(6); (b)(7)(C) documented she received a call from (b)(6); (b)(7)(C) stating that VOLKOV was placed on suicide watch per security due to his statement he just couldn't take it anymore. At 3:00 p.m., (b)(6); (b)(7)(C) documented a nursing round, at which time VOLKOV stated he was going to slit his wrist, appearing agitated and demonstrating a cutting motion with his hands. He stated he spoke German, followed by Muslim, Russian, and Dutch. Vital signs were not obtained but his respirations were noted to be even and unlabored. He was placed on suicide watch. An Internal Clinic Referral Form was submitted to behavioral health on an urgent basis by (b)(6); (b)(7)(C) and a Mental Health Protocols Order Sheet, completed by (b)(6); (b)(7)(C) and co-signed by LMHC (b)(6); (b)(7)(C) the following day at 10:20 a.m. ordered continuous visual observation in medical housing for active suicidal ideations, suicide tray with paper products only, suicide smock and suicide blanket only, no sharp objects, bedding, utensils, pencils, etc. He was to get no razor or laundry bag.

October 11, 2017 (Suicide Watch #2 Discontinued)

At 10:20 a.m., LMHC (b)(6); (b)(7)(C) documented a Mental Health Rounds/Contact Form, documenting the encounter was not done with an interpreter, as VOLKOV wanted to speak English. She notes, however, that it was "hard to understand his broken English". He complained of upset over officer and inmate ridicule about being Russian, and he believed he had enemies. He was scheduled to go to court to defend his asylum. He denied suicidal or homicidal ideation, stating he was just frustrated and felt misunderstood. He was released from suicide watch to general population, with no clothing or utensil restrictions. Follow-up was to be completed in one to two weeks.

October 15, 2017 (Suicide Watch #3 Initiated)

LPN (b)(6); (b)(7)(C) completed an untimed Internal Clinic Referral Form to behavioral health to urgently address VOLKOV's placement back on suicide watch by Sergeant (b)(6); (b)(7)(C) following the detainee's statement that he "just can't handle it anymore". The following day, **October 16, 2017,**

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

documented VOLKOV's refusal to be interviewed and signed a Mental Health Protocols Order Sheet, with continuous observation orders for active suicidal ideations, suicide tray with paper products only, suicide smock and suicide blanket only, no sharp objects, bedding, utensils, pencils, etc., and place in medical housing. Follow up was to occur on the following day; however, due to absent progress note or refusal of treatment documentation, completion of the follow-up cannot be verified.

October 17, 2017

At 2:50 p.m. (b)(6); (b)(7)(C) prescribed the antianxiety medication Ativan 2 mg to be taken by mouth every six hours as needed for anxiety/agitation. If the detainee refused the oral dose Ativan, it could be administered by intramuscular injection every six hours, as needed, for a maximum of four doses per 24 hours. This order was written by (b)(6); (b)(7)(C) as opposed to being a verbal order to a nurse; however, it was not accompanied by a corresponding assessment/progress note. A review of the MAR does not include the registering of this medication, and there is no evidence that Ativan was administered prior to October 27, 2017. Progress note documentation for October 18, 2017 is absent.

October 19, 2017

An unidentified nurse documented a progress note at 4:45 a.m., noting VOLKOV was asleep and resting quietly in A-7, with no acute distress noted, and on **October 20, 2017**, at 1:00 a.m. an unidentified RN documented VOLKOV was resting quietly in Booking.

NOTE: The Cell History Report shows the detainee went from A7 to Medical housing on October 19, 2017 and the Daily Record of Segregation documents he was housed in Medical, not booking. The reviewers have no explanation for the discrepancy.

