



Office of Information Governance and Privacy

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



U.S. Immigration
and Customs
Enforcement

April 8, 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
Sixth Interim Production

Dear Mr. Evers:

This letter is the sixth 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 524 pages of records were reviewed for this interim production. The 524 pages of records were located pursuant to a search of the ICE, Office of Professional Responsibilities (OPR). Of those 524 pages, 21 pages were determined to be non-responsive and 146 pages are deemed duplicates. The remaining 357 pages of records have been marked 2020-ICLI-00057-2059 through 2020-ICLI-00057-2415. Upon review, ICE has determined that portions of the 357 pages will be withheld pursuant to FOIA Exemptions (b)(6), (b)(7)(C) and (b)(7)(E) of the FOIA as described below:

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.

www.ice.gov

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
JR
VELASCO JR
Senior Paralegal, ICE FOIA for

Digitally signed by
ROLANDO VELASCO
Date: 2021.04.08
15:59:19 -04'00'

Fernando Pineiro Jr.
(A)FOIA Officer

Enclosure(s): 357 page(s)

cc:

Michael A. Tilghman II
Assistant United States Attorney
Civil Division
United States Attorney's Office
for the District of Columbia

555 Fourth Street, N.W.
Washington, D.C. 20530
(202) 252-7113

(b); (b)(7)(C)	
p)(6); (b)(7)(C)	
c. Huy Chi Tran 18-CRCL-1264	
d. Efraín Romero de la Rosa 18-CRCL-1339	
e. Augustina Ramirez-Arreola 19-CRCL-1377	
f. Wilfredo Padron 19-CRCL-1574	
g. Guerman Volkov 19-CRCL-1628	
h. Abel Reyes-Clemente 19-CRCL-1923	
i. Simratpal Singh 19-CRCL-1929	
j. Yimi Alexis Balderramos-Torres 19-CRCL-2069	
k. Pedro Arriago-Santoya 19-CRCL-2102	
l. Roberto Rodriguez-Espinoza 19-CRCL-2255	
m. Nebane Abienwi 20-CRCL-2304	
n. Roylan Hernandez-Diaz 20-CRCL-2323	
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p. (b)(6); (b)(7)(C)	
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ez. (b)(6); (b)(7)(C)	

f. Wilfredo Padron	19-CRCL-1574	20-CRCL-2661
i. Simratpal Singh	19-CRCL-1929	20-CRCL-2873

From: (b)(6); (b)(7)(C)
To:
Cc:
Subject: Follow up re: 19-02-ICE-0036
Date: Tuesday, February 4, 2020 2:28:06 PM

Thank you for all of the documents that you have made available to CRCL regarding the death of Wilfredo Padron (A022 776 291). Was a corrective action plan created following this incident? If so, has it been made available to CRCL? If not, could you please provide it to us and let us know what if any action ICE or MCDC has taken to implement the plan?

Thanks,

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

Contract Support Investigator
Compliance Branch
Office for Civil Rights and Civil Liberties
U.S. Department of Homeland Security
202.357.(b)(6);

(b)(6); (b)(7)(C)@associates.hq.dhs.gov

From: (b)(6); (b)(7)(C)
To: ERO CRCL
Subject: 19-08-ICE-0332: Detainee Death Review (Simratpal SINGH)
Date: Wednesday, April 29, 2020 12:16:08 PM
Attachments: SINGH Detainee Death Review_Final.pdf

ERO,

Thank you for all of the documents that you have made available to CRCL regarding the death of Simratpal SINGH (A 201 432 202). Mr. SINGH, who was in U.S. ICE custody at the La Paz County Adult Detention Facility (LPCADF) in Parker, Arizona, was pronounced dead on May 3, 2019 of a reported suicide. According to the ICE Office of Professional Responsibility, External Reviews and Analysis Unit (ERAU), Detainee Death Review (DDR), 23 areas of concern were identified. Please inform CRCL if a corrective action plan was created following this incident? If so, has it been made available to CRCL? If not, could you please provide it to us and let us know what, if any, action ICE or LPCADF has taken to implement the plan?

Thanks,

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

Policy Advisor
Office for Civil Rights and Civil Liberties
U.S. Department of Homeland Security

Tel (202) 351 (b)(6);

(b)(6); (b)(7)(C) q.dhs.gov

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Detainee Death Review Report

Simratpal Singh

Date of Death: May 3, 2019

Alien File Number: 201 432 202

Joint Integrity Case Management System (JICMS) # (b)(6); (b)(7)(C);
(b)(7)(E)

March 30, 2020

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

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DETAILS OF REVIEW

From June 18 to 19, 2019, U.S. Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited the La Paz County Adult Detention Facility (LPCADF) to review the circumstances surrounding Simratpal SINGH's death. ERAU was assisted in its review by contract subject matter experts (SMEs) in correctional healthcare and security who are employed by Creative Corrections, a national management and consulting firm.¹ As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to SINGH, in addition to conducting in-person interviews of individuals employed by LPCADF and the local ICE Enforcement and Removal Operations (ERO) field office.

SINGH was detained at LPCADF from April 30, 2019, through May 2, 2019. SINGH was a La Paz County Sheriff's Office (LPCSO) inmate from April 30, 2019 until the afternoon of May 2, 2019. On May 2, 2019 at 4:39 p.m., upon posting bond, SINGH's custody status changed from an LPCSO inmate to an ICE detainee. Approximately one hour later, LPCADF called a medical emergency after finding SINGH unresponsive in his cell. SINGH would eventually be transferred to the Abrazo West Campus (AWC) hospital from the La Paz Regional Hospital (LPRH), for a higher level of care. SINGH remained at AWC until his death on May 3, 2019. The Maricopa County Office of the Medical Examiner documented SINGH's cause of death as hanging and the manner of death as suicide.

FACILITY PROFILE

LPCADF is owned and operated by the LPCSO under a U.S. Marshals Service (USMS) Inter-Governmental Agreement (IGA), which authorizes ICE to utilize the facility for detainee bed space. LPCADF is authorized by ICE to house male and female detainees for periods less than 72 hours and has an as needed ICE detainee bed capacity.² The contract does not detail specific ICE standards LPCADF is required to comply with; however, the facility is required to conduct a yearly Operational Review Self-Assessment (ORSA) designed to assess the facility's compliance with certain requirements of the ICE National Detention Standards (NDS) 2000. Facility medical care and security are both provided by LPCADF staff. At the time of SINGH's death, the average ICE detainee daily population was three, and the facility housed no other ICE detainees.³

¹ See [Exhibit 1](#): Creative Corrections Healthcare and Security Compliance Analysis.

² See ERO Facility List Report, dated May 6, 2019; see also ERO Records Request, dated May 15, 2019.

³ *Ibid.*

IMMIGRATION AND CRIMINAL HISTORY

On February 5, 2019, U.S. Customs and Border Protection (CBP) arrested SINGH and seven other individuals SINGH was traveling with immediately upon their illegal entry into the United States near Otay Mesa, CA.

On February 12, 2019, CBP transferred SINGH into ICE ERO's custody at the San Luis Regional Detention Center (SLRDC).⁴

On February 20, 2019, ERO Phoenix transferred SINGH to the La Palma Correctional Center (LPCC). (b)(7)(E); (b)(3): Unspecified Statute

(b)(3): Unspecified Statute; (b)(7)(E)

(b)(7)(E); (b)(3): Unspecified Statute

On April 5, 2019, the USCIS Asylum Office in Arlington, VA, notified ICE ERO that th (b)(7)(E); (b)(3): Unspecified Statute

Form I-862, charging inadmissibility pursuant to Sections 212(a)(6)(A)(i) and 212(a)(7)(A)(i)(I) of the Immigration and Nationality Act (INA), as an alien present in the United States without being admitted or paroled, or who, at the time of application for admission, was not in possession of a valid entry document, respectively.⁹

On April 17, 2019, at an unknown time, ICE Deportation Officer (DO) (b)(6); (b)(7)(C) recommended SINGH's bond be set at \$73,500 per a Bond Determination Checklist. At 3:08 p.m. (b)(6); (b)(7)(C) supervisor, ICE Supervisory Detention and Deportation Officer (SDDO) (b)(6); (b)(7)(C) approved SINGH's release on bond for the recommended amount.¹⁰

On April 29, 2019, SINGH posted bond in the amount of \$73,500 and at that time, ERO Phoenix released him from ICE custody.¹¹

⁴ See Department of Homeland Security (DHS) Form I-216, Record of Persons Transferred, dated February 12, 2019. Although the ICE Enforce Alien Removal Module (EARM) records SINGH's SLRDC book-in date as February 9, 2019, ERAU confirmed with both CBP and ICE ERO, the date CBP physically transferred SINGH to SLRDC was February 12, 2019.

⁵ See EARM Detention History, entry dated February 20, 2019; see also EARM Case Actions & Decisions, entries dated February 8 and 21, 2019.

⁶ See DHS USCIS Form I-870, Record of (b)(3): Unspecified Statute; (b)(7)(E) dated March 28, 2019; see also (b)(7)(E); (b)(3): Unspecified Statute dated March 27, 2019.

⁷ See DHS USCIS Form I-870, Record of (b)(7)(E); (b)(3): Unspecified Statute dated March 28, 2019. (b)(6); (b)(7)(C)

¹⁰ See Bond Determination Checklist – Recommended Bond worksheet, dated April 17, 2019; see also DHS Form I-286, Notice of Custody Determination, dated April 17, 2019.

¹¹ See DHS Form I-352, Immigration Bond, dated April 29, 2019.

On April 30, 2019, at 1:07 p.m., the La Paz County Sheriff's Office (LPCSO) arrested SINGH for an alleged assault and sexual assault. At 3:50 p.m., LPCSO booked SINGH into LPCADF.¹²

On May 1, 2019, ERO Phoenix received an Alien Criminal Response Information Management System (ACRIME) notification of SINGH's arrest and book-in at LPCADF and lodged an DHS Form I-247A, Immigration Detainer – Notice of Action, against SINGH with the facility.¹³ On the same date, the Quartzsite Justice Court in Quartzsite, AZ, granted SINGH bond in the amount of \$5,000.¹⁴

On May 2, 2019, at approximately 4:39 p.m., SINGH's custody status changed from an LPSCO inmate to an ICE detainee at LPCADF as SINGH posted bond. On the same date, at an unknown time, the Executive Office for Immigration Review (EOIR) in Tucson, AZ, scheduled SINGH for a master hearing on May 17, 2019.¹⁵

CHRONOLOGY OF EVENTS

As there was a break in custody when ICE released SINGH on bond on April 29, 2019, ERAU is providing a summary of SINGH's medical care at the two ICE detention facilities that housed him prior to his detention at LPCADF for contextual purposes only.

SAN LUIS REGIONAL DETENTION CENTER

On February 12, 2019, at an unknown time, CBP transferred SINGH into ICE custody at SLRDC,¹⁶ where he was housed for 8 days.¹⁷

At 10:10 p.m., an unidentified¹⁸ nurse conducted SINGH's intake screening. Although the nurse did not use an interpreter for the encounter, he or she used an Intake form¹⁹ translated into Punjabi to complete the assessment and documented the following:

¹² See LPCSO Department Incident Report and narrative for incident 190401141; *see also* untitled LPCJ document with Booking Time, dated April 30, 2019. LPCADF is also known as the La Paz County Jail.

¹³ See ICE Significant Incident Report (SIR), dated May 4, 2019. Times listed in this report are based on the time zone in which an action or event occurred.

¹⁴ See La Paz County Bail Receipt and Release Order, dated May 1, 2019.

¹⁵ See ICE SIR, dated May 4, 2019.

¹⁶ SLRDC is contractually obligated to adhere to ICE NDS 2000.

¹⁷ See DHS Form I-216, DHS Records of Persons Transferred, dated February 12, 2019. Although SINGH's ICE EARM profile records that CBP transferred SINGH into ICE custody at SLRDC on February 9, 2019, CBP and SLRDC documents record SINGH's arrival date to SLRDC as February 12, 2019.

¹⁸ See LaSalle Corrections SLRDC Medical Intake Packet: Intake Screening section, dated February 12, 2019. A nurse initialed the LaSalle Medical Intake Packet; however, the individual's initials are illegible. (b)(6); (b)(7)(C) reviewed the Intake Screening form and signed it at 3:22 a.m. on February 13, 2019.

¹⁹ Although the LaSalle SLRDC Intake Screening form is approximately eight pages long, the Punjabi Intake form provided consists of one page with twelve primary questions. It is unclear how this form is used if not accompanied by an interpreter as not all questions solicit a simple yes or no response.

- SINGH's vital signs were within normal limits.²⁰
- SINGH denied pain, disability, and taking any medications currently or in the past year, to include over the counter or herbal supplements.
- SINGH was appropriate in behavior and did not appear to have abnormal physical, mental, or emotional characteristics.
- SINGH denied current or past thoughts of self-harm or suicide.
- There were no abnormal findings associated with SINGH's medical, dental, or mental health assessments.
- SINGH initialed an English copy of the SLRDC General Medical Consent Form.²¹

On February 14, 2019, SINGH's screening for tuberculosis (TB) symptoms came back negative.²²

On February 18, 2019, at 10:50 p.m., Registered Nurse (RN) [REDACTED] conducted SINGH's physical examination.²³ Using an abbreviated Assessment form translated into Punjabi, the RN made the same conclusions as the unidentified nurse, with the exception of documenting SINGH's elevated blood pressure of 127/82.²⁴

On February 19, 2019, the SLRDC Health Authority [REDACTED] (first name unknown), cleared SINGH for travel.²⁵ Another [REDACTED], documented SINGH had no medical, dental, or mental health problems.

SLRDC medical staff did not prescribe SINGH medication during his detention.

LA PALMA CORRECTIONAL CENTER

On February 20, 2019, ICE transferred SINGH to LPCC,²⁶ where he was housed for 68 days.²⁷

At 11:25 a.m., an unidentified RN conducted SINGH's intake screening, utilizing interpretation services, and documented the following:²⁸

²⁰ The average body temperature is 98.6 F; a normal resting heart rate/pulse for an adult ranges from 60 to 100 beats per minute; the normal range for respirations is 12 to 20 breaths per minute; and, according to the American Heart Association (AHA), a normal blood pressure reading is generally characterized as less than 120/80.

²¹ See LaSalle Corrections General Medical Consent Form, dated February 12, 2109.

²² See LaSalle Corrections SLRDC TB Screening and Testing form, dated February 14, 2019.

²³ See LaSalle Corrections SLRDC Medical Intake Packet: Physical Examination/Health Appraisal form, dated February 12, 2019.

²⁴ According to the AHA, this blood pressure reading indicates an elevated blood pressure; an elevated blood pressure is characterized by a systolic reading of 120 to 129 and a diastolic reading less than 80. ERAU notes, no medical staff at any of the three facilities SINGH resided at diagnosed him with hypertension. High blood pressure readings, especially for younger individuals, can be the result of a number of factors such as stress and physical activity.

²⁵ See LaSalle Corrections SLRDC Medical Transfer Summary, dated February 19, 2019.

²⁶ LPCC is contractually obligated to adhere to ICE's Performance Based National Detention Standards (PBNDS) 2011.

²⁷ See ICE EARM Detention History, dated February 20, 2019, to April 29, 2019.

²⁸ The nurse's signature is illegible; however, the nurse listed his or her title as an RN. See CoreCivic LPCC Intake Screening form, dated February 20, 2019.

- SINGH arrived with a transfer form from SLRDC.
- SINGH's vital signs were all within normal limits except for an elevated blood pressure of 120/86.²⁹
- SINGH denied experiencing pain, taking any medications, or having any medical complaints.

SINGH signed an English copy of the LPCC Healthcare Services General Consent form.³⁰ The RN cleared SINGH for general population.

On February 27, 2019, at an unknown time, (b)(6); (b)(7)(C) psychologist, conducted a mental health evaluation using an interpretation service.³¹ Under the mental health status section, the doctor noted SINGH's affect and mood were normal and that SINGH had no suicidal ideation or intent to harm himself. (b)(6); (b)(7)(C) documented that his impression was that SINGH was stable and that no actions needed to be taken in response to his assessment.

On February 28, 2019, at approximately 2:34 p.m., SINGH refused his initial health appraisal.³² (b)(6); (b)(7)(C) family nurse practitioner (FNP), documented that SINGH refused the examination because he stated he did not have any problems, and that she counseled him on the risks of refusing medical care.

On March 5, 2019, at 11:56 a.m., SINGH refused his dental screening as he stated he did not have any dental problems.³³ The nurse educated SINGH on the risks of refusing dental care.

On March 16, 2019, at 12:33 p.m., (b)(6); (b)(7)(C) treated SINGH with over-the-counter medication, acetaminophen (325 mg), 2 tablets, 3 times daily for 4 days, for complaints of a sore throat and non-productive cough,³⁴ utilizing the facility's Upper Respiratory Complaints nursing protocol form. All SINGH's vital signs were within normal limits.

On April 19, 2019, at an unknown time, SINGH submitted a sick call request with a complaint of back pain he said he had experienced for two days.³⁵ At 12:19 p.m. the next day, (b)(6); (b)(7)(C) assessed SINGH, who said his pain was a 6 out of 10, and treated him with over-the-counter

²⁹ According to the AHA, this blood pressure reading indicates stage one hypertension. Stage one hypertension is characterized by a systolic reading of 130 to 139 or a diastolic reading of 80 to 89.

³⁰ See CoreCivic Healthcare Services General Consent form, dated February 20, 2019.

³¹ See CoreCivic Comprehensive Mental Health Evaluation form, dated February 27, 2019.

³² See CoreCivic Refusal to Accept Medical Treatment form; see also CoreCivic Inmate/Resident Health Appraisal form, dated February 28, 2019. The FNP did not document if she utilized interpretation services to communicate with SINGH.

³³ See CoreCivic Refusal to Accept Medical Treatment form, dated March 5, 2019; see also Dental Progress Notes by (b)(6); (b)(7)(C) Doctor of Dental Surgery, dated March 5, 2019. Medical staff did not document if they utilized interpretation services to effectively communicate with SINGH.

³⁴ A non-productive cough is one that does not produce phlegm or mucus. See CoreCivic Upper Respiratory Complaints form, dated March 16, 2016; See also SINGH's Medication Administration Record (MAR). The RN did not note if he utilized interpretation services to effectively communicate with SINGH. The authorizing provider for the medication was (b)(6); (b)(7)(C).

³⁵ See SINGH's Sick Call Request, dated April 19, 2019; see also Back Pain form, dated April 20, 2019. The RN did not note if he utilized interpretation services to effectively communicate with SINGH. The authorizing provider for the medication was (b)(6); (b)(7)(C).

medication ibuprofen (200 mg), 2 tablets, 3 times daily for 4 days, utilizing the facility's Back Pain nursing protocol form. SINGH's vital signs were all within normal limits.

On April 29, 2019, at approximately 3:40 p.m.,³⁶ ICE Enforcement and Removal Assistant Mimi Forones processed SINGH's bond. At an unspecified time that day, ICE transported SINGH by bus from LPCC to Eloy Detention Center (EDC),³⁷ to be officially processed out of ICE custody. At this time, SINGH was no longer in ICE custody.

