## CONCLUSIONS

### Medical

### Compliance Findings

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

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

    - Radiology technician Sionson's license was not primary source verified. RN (b)(6); (b)(7)(C) license was issued on December 28, 2017, but not primary source verified until November 5, 2019.

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

    - During intake screening on September 19, 2019, ABIENWI reported he was a victim of sexual abuse in December 2017. (b)(6); (b)(7)(C) did not refer him for assessment by a mental health practitioner.

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

    - Documentation of emergency first aid training within the past year was not included in the training records of the six medical professionals involved in ABIENWI's care. RN (b)(6); (b)(7)(C) last received first aid training on April 28, 2018; (b)(6); (b)(7)(C) last received training on March 14, 2018; and (b)(6); (b)(7)(C) had no record of first aid training.

In addition, ERAU notes the following policy violation:

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

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

- (b)(6); (b)(7)(C) credential file does not have documentation of initial orientation and nurse competency training; (b)(6); (b)(7)(C) last received competency training on April 28, 2018; and (b)(6); (b)(7)(C) last received the training on March14, 2018.

**Area of Concern**

Given the circumstances, (b)(6); (b)(7)(C) exercised appropriate nursing judgment by contacting EMS when she could not reach the on-call provider on September 26, 2019. (b)(5) (b)(5) (b)(5) Notification would have allowed review of the reasons the RN was unable to reach the provider.

**Security**

**Compliance Findings**

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

**Area of Concern**

(b)(5) (b)(5) Archiving records is an expected and necessary practice; however, cataloging and storage in a manner that assures availability and analysis is part and parcel of a record retention plan that supports transparency and accountability.

(b)(6); (b)(7)(C) completed an entry initiated by Offic(b)(6); (b)(7)(C) t 3:10 p.m., documenting that ARRIAGO coded and his death was pronounced at that time.[121]

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

## CONCLUSIONS

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

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

   - An EKG ordered by(b)(6); (b)(7)(C) the time of the initial physical assessment on July 16, 2019 was not completed, and laboratory testing scheduled for July 17, 2019, was delayed one day, to July 18, 2019.

   - When ARRIAGO approached Captain(b)(6); (b)(7)(C) after he left the dining room on July 20, 2019, she recognized that he required medical attention and directed his escort to medical via wheelchair. However, despite her determination that ARRIAGO needed a wheelchair, she did not notify medical personnel that she was sending a detainee to the clinic, nor did she direct the escorting officer to enter through the back door rather than waiting area to signify more immediate attention may be required. (b)(5)

[121] See logbook for Off-Site Hospital Officer post, dated July 24, 2019. Office(b)(6); (b)(7)(C) ompleted no log entries after she documented the Code Blue at 2:40 p.m., including notification of her supervisors; instructions received; arrival of coroner and police department personnel if either or both occurred during her shift; and time authorized to return to the facility. Neither Officer(b)(6); nor her partner, Officer (b)(6); wrote incident reports describing events prior to and following ARRIAGO's death. ERAU's analysis of Post Order COR-PO-19, Off-Site Hospital Officer, and SDC policy 14-100, Detainee Death Procedures, found no requirements addressing deaths occurring at hospitals.

[122] *See* Chain of Custody form dated July 24, 2019.

[123] *See* email from (b)(6); (b)(7)(C) ated August 2, 2019, detailing ERO personnel involved and status of detainee's property.

[124] *See* email from(b)(6); OIC ICE, dated August 28, 2019.

- After the officer in the medical waiting room notified nursing staff that ARRIAGO was present, no nurses entered to visually observe him or ask his complaint. Despite the absence of evidence that there were other patients in the clinic at the time, nursing staff did not assess him for 36 minutes after he arrived in the waiting room, constituting a delay in care.

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

   - Evidence of a dental screening was not included in the medical file.

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

   - Officers did not use language assistance to complete ARRIAGO's admission processing.

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

   - The custody classification worksheet does not indicate language used during the interview; the section was left blank.

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

   - Due to what Captain (b)(6); called an oversight, ARRIAGO's housing unit was unsupervised for approximately five and a half hours on July 20, 2019, from start of shift at 6:00 a.m. to 11:24 a.m. After Officer (b)(6); assumed the post at 11:24 a.m., he left the unit unsupervised for 11 minutes, from 11:44 a.m. to 11:55 a.m., and for an hour and five minutes, from 11:58 p.m. and 1:03 p.m.

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

- Both before and after Officer (b)(6); (b)(7)(C) arrival on the unit, detainees moved in and out of the housing unit at will without accountability or documentation of their movement.