He had taken his medications and denied wanting to hurt himself. No distress was noted, and the RN noted he/she would continue to monitor him while housed in Medical Room 4. At 3:05 p.m., LMHC (b)(6); (b)(7)(C) entered a progress note, stating the nurses were alerted to her concern regarding VOLKOV's increasing agitation. She noted the order written on October 17, 2017 for intramuscular Ativan expired 24 hours after written. Nurses were asked to contact (b)(6); (b)(7)(C) for another such order. At 4:15 p.m., VOLKOV was observed resting quietly with no signs or symptoms of agitation, and there is no evidence an order was written or Ativan was given. The Vital Signs Flow Sheet shows vital signs were done almost daily beginning on the start date of October 20, 2017, directed on the form to be done "Every shift while housed in medical". Between the dates of October 20 to November 9, 2017, there is only one day, October 23, 2017, when they were done every shift, and there were seven days in which vital signs were not recorded on the flow sheet at all. Two days were not recorded as full sets of vital signs, with only the blood pressure and/or pulse documented. Five entries were scratched out with attempted over-writes and

could not be deciphered. There are no progress notes entered for the weekend of **October 21-22, 2017**.

October 23, 2017

At 2:43 p.m., (b)(6); (b)(7)(C) documented a late entry for checks done at 9:30 a.m. to 12:05 p.m. Vital signs in the right arm were recorded as follows: blood pressure significantly low at 79/56¹³, respirations normal at 16, pulse normal at 71, and temperature illegibly written but appears to be 94.7, which would be a sign of hypothermia. His weight was 192 pounds. The left arm blood pressure was low at 82/62 and pulse was normal at 74. He was given Gatorade, which he consumed in the RN's presence, and a blood pressure recheck at 11:05 a.m. was slightly improved at 90/56. He was noted to have a steady gait. VOLKOV stated, "Thank you" but after that only spoke Russian.

October 24, 2017

Only one nursing entry is documented in the progress note, timed 3:30 a.m. There is no reference to intake of fluids/Gatorade. The unidentified RN notes VOLKOV was quiet all night, took all medications, and was in no distress. He stated he wanted to go home. The following day of **October 25, 2017**, at 1:00 a.m., an unidentified RN documented VOLKOV was resting quietly in Medical Room 4. At 4:15 p.m. he was given Gatorade by (b)(6); (b)(7)(C). There are no progress notes entered for **October 26, 2017**.

October 27, 2017

At 1:50 p.m., (b)(6); (b)(7)(C) documented VOLKOV was heard yelling in his cell. (b)(6); (b)(7)(C) informed the nurse that he was banging his head on the door. He stopped banging his head when instructed but continued to yell. (b)(6); (b)(7)(C) advised the RN he had been requesting an Ativan injection, but (b)(6); (b)(7)(C) correctly explained, as the order was written, it could only be given if he was a threat to himself, and at that time "never posed a threat to himself". At 2:20 p.m., (b)(6); (b)(7)(C) prescribed Ativan 2mg every six hours for anxiety/agitation, as needed. If oral medication refused, may be given intramuscularly at the same dose and frequency up to a maximum of four doses per 24 hours. According to the MAR, an injection of Ativan 2 mg was administered intramuscularly by (b)(6); (b)(7)(C) RN at an undocumented time. Based on the undocumented time and the absence of a progress note addressing need for and administration of the injection, the time remains unknown. As none of the three nurses involved are currently employed at BCDC, they were

¹³ According to the Mayo Clinic, most doctors consider blood pressure too low only if it causes symptoms, while other experts define low blood pressure as readings lower than 90/60. If either number is below that, the pressure is abnormal. A sudden fall in blood pressure can be dangerous as it can cause falls related to dizziness, lightheadedness, fainting, blurred vision, and fatigue. Extreme hypotension can result in shock, identified by confusion, rapid shallow breathing, weak rapid pulse, and cold clammy skin.

unavailable for interview. Of note, (b)(6); (b)(7)(C) who prevented the intramuscular injection of Ativan based on how the order was written, was prudently acting in accordance with the National Commission on Correctional Healthcare, Standard J-I-02, which states, *“Though the right to refuse treatment is inherent in the notion of informed consent, exceptions may arise in psychiatric emergencies. State laws vary on this matter but, as a rule, forced psychotropic medication is employed only when the inmate is imminently dangerous to self or others due to mental disease or defect. Facilities that do not force psychotropic medication in an emergency generally transfer the patient immediately to a hospital emergency room for assessment and treatment.”*