At 7:08 p.m.,³⁸ a bus contracted by ICE to transport detainees who have been released from ICE custody at LPCC and EDC departed for the Phoenix Greyhound station.

SINGH'S NON-ICE ARREST EVENT

On April 30, 2019, at approximately 12:00 p.m., LPCSO Deputy (b)(6); (b)(7)(C) responded to a call from a Greyhound bus driver reporting that a female passenger had allegedly been sexually assaulted while the bus was heading westbound on Interstate 10, near Ehrenberg, AZ.³⁹ Deputy (b)(6); (b)(7)(C) noted that when he attempted to speak with SINGH, he did not speak English.

At approximately 1:07 p.m., Deputy (b)(6); (b)(7)(C) placed SINGH under arrest at the direction of another detective, and an Arizona Department of Public Safety state trooper transported SINGH to LPCADF.

LA PAZ COUNTY ADULT DETENTION FACILITY⁴⁰

April 30, 2019

At approximately 3:50 p.m.,⁴¹ LPSCO Sergeant (Sgt. (b)(6); (b)(7)(C)) and Corporal (Cpl. (b)(6); (b)(7)(C)) (b)(6); (b)(7)(C) booked SINGH into LPCADF as a county inmate.⁴² SINGH had a backpack, jacket, pants, miscellaneous papers, a shirt, and a pair of shoes in his possession.⁴³

At 7:20 p.m., RN (b)(6); (b)(7)(C) the LPCADF Medical Services Administrator, signed off on SINGH's intake screening and documented the following:⁴⁴

³⁶ See ICE Immigration Bond receipt, Form I-352, MIL-C-19-00180; see also Mimi Forones email: 'Bond Question,' dated September 13, 2019.

³⁷ See Jason Rheinfrank email: "ICE OPR Bond Question," dated September 16, 2019.

³⁸ *Ibid.*

³⁹ See LPCSO Investigation Narrative for incident 190401141 by LPCSO Deputy (b)(6); (b)(7)(C)

⁴⁰ At this time, SINGH entered LPCSO custody. The following information is included for contextual purposes as SINGH's custody status does not change to an ICE detainee at LPCADF until approximately 4:39 p.m. on May 2, 2019.

⁴¹ See untitled LPSCO document with booking time, dated April 30, 2019; see also LPCSO Booking Sign Off Sheet, undated.

⁴² ERAU interview with Commander (CDR) (b)(6); (b)(7)(C) dated June 18, 2019; see also LPCSO Booking Sign Off Sheet, undated.

⁴³ See untitled LPSCO property form, dated April 30, 2019.

⁴⁴ See Risk and Needs Screening form, dated April 30, 2019.

- SINGH's temperature was elevated at 100.1,⁴⁵ his pulse was elevated at 108 beats per minute, his blood pressure was elevated at 133/79, and his respiratory rate was 20 breaths per minute. He weighed 195 pounds.
- (b)(6); (b)(7)(C) selected "no" beside the fields "have you had a skin test for TB" and "are you allergic to any medications."⁴⁶
- (b)(6); (b)(7)(C) left all other fields on the screening form blank, including those about substance abuse, suicide risk, medical health, TB, dental problems, and consent for services.

(b)(6); (b)(7)(C) stated she was unable to complete SINGH's intake screening as he did not speak English and she was not aware LPCADF had a language line at the time.⁴⁷ Furthermore, she was unable to clarify how she knew that SINGH was not allergic to or taking any medications. RN (b)(6); (b)(7)(C) recalled the only words SINGH was able to convey to the nurse in English were "court" and "lawyer."

In a late chart note entry for this encounter, (b)(6); (b)(7)(C) documented that SINGH spoke Punjabi, which made communication difficult.⁴⁸ She also stated SINGH did not exhibit any suicidal or homicidal ideations, that his vital signs were within normal limits, and that he did not appear in distress. (b)(6); (b)(7)(C) stated that she based her determination that SINGH was not suicidal on her observation of SINGH's appearance. She clarified that she concluded SINGH's vital signs were within normal limits based on her knowledge and experience as the facility did not have nursing protocols that established normal vital sign ranges and thresholds or guidelines for subsequent nursing action. The last note (b)(6); (b)(7)(C) entered in SINGH's medical record related to this encounter was that LPCADF housed SINGH in accordance with the facility's protocol.

CDR (b)(6); (b)(7)(C) explained that because SINGH's charges included a sexual offense, LPCADF assigned him to a single-cell unit.⁴⁹ (b)(6); (b)(7)(C) explained that LPCADF assigned SINGH to the juvenile cell for his own protection, consistent with standing procedure for inmates

⁴⁵ According to the Mayo Clinic, a normal temperature is 98.6 degrees Fahrenheit. Oral temperature readings of 100 degrees Fahrenheit or higher can indicate a fever is present.

⁴⁶ A PPD skin test occurs when a solution is injected into the skin to determine whether a person has been infected with TB. ERAU notes that once (b)(6); (b)(7)(C) selected "no" to the TB question, the CorEMR system automatically created a task for LPCADF medical staff to administer a PPD skin test in 7 days, on May 7, 2019. During her interview with ERAU on June 18, 2019, (b)(6); (b)(7)(C) stated officers sometimes house inmates/detainees in general population before they are assessed by medical or PPD's are placed. During her interview with ERAU on June 18, 2019, Licensed Practical Nurse (LPN) (b)(6); (b)(7)(C) also stated officers had a habit of putting arrestees in cells before they were medically cleared and did not always notify medical there was a new arrestee that had been booked in.

⁴⁷ ERAU interview with (b)(6); (b)(7)(C) dated June 18, 2019; *see also* LPCADF CorEMR Chart Notes late entry for April 30, 2019, dated May 7, 2019. In his interview with ERAU on June 18, 2019, (b)(6); (b)(7)(C) stated after SINGH's death, he learned for the first time, after working at the facility for seven and a half years, that LPCSO dispatch, located in the same building as LPCADF, had access to a language line.

⁴⁸ ERAU notes LPCADF medical staff entered all chart notes related to SINGH into CorEMR after his death. During her interview with ERAU on June 18, 2019, (b)(6); (b)(7)(C) stated she did not think to document her actions in the chart notes until she was directed to do so (it is unclear who directed medical staff to document their actions). When asked if the facility had nursing protocols, (b)(6); (b)(7)(C) stated they were very scant.

⁴⁹ ERAU interview with (b)(6); (b)(7)(C) dated June 18, 2019.

charged with sexual offenses.⁵⁰ (b)(6); (b)(7)(C) confirmed for ERAU that there is no documentation of SINGH's housing placement on this date, no administrative segregation order, and no documented supervisory authority for the placement. Additionally, staff did not initiate a segregation log to record activities, privileges, and rounds by officers, supervisors, and medical staff.⁵¹

May 1, 2019

At approximately 9:00 a.m.,⁵² the Quartzsite Justice Court set SINGH's bail at \$5,000 during his initial court appearance.

At 7:44 p.m., ICE received an Immigration Alien Query (IAQ) notice of SINGH's arrest.⁵³ As a result, at approximately 9:26 p.m.,⁵⁴ ERO Phoenix DO (b)(6); (b)(7)(C) looked into the information sent by the ICE LESC and prepared a detainer to place a hold on SINGH at LPCADF.⁵⁵

At 8:39 p.m.,⁵⁶ an unknown officer conducted LPCADF's first and only documented security round of the cell⁵⁷ SINGH was housed in.

⁵⁰ See Mohave County Sheriff's Office (MCSO) Incident Report 19-016384 interview transcript with (b)(6); (b)(7)(C) dated May 2, 2019. MCSO investigated the death of SINGH in LPCSO/ICE custody as MCSO and LPCSO assist one another with each other's internal investigations to maintain impartiality.

⁵¹ ERAU interview with (b)(6); (b)(7)(C) dated June 18, 2019.

⁵² See Victim Request for, or Waiver of, Pre-Conviction and/or Pre-Adjudication Rights form, entry dated May 1, 2019; see also Determination of Release Conditions and Release Order or Commit before Conviction, dated May 1, 2019.

⁵³ See IAQ notice, dated May 1, 2019. When a federal, state, or local law enforcement entity makes an arrest and fingerprints a subject, the individual's fingerprints are submitted to the FBI and compared against DHS databases, which creates an IAQ. If a match occurs, ICE's Law Enforcement Support Center (LESC) generates an Immigration Alien Response (IAR), which provides information regarding the subject's immigration status, criminal history, and other important biographical information to ERO teams in the field for review.

⁵⁴ See (b)(6); (b)(7)(C) email "ICE OPR Detainer Question," dated September 18, 2019; see also ACRIME Comment Date/Time field, dated May 1, 2019.

⁵⁵ *Ibid.* Because LPCADF could not locate that detainer at the time of this review, ERAU was unable to confirm if (b)(6); (b)(7)(C) notified LPCADF of a possible detainer on May 1, 2019.

⁵⁶ See Download Details report, entry dated May 1, 2019.

⁵⁷ LPCADF housed SINGH in its juvenile cell, which is located in a small secluded area of the facility where no other cells exist; the cell was equipped with a call button/intercom device. LPCADF uses the juvenile cell as overflow when the intake cells are occupied and when individuals need to be placed in protective custody. During his telephonic interview with MCSO detectives on May 22, 2019, (b)(6); (b)(7)(C) stated SINGH consistently used the call button that connected him with the LPCADF Tower Control (central control) in Booking to report he could not breathe. (b)(6); (b)(7)(C) further explained that he thought SINGH may have been claustrophobic and that when he would check on SINGH in the juvenile cell, he did not sense any issues with the air but added that in his experience inmates often claim health issues that may or may not be valid to simply get out of the cell. Additionally, (b)(6); (b)(7)(C) told MCSO detectives SINGH may have been housed in the juvenile cell because the facility already had two inmates on suicide watch in the two single cells located within the intake/booking area.

May 2, 2019

At 7:18 a.m., an unknown officer conducted a security round⁵⁸ of the two medical cells immediately adjacent to the juvenile cell SINGH was housed in, separated by a secure door, but did not record a security round of the juvenile cell.

At approximately 9:28 a.m.,⁵⁹ as Officer (b)(6); (b)(7)(C) was completing his morning duties, which included ensuring county inmates and ICE detainees were housed appropriately, he noticed LPCADF staff had not completed SINGH's booking and classification assessment since his arrival. (b)(6); (b)(7)(C) then escorted SINGH from his cell to the booking area.

For the first five minutes of their encounter, Officer (b)(6); (b)(7)(C) attempted to communicate with SINGH in Punjabi using Google Translate, without success.⁶⁰ Officer (b)(6); (b)(7)(C) stated that SINGH looked at him like he was crazy when he asked SINGH if he could understand what he was typing. SINGH was able to communicate his desire for the officer to call a telephone number he had when he was arrested. SINGH then cupped his hand and motioned as if he were putting a mask over his mouth and nose, appearing to breathe with difficulty. When Officer (b)(6); (b)(7)(C) asked if SINGH needed oxygen, SINGH repeated the same gesture. Officer (b)(6); (b)(7)(C) was unable to understand what SINGH was trying to communicate.

At approximately 9:33 a.m.,⁶¹ Officer (b)(6); (b)(7)(C) left the booking area to find medical staff, but as they were not in their office, he proceeded to Dispatch, who gave him the telephone number and password for the county's interpretation services provider. As Dispatch notified (b)(6); (b)(7)(C) their language line most likely did not have a Punjabi interpreter, he did not attempt to call the language line.

At approximately 9:49 a.m.,⁶² (b)(6); (b)(7)(C) returned to the booking area with SINGH's property bag. Within SINGH's backpack was an address book SINGH used to identify three names and numbers. (b)(6); (b)(7)(C) then requested (b)(6); (b)(7)(C) who was in the booking area at that time, be present while he called to see if the individuals whose names SINGH identified could interpret for him.

An unknown male individual,⁶³ who spoke English, answered the number (b)(6); (b)(7)(C) called and spoke with SINGH for approximately 30 seconds in another language before the officer took over

⁵⁸ See Download Details, entry dated May 2, 2019. The wands LPCADF staff use to electronically log rounds they conduct do not log who conducted the round. Additionally, as medical staff does not possess a wand, their rounds are not logged unless done so manually.

⁵⁹ ERAU is unable to confirm the accuracy of this time as the LPCADF booking area video is not time stamped; however, the video file was labeled 9:28 a.m., which aligns with (b)(6); (b)(7)(C) May 7, 2019, LPCSO incident statement narrative timeline of events. ERAU has chronologically timed events related to this encounter based on the booking area surveillance footage and the time that elapsed between 9:28 a.m. and subsequent events.

⁶⁰ See booking area surveillance footage, dated May 2, 2019; see also LPCSO Supplemental Narrative by (b)(6); (b)(7)(C), dated May 7, 2019; ERAU interview with (b)(6); (b)(7)(C) dated June 18, 2019.

⁶¹ *Ibid.*

⁶² *Ibid.*

⁶³ As (b)(6); (b)(7)(C) did not retain a copy of the names of the individuals who he called for SINGH, he was uncertain of their names or relationship to SINGH when asked by ERAU. Although he provided a copy of the individuals' names and numbers to SINGH, ERAU was unable to review SINGH's property to determine who the officer called as Sgt.

the call.⁶⁴ The individual on the telephone notified (b)(6); (b)(7)(C) that he was in route to post SINGH's bond, and the officer informed the individual he had been notified that morning ICE had lodged a detainer against SINGH.

At approximately 9:58 a.m.,⁶⁵ Sgt. (b)(6); (b)(7)(C) brought SINGH's booking file to the computer desk in the booking area where SINGH, (b)(6); (b)(7)(C) were congregated, but could not locate the ICE detainer. With the individual still on the phone, Officer (b)(6); (b)(7)(C) asked him about the gesture SINGH had made several times and if SINGH had any medical conditions the individual was aware of. The individual said SINGH was fine and only needed Tylenol for back pain. As SINGH was receiving normal food at the facility, but not eating, (b)(6); (b)(7)(C) asked the individual about allergies to any medications or food.⁶⁶ The individual responded that SINGH was a vegetarian, did not have any allergies to food or medication, and that he was about two to three hours away and hoped they would have the matter about the detainer resolved by the time he arrived.⁶⁷ (b)(6); (b)(7)(C) asked no other questions related to SINGH's medical or mental health history.⁶⁸

At approximately 10:00 a.m.,⁶⁹ (b)(6); (b)(7)(C) handed SINGH a piece of paper with the names and numbers of the three individuals he previously wrote down and escorted SINGH back to his cell.

At 10:38 a.m., (b)(6); (b)(7)(C) completed SINGH's initial classification assessment.⁷⁰ Officer (b)(6); (b)(7)(C) applied a risk classification of maximum based on SINGH's criminal charges of sexual assault and assault from his recent arrest.⁷¹ Officer (b)(6); (b)(7)(C) also filled out the Alcohol and Drug Abuse section of the form recording that SINGH had "no social, economic, or legal problems related to abuse" but clarified for the ERAU review team that he filled that portion out solely based on SINGH's criminal history.⁷² Officer (b)(6); (b)(7)(C) did not obtain supervisory approval of the assessment, but per (b)(6); (b)(7)(C) and facility policy, supervisors are not required to review classification decisions at LPCADF.⁷³

Thomas Moore processed SINGH's property and sent it to the ERO Yuma sub-office prior to ERAU's site visit. As documented on the La Paz County Bail Receipt and Release Order, an individual named (b)(6); (b)(7)(C) posted SINGH's \$5,000 bond.

⁶⁴ See LPCSO Supplemental Narrative by (b)(6); (b)(7)(C) dated May 7, 2019.

⁶⁵ See booking area surveillance footage, dated May 2, 2019; see also LPCSO Supplemental Narrative by Officer (b)(6); (b)(7)(C) dated May 7, 2019.

⁶⁶ See LPCADF CorEMR Chart Notes late entry for May 2, 2019, dated May 7, 2019.

⁶⁷ *Id.*; see also LPCSO Supplemental Narrative by Officer (b)(6); (b)(7)(C) dated May 7, 2019.

⁶⁸ ERAU interview with (b)(6); (b)(7)(C) dated June 18, 2019. LPN (b)(6); (b)(7)(C) stated during the call between the individual on the other end of the phone, him, (b)(6); (b)(7)(C) and SINGH, he was not sure if the individual on the phone was conveying everything SINGH was telling them as the individual and SINGH continued to talk back-and-forth with each other outside of prompted questions.

⁶⁹ See booking area surveillance footage, dated May 1, 2019; see also LPCSO Supplemental Narrative by Officer (b)(6); (b)(7)(C) dated May 7, 2019.

⁷⁰ See LPCSO Formal Classification Assessment form, dated May 2, 2019.

⁷¹ *Ibid.*

⁷² *Ibid.*; ERAU interview with Officer (b)(6); (b)(7)(C) dated June 18, 2019.

⁷³ ERAU interview with CDR (b)(6); (b)(7)(C) dated June 18, 2019.

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

also completed a Segregated Housing Order assigning SINGH to protective custody in H Pod based on SINGH's sexual assault charge.⁷⁴ Officer (b)(6); (b)(7)(C) erroneously documented on the form that SINGH's arrest date was May 1, 2019, and signed the order as the approving authority. (b)(6); (b)(7)(C) informed ERAU that although the form lists Shift Supervisor, Command Staff, and Medical as authorized approving authorities, officers do not obtain approval to assign inmates or detainees to segregation in practice.⁷⁵ As the inmate/detainee signature area on the form was also left blank, (b)(6); (b)(7)(C) explained that inmates and detainees at LPCADF do not typically sign for anything except property when they leave. He went on to state that LPCADF has inmates/detainees sign the segregation order form on a case-by-case basis, for instance, if an inmate or detainee requested to be placed in segregation or protective custody.⁷⁶

(b)(6); (b)(7)(C) documented on the form that the time of protective custody placement in H Pod was 10:00 a.m.; however, LPCADF staff did not transfer SINGH from the juvenile cell to H Pod prior to the medical emergency that occurred approximately eight hours later that day. (b)(6); (b)(7)(C) stated SINGH was pending medical clearance to H pod.⁷⁷

At 10:51 a.m., (b)(6); (b)(7)(C) entered a system alert for a vegetarian diet for SINGH.⁷⁸

At 3:13 p.m., (b)(6); (b)(7)(C) entered an electronic task in CorEMR for daily nursing segregation rounds until Wednesday, May 15, 2019.⁷⁹ ERAU notes there was no documentation provided to support that nursing staff completed a round prior to the medical emergency.⁸⁰

At an unknown time, two individuals, who identified themselves as (b)(6); (b)(7)(C) Singh, arrived at LPCADF to post SINGH's bond.⁸¹ During the process to bond SINGH out of La Paz County custody, Detective Draper (first name unknown) notified (b)(6); (b)(7)(C) that ICE may have lodged a detainer against SINGH.