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

   - Officer (b)(6); (b)(7)(C) did not adequately supervise the unit. The video evidence shows he made only one, partial security round in two hours after he arrived on the post, during which he did not look in cells and which he did not log. While seated at the officer's station, video evidence does not support that he actively monitored detainee activity.

(b)(5)

**Areas of Concern**

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

- As noted in the above deficiency, Captain (b)(6); (b)(7)(C) did not notify medical that ARRIAGO was en route to the clinic for abdominal pain, and did not instruct Officer (b)(6); (b)(7)(C) to take him to the clinic's examination area entrance rather than the waiting room. ARRIAGO waited for 36 minutes before he received medical attention, in part due to Captain (b)(6); (b)(7)(C) ctions, and in part because of the facility's practice of allowing detainees to seek healthcare services on walk-in basis. Specifically, the practice does not include procedures that require nursing staff to determine priority of care for walk-in patients based on triage of the complaint. (b)(5) (b)(5)

- Although not germane to ARRIAGO's care and custody, the security lapses incidentally discovered by ERAU are of significant concern. Specifically, Captain (b)(6); (b)(7)(C) failure to staff the housing unit for more than half the shift, Officer (b)(6); (b)(7)(C) absenting himself from the post without relief, and unrestricted, unaccounted for movement of detainees in and out of the housing unit. Combined and individually, these practices jeopardize facility security, and staff and detainee safety. (b)(5) (b)(5)

- Office (b)(6); (b)(7)(C) nade only five entries to the 6A housing unit logbook after he assumed the post on July 20, 2019. The first falsely documents that he arrived at 11:00 a.m., 24 minutes before the video shows he entered. The subsequent entries include no security checks, although as noted above, he appeared to make at least a partial round when he arrived. Officer (b)(6); did not log accurately and clearly, his time off post, and did not document detainee movement, including for the lunch meal.

- The officer assigned to the medical department did not adequately supervise two detainee workers in the waiting room on July 20, 2019. While the detainees ate lunch, one concealed an item in a plastic bag under his shirt. After they finished lunch, one pushed the intercom button, following which the control officer opened the door and both detainees exited the medical waiting area without pat search and discovery of the concealed item.

- Officers assigned to the hospital detail did not make entries to the hospital logbook in strict adherence with Post Order, COR-PO-19, Off-site Hospital Officer. Most notably, they did not consistently document required notification and supervisory approval when they removed and did not replace restraints, whether or not appropriate from a medical standpoint, and did not clearly document restraints in place during mandated checks. In addition, the officers present at the time of ARRIAGO's death did not complete a log entry contemporaneously documenting pronouncement of death, and events that occurred thereafter.

- The officers present at the time of ARRIAGO's death also did not complete incident reports. Post Order COR-PO-19, Off-site Hospital Officer, and facility policy, 14-100, Detainee Death Procedures, are silent on expectations for officers following the death of a detainee, including submission of incident reports and completion of after action reviews. ARRIAGO's transport to the hospital did not follow a medical emergency for which review of actions surrounding the emergency would have been appropriate. However, documentation in the form of written reports by officers present at the hospital at the time of a detainee's death, up to and including transferring custody of the body, supports accountability.

# APPENDIX
# Laboratory Results

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

[125] Absolute Neutrophils are white blood cells that fight infection. Elevated neutrophils can indicate malnutrition, malignancies, or bone marrow depression.
[126] Basophils are a type of white blood cells that fight infection.
[127] Eosinophils are a type of white blood cells that fight infection.
[128] Hematocrit is the ratio of the volume of red blood cells to the total volume of blood. A low hematocrit can signify anemia, hemodilution, or leukemia.
[129] Hemoglobin is the protein molecule in red blood cells that carries oxygen from the lungs to the body's tissues and returns carbon dioxide from the tissues back to the lungs. A low hemoglobin signifies anemia.

On July 31, 2019, Officer A (b)(6); (b)(7)(C) released ARRIAGO's personal property to Captain (b)(6); (b)(7)(C) who then released it to Deportation Officer (DO) (b)(6); (b)(7)(C)

On August 2, 2019, SDDO (b)(6); (b)(7)(C) ook custody of ARRIAGO's property.[131] The Mexican Consulate declined to accept the property when offered by ERO because they were unable to confirm ARRIAGO was a Mexican citizen.[132] ERO then returned the property to SDC to be held in storage in the event the Mexican Consulate verified ARRIAGO's citizenship.