At 3:25 p.m. the same day, (b)(6); (b)(7)(C) ACHS Corporate Clinical Coordinator for Behavioral Health called in response to a message left with the Mental Health Department. Her response directed that “emergency psychotropic medication” can only be used if a patient is a threat to himself or someone else. The reviewer finds the orders written prior to this date for intramuscular injection of Ativan were misleading for nurses conducting medication administration. During interview (b)(6); (b)(7)(C) argued that the practice of involuntary psychotropic administration is very common and denied that his orders were in error, as “There is no harm in giving the medication before the patient gets agitated to the point of hurting himself.” He also asserted Ativan would not have required an informed consent since it was a PRN/as needed medication. In the absence of a psychotropic informed consent for the use of Thorazine, he replied it may have been filed in someone else’s record, as he was certain he had completed it. On request of this signed consent, the HSA was also unable to locate it. In opposition to (b)(6); (b)(7)(C)’s rationale for not completing a consent form, Ativan had been given regularly, as opposed to on a PRN basis, during the period of October 31, 2017, to November 14, 2017,

October 29, 2017

At 8:30 p.m. (b)(6); (b)(7)(C) documented VOLKOV took his night time medications, along with Ativan 2 mg orally for anxiety, as verified by the MAR. There is no progress note documentation, however, to describe anxiety or agitation which would justify the administration of PRN Ativan. Of note, there was no documentation the prior day of **October 28, 2017**.

October 30, 2017

At an undocumented time, (b)(6); (b)(7)(C) assessed VOLKOV for his complaint of left inguinal hernia pain and request for surgical correction. Vital signs recorded by (b)(6); (b)(7)(C) 12:30 p.m. were as follows: 98.8, pulse 74, respirations 16, and blood pressure 92/54, all within normal limits, except for the low blood pressure. The assessment found the hernia to be “bulging” but reducible and therefore, not meeting criteria for surgical correction. During interview (b)(6); (b)(7)(C) stated the hernia could have caused the small bowel obstruction¹⁴. As previously noted, the left inguinal

¹⁴ Small bowel obstruction is a blockage in the small intestine, usually caused by scar tissue, **hernia**, or cancer.

hernia was not included on the Master Problem List to serve as communication to other nurses and providers, as well as to ensure provider follow-up during future clinical encounters. VOLKOV was educated about inguinal hernias, and he agreed to the decision not to proceed with surgical correction. A clinical follow-up was not ordered. Of note, there was no mention as to whether or not a hernia belt authorized on September 12, 2017, was accessible or being used.

At 2:00 p.m., an unidentified nurse documented VOLKOV was becoming agitated in his cell, repeatedly yelling “One case, one judge”. He requested Ativan to help “his head”. (b)(6); (b)(7)(C) renewed the Ativan order, 2 mg by mouth for three days, as needed, absent a directive to administer the drug intramuscularly if the oral dose was refused. According to the MAR, one dose of medication was administered, although the time is not noted.

October 31, 2017

At 11:28 a.m., LMHC (b)(6); (b)(7)(C) documented a Mental Health Rounds/Contact Form, as a follow-up from the October 27, 2018, encounter. VOLKOV was described as disheveled and unshowered. He was fully oriented and offered good eye contact. While cooperative, his mood was irritable. When asked if he wanted to hurt himself or anyone else, he replied he wasn’t sure. He then “rambled on” about his pending court. It was noted by LMHC (b)(6); (b)(7)(C) that he responded better to men, most likely because of his culture. He remained on suicide watch, with follow-up planned for October 31, 2017, which is deemed to be an error, with the next follow-up being November 1, 2017.