At 3:59 p.m., ICE DO (b)(6); (b)(7)(C) faxed LPCADF SINGH's DHS Form I-247A, DHS Form I-216, and Department of Justice (DOJ) Form I-203A, Order to Detain or Release Alien.⁸²

At this point, (b)(6); (b)(7)(C) told (b)(6); (b)(7)(C) that if he posted SINGH's bond, SINGH would remain at LPCADF until ICE transported him to another ICE detention facility.⁸³ (b)(6); (b)(7)(C) Singh

⁷⁴ See LPSCO-ADF Segregated Housing Order, dated May 2, 2019. The H Pod maintains five individual cells with showers.

⁷⁵ ERAU interview with (b)(6); (b)(7)(C), dated June 18, 2019.

⁷⁶ ERAU interview with Officer (b)(6); (b)(7)(C) dated June 18, 2019. ERAU notes Facility Policy 2.6, Special Management Inmates, clarifies county inmates' signatures are not required when they are placed on protective segregation status.

⁷⁷ See LPCSO Supplemental Narrative by Officer (b)(6); (b)(7)(C), dated May 7, 2019.

⁷⁸ See CorEMR Alert History, entry dated May 2, 2019.

⁷⁹ See CorEMR Tasks, entry dated May 2, 2019.

⁸⁰ During his interview on June 18, 2019, (b)(6); (b)(7)(C) stated medical did not have a wand to electronically record their rounds.

⁸¹ See LPCSO Incident Narrative by (b)(6); (b)(7)(C) dated May 2, 2019. ERAU was unable to confirm the identities of these individuals as LPCADF did not copy the identification the individuals presented (b)(6); (b)(7)(C). During his (b)(7)(E); (b)(3); Unspecified Statute on March 27, 2019, SINGH stated if he were released from custody, he would live with his family friend, (b)(6); (b)(7)(C) in the U.S.

⁸² See DHS Form I-247A, dated May 2, 2019; see also DHS Form I-216, dated May 2, 2019; see also DOJ Form I-203A, dated May 2, 2019; see also Fax Confirmation 19286695442, dated May 2, 2019

⁸³ See LPCSO Incident Narrative by (b)(6); (b)(7)(C) dated May 2, 2019.

stated he needed to make a few calls, then returned affirming SINGH's family still wished to post his bond.

At 4:25 p.m. (b)(6); (b)(7)(C) sent an email to (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) to inform them SINGH was ready for release to ICE. (b)(6); (b)(7)(C) requested they transport SINGH to the ERO Yuma Sub-Office the next day.⁸⁴

Once (b)(6); (b)(7)(C) finished processing SINGH's bond,⁸⁵ (b)(6); (b)(7)(C) asked if (b)(6); (b)(7)(C) individual with him would be able to visit with SINGH.⁸⁶ Although according to (b)(6); (b)(7)(C) facility policy protocol dictates visitors should make their requests to visit 24-hours in advance, (b)(6); (b)(7)(C) made an exception, as (b)(6); (b)(7)(C) stated they had traveled from Fresno, California. (b)(6); (b)(7)(C) asked (b)(6); (b)(7)(C) if they could ask SINGH about any medical issues he had so that he could advise medical staff. (b)(6); (b)(7)(C) agreed.

At approximately 4:27 p.m.,⁸⁷ (b)(6); (b)(7)(C) escorted SINGH to the visitation room for a non-contact visit. A minute later, SINGH's two visitors entered the other side of the visitation room, which is separated by glass windows. After some difficulties with the visitor station phones, SINGH sat down at phone station two and spoke with the two individuals for approximately 35 minutes, or until approximately 5:03 p.m. Once the two individuals left the visitation room, they handed (b)(6); (b)(7)(C) piece of paper that stated, "breathing problem, nose needs surgery and back pain."⁸⁸ As SINGH did not appear to have any life-threatening issues, (b)(6); (b)(7)(C) saved the piece of paper to provide to medical staff after evening pill call.⁸⁹

In order for SINGH to be released from La Paz County custody into ICE custody, he first had to post the bond related to his criminal charges. Consequently, at 4:39 p.m., SINGH's custody status changed from a La Paz County inmate to an ICE detainee housed at LPCADF where (b)(6); (b)(7)(C) posted SINGH's bond.⁹⁰

At approximately 5:13 p.m., before (b)(6); (b)(7)(C) escorted SINGH back to his cell from the visitation room, (b)(6); (b)(7)(C) gestured for SINGH to sign a document, and SINGH complied.⁹¹ SINGH then pointed at the air vent on the wall, and again made the same gesture placing his hand, in the shape of a mask, over his nose and mouth, and panted heavily.

⁸⁴ See (b)(6); (b)(7)(C) email: 'Transportation – Subject at LPCJ,' dated May 2, 2019.

⁸⁵ See (b)(6); (b)(7)(C) email: 'Surveillance Footage Request,' dated September 12, 2019.

⁸⁶ See LPCSO Incident Narrative by (b)(6); (b)(7)(C) dated May 2, 2019.

⁸⁷ See CAM 16 visitor area surveillance footage, dated May 2, 2019. As LPCADF's surveillance system was not synced properly, ERAU created an estimated timeline of events working back from when EMS arrived to SINGH's cell at 6:03 p.m., as confirmed by both the EMS report and (b)(6); (b)(7)(C) body camera footage. The LPCADF surveillance system time stamped different camera angles with times that were not possible based on confirmed events, such as the arrival time of EMS and the length of time SINGH was in his cell between (b)(6); (b)(7)(C) returning him from the visitation room and EMS' arrival (approximately 48 minutes between events).

⁸⁸ See LPCSO Incident Narrative by (b)(6); (b)(7)(C) dated May 2, 2019.

⁸⁹ *Id.* Pill call refers to the daily time medical staff distributes medications to detainees requiring medication.

⁹⁰ See (b)(6); (b)(7)(C) email: 'Surveillance Footage Request,' dated September 12, 2019.

⁹¹ See CAM 16 visitor area surveillance footage, time stamped between 5:00 p.m. and 5:48 p.m. ERAU notes the document could not be identified through the footage. According to (b)(6); (b)(7)(C) the document was most likely related to SINGH's bond or court paperwork. See also (b)(6); (b)(7)(C) email: 'SINGH Questions,' dated September 19, 2019.

On the way back to his cell, SINGH stopped at the intake clothing rack and pointed to his feet. As he was not wearing socks under his clog footwear (b)(6); (b)(7)(C) provided SINGH with a pair of socks before returning him to his cell.⁹²

At approximately 5:15 p.m., (b)(6); (b)(7)(C) escorted SINGH into his cell.⁹³

The following times are based on the surveillance footage from the camera in SINGH's cell, unless stated otherwise.⁹⁴

At approximately 5:31 p.m., SINGH entered the shower unit in the corner of his room, fully clothed, holding socks.

At approximately 5:38 p.m., SINGH placed his folded bunkbed mattress on the upper bunk and a minute later, drank a cup of water from his sink.

At approximately 5:43 p.m., SINGH appeared to crouch over in front of his bunkbed. This is the last movement that can be seen in the distorted video footage.

LPCADF did not record any security rounds of the juvenile cell on this date.⁹⁵ According to CDR (b)(6); (b)(7)(C) officers conduct rounds every hour but do not always use the facility wands that electronically record their rounds, which is why, he explained, the LPCSO Jail Event Summary report he provided ERAU included limited information. When asked about specific post orders officers follow, (b)(6); (b)(7)(C) stated there had been none in place since 2010 or 2011.⁹⁷

At approximately 5:50 p.m.,⁹⁸ as Officer (b)(6); (b)(7)(C) was serving evening meals with county inmate (b)(6); (b)(7)(C), county inmate (b)(6); (b)(7)(C) approached SINGH's cell and informed Officer (b)(6); (b)(7)(C) that SINGH had hanged himself. Officer (b)(6); (b)(7)(C) walked to the

(b)(6); (b)(7)(C)
⁹² (b)(6); (b)(7)(C) told MCSO detectives inmates are given one pair of socks at intake, and another pair when housed; however, because booking staff did not document clothing items issued to SINGH upon arrival, ERAU cannot verify whether he received a pair of socks when admitted. See MCSO Incident Report 19-016384 interview transcript with (b)(6); (b)(7)(C), dated May 2, 2019.

⁹³ See Camera 6 Surveillance Footage, time stamped 5:47 p.m. to 5:49 p.m., dated May 2, 2019.

⁹⁴ ERAU notes, as the quality of the surveillance footage from the one operational camera in SINGH's cell was extremely poor, SINGH is not in clear view for most of the video and it was extremely difficult to decipher the events that transpired. See Juvenile Cell Surveillance Footage, from May 2, 2019.

⁹⁵ See Download Details report, entry dated May 1, 2019; see also LPCSO Jail Event Summary Report, dated May 2, 2019 - May 4, 2019.

⁹⁶ ERAU interview with (b)(6); (b)(7)(C) dated June 18, 2019.

⁹⁷ See (b)(6); (b)(7)(C) email: 'Post Orders,' dated May 15, 2019.

⁹⁸ See LPCSO Incident Narrative (b)(6); (b)(7)(C), dated May 2, 2019; see also LPCSO incident narrative by Officer (b)(6); (b)(7)(C) dated May 2, 2019. Officer (b)(6); (b)(7)(C) stated this occurred at approximately 5:40 p.m.; however, (b)(6); (b)(7)(C) stated it occurred at approximately 5:50 p.m., which aligns more appropriately with confirmed events, such as when EMS was called at 5:58 p.m.

⁹⁹ Officer (b)(6); (b)(7)(C) informed MCSO Detectives that although she was not a certified officer, LPCADF allowed her to work on her own in Tower Control and to serve meals to inmates and detainees. During her interview with ERAU on June 18, 2019, Officer (b)(6); (b)(7)(C) stated she was unaware of the proper procedures in the event of a medical emergency as she was not slated to start academy training until August 2019. See MCSO Incident Report 19-016384 interview transcript with Officer (b)(6); (b)(7)(C) dated May 2, 2019; see also LPCSO incident Narrative by (b)(6); (b)(7)(C) dated May 2, 2019.

window and saw SINGH's pale face with his eyes open; she ran from the medical wing to intake where (b)(6); (b)(7)(C) was booking a new inmate and stated, "It's bad." (b)(6); (b)(7)(C) then ran to SINGH's cell, and at approximately 5:56 p.m., SINGH's cell door opened. (b)(6); (b)(7)(C) then ran back out of the cell to give instructions to staff, and asked Trooper (b)(6); (b)(7)(C) who responded to SINGH's cell with him, to go to Dispatch and notify them of the situation.¹⁰⁰ (b)(6); (b)(7)(C) told Officer (b)(6); (b)(7)(C) to relieve (b)(6); (b)(7)(C) from Tower Control so (b)(6); (b)(7)(C) could assist him.

At approximately 5:57 p.m., (b)(6); (b)(7)(C) stood near the base of the bunk bed and looked towards SINGH. (b)(6); (b)(7)(C) then called for medical over the radio.¹⁰¹ When (b)(6); (b)(7)(C) returned to SINGH's cell, he, (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) pulled SINGH's legs out from under the bunk, stabilized his body and neck, and then (b)(6); (b)(7)(C) cut SINGH down using a knife rather than a cut down tool.¹⁰² Cardiopulmonary resuscitation (CPR) efforts alternated between (b)(6); (b)(7)(C)

When asked by ERAU why he did not immediately call a medical emergency over the radio and, pending arrival for assistance, lift SINGH upward to relieve pressure on his neck, (b)(6); (b)(7)(C) said he believed SINGH was already deceased. (b)(6); (b)(7)(C) reported seeing no signs of life and stated SINGH appeared gray in color, was foaming at the mouth, and had urinated on himself.¹⁰³

At 5:58 p.m., EMS received a call from LPCADF about a potential suicide.¹⁰⁴

At approximately 6:01 p.m., (b)(6); (b)(7)(C) entered SINGH's cell. (b)(6); (b)(7)(C) stated when she saw an officer running, she knew something was happening, then was directed to the booking area per a call over the radio. LPSCO inmates directed her where to go because she stated no one told her exactly where to be.¹⁰⁶

¹⁰⁰ See Juvenile Cell Surveillance Footage, from May 2, 2019; see also MCSO Incident Report 19-016384 interview transcript with (b)(6); (b)(7)(C) dated May 2, 2019. LPCADF did not provide ERAU with the Tower Control Logbook, which would have recorded the time 911 was called and subsequent events relating to EMS's arrival and departure.

¹⁰¹ See MCSO Incident Report 19-016384 interview transcript with (b)(6); (b)(7)(C) dated May 2, 2019.

¹⁰² See Sgt. (b)(6); (b)(7)(C) body camera footage, dated May 2, 2019. SINGH's bedsheets appear to be tied around the upper bunk's frame while SINGH's socks appeared to have been tied around his neck to the sheets. When asked about the knife by MCSO detectives, (b)(6); (b)(7)(C) stated he had retrieved it from a box behind the booking desk in order to cut SINGH down from the bunk. He said the knife, which the MCSO evidence list documents is a Zombie Killer folding knife, was in the box because he had not had a chance to dispose of it. (b)(6); (b)(7)(C) explained that in the commotion of the emergency, he told (b)(6); (b)(7)(C) to get the cut-down tool, but realized that as a new employee, she may not know to what he was referring.

¹⁰³ ERAU interview with (b)(6); (b)(7)(C), dated June 18, 2019.

¹⁰⁴ See River Medical Pre-Hospital Care Report, dated May 2, 2019.

¹⁰⁵ See Juvenile Cell Surveillance Footage, from May 2, 2019.

¹⁰⁶ ERAU interview with (b)(6); (b)(7)(C) dated June 18, 2019.

At 6:02 p.m., (b)(6); (b)(7)(C) turned his body camera on¹⁰⁷ and EMS arrived at LPCADF where staff notified them SINGH was in cardiac arrest.¹⁰⁸

The following times are based on (b)(6); (b)(7)(C) body camera footage,¹⁰⁹ unless stated otherwise:

At 6:02 p.m., while performing chest compressions, (b)(6); (b)(7)(C) directed (b)(6); (b)(7)(C) retrieve the automatic external defibrillator (AED) device. (b)(6); (b)(7)(C) then used a knife to cut SINGH's shirt open and the ligature from around his neck.

At 6:03 p.m., EMS arrived at SINGH's cell and LPCADF staff informed them the facility was unaware of the last time anyone saw SINGH alive.¹¹⁰ EMS immediately took over CPR, and within 40 seconds of arrival, adhered the AED pads to SINGH's chest.¹¹¹ The AED machine analyzed SINGH's heart rhythm after which time it directed CPR to continue. EMS documented SINGH's blood pressure as 0/0 at this time.¹¹²

At 6:05 p.m., (b)(6); (b)(7)(C) took over CPR from the paramedics, as they started a peripheral intravenous line (IV);¹¹³ CPR switched off between (b)(6); (b)(7)(C) and the paramedics several times.

At 6:08 p.m., a paramedic stated that whoever called EMS did not mention anything about CPR being in process. (b)(6); (b)(7)(C) then stated, "it did not come over the radio very well" to which the paramedic responded in concurrence, "[inaudible] it was attempted."

At 6:12 p.m., (b)(6); (b)(7)(C) assisted a paramedic with attaching an oxygen tank to the bag valve mask (BVM) providing rescue breaths to SINGH.¹¹⁴

At 6:16 p.m., paramedics lifted SINGH onto a gurney and continued his CPR as they moved through the facility to the ambulance.

At 6:18 p.m., paramedics lifted SINGH into the ambulance.

¹⁰⁷ During his interview with ERAU on June 18, 2019, (b)(6); (b)(7)(C) stated he was in the Sheriff's office (where the facility is located) when Dispatch advised there was an attempted suicide. He went back to check on the situation, as he thought the situation had already been handled since Dispatch said it was an "attempted" suicide. (b)(6); (b)(7)(C) stated although he was told he would be interviewed the week after the incident, he was not, and no one requested he write an incident report.

¹⁰⁸ See River Medical Pre-Hospital Care Report, dated May 2, 2019.

¹⁰⁹ See (b)(6); (b)(7)(C) body camera footage, dated May 2, 2019.

¹¹⁰ See River Medical Pre-Hospital Care Report, dated May 2, 2019.

¹¹¹ Five days after the medical emergency, (b)(6); (b)(7)(C) documented that she retrieved the AED and applied the AED pads, resulting in a no shock analysis. The River Medical EMS report also states an AED was used prior to EMS arrival, without defibrillation. To the contrary, (b)(6); (b)(7)(C) body camera footage shows that approximately 30 seconds before the EMS responders arrive, (b)(6); (b)(7)(C) asks (b)(6); (b)(7)(C) to retrieve the AED. In order for (b)(6); (b)(7)(C) to apply the AED pads, SINGH's shirt would first have to be removed to properly adhere the AED pads. Seconds later, (b)(6); (b)(7)(C) cuts SINGH's shirt off. When SINGH's chest is exposed, there are no AED pads present. Within seconds, EMS is on scene and shortly thereafter applies AED pads. See CorEMR Chart Notes, entry dated May 7, 2019.

¹¹² See River Medical Pre-Hospital Care Report Vital Signs, dated May 2, 2019.

¹¹³ *Ibid.*

¹¹⁴ A BVM, also known as an AMBU (Artificial Manual Breathing Unit) bag, is a hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately.

At 6:26 p.m., EMS left the facility for LPRH with SINGH still in asystole,¹¹⁵ where they arrived approximately four minutes later.¹¹⁶

The LPRH nursing record documented the reason for SINGH's arrival to the emergency department (ED) as a suicide attempt by hanging.¹¹⁷ The ED recorded SINGH's date of birth as May 29, 1987, listed five current medications, and stated he had a history of a prior suicide attempt and depression, all of which were inconsistent with SINGH's facility medical record.¹¹⁸

At approximately 6:30 p.m., Sgt. (b)(6); (b)(7)(C) requested LPCSO Patrol Deputy (b)(6); (b)(7)(C) report to the hospital where EMS had transported SINGH.¹¹⁹ At an unknown time, but shortly after Deputy (b)(6); (b)(7)(C) arrival, LPRH medical staff notified Deputy (b)(6); (b)(7)(C) that SINGH had a pulse and would be airlifted to AWC.

At approximately 6:50 p.m., ED personnel placed SINGH on a ventilator.¹²⁰

At 6:53 p.m., LPRH (b)(6); (b)(7)(C) called AWC to transfer SINGH to a higher acuity care facility.¹²¹

At 7:11 p.m., Trauma Surgeon (b)(6); (b)(7)(C) at AWC accepted SINGH's transfer to her ED, and (b)(6); (b)(7)(C) provided transfer documentation.¹²²

At 7:21 p.m., a Native Air flight in Lake Havasu City, AZ, was dispatched.¹²³ Thirty-one minutes later, the Native Air flight arrived at LPRH. The hospital provided the same medical history it had to the Native Air medical staff.

At 9:08 p.m., the flight departed LPRH for AWC (b)(6); (b)(7)(C) stayed at the hospital until the flight departed. Along the way, medical staff continued assisting SINGH's breathing with a BVM and monitored his blood pressure and end-tidal CO₂ (ETCO₂); however, he was expelling copious amounts of frothy sputum¹²⁴ from the endotracheal tube.¹²⁵

¹¹⁵ Asystole refers to total cessation of the heart's electrical activity, also referred to as flatline on a heart monitor.