On August 6, 2019, SDDO (b)(6); (b)(7)(C) -mailed Deputy Field Office Director (DFOD) (b)(6); (b)(7)(C) informing him that DOs from ERO (b)(6); (b)(7)(C) had visited ARRIAGO's last known residence in an attempt to obtain information from former neighbors about his next of kin but were unsuccessful.[133]

On November 6, 2019, the State of Georgia Associate Medical Examiner (b)(6); (b)(7)(C) documented ARRIAGO's cause of death as valvular heart disease with cardiomegaly and hepatic cirrhosis, and the manner of death as natural.[134]

On January 28, 2020, the Georgia Department of Public Health issued ARRIAGO's death certificate and documented his cause of death as valvular heart disease with cardiomegaly and hepatic cirrhosis.[135]

## FINDINGS

ERAU reviewed the medical care SDC provided ARRIAGO, as well as the facility's efforts to ensure he was safe and secure while detained at the facility. ERAU found SDC failed to comply with 7 of the requirements of the ICE PBNDS 2011. Additionally, ERAU has included other areas of concern that are not covered by the PBNDS 2011. These deficiencies and areas of concern are noted for informational purposes only and should not be construed as contributory to the detainee's death.

1. ***Admission and Release,* Section (II)(9):** "The facility shall provide communication assistance to detainees with disabilities and detainees who are limited in their English Language Proficiency (LEP)… The facility will also provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translations services, to provide them with meaningful access to its programs and activities."

    - On July 10, 2019, during intake, several officers did not utilize interpretation services or provide forms in a language ARRIAGO could understand.

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[130] *See* Chain of Custody form, dated July 24, 2019.
[131] *See* DO (b)(6); (b)(7)(C) e-mail: "RE: Information Request: OPR Detainee Death Review of Perez [sic] ARRIAGO-Santoya #A216 428 457," dated August 2, 2019.
[132] *See* Officer in Charge (b)(6); e-mail: "RE: Personal Property for PEDRO ARRIAGO-SANTOYA (#A216 428 457)," dated August 28, 2019.
[133] *See* SDDO Eccles e-mail: "FW: Next of kin for Pedro ARRIAGO-Santoya, A216 428 457," dated August 6, 2019.
[134] *See* Exhibit 2: State of Georgia, Autopsy Official Report, dated November 6, 2019.
[135] *See* Exhibit 3: Georgia Department of Public Health, Georgia Death Certificate, State File Number: 2019GA000085460, signed January 28, 2020.

2. ***Custody Classification System,* Section (V)(C):** "Classification staff shall utilize translation services when necessary."

   - On July 10, 2019, Office(b)(6); (b)(7)(C) did not use language interpretation services during ARRIAGO's classification interview.

3. ***Facility Security and Control,* Section (V)(A):** "Each facility shall ensure that it maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse assault, other forms of violence or harassment to prevent significant self-harm and suicide."

   - On July 20, 2019, Captain(b)(6); (b)(7)(C) confirmed that due to her oversight, housing unit 6A was unsupervised from 6:00 a.m. to 11:24 a.m., when Officer(b)(6); (b)(7)(C) arrived at the unit. After Office(b)(6); (b)(7)(C) assumed his post, more than an hour after Captain(b)(6); (b)(7)(C) assigned him, he then left the unit unsupervised twice, for 11 minutes from 11:44 a.m. to 11:55 a.m., and for an hour and five minutes from 11:58 a.m. to 1:03 p.m.

(b)(5)

4. ***Facility Security and Control*, Section (V)(D)(1):** "As prescribed by standard "2.9 Post Orders," staff shall observe, supervise and control movement of detainees from one area to another. No detainee may ever be given authority over, or be permitted to exert control over, another detainee."

   - On July 20, 2019, before and after Offic(b)(6); (b)(7)(C) arrival to housing unit 6A, detainees entered and exited the housing unit without accountability or documentation of their movement.

(b)(5)

5. ***Facility Security and Control,* Section (V)(F):** "Frequent unannounced security inspections shall be conducted on day and night shifts to control the introduction of contraband; identify and deter sexual abuse of detainees; ensure facility safety, security and good order; prevent escapes; maintain sanitary standards; and eliminate fire and safety hazards ... Each officer who assumes a post assignment shall conduct a security check of the area, record the results in the post logbook, and prepare and submit maintenance work requests as necessary."

   - On July 20, 2019, video surveillance shows Offic(b)(6); (b)(7)(C) made only one partial security check two hours after arriving to housing unit 6A; however, during that check he did not

look in the cells or make entries in the logbook, to include his departure from post or detainee movement.