At an undocumented time (b)(6); (b)(7)(C) completed a Psychiatric Progress Note. A language of preference and use of interpretation service were not addressed. The subjective note states VOLKOV had no prior mental health history but was now agitated, banging his head and screaming while on suicide watch. He continued to express thoughts of self-harm, stating, “I just want to die. You don’t deport me to Russia.” He added, “Two months ago I was a different man. I am sitting like an idiot here.” His speech was coherent, and his thought content was unremarkable. He denied active hallucinations but stated “I have seizure.” It is unknown if he did in fact have an undocumented seizure, or if he meant he had a seizure in the past. The reviewer believes the use of effective interpretation service would have been prudent to clarify this claim. He was described as disheveled, agitated, overly dramatic, depressed, and anxious. He was diagnosed with acute stress disorder and response to treatment was deemed “Partial”. At 7:20 p.m., (b)(6); (b)(7)(C) discontinued previous orders for Ativan and started Ativan 2 mg by mouth twice daily for 30 days and started Thorazine¹⁵ 50 mg by mouth twice daily. Of note, the Ativan was not a PRN order but was to be administered regularly twice daily. A review of the MAR verifies the first dose was administered the morning of November 1, 2017, and it was regularly

¹⁵ Thorazine (*chlorpromazine*) is a psychotropic medication used to treat behavior disorders.

administered and accepted twice daily until the evening dose on November 7, 2018, at which time the order was changed. VOLKOV was also compliant with Thorazine treatment. The Abnormal Involuntary Movement Scale (AIMS)¹⁶ on this date was normal with a score of zero. The next AIMS score with the same findings was documented on November 9, 2017. This was the last one done for the remainder of the VOLKOV's detention period. During interview I (b)(6); (b)(7)(C) stated AIMS should be done every six months when a detainee is receiving high risk psychotropic medication, such as Thorazine. The next follow-up was to be scheduled in two weeks.

November 1, 2017

At 11:00 a.m., an unidentified nurse documented she provided Gatorade. At 2:25 p.m., LMHC (b)(6); (b)(7)(C) documented a Mental Health Rounds/Contact Form, documenting that VOLKOV stated he wanted to kill himself. He presented as alert and cooperative, with a dysphoric mood. He was still talking about his court case but was redirected to talk about his girlfriend who he believed abandoned him. He appeared depressed over this. He continued stating he trusted no one and would not until he knew the outcome of the court case on November 8, 2017. LMHC (b)(6); (b)(7)(C) noted he had been seen by (b)(6); (b)(7)(C) on the previous day, October 31, 2017 and was placed on mental health medications for stress. He remained on suicide watch because he verbalized wanting to die. He was scheduled for follow up on November 2, 2017.

November 2, 2017

At 11:28 a.m., LMHC (b)(6); (b)(7)(C) documented a Mental Health Rounds/Contact Form as follow-up. He was observed sitting on the side of his bed with continued ranting, "One court, one prison." He stated he would like to be in a regular unit, but he continued to refuse to articulate how he intended to keep himself safe. Suicide watch was continued.

At 4:30 p.m., RN (b)(6); (b)(7)(C) documented VOLKOV was still housed in medical on suicide watch. He did not respond to questions in English and switched between languages. He did respond to orders positively, however. (b)(6); (b)(7)(C) advised (b)(6); (b)(7)(C) of (b)(6); (b)(7)(C) request to have the Tegretol increased. (b)(6); (b)(7)(C) prescribed, per verbal order, a dosage increase in Tegretol to 400 mg twice daily for 30 days, doubling the previous dosage. The reviewer believes (b)(6); (b)(7)(C) may have requested this increase following the October 31, 2018, statement by VOLKOV, "I have seizure". Nonetheless, the medication increase was inappropriate in the absence of (b)(6); (b)(7)(C) evaluation and order for a Tegretol level after the first month of dosing, to ensure the doubling of the dosage was within therapeutic range, without risk of serious adverse effects.

November 3, 2017

¹⁶ AIMS, Abnormal Involuntary Movement Scale, is a test to determine the presence of potentially serious side effects from psychotropic medications.