¹¹⁶ See River Medical Pre-Hospital Care Report, dated May 2, 2019.

¹¹⁷ See LPRH ED Record, dated May 2, 2019.

¹¹⁸ *Ibid.* It is unclear why the hospital recorded SINGH's date of birth as May 29, 1987. Furthermore, the medications listed were: Clonazepam 1 tablet, daily; Divalproex SOD, (500 mg) 2 tablets at bedtime; Doxepin (100 mg), 1 capsule at bedtime; Olanzapine (10 mg), 1 tablet at bedtime; and Prazosin (2 mg), 1 capsule at bedtime; all but one (i.e. Prazosin) are typically prescribed to treat mental health conditions. Although the medication source field stated "patient/family," the hospital also documented it was unable to verify the medications or the source of the information.

¹¹⁹ LPCSO did not provide continuous custody supervision of SINGH after he left LPCADF in the ambulance or after he left LPRH. See Law Supplemental Narratives by (b)(6); (b)(7)(C) dated July 25, 2019.

¹²⁰ A ventilator is a breathing machine that provides a patient with oxygen when they are unable to breathe on their own. As the hospital records list three separate times related to when the hospital placed SINGH on a ventilator, ERAU has listed the provided time as an approximate. See LPRH ED Record, dated May 2, 2019.

¹²¹ See LPRH ED Record, dated May 2, 2019.

¹²² See Request Consent Transfer - Certification for Transfer form, dated May 2, 2019.

¹²³ See Native Air Arizona Flight Number FV19-061637 report, dated May 2, 2019. According to the Native Air Arizona Flight Number FV19-061637 report, the estimated drive time to the hospital was 180 minutes versus a 50-minute flight.

¹²⁴ Sputum is mucous coughed up from the respiratory tract.

¹²⁵ See Native Air Arizona Flight Number FV19-061637 report, dated May 2, 2019.

At approximately 9:10 p.m., (b)(6); (b)(7)(C) called ERO Yuma sub-office (b)(6); (b)(7)(C) and notified them SINGH had just attempted suicide and was at the hospital.¹²⁶

At 9:57 p.m., the flight from LPRH arrived at AWC.¹²⁷

At 10:03 p.m., AWC medical staff assessed SINGH and documented he presented with an altered mental state and was in critical condition.¹²⁸

At approximately 11:00 p.m., LPCAD (b)(6); (b)(7)(C) and Officer (b)(6); (b)(7)(C) arrived to AWC to provide custody supervision.¹²⁹ Officer (b)(6); (b)(7)(C) documented that both he and (b)(6); (b)(7)(C) reported to SINGH's room when they arrived and then approximately 30 minutes later, Sgt. (b)(6); (b)(7)(C) departed to check into a local hotel as (b)(6); (b)(7)(C) was to provide vigil until 8:00 a.m. when (b)(6); (b)(7)(C) would relieve him.¹³⁰ (b)(6); (b)(7)(C) reported from about midnight until 1:00 a.m., nurses were entering the room to perform routine checks and then suddenly SINGH's blood pressure dropped.¹³¹

DAY OF DEATH – MAY 3, 2019

At 1:43 a.m., (b)(6); (b)(7)(C) documented she was called to SINGH's bedside for a code event, at which time medical staff performed advanced cardiac life support measures.¹³² (b)(6); (b)(7)(C) documented that, "Given the extremis [sic] of this patient and subsequent multiorgan system failure secondary to prolonged hypoxia and shock, we will provide supportive care up until the patient suffers another code event at which point we will withdraw care as the current measures are becoming futile." After multiple resuscitation attempts, SINGH succumbed to his injuries.¹³³

At 1:58 a.m., (b)(6); (b)(7)(C) pronounced SINGH's death. The preliminary cause of death was cardiac arrest from complications of asphyxia.¹³⁴

At 3:18 a.m., SINGH's body was transported to the morgue.¹³⁵

¹²⁶ See ICE (b)(6); (b)(7)(C) email: 'Be advised!', dated May 2, 2019.

¹²⁷ See Native Air Arizona Flight Number FV19-061637 report, dated May 2, 2019.

¹²⁸ See AWC Emergency/Urgent Care Note, dated May 2, 2019.

¹²⁹ ERAU interview with Officer (b)(6); (b)(7)(C) dated June 18, 2019; see also LPSCO Supplemental Narrative by Officer (b)(6); (b)(7)(C) dated May 9, 2019.

¹³⁰ During his interview with ERAU on June 18, 2019, (b)(6); (b)(7)(C) stated none of SINGH's friends or relatives were present during the events that transpired. AWC documented that they made multiple attempts to get in touch with SINGH's next of kin by contacting the LPCSO but were told to call back in the morning. (b)(6); (b)(7)(C) did not keep a log of events as he kept watch at the hospital. (b)(6); (b)(7)(C) did not write an incident report.

¹³¹ See LPSCO Supplemental Narrative by (b)(6); (b)(7)(C) dated May 9, 2019.

¹³² See AWC Progress Note, dated, May 3, 2019.

¹³³ See AWC Discharge Summary, dated May 10, 2019.

¹³⁴ *Ibid.*; see also Exhibit 2: State of Arizona Certificate of Death 102-2019-031160, certified May 4, 2019.

¹³⁵ See AWC Notification of Death, dated May 3, 2019. As (b)(6); (b)(7)(C) did not maintain a hospital log, many events that transpired outside of nurses' notes are unclear. During his interview with ERAU, Officer (b)(6); (b)(7)(C) stated he remained at AWC until approximately 3:00 or 4:00 a.m.

At approximately 7:46 a.m., ERO Phoenix notified ERO Headquarters of SINGH's death.¹³⁶

At approximately 8:30 a.m., ERO Phoenix called the ICE OPR Joint Intake Center (JIC) to report SINGH's death.¹³⁷

At approximately 10:00 a.m., ERO Phoenix reported SINGH's death to the DHS Office of Inspector General duty agent.¹³⁸

At approximately 10:30 a.m., ERO Phoenix notified the Consulate General of India in San Francisco, California (CA), of SINGH's death.

At 1:14 p.m., the Maricopa County Forensic Science Center (MCFSC) accepted custody of SINGH's body.¹³⁹

POST DEATH EVENTS

On May 8, 2019, at an unknown time, the ERO Yuma sub-office documented receipt of SINGH's property, which LPCADF Sgt. (b)(6); (b)(7)(C) closed out on May 3, 2019.¹⁴⁰

On May 7, 2019, the Phoenix Field Office Director (FOD) wrote a letter to SINGH's parents, expressing his condolences, addressed to the Consulate General of India in San Francisco.¹⁴¹

On May 10, 2019, at 12:07 p.m., the MCFSC released SINGH's body to a local funeral home.¹⁴²

On June 17, 2019, at approximately 2:58 p.m., the ERO Yuma sub-office shipped SINGH's property to the Consulate General of India in San Francisco, CA, whose staff signed for it on June 20, 2019.

On July 31, 2019, the Maricopa County Office of the Medical Examiner documented SINGH's cause of death as hanging and the manner of death as suicide.¹⁴³

FINDINGS

ERAU reviewed the medical care LPCADF provided SINGH, as well as their efforts to ensure he was safe and secure while detained at the facility. As a facility that houses ICE detainees for less than 72 hours, LPCADF is not contractually obligated to comply with all of the requirements of

¹³⁶ See ICE SIR, dated May 3, 2019.

¹³⁷ *Ibid.*

¹³⁸ *Ibid.*

¹³⁹ See Exhibit 3: Maricopa County Forensic Science Center: Record of Admission, dated May 3, 2019.

¹⁴⁰ See untitled LPSCO property form Disposition Release time, entry dated May 3, 2019; see also DOJ INS Baggage and Personal Effects of Detained Alien, Form I-43, and ICE Baggage Check (3882109), Form 12-I-77, dated May 8, 2019.

¹⁴¹ See letter from ERO FOD Lucero addressed to "Parents of Mr. Simratpal Singh," dated May 7, 2019.

¹⁴² See Exhibit 3: Maricopa County Forensic Science Center: Record of Admission, dated May 3, 2019.

¹⁴³ See Exhibit 4: Maricopa County Medical Examiner Report, case 19-03827, date signed July 31, 2019.

the ICE NDS 2000.¹⁴⁴ However, LPCADF is required to conduct a yearly ORSA¹⁴⁵ to assess the facility's compliance with certain requirements of the ICE NDS 2000.¹⁴⁶ For purposes of a comprehensive review, ERAU assessed LPCADF's compliance with the medical care, safety, and security standards within ICE NDS 2000, referred to the requirements outlined in the ORSA, and identified 23 areas of concern. These findings are noted for informational purposes only and should not be construed as contributory to the detainee's death.

1. LPCADF Detention Officer (b)(6); (b)(7)(C) was the first LPCADF staff member to discover SINGH's suicide, and (b)(6); (b)(7)(C) as a first responder. However, (b)(6); (b)(7)(C) was not CPR-certified, and LPCADF was unable to provide a CPR certification card for (b)(6); (b)(7)(C). Moreover, (b)(6); (b)(7)(C) an LPCSO Patrol Sgt. who did not work for the facility but happened to be in the building at the time of the medical emergency, was the only individual who accompanied EMS the entire time they were at LPCADF, escorted them to the ambulance, and performed multiple rounds of CPR on SINGH, but also did not have a current CPR certification.

Relevant NDS 2000 component: *Medical Care*, Section (III)(H)(2): "Detention staff will be trained... this training will be provided by a responsible medical authority in cooperation with the Officer In Charge and will include the following: ... (2) The administration of first aid and CPR...."

2. LPCADF could not produce documentation demonstrating periodic refresher training occurred and did not produce curricula or lesson plans demonstrating that its initial training included the required topics. LPCADF security personnel reported they only received suicide prevention and intervention training during initial training, while LPCADF nursing staff reported they had never received suicide prevention and intervention training. Furthermore, Officer (b)(6); (b)(7)(C) had not yet received training prior to when she discovered SINGH.

Applicable ORSA component: *Suicide Prevention and Intervention*, Section (1): "Every new staff member receives suicide-prevention training. Suicide-prevention training occurs during the employee orientation program."

Relevant NDS 2000 component: *Suicide Prevention and Intervention*, Section (III)(A): "All staff will receive training, during orientation and periodically, in the following: recognizing signs of suicidal thinking, including suspect behavior; facility referral procedures; suicide-prevention techniques; and responding to an in-progress suicide attempt. All training will include the identification of suicide risk factors and the psychological profile of a suicidal detainee."

¹⁴⁴ See U.S. DOJ, USMS Modification of Intergovernmental Agreement, dated June 4, 2002, This modification officially authorized ICE as a federal user agency on the USMS IGA contract with LPCADF.

¹⁴⁵ See Exhibit 5: LPCADF 2018 ORSA, dated September 13, 2018.

¹⁴⁶ The highest-ranking facility official, (b)(6); (b)(7)(C) completed LPCADF's 2018 ORSA and found the facility fully compliant with all 29 of the 29 standards the ORSA covers. However, during ERAU's on-site review, he indicated he had never heard of the ICE NDS 2000.

3. Despite SINGH's inability to speak more than a few words of English, at no time did LPCADF staff utilize interpretation services. On April 30, 2019, LPCADF security staff did not document SINGH's primary language or the reason they did not complete SINGH's intake process. Additionally, (b)(6); (b)(7)(C), who conducted SINGH's initial assessment, was unable to complete the assessment due to the language barrier; nevertheless, she did not document the language barrier issue in SINGH's medical record until after his death. (b)(6); (b)(7)(C) also stated she was unaware LPCADF had a telephonic interpretation service until after SINGH's death. Furthermore, nursing staff, including the facility's longest tenured nurse, I (b)(6); (b)(7)(C), said he had never used, nor was he aware that LPCADF had access to interpretation services.

Applicable facility policy: Receiving Screening/Assessment: "The receiving screening form is available in English and Spanish. Other language needs will utilize the language line."

Relevant NDS 2000 component: Medical Care, Section (III)(D): "If language difficulties prevent the health provider/officer from sufficiently communicating with the detainee for purposes of completing the medical screening, the officer shall obtain translation assistance. Such assistance may be provided by another officer or by a professional service, such as a telephone translation service."

4. During SINGH's initial assessment on April 30, 2019, (b)(6); (b)(7)(C) did not complete SINGH's medical and mental health screening or assess his suicide risk. Additionally, on May 2, 2019, two days after SINGH's admission to LPCADF, (b)(6); (b)(7)(C) contacted individuals SINGH pointed out from his address book to interpret. During one phone conversation between SINGH (b)(6); (b)(7)(C) and SINGH's English-speaking associate (b)(6); (b)(7)(C) did not take the opportunity to inquire about any known medical or mental health history, or possible suicidal ideation. Pursuant to the conversation, LPN (b)(6); (b)(7)(C) entered a task order for a vegetarian diet but did not enter a chart note about the encounter until May 7, 2019, after SINGH's death.

Applicable ORSA components:

Admission and Release, Section 2: "Medical screenings are performed by medical staff or persons who have received specialized training for the purpose of conducting an initial health screening."

Medical Care, Section 2: "The facility's in-processing procedures for arriving detainees include medical screening."

Applicable facility policies:

Receiving Screening/Assessment: "The receiving screening will be preformed [sic] immediately upon inmates' arrival into the booking area."

Suicide Prevention & Intervention, Identification, Section 5.2.1.2: “Every arrival into this facility shall be evaluated for risk indicators.” Risk indicators according to Section 5.2.1.3 are: “additional charges, sentencing, receiving bad news, embarrassing or very serious charges.”

Relevant NDS 2000 components:

Medical Care, Section (III)(D): “All new arrivals shall receive initial medical and mental health screening immediately upon their arrival by a health care provider or an officer trained to perform this function. This screening shall include observation and interview items related to the detainee’s potential suicide risk and possible mental disabilities, including mental illness and mental retardation”

Suicide Prevention and Intervention, Section (III)(B): “Suicide potential will be an element of the initial health screening of a new detainee, conducted by either the health care provider or a specially trained officer.”

5. On April 30, 2019, during (b)(6); (b)(7)(C) s initial assessment of SINGH, she took vitals and scheduled SINGH’s TB testing for seven days following his arrival.

Applicable ORSA component: *Access to Medical Care*, Section 5: “Medical screening includes a Tuberculosis (TB) test.”

Relevant NDS 2000 component: *Medical Care*, Section (III)(D): “All new arrivals shall receive TB screening by PPD (mantoux method) or chest x-ray... If the initial screening is negative, the detainee will be allowed to join the general population.”

6. SINGH did not sign a general consent for medical treatment at any point during his detention at LPCADF.

Relevant NDS 2000 component: *Medical Care*, Section (III)(L): “The facility health care provider will obtain signed and dated consent forms from all detainees before any medical examination or treatment, except in emergency circumstances.”

7. LPCADF’s single-room medical clinic does not have a curtained area for patient privacy. MCSO detectives, who investigated SINGH’s death, interviewed an inmate worker who reported overhearing medical information being exchanged in the clinic as the laundry room, staffed by inmate workers, is right beside the clinic.

Relevant NDS 2000 component: *Medical Care*, Section (III)(M): “All medical providers shall protect the privacy of detainees’ medical information to the extent possible while permitting the exchange of health information required to fulfill program responsibilities and to provide for the well-being of detainees.”

8. According to (b)(6); (b)(7)(C) LPCADF has not maintained post orders since 2010 or 2011.

Relevant NDS 2000 component: *Post Orders*, Section (III)(A) and (D): “Written orders shall specify the duties of each post in the facility, along with the procedures to be followed in carrying out those duties.”; and “Post orders will be kept current at all times. Post orders will be reviewed and updated yearly or sooner when deemed necessary.”

9. (b)(6); (b)(7)(C) confirmed that LPCADF does not have a formal orientation process for detainees. Additionally, the LPCADF local handbook, geared mostly towards inmates, was only available in English on kiosks located in the facility housing units, not in the cell where SINGH was located. Due to the language barrier, SINGH had no access to information about facility operations, including how to access healthcare. Moreover, the facility had neither electronic nor physical copies of the ICE National Detainee Handbook in any of the 11 available languages, including Punjabi, the language SINGH spoke.

Applicable ORSA components:

Admission and Release, Section (1): “In-processing includes an orientation of the facility.”

Detainee Handbook, Section (1): “The detainee handbook is written in English and translated into Spanish, or into the next most-prevalent language(s).”

Relevant NDS 2000 components:

Admission and Release, Section (III)(A)(1) and (K): “The orientation process supported by a video (INS) and handbook shall inform new arrivals about facility operations, programs, and services;” and, “Upon admission every detainee will receive a detainee handbook. It will fully describe all policies, procedures, and rules in effect at the facility, in accordance with the Detainee Handbook standard.”

Detainee Handbook, Section (E): “The handbook will be written in English and translated into Spanish and, if appropriate, into the next most-prevalent language(s) among the facility’s detainees. The OIC will provide translation assistance to detainees exhibiting literacy or language problems and those who request it. This may involve translators from the private sector or from the detainee population.”

10. There is no record (b)(6); (b)(7)(C) issued SINGH clothing, bed linens, towels or hygiene items upon his arrival to LPCADF.

Applicable ORSA components:

Admission and Release, Sections (8) and (9): “(8) Detainees are issued appropriate and sufficient clothing and bedding for climatic conditions; and (9) The facility provides and replenished personal hygiene items as needed.”

Issuance and Exchange of Clothing, Bedding, and Towels, Sections (1) and (2): “(1) All new detainees are issued clean, temperature-appropriate, presentable clothing during in-processing; and (2) New detainees are issued clean bedding, linens, and a towel.”

Relevant NDS 2000 components:

Admission and Release, Section (III)(A)(2): “Staff will issue arriving detainees personal hygiene items, clothing, sheets and blankets appropriate for local weather conditions.”

Issuance and Exchange of Clothing, Bedding, and Towels, Sections (B) and (C): “(B) All new detainees shall be issued clean, temperature-appropriate, presentable clothing during in-processing; and (C) All new detainees shall be issued clean bedding, linens and towels.”

11. LPCADF personnel did not document SINGH’s assignment to the juvenile cell during or following booking, including when or why they placed him in that cell, nor was supervisory approval documented. According to (b)(6); (b)(7)(C) PCADF placed SINGH in the juvenile cell for protective custody purposes due to his sexual assault charge; however, LPCADF staff did not complete a segregated housing order for protective custody until two days following his intake, May 2, 2019. The staff member assigned SINGH to the H Pod the morning of SINGH’s death, not the juvenile cell he was housed in. Additionally, the protective custody segregated housing order completed by (b)(6); (b)(7)(C) was not approved by a supervisor. (b)(6); (b)(7)(C) stated LPCADF does not require supervisory approval of administrative segregation placement as a matter of routine.

Applicable ORSA component: *Special Management Unit, Administrative Segregation*, Section 2, “In exigent circumstances, staff may place a detainee in the SMU (administrative) before a written order has been approved. A copy of the order given to the detainee within 24 hours.”