(b)(5)

6. ***Medical Care*, Section (V)(A)(2)(3):** "Every facility shall directly or contractually provide its detainee population with the following: … 2) Medically necessary and appropriate medical, dental, and mental health care and pharmaceutical services; 3) Comprehensive, routine and preventive health care, as medically indicated."

   - On July 16, 2019, PA (b)(6); (b)(7)(C) ordered an EKG and laboratory tests; however, nursing staff never completed the EKG, and although PA (b)(6); (b)(7)(C) clarified during her interview that her intent was for the laboratory tests and EKG to be completed on July 18, 2019, the medical record shows it should have been completed on July 17, 2019.

   - On July 20, 2019, after ARRIAGO arrived at the medical waiting room, the medical officer notified nursing staff that ARRIAGO was present; however, nurses did not visually observe him or ask about his complaint until 36 minutes after his arrival. ERAU notes SDC's procedures do not require either nursing staff to determine priority of care for walk-in patients, security personnel to advise medical in advance of bringing detainees to the medical clinic, or a coordinated effort to determine priority of care for patients escorted to medical by security.

7. ***Medical Care*, Section (V)(R):** "An initial dental screening shall be performed within 14 days of the detainee's arrival. The initial dental screening may be performed by a dentist or a properly trained qualified health provider."

   - On July 16, 2019, PA (b)(6); (b)(7)(C) completed ARRIAGO's initial physical examination; however, there is no evidence of a dental screening in the medical record.

## AREAS OF CONCERN

Although not violations of the ICE PBNDS 2011, ERAU noted the following concerns regarding ARRIAGO'S medical care, safety, and security at SDC:

1. *CoreCivic Housing Unit Post Order*, Section (III)(B)(1): "Perform random pat searches of inmates/residents entering or exiting the unit."

   - On July 20, 2019, Office (b)(6); (b)(7)(C) d not randomly pat search detainees that entered or exited the housing unit.

2. *CoreCivic Medical Post Order,* Section (III)(D): "Pat search all detainees as they enter and exit the infirmary."

   - On July 20, 2019, while in the medical waiting room, Officer (b)(6); (b)(7)(C) did not adequately supervise two detainee workers who sat in the waiting room to eat their lunch. While the detainees ate lunch, one detainee concealed bread in a plastic bag under his shirt. After they finished eating, they pushed the intercom button and exited the waiting room without a pat-down search, allowing them to depart with the concealed item undiscovered.

3. *CoreCivic Off-Site Hospital Officer Post Order*, Section (III)(E)(2): "When in a hospital bed, the inmate/resident will have two (2) appendages/extremities secured to the movable bed at all times. If the inmate/resident cannot be restrained to the bed with two (2) appendages/extremities immediately notify the Shift Supervisor. Any exception to this rule must be approved by the on-duty Shift Supervisor prior to the removal of mechanical restraints."

   - Officers assigned to hospital duty did not consistently document required notification and supervisory approval when they removed restraints.

4. *CoreCivic Off-Site Hospital Officer Post Order*, Section (III)(E)(7): "[Officers] are required to conduct restraint checks every fifteen (15) minutes and must log completion of the check in the post logbook."

   - On July 20, 2019, between 5:55 p.m. and 7:21 p.m., Officer (b)(6); (b)(7)(C) did not document any restraint checks.

   - On July 21, 2019, between 12:00 a.m. to 2:00 a.m. and 4:00 a.m. to 7:00 a.m., Officer (b)(6); (b)(7)(C) documented restraint checks every 30 minutes rather than every 15 minutes.

5. The officers present at the time of ARRIAGO's death did not complete a logbook entry *contemporaneously* documenting pronouncement of death and the events that occurred thereafter, nor did they complete incident reports. *CoreCivic Off-site Hospital Officer Post Order* COR-PO-19 and Facility Policy 14-100, *Detainee Death Procedures*, are silent on expectations for officers following the death of a detainee, including submission of incident reports and completion of after-action reviews. While ARRIAGO's transport to the hospital did not follow a medical emergency, for which an after-action review surrounding the emergency would have been appropriate, written reports by officers present at the hospital at the time of a detainee's death supports accountability.

**EXHIBITS**

1. ARRIAGO Detainee Death Review Health and Security Compliance Analysis, dated October 15, 2019.
2. State of Georgia, Autopsy Official Report, dated November 6, 2019.
3. Georgia Department of Public Health, Georgia Death Certificate, State File Number: 2019GA000085460, signed January 28, 2020.