Applicable facility policy: *Special Management Inmates, Segregation Placement and Review*, Section 2.6.3.4: “Initial placement into segregation shall be documented on the Segregated Housing Order... If a change in the type of confinement occurs, a new Segregated Housing Order shall be generated identifying the circumstances and type of segregation. The shift supervisor must sign all segregated housing orders.”

Relevant NDS component: *Special Management Unit, Administrative Segregation*, Section (III)(B): “A written order shall be completed and approved by a supervisory officer before a detainee is placed in administrative segregation, except when exigent circumstances make this impracticable.”

12. When LPCADF officers placed SINGH in the juvenile cell for segregation, they did not initiate a log to record activities and privileges, including meals, recreation, time out of cell, or staff rounds. Between his assignment to the cell at an unknown time on April 30, 2019, and the medical emergency shortly before 6:00 p.m. on May 2, 2019, security personnel only recorded one round, on May 1, 2019 at 8:39 p.m. Moreover, nurses made no rounds, reportedly because LPCADF officers did not notify them SINGH was in the juvenile cell. If additional rounds were completed by LPCADF staff, there was no documentation provided to support it. According to (b)(6); (b)(7)(C), at the time of SINGH’s housing at LPCADF, medical staff conducted segregation rounds every three days for

inmates/detainees pursuant to facility policy *Special Management Inmates*, Chapter 200, Section 2.6; however, after SINGH's death they changed medical segregation rounds to occur daily.

Applicable ORSA components:

Security Inspections, Sections (2) and (11): (2) "Every officer is required to conduct a security check of his/her assigned area. The results are documented;" and, (11) "Every search of the SMU and other housing units is documented."

Special Management Unit (SMU), Administrative Segregation, Sections (10) and (11): (10) "The SMU maintains a permanent log of detainee-related activity, e.g., meals served, recreation, visitors etc.; and (11) Staff record whether the detainee ate, showered, exercised... during every shift."

Applicable facility policy: *Special Management Inmates*, Documentation, Section 2.6.4.3 and 2.6.4.5: "Documentation of each inmate/detainee placed into segregation shall be maintained. At a minimum, the documentation shall include: (2.6.4.3.5) Spillman Jail Log (logging any/all activities/problems/incidents relating to segregated inmates)."

Relevant NDS 2000 component: *Special Management Unit, Administrative Segregation*, Section (III)(E): "A permanent log will be maintained in the SMU. The log will record all activities concerning the SMU detainees, e.g., meals served, recreation, visitors, etc."

13. On May 2, 2019, LPCADF staff classified SINGH, two days after admission. Although ICE NDS 2000 and LPCADF policy require an initial classification to occur at intake, one was not completed. Moreover, although the facility attempted to conduct a Formal Classification Assessment within 24 to 72 hours in accordance with their own policy, no interpretation services were used; consequently, questions were answered based solely on SINGH's criminal history. Furthermore, a supervisor never reviewed or approved the classification. Per (b)(6); (b)(7)(C) supervisors do not routinely review classification decisions and the facility policy does not require they do so.

Applicable facility policies:

Inmate Classification, Pre-Classification Assessment (TRIAGE), Section 3.3.2: "The LPCSO-ADF shall conduct a Pre-Classification Assessment (TRIAGE) of incoming arrestees, commitments and other inmates booked into the facility... The Triage should begin immediately after accepting custody of an inmate."

Inmate Classification, Classification Assessment, Section 3.3.3: "Within 24 to 72 hours, the Disciplinary & Classification Officer (D&C Officer) will complete the Formal Classification Assessment in Spillman, utilizing additional information not readily available to Booking Staff."

Relevant NDS 2000 components:

Detainee Classification System, Section (III)(A)(1): “The classification system ensures: All detainees are classified upon arrival, before being admitted into the general population.”

Detainee Classification System, Section (III)(A)(3): “The first-line supervisor will review and approve each detainee’s classification.”

14. (b)(6); (b)(7)(C) used a knife rather than a cut-down tool to cut SINGH from the bunk bed. After asking for a seatbelt cutter with a negative response from LPCADF staff (b)(6); (b)(7)(C) also used a knife to cut through SINGH’s shirt and remove the ligature from his neck, placing SINGH at risk for further injury.

Applicable ORSA component: *Contraband*, Section (1): “The facility follows a written procedure for handling illegal contraband. Staff inventory, hold, and report it when necessary to the proper authority for action/possible seizure.”

Applicable facility policies:

Searches and Contraband Control, Weapons, Section 2.9.8.9.3: “All contraband identified as criminal in accordance with ARS 13-2501 shall be properly secured maintaining an accurate chain of custody log.”

Searches and Contraband Control, Disposition of Contraband Not Used as Criminal Evidence, Section 2.9.9.5: “Contraband, excluding nuisance contraband, shall be disposed of by the Shift Supervisor.”

Relevant NDS 2000 components:

Contraband, Section (I): “Detention staff will handle and properly dispose of contraband in accordance with the standard operating procedures of the facility. Contraband will be destroyed in the presence of at least one official observer, and those involved will document every instance of contraband-destruction.”

Contraband, Section (III)(A): “Hard contraband includes any item that is inherently dangerous as a weapon or tool of violence; e.g., a knife, explosives, a ‘zipgun’, brass knuckles, etc.”

15. LPCADF did not maintain continuous supervision of SINGH after EMS departed the facility. An LPCADF supervisor did not dispatch Deputy (b)(6); (b)(7)(C) to LPRH until approximately 6:30 p.m., after SINGH arrived at the hospital. At approximately 8:00 p.m., LPCADF dispatched (b)(6); (b)(7)(C) and Officer (b)(6); (b)(7)(C) to AWC hospital, as LPRH was preparing to transfer SINGH to AWC for a higher level of care. At approximately 9:08 p.m., once the Native Air flight left LPRH for AWC hospital, Deputy (b)(6); (b)(7)(C) hospital vigil duties ended. As neither Deputy (b)(6); (b)(7)(C) or Officer (b)(6); (b)(7)(C) maintained a log of events during their respective hospital watches, ERAU was unable to determine how long SINGH remained unaccompanied at both LPRH and AWC.

Applicable facility policies:

Hospitalization of Detainee's [sic], *Responsibility*, Section 5.6.1.1: "The assigned escorting officer (s) shall not leave a detainee unattended for any reason while outside of the secure LPCSO-ADF."

Hospitalization of Detainee's [sic], *Hospital Log*, Section 5.6.2.1: "Escorting officers shall maintain a Hospital Log throughout the duration of the detainees [sic] medical stay."

16. According to CDR (b)(6); (b)(7)(C) all inmates and detainees admitted to LPCADF are strip searched.

Applicable ORSA component: *Admission and Release*, Section (4): "Detainees are stripped searched only when cause has been established and not as routine policy. Non-criminal detainees are not strip-searched but are patted down, unless reasonable suspicion is established."

Relevant ICE Change Notice, *Admission and Release – National Detention Standard Strip Search Policy*, dated October 15, 2007, "Facilities are reminded that strip searches, cavity searches... and other required exposure of the private parts of a detainee's body for the purpose of searching for contraband are prohibited, absent reasonable suspicion of contraband possession."

17. The only documented admission process (b)(6); (b)(7)(C) completed was an inventory of SINGH's funds and property on April 30, 2019. SINGH's signature does not appear on the inventory, nor does an address book later found by (b)(6); (b)(7)(C) in SINGH's backpack. No other contents of SINGH's backpack were inventoried.

Applicable ORSA component: *Admission and Release*, Section (5): "... Staff prepares a complete inventory of each detainee's possessions. The detainee receives a copy."

18. There is no backup RN to oversee the LPNs when (b)(6); (b)(7)(C), who also serves as the facility's HSA, is unavailable. During their interviews with ERAU, nurses reported overwhelming workloads and long hours.

Relevant NDS 2000 component: *Medical Care*, Section (III)(A): "All facilities will employ, at a minimum, a medical staff large enough to perform basic exams and treatments for all detainees."

19. On April 30, 2019, (b)(6); (b)(7)(C) documented SINGH had an elevated blood pressure and pulse during his initial assessment. At no other point during SINGH's detention at LPCADF did medical staff re-check his blood pressure.

20. After (b)(6); (b)(7)(C) radioed for (b)(6); (b)(7)(C) to respond to the medical emergency, RN (b)(6); (b)(7)(C) did not respond with any medical equipment. She reported that this was because (b)(6); (b)(7)(C) radio call asking for medical assistance was unclear. She also did not enter a note into the medical record detailing the medical emergency until May 7, 2019, after SINGH's death.
21. LPCADF allowed Officer (b)(6); (b)(7)(C) to perform limited Detention Officer duties on an unsupervised basis before she completed formal training of any kind. Having not been trained, she was unable to take appropriate action when she discovered SINGH's suicide attempt.
22. When (b)(6); (b)(7)(C) responded to SINGH's cell, he did not immediately call a medical emergency over the radio and did not enter the cell to lift SINGH upward pending the arrival of additional staff.
23. LPCSO turned over the investigation of SINGH's suicide to the MCSO. Although not documented by LPCADF, the MCSO report suggests SINGH's cell was treated as a crime scene in accordance with facility policy 5.3.3, Inmate Death. The MCSO report did not offer any conclusions within its scope, and LPCSO did not conduct an internal after-action review to identify any internal policy violations.

EXHIBITS

1. Creative Corrections Healthcare and Security Compliance Analysis.
2. State of Arizona Certificate of Death 102-2019-031160, certified May 4, 2019.
3. Maricopa County Forensic Science Center: Record of Admission, dated May 3, 2019.
4. Maricopa County Medical Examiner Report, case 19-03827, signed July 31, 2019.
5. LPCADF 2018 ORSA, dated September 13, 2018.

From: (b)(6); (b)(7)(C)
To: (b)(6);
Cc: ERO CRCL
Subject: FW: Detainee Death Notification - Choung Woong AHN
Date: Tuesday, May 19, 2020 8:25:32 AM

From: (b)(6); (b)(7)(C)@ice.dhs.gov>
Sent: Monday, May 18, 2020 8:04 PM
Subject: Detainee Death Notification - Choung Woong AHN

The message below is distributed on behalf of Executive Associate Director Enrique M. Lucero:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Choung Woong AHN, A042 028 791.

ISSUE:

On May 17, 2020, U.S. Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) San Francisco reported the death of ICE detainee Choung Woong AHN, A42 028 791, a 74-year-old citizen of South Korea at the Mesa Verde ICE Processing Facility (MVIPF) in Bakersfield, CA. Emergency Medical Services (EMS) pronounced AHN deceased at 9:52 p.m. Pacific Daylight Time (PDT). Medical staff has not identified the preliminary cause of death.

Consistent with ICE policy, ERO San Francisco notified the DHS Office of Inspector General (OIG), and the ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO San Francisco provided telephonic notification of AHN's death to the Consulate General of South Korea in San Francisco, CA. ERO San Francisco also provided information about AHN's next of kin. The Consulate General will notify the next of kin about AHN's death.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On November 3, 1988, the former Immigration and Naturalization Service at San Francisco, CA admitted AHN into the U.S. as a lawful permanent resident (P-51, sibling of an adult U.S. Citizen).

On June 25, 2013, the Superior Court of California, County of Alameda, convicted AHN for the offense of attempted murder in violation of California Penal Code (CPC) Section 187(a) with an enhancement for using a firearm in violation of CPC Section 12022.5. The court imposed a sentence of seven years in prison for the offense of attempted murder with an additional three years for the firearms enhancement.

On February 21, 2020, ERO San Francisco arrested AHN upon his release from Solano State Prison in Vacaville, CA. On the same date, ERO San Francisco served AHN a Notice to

Appear, Form I-862, charging AHN as being a removable alien under § 237 (a)(2)(A)(iii) of the Immigration and Nationality Act, as an alien whom after admission is convicted of an aggravated felony.

On March 12, 2020, the Mercy Truxtun Hospital admitted AHN for cough with history of right hilar mass.

On March 18, 2020, the Mercy Truxtun Hospital discharged AHN and he returned to the MVIPIF. On the same day, an immigration judge (IJ) continued AHN's case due to his hospitalization.

On March 24, 2020, the IJ reset AHN's case to allow more time for him to obtain an attorney.

On April 2, 2020, the IJ reset AHN's case in order to allow more time for him to obtain an attorney.

On April 14, 2020, the IJ reset AHN's case in order to allow more time for him to obtain an attorney.

On April 15, 2020, the Office of the Principal Legal Advisor received notice of a habeas and incoming Temporary Restraining Order (TRO) for release based on AHN's possible vulnerability to COVID-19.

On April 28, 2020, ERO San Francisco reviewed AHN's custody status to determine risk status due to the COVID-19 pandemic. ERO San Francisco determined AHN was a member of the risk factor 1 due to his age and medical history. ERO San Francisco found that AHN was not amenable to release due to his violent criminal history. On the same date, an IJ continued AHN's case.

On May 4, 2020, the U.S. District Court for the Northern District of California denied AHN's motion for a temporary restraining order in the case Ahn, et al. v. Barr, et al., 3:20-cv-02604-JD

On May 12, 2020, MVIPIF staff escorted AHN to the facility medical unit after AHN complained of chest pains. At approximately 3:13 p.m. PDT, the Memorial Hospital in Bakersfield, CA admitted AHN for chest pain. On the same date, the IJ reset AHN's case to May 19, 2020, due to his hospitalization.

On May 13, 2020, the U.S. District Court for the Northern District of California denied AHN's request for bail.

On May 14, 2020, the Memorial Hospital discharged AHN and he returned to MVIPIF. MVIPIF staff placed AHN in medical isolation housing to begin a 14-day isolation pursuant to ICE Health Service Corps (IHSC) COVID-19 protocols due to AHN having been offsite at the hospital.

On May 17, 2020, AHN missed a fifth consecutive meal. AHN stated he was upset about being placed in medical isolation protocols and that he was not hungry. AHN stated that he was not on a hunger strike and that he had instead, been consuming commissary items.

On May 17, 2020, at 9:10 p.m. PDT, staff at MVIPT discovered AHN hanging from the shower in his cell. MVIPT staff immediately cut AHN down, began Cardiopulmonary Resuscitation (CPR).

At approximately 9:12 p.m. PDT, MVIPT staff called EMS via a call to 911.

At approximately 9:19 p.m. PDT, officers from the Bakersfield, CA Police Department and EMS from Hall Ambulance Service arrived at MVIPT and continued CPR until 9:51 p.m. PDT.

At 9:52 p.m. PDT, Emergency Medical Technician (b)(6); (b)(7)(C) pronounced AHN deceased.

At approximately 10:15 p.m. PDT, the coroner and Bakersfield Police departed MVIPT with AHN's body.

At approximately 10:30 p.m. PDT, the Field Office Director for ERO San Francisco notified HQ ERO Field Operations of AHN's death.

On May 18, 2020, at 12:26 p.m. PDT, an ERO San Francisco Assistant Field Office Director notified the JIC of AHN's death.

At approximately 12:30 p.m. PDT, ERO San Francisco Chief of Staff notified OPR of AHN's death.

At approximately 1:05 p.m. PDT, ERO San Francisco notified the Korean Consulate in San Francisco, CA of AHN's death and requested that they notify the next-of-kin.

AHN is the 12th detainee to pass away in ICE custody in Fiscal Year 2020.

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From: (b)(6); (b)(7)(C)
To: (b)(6); (b)(7)(C)
Cc: (b)(6); (b)(7)(C)
Subject: FW: Detainee Death Notification - David HERNANDEZ-Colula
Date: Friday, February 21, 2020 7:04:39 AM

Not sure who is on the distro.

From: (b)(6); (b)(7)(C)@ice.dhs.gov>
Sent: Thursday, February 20, 2020 9:40 PM
Subject: Detainee Death Notification - David HERNANDEZ-Colula

The message below is distributed on behalf of Executive Associate Director Enrique M. Lucero:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: David HERNANDEZ-Colula, A206 652 911.

ISSUE:

On February 20, 2020, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) Detroit, reported the death of ICE detainee David HERNANDEZ-Colula, a 34-year-old citizen of Mexico, at St. Elizabeth Hospital in Youngstown, OH. Doctors declared HERNANDEZ deceased at 1:49 a.m. Eastern Standard Time (EST), on February 20, 2020. The preliminary cause of death is suicide by hanging.

ERO Detroit notified the Department of Homeland Security Office of Inspector General and ICE Office of Professional Responsibility via the Joint Intake Center. ERO Detroit staff advised that next-of-kin notification was made by the Assistant Warden of the Northeast Ohio Correctional Center (NEOCC). The local Mexican Consulate was notified telephonically on February 20, 2020.

All media inquiries will be referred to ICE Office of Public Affairs.

BACKGROUND:

On an unknown date and location, HERNANDEZ entered the United States without admission or parole by an immigration officer.

On December 4, 2014, the U.S. Border Patrol (USBP) arrested HERNANDEZ near Rochester, NY, during Greyhound Bus transportation check duties. USBP served HERNANDEZ 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 admission or parole.

On December 5, 2014, USBP transferred HERNANDEZ to ERO Buffalo custody for removal proceedings. On the same date, ERO Buffalo granted HERNANDEZ a \$5000 bond.

On December 8, 2014, HERNANDEZ was released from ICE custody upon posting bond.

On May 18, 2016, an immigration judge (IJ) in Buffalo, NY, consolidated HERNANDEZ' case with his spouse, (b)(6); (b)(7)(C) and his minor child Carlos (b)(6); (b)(7)(C)

On September 27, 2016, an IJ in Buffalo, NY, granted a change of venue to Cleveland, OH, after HERNANDEZ moved to Ohio.

On or about July 16, 2018, the Sturgis, MI, Police Department (Sturgis PD) arrested HERNANDEZ for domestic assault. There is no disposition on this case.

On May 8, 2018, an IJ in Cleveland, OH, continued the case to December 12, 2019.

On December 4, 2019, the Sturgis PD encountered HERNANDEZ during a civil dispute with his spouse. Sturgis PD arrested HERNANDEZ for outstanding warrants from his previous domestic assault arrests and booked him into the St. Joseph County Jail (SJCJ) in Centreville, MI.

On December 5, 2019, the Pacific Enforcement Response Center in Laguna Nigel, CA, lodged an Immigration Detainer- Notice of Action, Form I-247A, on HERNANDEZ.

On December 6, 2019, ERO Detroit arrested HERNANDEZ upon release from the SJCJ and booked him into ICE custody at the Calhoun County Jail in Battle Creek, MI.

On December 10, 2019, ERO Detroit transferred HERNANDEZ to the Northeast Ohio Correctional Center (NEOCC) in Youngstown, OH.

On December 12, 2019, ERO Detroit cancelled HERNANDEZ' bond.

On December 13, 2019, a NEOCC correctional officer conducting population count witnessed HERNANDEZ begin to place a blanket around his neck. Upon noticing the officer, HERNANDEZ quickly removed the blanket. Upon arrival to NEOCC Health Services, medical staff observed small abrasions to HERNANDEZ's left wrist. NEOCC staff placed HERNANDEZ on continuous medical watch.

On December 16, 2019, NEOCC medical staff cleared HERNANDEZ from Medical watch/observation, following an assessment in which HERNANDEZ denied present suicidal ideation. HERNANDEZ was transferred to general population.

On February 19, 2020, NEOCC medical staff conducted a mental health evaluation on HERNANDEZ. Notes from the evaluation state detainee cited no current needs, concerns, or problems. Security reported no unusual or problematic behaviors.

On the same date, an IJ in Cleveland, OH, continued HERNANDEZ' case to February 25, 2020.

On February 20, 2020, at approximately 1:09 a.m. (EST), an NEOCC officer conducting a security check discovered HERNANDEZ hanging from the top bunk of his cell, identified as

cell #B-5-121. The officer immediately called for Emergency Response Team (ERT) assistance.

At approximately 1:10 a.m. (EST), ERT staff responded to the scene, assisted HERNANDEZ to the ground, and began performing cardio-pulmonary resuscitation (CPR). Staff called for emergency services.

At approximately 1:12 a.m. (EST), NEOCC Health Services arrived at the scene and continued to conduct CPR while applying an automatic external defibrillator.

At approximately 1:24 a.m. (EST), outside emergency services arrived at the facility, responded to the scene, and continued CPR.

At approximately 1:26 a.m. (EST), emergency medical technicians (EMT) took over life saving measures.

At approximately 1:45 a.m. (EST), the ambulance exited the facility with HERNANDEZ.

At approximately 1:49 a.m. (EST), medical providers at St. Elizabeth's Hospital pronounced HERNANDEZ deceased.

At approximately 2:16 a.m. (EST), NEOCC staff provided telephonic notification to ERO Detroit via a voicemail message.

At approximately 4:30 a.m. (EST), the assistant warden from NEOCC notified the next of kin, (b)(6); (b)(7)(C) is currently in removal proceedings and on the alternatives to detention program.

At approximately 6:04 a.m. (EST), an Assistant Field Office Director (AFOD) for ERO Detroit received the voicemail message from NEOCC regarding the detainee death.

At approximately 6:33 a.m. (EST), the Deputy Field Office Director (DFOD) for ERO Detroit notified ERO HQ Field Operations of HERNANDEZ'S death.

At approximately 8:28 a.m. (EST), ERO Detroit notified the Joint Intake Center of HERNANDEZ's death.

At approximately 8:30 a.m. (EST), ERO Detroit notified the local Office of the Principal Legal Advisor and the local ICE Office of Public Affairs.

At approximately 9:22 a.m. (EST), ERO Detroit notified the Office of Professional Responsibility.

HERNANDEZ is the seventh detainee to pass away in ICE custody in Fiscal Year 2020.

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From: (b)(6); (b)(7)(C)
To:
Cc: (b)(6); (b)(7)(C)
Subject: FW: Detainee Death Notification - Maria Celeste OCHOA-Yoc de Ramirez - A213 441 658 - (b)(6); DD
Date: Sunday, March 8, 2020 5:12:44 PM

Dear CRCL,

CPD received a notification of the death of an ICE detainee, Maria Celeste **Ochoa-Yoc de Ramirez – A213 441 658**. CPD is coordinating with ERO Dallas Field Office for the information/documents related to detainee Maria Ochoa-Yac de Ramirez. Please find the ES below.

To facilitate the gathering and sharing of the information related to the death, CPD created a folder labeled (b)(6); (b)(7)(C) - Ochoa-Yoc de Ramirez, Maria in the SP site.

Thank you,

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

ICE | PCN - Washington, DC 20024

U.S. Department of Homeland Security

O: 202-732-(b)(6); (b)(7)(C) C: 202.379.(b)(6); (b)(7)(C) @ice.dhs.gov

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From: (b)(6); (b)(7)(C) @ice.dhs.gov>

Date: Sunday, Mar 08, 2020, 12:13 PM

Subject: Detainee Death Notification - Maria Celeste OCHOA-Yoc de Ramirez

The message below is distributed on behalf of Executive Associate Director Enrique M. Lucero:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Maria Celeste OCHOA-Yoc de Ramirez, A213 441 658.

ISSUE:

On March 8, 2020, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) Dallas, reported the death of ICE detainee Maria Celeste OCHOA- Yoc de Ramirez, a 22-year-old female citizen of Guatemala, at the Texas Health Downtown Fort Worth Hospital (THDFW) in Fort Worth, Texas. Doctors declared OCHOA

deceased at 8:42 a.m. Central Time (CT), on March 8, 2020. THDFW has not established an official cause of death.

ERO Dallas notified the Department of Homeland Security Office of Inspector General and the ICE Office of Professional Responsibility via the Joint Intake Center. The local Guatemalan Consulate notified the next-of-kin on March 8, 2020.

All media inquiries will be referred to ICE Office of Public Affairs.

BACKGROUND:

On September 4, 2019, the U.S. Border Patrol (USBP) arrested OCHOA upon her illegal entry into the United States near Hidalgo, TX.

On September 5, 2019, USBP served OCHOA a Notice and Order of Expedited Removal, Form I-860, charging her with removability pursuant to Section 212(a)(7)(A)(i)(I) of the Immigration and Nationality Act (INA), as an immigrant without a valid, unexpired immigrant visa or other document required for admission. On the same date, OCHOA claimed fear of returning to Guatemala.

On September 6, 2019, USBP transferred OCHOA to the custody of ERO San Antonio at the El Valle Detention Facility in Raymondville, TX.

On September 12, 2019, ERO San Antonio transferred OCHOA to ERO Dallas for detention at the Kay County Detention Center (KCDC) in Newkirk, OK.

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

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

On October 8, 2019, ERO Dallas served OCHOA a Notice to Appear, Form I-862, charging her with removability pursuant to Section 212(a)(7)(A)(i)(I) of the INA.

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

On February 7, 2020, KCDC transported OCHOA to the Alliance Health Hospital (AHH) in Ponca City, OK for evaluation. The AHH admitted OCHOA for a gall bladder procedure.

On February 9, 2020, OCHOA had her gall bladder surgically removed.

On February 10, 2020, OCHOA returned to the KCDC following medical discharge from AHH.

On February 13, 2020, ERO Dallas transferred OCHOA to the Prairieland Detention Center (PDC) in Alvarado, TX.

On February 18, 2020, the PDC contract staff transported OCHOA to the Texas Health Huguley Hospital (THHH) in Burleson, TX for abdominal pain related to her gall bladder removal.

On February 24, 2020, the IJ continued OCHOA's scheduled hearing due to her hospitalization.

On February 28, 2020, THHH transferred OCHOA to THDFW for specialty treatment of her conditions.

On March 5, 2020, at approximately 7:45 p.m. CT, THDFW transferred OCHOA to high level cardiac care for a heartrate of 168 and elevated lactic acid. THDFW reported OCHOA to be alert and oriented but had difficulty breathing.

At approximately 9:10 p.m. CT, THDFW diagnosed the OCHOA's condition as "worsening sepsis."

At approximately 9:25 p.m. CT, THDFW initiated a code blue for respiratory distress and respiratory failure, which resulted in OCHOA being intubated. The physician also administered Ativan.

At approximately 11:50 p.m. CT, OCHOA had a seizure. THDFW reported her condition as life threatening and placed her in a medically induced coma.

At approximately 11:52 p.m. CT, chest scans revealed aspiration pneumonia in the lower portion of the OCHOA's lungs. Medical staff provided OCHOA with plasma due to continued blood ooze. OCHOA showed significantly abnormal bloodwork results.

On March 6, 2020, at approximately 7:23 a.m. CT, THDFW reported a new diagnosis of pneumonia with organ failure. THDFW listed OCHOA in a life-threatening condition.

On March 8, 2020, at approximately 8:42 a.m. CT, medical providers at THDFW pronounced OCHOA deceased.

At approximately 9:02 a.m. CT, the Field Office Director (FOD) for ERO Dallas notified ERO HQ Domestic Operations of OCHOA's death.

At approximately 9:20 a.m. CT, ERO Dallas notified the Joint Intake Center of OCHOA's death.

At approximately 9:54 a.m. CT, the FOD for ERO Dallas notified ERO HQ Custody Operations of OCHOA's death.

At approximately 9:54 a.m. CT, ERO Dallas notified the local ICE Office of the Principal Legal Advisor and the local ICE Office of Public Affairs of OCHOA's death.

At approximately 9:54 a.m. CT, ERO Dallas notified the ICE Office of the Congressional Relations of OCHOA's death.

At approximately 9:58 a.m. CT, ERO Dallas notified the ICE Office of Professional

Responsibility of OCHOA's death.

At approximately 10:25 a.m. CT, ERO Dallas notified the Consulate of Guatemala Consul General, Ricardo Montes of OCHOA's death. Consul General Montes confirmed he would notify the next-of-kin, Jimmy and Estuardo Ochoa (brothers).

OCHOA is the eighth detainee to pass away in ICE custody in Fiscal Year 2020.

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From: (b)(6); (b)(7)(C)
To:
Cc:
Subject: FW: Detainee Death Notification - Nebane ABIENWI
Date: Wednesday, October 2, 2019 1:06:48 PM
Importance: High

(b)(6); (b)(7)(C)
Unit Chief, SDDO
ICE/ERO Custody Reporting & Strategy
202-732-(b)(6); (b)(7)(C)

From: (b)(6); (b)(7)(C)@ice.dhs.gov>
Sent: Wednesday, October 2, 2019 1:05 PM
To: (b)(6); (b)(7)(C)@ice.dhs.gov>
Cc: (b)(6); (b)(7)(C)@ice.dhs.gov>; (b)(6); (b)(7)(C)@ice.dhs.gov>
Subject: FW: Detainee Death Notification - Nebane ABIENWI
Importance: High

FYSA

From: (b)(6); (b)(7)(C)@ice.dhs.gov>
Sent: Wednesday, October 2, 2019 12:53 PM
Subject: Detainee Death Notification - Nebane ABIENWI
Importance: High

The message below is distributed on behalf of Acting Executive Associate Director Timothy S. Robbins:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Nebane ABIENWI, A213 187 584.

ISSUE:

On October 1, 2019, ICE Enforcement and Removal Operations (ERO) San Diego reported the death of ICE detainee Nebane ABIENWI, A213 187 584, a 37-year-old citizen of Cameroon, at the Sharp Chula Vista Medical Center in Chula Vista, CA. The medical staff pronounced ABIENWI deceased at 12:05 p.m. PDT. Medical staff identified the preliminary cause of death as brain death secondary to herniation secondary to basal ganglia hemorrhage.

Consistent with ICE policy, ERO San Diego notified the DHS Office of Inspector General (OIG), and the ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO San Diego also provided telephonic notification of ABIENWI's death to the Consulate General of Cameroon in Washington, DC. The Consulate General of Cameroon in Washington identified next of kin for ABIENWI.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On September 5, 2019, U.S. Customs and Border Protection (CBP) encountered ABIENWI as he applied for admission into the United States at the San Ysidro, CA, Port of Entry. During an oral interview, and in a sworn statement, ABIENWI admitted to being a citizen and national of Cameroon by virtue of birth in Bameda, Cameroon on October 28, 1981. CBP served ABIENWI with a Notice and Order of Expedited Removal, Form I-860, charging inadmissibility under section 212(a)(7)(A)(i)(I) of the Immigration and Nationality Act (INA), as an immigrant without a valid visa (b)(6); (b)(7)(C)

On September 19, 2019, CBP transferred ABIENWI to the custody of ERO San Diego at the Otay Mesa Detention Center (OMDC) in San Diego, CA.

On September 20, 2019, ERO San Diego referred ABIENWI's case to U.S. Citizenship and Immigration Services (b)(7)(E); (b)(3):Unspecified Statute

On September 26, 2019, at approximately 3:28 a.m. PDT, ICE Health Service Corp (IHSC) staff at OMDC responded to a medical emergency in a housing unit. Other detainees in ABIENWI's housing unit observed him fall off his bunk to the floor.

At 3:50 a.m. PDT, OMDC staff contacted Emergency Medical Services (EMS).

At 4:12 a.m. PDT, EMS arrived at OMDC and began treatment of ABIENWI.

At 4:34 a.m. PDT, EMS departed OMDC with ABIENWI for the Sharp Chula Vista Medical Center. Medical staff at the hospital admitted ABIENWI because he was nonresponsive to questions and commands, had jerky movements, and showed left side paralysis. Medical staff intubated ABIENWI.

At approximately 9:55 a.m. PDT, a CoreCivic detention officer notified ERO San Diego a doctor from the Sharp Chula Vista Medical Center needed ABIENWI's family contact information because he was hemorrhaging in the brain and might succumb to his injuries within the next 24 hours.

At approximately 2:27 p.m. PDT, ERO San Diego called (b)(6); (b)(7)(C) a friend of ABIENWI listed in ABIENWI's alien file. ERO San Diego requested assistance from (b)(6); (b)(7)(C) with providing contact information for ABIENWI's family.

On September 27, 2019, at approximately 2:00 a.m. PDT, a CoreCivic detention officer reported that medical staff at the Sharp Chula Vista Medical Center described ABIENWI's neurological functioning as getting worse, and a CT scan was scheduled. IHSC reported ABIENWI was unresponsive and had a fever throughout the night which finally broke in the morning.

At approximately 10:44 a.m. PDT, ERO San Diego left a voicemail for (b)(6); (b)(7)(C) Lamine at the Consulate of Cameroon requesting assistance with notifying any next of kin for ABIENWI.

At approximately 11:13 a.m. PDT, ERO San Diego emailed the Consulate of Cameroon with ABIENWI's alien number, date of birth, and copies of his Cameroon ID card and birth certificate.

At approximately 12:42 p.m. PDT, ERO San Diego contacted (b)(6); (b)(7)(C) from the Consulate of Cameroon. ERO San Diego informed (b)(6); (b)(7)(C) of ABIENWI's medical status. (b)(6); (b)(7)(C) said his office would try to locate family members for ABIENWI.

At approximately 3:00 p.m. PDT, ERO staff located medical certificates in ABIENWI's property. The medical certificates indicate that ABIENWI received treatment for hypertension/high blood pressure on August 30, 2019, in Tijuana, Mexico at a hospital named Centro De Salud Tijuana. ABIENWI was prescribed Captopril and Ranitidina medications.

At approximately 3:22 p.m. PDT, ERO San Diego provide (b)(6); (b)(7)(C) additional information about ABIENWI's injury.

On September 29, 2019, at approximately 5:01 a.m. PDT, IHSC notified ERO San Diego that ABIENWI remained comatose, unresponsive, and received tube feeding.

On September 30, 2019, at approximately 5:03 a.m. PDT, IHSC notified ERO San Diego that there were no changes to ABIENWI's status.

On September 30, 2019, at approximately 12:22 p.m. PDT, ERO San Diego called (b)(6); (b)(7)(C), and he provided the phone number to ABIENWI's brother, (b)(6); (b)(7)(C) living in South Africa. ERO San Diego contacted (b)(6); (b)(7)(C) and related his brother's condition. (b)(6); (b)(7)(C) identified ABIENWI's wife as (b)(6); (b)(7)(C) living in Cameroon. (b)(6); (b)(7)(C) provided her contact information.

At approximately 2:13 p.m. PDT, ERO San Diego and IHSC called ABIENWI's wife in Cameroon. During this phone call, OMDC personnel and IHSC medical staff answered (b)(6); (b)(7)(C)'s question regarding her husband. OMDC staff provided M (b)(6); (b)(7)(C) the phone number to the hospital so she could speak to the attending physician for an update on her husband.

At approximately 9:24 p.m. PDT, IHSC notified ERO San Diego there were no reported changes to ABIENWI's status, the prognosis was grim to poor.

On October 1, 2019, at approximately 6:07 a.m. PDT, IHSC notified ERO San Diego there were no reported changes to ABIENWI's status.

At approximately 12:05 p.m., medical staff at the Sharp Chula Vista Medical Center pronounced ABIENWI brain dead.

At approximately 12:38 p.m. PDT, ERO San Diego called ABIENWI's wife, (b)(6); (b)(7)(C). During this phone call IHSC notified (b)(6); (b)(7)(C) that her husband passed.

At approximately 1:06 p.m. PDT, IHSC notified ERO San Diego that medical staff at the Sharp Chula Vista Medical Center pronounced ABIENWI dead at 12:05 p.m. PDT. Medical staff identified the cause of death as brain death secondary to herniation secondary to basal ganglia hemorrhage.

At approximately 2:37 p.m. PDT, medical staff at the Sharp Chula Vista Medical Center discontinued the use of the ventilator. ABIENWI's cardiac function stopped shortly thereafter.

At approximately 3:06 p.m. PDT, ERO San Diego notified the Consulate General of Cameroon of ABIENWI's death.

ABIENWI is the first detainee to pass away in ICE custody in fiscal year 2020.

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From: ERO CRCL
To: (b)(6); (b)(7)(C)
Cc: (b)(6); (b)(7)(C); ERO CRCL
Subject: FW: Detainee Death Notification - Orlan Ariel CARCAMO-Navarro - A213 563 372 (b)(6); (b)(7)(C) D (SNA)
Date: Thursday, March 19, 2020 8:41:26 AM

Dear CRCL,

CPD received a notification of the death of an ICE detainee, **Orlan CARCAMO-Navarro – A213 563 372**. CPD is coordinating with ERO San Antonio Field Office for the information/documents related to detainee Orlan Carcamo

CPD created a folder labeled (b)(6); (b)(7)(C) – Carcamo Navarro, Orlan in the CRCL SP site.

Thank you,

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

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

ICE | PCN - Washington, DC 20024

U.S. Department of Homeland Security

O: 202-732 (b)(6); (b)(7)(C) C: 202.379 (b)(6); (b)(7)(C) E: (b)(6); (b)(7)(C)@ice.dhs.gov

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From: (b)(6); (b)(7)(C)@ice.dhs.gov>
Sent: Thursday, March 19, 2020 8:01 AM
To: (b)(6); (b)(7)(C)@ice.dhs.gov>
Subject: FW: Detainee Death Notification - Orlan Ariel CARCAMO-Navarro

Masking sure you saw this.

From: (b)(6); (b)(7)(C)@ice.dhs.gov>
Sent: Wednesday, March 18, 2020 9:56 PM
Subject: Detainee Death Notification - Orlan Ariel CARCAMO-Navarro

The message below is distributed on behalf of Executive Associate Director Enrique M. Lucero:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Orlan Ariel CARCAMO-Navarro, A213 563 372.

ISSUE:

On March 18, 2020, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) San Antonio, reported the death of ICE detainee Orlan Ariel CARCAMO-Navarro, a 27-year-old citizen of Honduras, at Karnes County Residential Center (KCRC) in Karnes City, TX. Karnes County Emergency Medical Services (EMS) declared CARCAMO deceased at 12:55 a.m. Central Standard Time (CST), on March 18, 2020. The preliminary cause of death is asphyxiation due to hanging.

ERO San Antonio notified the Department of Homeland Security Office of Inspector General and ICE Office of Professional Responsibility via the Joint Intake Center. ERO San Antonio has been unable to make notification to the next-of-kin. ERO San Antonio notified the Honduran Consulate telephonically on March 18, 2020.

All media inquiries will be referred to ICE Office of Public Affairs.

BACKGROUND:

On February 19, 2020, CARCAMO applied for admission as a member of a family unit at the Presidio Texas Port of Entry and requested asylum. U.S. Customs and Border Protection (CBP) served CARCAMO a Notice and Order of Expedited Removal, Form I-860, charging removability pursuant to Section 212(a)(7)(A)(i)(I) of the Immigration and Nationality Act (INA), as an immigrant without a valid, unexpired immigrant visa or other document required for admission.

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

On February 28, 2020, the APSO served CARCAMO a Record of Negative Credible Fear Finding and Request for Review by Immigration Judge, Form I-869. CARCAMO requested an immigration judge (IJ) review of the APSO determination.

On March 11, 2020, an IJ in San Antonio, TX affirmed the negative APSO decision and returned the case to ICE for removal of the family unit.

On March 18, 2020, at approximately 12:30 a.m. CST, a GEO Residential Advisor (RA) conducting a routine security check discovered CARCAMO hanging from the shower rod in his room. The RA immediately called for emergency medical assistance.

At approximately 12:32 a.m. CST, GEO medical and security staff responded to the scene, began performing cardio-pulmonary resuscitation (CPR), and called for Emergency Medical Services (EMS) via a call to 911.

At approximately 12:42 a.m. CST, Karnes County EMS arrived at the facility, responded to the scene, and continued CPR.

At approximately 12:47 a.m. CST, GEO staff provided telephonic notification to ERO San Antonio.

At approximately 12:48 a.m. CST, an Assistant Field Office Director (AFOD) for ERO San

Antonio received the call from GEO regarding the detainee suicide attempt.

At approximately 12:52 a.m. CST, the Deputy Field Office Director (DFOD) for ERO San Antonio notified ERO HQ Field Operations of CARCAMO'S suicide attempt.

At approximately 12:55 a.m. CST, Karnes County EMS terminated CPR. EMS contacted Precinct 2 Justice of the Peace, (b)(6); (b)(7)(C) Justice of the Peace (b)(6); (b)(7)(C) established CARCAMO's time of death as 12:30 a.m.

At approximately 1:35 a.m. CST, ERO San Antonio notified the Joint Intake Center of CARCAMO's death.

At approximately 1:41 a.m. CST, ERO San Antonio notified the Office of Professional Responsibility of CARCAMO's death.

At approximately 5:57 a.m. CST, Rhodes Funeral Home arrived at the facility.

At approximately 6:16 a.m. CST, Rhodes Funeral Home exited the facility with CARCAMO.

At approximately 7:00 a.m. CST, ERO San Antonio notified the local ICE Office of Public Affairs of CARCAMO's death.

At approximately 8:21 a.m. CST, ERO San Antonio notified the Honduran Consulate. The Honduran Consulate is attempting to locate and notify the next of kin.

At approximately 9:29 a.m. CST, ERO San Antonio notified the local Office of the Principal Legal Advisor.

CARCAMO is the ninth detainee to pass away in ICE custody in Fiscal Year 2020.

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From: (b)(6); (b)(7)(C)
To:
Cc: (b)(6); (b)(7)(C)
Subject: FW: Detainee Death Notification - Ramiro HERNANDEZ-Ibarra
Date: Sunday, March 22, 2020 1:22:05 PM

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

Please notify DHS CRCL and begin the document collection.

Jessica, please update the tracker.

R,

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

From: (b)(6); (b)(7)(C) @ice.dhs.gov>
Sent: Sunday, March 22, 2020 12:09 PM
Subject: Detainee Death Notification - Ramiro HERNANDEZ-Ibarra

The message below is distributed on behalf of Executive Associate Director Enrique M. Lucero:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Ramiro HERNANDEZ-Ibarra, A097 743 041.

ISSUE:

On March 21, 2020, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) San Antonio, reported the death of ICE detainee Ramiro HERNANDEZ-Ibarra, a 42-year-old citizen of Mexico, at the Valley Baptist Medical Center (VBMC) in Harlingen, TX. VBMC declared HERNANDEZ deceased at 5:46 a.m. Central Daylight Time (CDT), on March 21, 2020. The preliminary cause of death is septic shock. ERO San Antonio notified the Department of Homeland Security Office of the Inspector General and the ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO San Antonio notified the Mexican Consulate telephonically at 6:27 a.m. CDT.

The Mexican Consulate notified the next-of-kin at 6:28 a.m. CST.

All media inquiries will be referred to ICE Office of Public Affairs.

BACKGROUND:

On June 23, 1999, HERNANDEZ entered the United States near Pharr, TX without having been admitted or paroled by an immigration officer. The U.S. Border Patrol (USBP) arrested HERNANDEZ at that time and granted him a voluntarily return (VR) to Mexico.

On June 27, 1999, HERNANDEZ re-entered the United States near Hidalgo, TX without having been admitted or paroled by an immigration officer. The USBP arrested HERNANDEZ at that time and granted him a VR to Mexico the same day.

On July 3, 2000, HERNANDEZ re-entered the United States near Pharr, TX without having been admitted or paroled by an immigration officer. The USBP arrested HERNANDEZ near Alamo, TX the same day and granted him a VR to Mexico the same day.

On May 7, 2001, HERNANDEZ re-entered the United States near Hidalgo, TX without having been admitted or paroled by an immigration officer. The USBP arrested HERNANDEZ at that time and granted him a VR to Mexico the same day.

On May 12, 2001, HERNANDEX re-entered the United States near Pharr, TX without having been admitted or paroled by an immigration officer. The USBP arrested HERNANDEZ at that

time and granted him a VR to Mexico the same day.

On an unknown date at an unknown time, HERNANDEZ entered the United States without having been admitted or paroled by an immigration officer.

On October 29, 2003, the Texas Department of Public Safety arrested HERNANDEZ on charges of driving while intoxicated (DWI).

On December 29, 2003, the Texas County Court at Law No. 2 at Edinburg, TX convicted HERNANDEZ of DWI and imposed a sentence of 30 days of confinement.

On December 30, 2003, the USBP encountered HERNANDEZ at the Hidalgo County Jail (HCJ) in Edinburg, TX subsequent to his arrest for DWI. The USBP lodged an Immigration Detainer-Notice of Action, Form I-247 with HCJ.

On December 31, 2003, HCJ released HERNANDEZ to USBP. On the same day, the U.S. District Court for the Southern District of Texas convicted HERNANDEZ of violating 8 USC 1325 Illegal Entry and imposed a sentence of time served and returned HERNANDEZ to the custody of the USBP. The USBP granted HERNANDEZ a VR to Mexico the same day.

On an unknown date at an unknown time, HERNANDEZ entered the United States without having been admitted or paroled by an immigration officer.

On May 7, 2010, USBP arrested HERNANDEZ near McAllen, TX and issued a him a Notice to Appear (NTA), 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 admission or parole by an immigration officer.

On May 9, 2010, USBP transferred HERNANDEZ to ERO San Antonio at the Harlingen Staging Facility in Harlingen, TX.

On May 10, 2010, ERO San Antonio transferred HERNANDEZ to the Willacy County Detention Center in Raymondville, TX.

On June 8, 2010, an immigration judge (IJ) in Harlingen, TX granted HERNANDEZ a voluntary departure to Mexico under safeguards.

On June 9, 2010, ERO San Antonio witnessed HERNANDEZ's voluntary departure to Mexico.

On an unknown date at an unknown time, HERNANDEZ entered the United States without having been admitted or paroled by an immigration officer.

On December 20, 2019, the Hidalgo County Sheriff's Office arrested HERNANDEZ on charges of assault – cause bodily injury – family member.

On the following day, ERO San Antonio encountered HERNANDEZ at the HCJ in Edinburg, TX. ERO San Antonio served HERNANDEZ a NTA, Form I-862, charging removability pursuant to Section 212(a)(6)(A)(i) of the INA, as an alien present without admission or parole by an immigration officer. ERO San Antonio lodged an Immigration Detainer – Notice of Action, Form I-247A with HCJ.

On January 14, 2020, the Hidalgo County Court at Law No 6 convicted HERNANDEZ of assault- cause bodily injury – family member and imposed a sentence of 24 days of confinement (time served).

On the following day, ERO San Antonio took custody of HERNANDEZ and detained him without bond at the Port Isabel Detention Center (PIDC) in Los Fresnos, TX pending the outcome of his removal proceedings.

HERNANDEZ's initial hearing before the Executive Office for Immigration Review (EOIR) at PIDC was set for June 1, 2020.

On February 13, 2020, HERNANDEZ submitted a request to EOIR to be removed to Mexico and expressed dissatisfaction with being detained. His hearing was advanced to April 6, 2020.

On March 18, 2020, at approximately 11:18 p.m. CDT, PIDC personnel escorted HERNANDEZ to the PIDC infirmary for evaluation and observation.

On March 19, 2020 at approximately 5:25 a.m. CDT, the ICE Health Service Corps (IHSC)

medical staff determined HERNANDEZ required immediate medical attention due to flank pain.

At approximately 5:30 a.m. CDT, PIDC contacted emergency medical services (EMS) via a call to 911.

At approximately 5:54 a.m. CDT the Port Isabel EMS arrived at PIDC. They immediately departed PIDC with HERNANDEZ to the VBMC emergency room.

At approximately 6:30 a.m. CDT, EMS arrived with HERNANDEZ at the VBMC emergency room. After evaluation, VBMC admitted HERNANDEZ.

At approximately 4:12 p.m. CDT, IHSC notified ERO San Antonio that VBMC transferred HERNANDEZ into the Intensive Care Unit (ICU) in critical condition.

On March 20, 2020 at approximately 4:20 p.m. CDT (b)(6); (b)(7)(C) of the VBMC notified IHSC that HERNANDEZ's organs were shutting down and diagnosed him as having organ failure.

(b)(6); (b)(7)(C) also advised them to contact next-of-kin. HERNANDEZ remained unresponsive while in ICU.

At approximately 5:30 p.m. CDT, HERNANDEZ's wife invoked do not resuscitate measures to the VBMC medical staff.

On March 21, 2020 at approximately 5:46 a.m. CDT (b)(6); (b)(7)(C) established HERNANDEZ's time of death as 5:46 a.m. CDT. The initial cause of death as septic shock.

At approximately 6:25 a.m. CDT, the Field Office Director for ERO San Antonio notified ERO HQ Domestic Operations of HERNANDEZ's death.

At approximately 6:27 a.m. CDT, ERO San Antonio notified the JIC and (b)(6); (b)(7)(C) of the Mexican Consulate of HERNANDEZ's death.

At approximately 6:28 a.m. CDT, ERO San Antonio notified OPR and the local Office of the Principal Legal Advisor of HERNANDEZ's death.

At approximately 6:45 a.m. CDT, ERO San Antonio notified the local ICE Public Affairs Officer of HERNANDEZ's death.

HERNANDEZ is the tenth detainee to pass away in ICE custody in Fiscal Year 2020.

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From: (b)(6); (b)(7)(C)
To:
Cc:
Subject: FW: Detainee Death Notification - Samuelino MAVINGA
Date: Monday, December 30, 2019 10:08:35 AM

From: (b)(6); (b)(7)(C)@ice.dhs.gov>
Sent: Monday, December 30, 2019 10:06 AM
Subject: Detainee Death Notification - Samuelino MAVINGA

The message below is distributed on behalf of Acting Executive Associate Director Timothy S. Robbins:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Samuelino MAVINGA, A213 171 482.

ISSUE:

- On December 29, 2019, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) El Paso, reported the death of ICE detainee, Samuelino MAVINGA, a 40-year-old citizen of France, at the Presbyterian Hospital (PH) in Albuquerque, NM. The on-call physician declared MAVINGA deceased at 12:20 p.m. Mountain Standard Time (MST), on December 29, 2019. The preliminary cause of death is cardiac arrest.

ERO El Paso notified the Department of Homeland Security Office of Inspector General and ICE Office of Professional Responsibility via the Joint Intake Center. ERO El Paso staff was unable to locate any family members for MAVINGA as he was homeless when he was encountered by U.S. Customs and Border Protection. ERO El Paso notified the Consulate General of France in Washington, DC on December 29, 2019.

- All media inquiries will be referred to ICE Office of Public Affairs.

BACKGROUND:

On November 28, 2018, U.S. Customs and Border Protection Officers admitted MAVINGA into the United States at the John F. Kennedy International Airport in New York, NY as a visitor for pleasure under the Visa Waiver Program until February 27, 2019.

On November 11, 2019, U.S. Border Patrol (USBP) encountered MAVINGA at a USBP checkpoint in Sierra Blanca, TX while conducting passenger bus inspections. USBP determined that MAVINGA remained in the United States for a period longer than authorized and is in violation of his immigration status. USBP processed MAVINGA for a removal pursuant to Section 237 of the Immigration and Nationality Act (INA), as a Visa Wavier Program Violator (overstay).

On November 12, 2019, USBP released MAVINGA to ERO El Paso custody. ERO El Paso transferred MAVINGA to the Otero County Processing Center, in Chaparral, NM pending his

removal from the United States.

On November 15, 2019, MAVINGA claimed fear of returning to his country and requested asylum. ERO El Paso submitted a Notice of Referral to Immigration Judge, Form I-863 to the Executive Office for Immigration Review to initiate asylum proceedings.

On December 5, 2019, an immigration judge issued an oral decision granting MAVINGA's request to withdraw his application for asylum, withholding of removal under INA 241 and withholding of removal under convention against torture.

On December 11, 2019, ERO El Paso transferred MAVINGA to the Torrance County Detention Facility (TCDF) in Estancia, NM pending removal from the United States.

On December 12, 2019, TCDF medical staff advised ERO El Paso that TCDF staff transported MAVINGA, to PH for treatment and evaluation of emaciation, low body mass index, low blood pressure, scleral jaundice, frequent unproductive cough, slow mentation, tangential speech, left anterior chest with diminished, adventitious lung sounds, decreased reflexes, potential sepsis and sigmoid volvulus (twisting of the large intestines, causing large bowel obstruction).

On December 16, 2019, PH medical staff conducted a colectomy surgical procedure on MAVINGA.

On December 18, 2019, ERO El Paso contacted the Consulate of France, via telephone, and notified them of MAVINGA's hospital admission and requested the issuance of a travel document (TD).

On December 19, 2019, ERO El Paso contacted the Consulate of France, via email, for issuance of a TD and uploaded proof of French citizenship.

On December 20, 2019, ERO El Paso received an email from the Consulate of France indicating that they would issue the TD once an itinerary was issued. ERO El Paso began working on travel arrangements for MAVINGA to provide to the Consulate of France for TD issuance.

On December 25, 2019, PH medical staff transferred MAVINGA into the Intensive Care Unit after he went into respiratory distress during an intubation procedure which required Cardiopulmonary Resuscitation (CPR). PH physicians stabilized MAVINGA, but he remained in critical condition.

On December 29, 2019, at approximately 3:00 a.m., MST, MAVINGA went into cardiac arrest and needed to be resuscitated through CPR., PH medical staff stabilized MAVINGA, but he remained in critical condition.

On December 29, 2019, at approximately 4:00 a.m. MST, MAVINGA went into cardiac arrest for the second time and needed to be resuscitated through CPR. PH medical staff stabilized MAVINGA, but he remained in critical condition. PH medical staff determined that if MAVINGA went into cardiac arrest again they would not resuscitate.

On December 29, 2019, at approximately 12:20 p.m. MST, MAVINGA went into cardiac arrest for the third time and was pronounced deceased by a PH on call physician.

At approximately 12:35 p.m. MST, the TCDF warden notified ERO El Paso of MAVINGA's death.

At approximately, 12:52 p.m. MST, ERO El Paso acting deputy field office director (DFOD) notified HQ ERO Field Operations of MAVINGA's death.

At approximately, 2:20 p.m. MST, ERO El Paso acting DFOD notified the Joint Intake Center of the MAVINGA's death.

At approximately, 2:38 p.m. MST, ERO El Paso assistant field office director for ERO El Paso in Albuquerque, NM, arrived at PH to obtain MAVINGA's personal effects as well as the preliminary paperwork on the death.

MAVINGA is the fourth detainee to pass away in ICE custody in fiscal year 2020.

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From: (b)(6); (b)(7)(C)
To: (b)(6); (b)(7)(C)
Cc: ERO CRCL
Subject: FW: Detainee Death Notification - Santiago BATEN-Oxlaj
Date: Monday, May 25, 2020 9:49:24 AM
Importance: High

(b)(6);

OT is authorized so that the field can start gathering the documents.

R,

(b)(6);

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

Unit Chief, Custody Reporting and Strategy Unit
Custody Programs Division
Enforcement and Removal Operations (ERO)
DHS U.S. Immigration and Customs Enforcement (ICE)
Office: 202 732 (b)(6); (b)(7)(C)
Cell: 202 271 (b)(6)
(b)(6); (b)(7)(C) @ice.dhs.gov

From: (b)(6); (b)(7)(C) @ice.dhs.gov>
Sent: Sunday, May 24, 2020 5:39 PM
Subject: Detainee Death Notification - Santiago BATEN-Oxlaj

The message below is distributed on behalf of Executive Associate Director Enrique M. Lucero:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Santiago BATEN-Oxlaj, A216 635 071.

ISSUE:

On May 24, 2020, ICE Enforcement and Removal Operations (ERO) Atlanta, reported the death of ICE detainee Santiago BATEN-Oxlaj, a 34-year-old citizen of Guatemala, at the Piedmont Columbus Regional Hospital (PCRH) in Columbus, GA. Doctors pronounced BATEN deceased at 5:03 a.m. Eastern Daylight Time (EDT). The preliminary cause of death is Coronavirus disease (COVID-19).

Consistent with ICE policy, ERO Atlanta notified the DHS Office of Inspector General (OIG), and the ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO Atlanta staff attempted to notify BATEN's next-of-kin but has been unable to make contact. ERO Atlanta provided telephonic notification of BATEN's death to the Consulate General of Guatemala in Atlanta, GA. ERO Atlanta also provided information about BATEN's next-of-kin.

All media inquiries will be referred to ICE Office of Public Affairs.

BACKGROUND:

On an unknown date, BATEN entered the United States at an unknown location without being admitted or paroled after inspection by an immigration officer.

On June 18, 2019, the Kennesaw Municipal Court in Kennesaw, GA convicted BATEN of driving without a valid license and sentenced him to two days of confinement.

On February 19, 2020, the Marietta Municipal Court in Marietta, GA convicted BATEN of driving under the influence and sentenced him to one day of confinement and 11 months and 28 days of probation.

On March 2, 2020, ERO Atlanta arrested BATEN at the Marietta Municipal Probation Office and served him with a Notice to Appear, Form I-862, charging inadmissibility pursuant to Section 212(a)(6)(A)(i) of the Immigration and Nationality Act (INA), as an alien present in the United States without admission or parole by an immigration officer.

On March 18, 2020, an immigration judge (IJ) denied BATEN's request for release on an immigration bond.

On March 26, 2020, an IJ granted BATEN voluntary departure under safeguards to Guatemala with instructions to depart on or before April 27, 2020.

On April 17, 2020, the Stewart Detention Center Medical Director informed ERO Atlanta that BATEN had been admitted to the PCRH in Columbus, GA for evaluation and treatment of decreased oxygen saturation levels. The hospital subsequently informed ERO Atlanta that BATEN tested positive for COVID-19 and began utilizing treatment regimens including convalescent plasma donation, Hydroxychloroquine, and Remdesivir.

On May 24, 2020, at approximately 4:45 a.m. EDT, BATEN went into cardiopulmonary arrest and the PCRH medical staff initiated advance life support.

At approximately 5:03 a.m. EDT, the PCRH Doctor pronounced BATEN deceased after echocardiogram no longer showed heart activity.

At approximately, 5:56 a.m. EDT, the Acting Field Office Director for ERO Atlanta notified HQ ERO Field Operations of BATEN's death.

At approximately, 6:56 a.m. EDT, ERO Atlanta, notified the Consulate General of Guatemala in Atlanta of BATEN's death and requested that they notify the next-of-kin.

At approximately, 6:58 a.m. EDT, the Acting Field Office Director for ERO Atlanta notified the Joint Intake Center (JIC) and the JIC OPR duty agent of BATEN's death.

At approximately, 7:45 a.m. EDT, the Consulate General of Guatemala in Atlanta contacted BATEN's spouse and notified of BATEN's death.

BATEN is the 13th detainee to pass away in ICE custody in Fiscal Year 2020.

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recipient or believe you have received this communication in error, please do not print, copy, retransmit, disseminate, or otherwise use this information. Please inform the sender that you received this message in error and delete the message from your system.

From: (b)(6); (b)(7)(C)
To:
Cc: [Johnson, Tae D](#)
Subject: FW: Detainee Death Notification - Simratpal SINGH
Date: Saturday, May 4, 2019 8:58:32 AM

FYSA

CG, update death for Monday reporting

DSCU prepare and submit death file to CP

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

Sent with BlackBerry Work
(www.blackberry.com)

From: (b)(6); (b)(7)(C) @ice.dhs.gov>
Date: Saturday, May 04, 2019, 8:46 AM
To: #ERO Notification of Detainee Death (b)(7)(E) @ice.dhs.gov>
Cc: #ERO CHIEFS OF STAFF (b)(7)(E) ice.dhs.gov>
Subject: Detainee Death Notification - Simratpal SINGH

The message below is distributed on behalf of Acting Executive Associate Director Nathalie R. Asher

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Simratpal SINGH, A201 432 202.

ISSUE:

On May 3, 2019, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) Phoenix reported the death of ICE detainee Simratpal SINGH, A201 432 202, a 21-year-old citizen of India at the Abrazo West Campus Hospital in Goodyear, AZ. Medical staff at the hospital pronounced SINGH deceased on May 3, 2019, at 1:58 a.m. MST. The medical staff identified the preliminary cause of death as cardiopulmonary arrest caused by a suicide attempt.

Consistent with ICE policy, ERO Phoenix notified the U.S. Department of Homeland Security, Office of Inspector General (OIG), and the ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO Phoenix also provided telephonic notification of SINGH's death to the Consulate General of India in San Francisco, CA, who will, in turn, notify SINGH's next of kin.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On February 5, 2019, the U.S. Border Patrol (USBP) arrested SINGH near Otay Mesa, CA,

immediately after his illegal entry into the United States. The USBP served SINGH 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 Nationality Act (INA), as an immigrant not in possession of a valid unexpired immigrant visa, reentry permit, border crossing card, or other valid document required by the INA. On the same date, SINGH claimed fear of persecution or torture if returned to India.

On February 9, 2019, the USBP turned SINGH over to ERO Phoenix at the San Luis Regional Detention Center.

On February 20, 2019, ERO Phoenix transferred SINGH to the Eloy Detention Center (EDC) in Eloy, AZ, pending a credible fear interview before an Asylum Pre-Screening Officer (APSO).

On April 17, 2019, the APSO found that SINGH (b)(7)(E); (b)(3):Unspecified Statute and served him a Notice to Appear, Form I-862, charging inadmissibility pursuant to Section 212(a)(6)(A)(i) of the INA, as an alien present in the United States without being inspected, admitted or paroled, or who arrived in the United States at any time or place other than as designated by the Attorney General.

On the same date, ERO Phoenix granted SINGH a bond in the amount of \$73,500.

On April 29, 2019, SINGH posted his bond and ERO Phoenix released him from custody.

On April 30, 2019, the La Paz County Sheriff's Office (LPCSO) arrested SINGH near Ehrenberg, AZ for assault and sexual assault. On the same date, LPCSO booked SINGH into the La Paz County Jail.

On May 1, 2019, ERO Phoenix received an ACRIME notification of SINGH's arrest and book-in at the La Paz County Jail. ERO Phoenix lodged an Immigration Detainer – Notice of Action, Form I-247A against SINGH with the facility.

On May 2, 2019, the Quartzsite Justice Court in Quartzsite, AZ granted SINGH a bond in the amount of \$5,000.

On the same date, the Executive Office for Immigration Review (EOIR) in Tucson, AZ scheduled SINGH for a master hearing on May 17, 2019.

On the same date, at approximately 3:45 p.m. MST, La Paz County Jail personnel contacted the ERO Phoenix, Yuma Sub-Office to confirm ICE would take custody of SINGH. ERO Phoenix submitted another Immigration Detainer – Notice of Action, Form I-247A and a Warrant for Arrest of Alien, Form I-200, for SINGH. ERO Phoenix also submitted an Order to Detain, Form I-203A, and made arrangements to transport SINGH to the ERO Yuma Sub-Office the following day for further processing.

At approximately 4:30 p.m. MST, SINGH posted bond in his criminal case and SINGH became an ERO Phoenix detainee at the La Paz County Jail.

At approximately 5:56 p.m. MST, La Paz County Jail personnel called a medical emergency

after discovering SINGH in his cell with what appeared to be socks tied around his neck and attached to the bed post. SINGH was lying on the ground unresponsive and not breathing. La Paz County Jail personnel immediately began administering cardiopulmonary resuscitation (CPR).

At approximately 5:59 p.m. MST, La Paz County Jail personnel contacted the Parker, AZ Fire Department (PFD) and River Medical Emergency Medical Services (EMS).

At approximately 6:15 p.m. MST, EMS and PFD personnel arrived on scene and determined that SINGH did not have a pulse or heart rhythm. EMS and PFD personnel took over CPR efforts at that time.

At approximately 6:20 p.m. MST, EMS transported SINGH via ambulance to the La Paz Regional Hospital in Parker, AZ.

At approximately 6:58 p.m. MST, La Paz Regional Hospital medical staff regained SINGH's pulse and heart rhythm.

At approximately 9:53 p.m. MST, Air Methods Careflight EMS air lifted SINGH to the Abrazo West Campus Hospital in Goodyear, AZ.

At approximately 10:43 p.m. MST, SINGH arrived at Abrazo West Campus Hospital. SINGH arrived in a deep comatose state with a pulse and heartbeat. Shortly after arrival, SINGH experienced sudden cardiac arrest which required life-saving measures. Medical staff were able to resuscitate and re-stabilize SINGH. However, SINGH experienced another sudden cardiac event and despite the best efforts of medical staff, they were unable to resuscitate SINGH.

On May 3, 2019, at approximately 1:58 a.m. MST, the attending physician pronounced SINGH dead at 1:58 a.m. MST.

At approximately 7:46 a.m. MST, ERO Phoenix notified ERO Headquarters, Acting Deputy Assistant Director for Domestic Operations of SINGH's death.

At approximately 8:30 a.m. MST, ERO Phoenix telephonically notified OPR through the JIC.

At approximately 10:00 a.m. MST, ERO Phoenix telephonically notified the OIG duty agent of SINGH's death.

At approximately 10:30 a.m. MST, ERO Phoenix telephonically contacted the Consul General of India in San Francisco, CA and provided notification of SINGH's death.

SINGH is the fifth detainee to pass away in ICE custody in fiscal year 2019.

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From: (b)(6); (b)(7)(C)
To: (b)(6); (b)(7)(C)
Subject: RE: Detainee Death Notification - Roylan HERNANDEZ-Diaz - A203 637 060 - NOL
Date: Wednesday, October 16, 2019 3:43:55 PM

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

From: (b)(6); (b)(7)(C) <(b)(6); (b)(7)(C)@ice.dhs.gov>
Sent: Wednesday, October 16, 2019 3:33 PM
To: (b)(6); (b)(7)(C) <(b)(6); (b)(7)(C)@HQ.DHS.GOV>
Cc: (b)(6); (b)(7)(C) <(b)(6); (b)(7)(C)@hq.dhs.gov>; (b)(6); (b)(7)(C) <(b)(6); (b)(7)(C)@HQ.DHS.GOV>
Subject: FW: Detainee Death Notification - Roylan HERNANDEZ-Diaz - A203 637 060 - NOL
Importance: High

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

CPD was just received a notification of the death of an ICE detainee, Hernandez-Diaz, Roylan, A203 637 060.

Thank you,

(b)(6); (b)(7)(C)
ICE | PCN - Washington, DC 20024
U.S. Department of Homeland Security
O: 202-732-(b)(6); (b)(7)(C) C: 202-379-(b)(6); (b)(7)(C) <(b)(6); (b)(7)(C)@ice.dhs.gov>

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From: (b)(6); (b)(7)(C) <(b)(6); (b)(7)(C)@ice.dhs.gov>
Sent: Wednesday, October 16, 2019 3:23 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)@associates.ice.dhs.gov>
Cc: (b)(6); (b)(7)(C) <(b)(6); (b)(7)(C)@ice.dhs.gov>; (b)(6); (b)(7)(C) <(b)(6); (b)(7)(C)@associates.ice.dhs.gov>; (b)(6); (b)(7)(C) <(b)(6); (b)(7)(C)@associates.ice.dhs.gov>; (b)(6); (b)(7)(C) <(b)(6); (b)(7)(C)@ice.dhs.gov>
Subject: FW: Detainee Death Notification - Roylan HERNANDEZ-Diaz
Importance: High

(b)(6); (b)(7)(C)
Unit Chief, SDDO
ICE/ERO Custody Reporting & Strategy

From: (b)(6); (b)(7)(C) @ice.dhs.gov>

Date: Wednesday, Oct 16, 2019, 3:00 PM

Subject: Detainee Death Notification - Roylan HERNANDEZ-Diaz

The message below is distributed on behalf of Acting Executive Associate Director Timothy S. Robbins:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Roylan HERNANDEZ-Diaz, A203 637 060.

ISSUE:

On October 15, 2019, ICE Enforcement and Removal Operations (ERO) New Orleans reported the death of ICE detainee Roylan HERNANDEZ-Diaz, A203 637 060, a 43-year old citizen of Cuba, at the Richwood Correctional Center (RCC), Richwood, LA. RCC medical staff pronounced HERNANDEZ deceased at 2:21p.m. CDT and identified the preliminary cause of death as suicide.

Consistent with ICE policy, ERO New Orleans notified DHS Office of Inspector General, and the ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO New Orleans also provided electronic notifications of HERNANDEZ's death to the Acting Assistant Attaché of Removal in Cuba for notification to the Government of Cuba, as well as for him to provide notification to next of kin with information obtained from HERNANDEZ's file.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On May 19, 2019, U.S. Customs and Border Patrol (CBP) encountered HERNANDEZ as he applied for admission into the United States at the El Paso, TX Paso Del Norte, Port of Entry. CBP served HERNANDEZ with 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 Nationality Act (INA), as an immigrant without a valid visa. During initial interview, HERNANDEZ made a claim of fear of returning to Cuba.

On May 20, 2019, CBP transferred HERNANDEZ into the custody of ERO El Paso.

On May 23, 2019, ERO El Paso transferred HERNANDEZ to the Tallahatchie County Correctional Facility, Tutwiler, MS, located within the ERO New Orleans Field Office.

On May 24, 2019, ERO New Orleans referred HERNANDEZ's case to U.S. Citizenship and Immigration Service (USCIS) (b)(7)(E); (b)(3):Unspecified Statute

On June 5, 2019, USCIS determined HERNANDEZ (b)(7)(E); (b)(3):Unspecified Statute and served him a Notice to Appear, Form I-862, charging inadmissibility pursuant to section

212(a)(7)(A)(i)(I) of the INA, as an immigrant without a valid visa.

On June 13, 2019, HERNANDEZ was transferred to RCC.

On August 5, 2019, HERNANDEZ filed a request for parole with ERO New Orleans.

On August 20, 2019, ERO New Orleans denied the request for parole.

On August 21, 2019, an immigration judge (IJ) in Richwood, LA, found HERNANDEZ removable and provided him with an Application for Asylum and for Withholding of Removal, Form I-589. The IJ reset the case for an individual hearing on October 9, 2019 to address the I-589.

On September 16, 2019, HERNANDEZ filed a request for a parole redetermination.

On September 27, 2019, HERNANDEZ filed an I-589 with the Executive Office for Immigration Review.

On October 8, 2019, ERO New Orleans denied HERNANDEZ's request for parole redetermination.

On October 9, 2019, an IJ reset the case for January 30, 2020.

On October 10, 2019, RCC placed HERNANDEZ in administrative segregation for observation and monitoring due to threatening a hunger strike.

On October 11, 2019, RCC observed HERNANDEZ eating his dinner meal.

On October 12, 2019, RCC observed HERNANDEZ eating his breakfast meal.

On October 15, 2019, RCC notified ERO New Orleans that HERNANDEZ had missed his ninth consecutive meal and declared a hunger strike, citing his frustration with the immigration process.

At approximately 2:04 p.m. CDT, RCC facility captain walked by HERNANDEZ's cell and noticed a strong odor coming from the cell. The RCC facility captain attempted to visibly check on HERNANDEZ by looking through the cell door window but couldn't see him; at that time, RCC captain entered the cell and found HERNANDEZ hanging from his top bunk with a bedsheet attached to his neck. The RCC facility captain immediately called a medical emergency and requested medical assistance.

At approximately 2:14 p.m. CDT, RCC medical staff arrived on the scene and were not able to find a pulse (radial or carotid), could not find nor hear respirations, noticed that there was red mottling in HERNANDEZ's bilateral arms and hands, and that HERNANDEZ had evacuated his bowels.

At approximately 2:15 p.m. CDT, RCC notified ERO New Orleans that HERNANDEZ had apparently committed suicide by hanging himself with a bedsheet in his cell. RCC notified the coroner and local authorities.

At approximately 2:21 p.m. CDT, RCC medical staff pronounced HERNANDEZ deceased. RCC medical staff tentatively identified the cause of death as suicide pending coroner's report.

At approximately 2:34 p.m. CDT, ERO New Orleans telephonically notified ERO Headquarters, Assistant Director for Field Operations of HERNANDEZ's death.

At approximately 3:39 p.m. CDT, RCC staff telephonically notified HERNANDEZ's family in Tampa, FL of his death.

At approximately 3:46 p.m. CDT, ERO New Orleans notified the Acting Assistant Attaché for Removal with the U.S. Embassy in Havana, Cuba of HERNANDEZ's death.

At approximately 4:07 p.m. CDT, ERO New Orleans electronically notified the ERO Headquarters, Assistant Director of Custody Management of HERNANDEZ's death.

At approximately 4:11 p.m. CDT, ERO New Orleans notified OPR through the JIC of HERNANDEZ's death

HERNANDEZ is the second detainee to pass away in ICE custody in fiscal year 2020.

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From: (b)(6); (b)(7)(C) <[REDACTED]@ice.dhs.gov>
Date: Wednesday, Sep 11, 2019, 2:22 PM
Cc: #ERO CHIEFS OF STAFF (b)(7)(E) <[REDACTED]@ice.dhs.gov>
Subject: Detainee Death Notification - Rodriguez-Espinoza, Roberto

The message below is distributed on behalf of Acting Executive Associate Director Timothy S. Robbins

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Roberto RODRIGUEZ-Espinoza, A215 809 440.

ERO Chicago-Roberto RODRIGUEZ-Espinoza A215 809 440

ISSUE:

Enforcement and Removal Operations (ERO) Chicago reported the death of ICE detainee Roberto RODRIGUEZ-Espinoza, A215 809 440, a 37-year-old citizen of Mexican in removal proceedings. On September 10, 2019, Northwestern Medicine Central DuPage Hospital (CDH) in Winfield, IL. Medical staff pronounced RODRIGUEZ dead at 9:35 p.m. Central Standard Time (CST) today. CDH identified the preliminary cause of death as subdural hematoma.

BACKGROUND:

On an unknown date, RODRIGUEZ entered the United States at an unknown location without admission or parole by an immigration officer.

On May 29, 2008, the Circuit Court of Cook County (CCCC) in Chicago, IL convicted RODRIGUEZ of theft and sentenced him to six months' probation. ERO Chicago did not have any contact with RODRIGUEZ at this time.

On September 21, 2016, CCCC convicted RODRIGUEZ of burglary and sentenced him to 324 days in custody with credit for time served and two years' probation. ERO Chicago did not have any contact with RODRIGUEZ at this time.

On September 3, 2019, Homeland Security Investigations (HSI) Gang and Safety Unit Chicago encountered RODRIGUEZ in Chicago, IL (b)(7)(E) [REDACTED] with the Chicago Police Department. HSI had RODRIGUEZ under investigation at the time he was encountered. HSI Chicago arrested RODRIGUEZ and detained him at McHenry County Adult Correctional Facility (MCACF) in Woodstock, IL.

On September 3, 2019, MCACF medically screened RODRIGUEZ during the intake process and he claimed no medical or mental health history nor current intake of medications; however, he admitted to drinking a six pack of alcohol daily. RODRIGUEZ had not yet undergone a complete physical exam at MCACF, which is normally required within 14 days of intake.

On September 4, 2019, ERO Chicago transported RODRIGUEZ to Broadview Service Staging Area (BSSA) in Broadview, IL and issued him a Notice to Appear, Form I-862, charging inadmissibility pursuant to Section 212(a)(6)(A)(i) of the Immigration and Nationality Act (INA), as an alien who is

present in the United States without admission or parole by an immigration officer. ERO Chicago returned RODRIGUEZ to MCACF after completing processing.

On September 7, 2019, at approximately 3:30 p.m. CST, MCACF correctional staff observed RODRIGUEZ acting confused and unfamiliar with his surroundings. MCACF contacted MCACF medical regarding RODRIGUEZ' behavior. At this time, MCACF medical staff completed a medical re-evaluation to include vital signs and coordinated RODRIGUEZ's movement to the medical housing unit for further observation. MCACF medical staff indicated that RODRIGUEZ could be detoxing and commenced an alcohol detoxing treatment per the physician's order.

At approximately 10:47 p.m. CST, the MCACF physician ordered RODRIGUEZ transported to the Northwestern Medicine Woodstock Hospital (NWMWH) in Woodstock, IL, emergency room for further evaluation due to his altered mental status as a result of reported history of alcohol abuse.

On September 8, 2019, at approximately 4:58 a.m. CST, NWMWH transferred RODRIGUEZ via ambulance to Northwestern Medicine Huntley Hospital (NWMHH), in Huntley, IL, due to his continuous erratic behavior and his severe altered mental status. On the same date, NWMHH sedated and intubated RODRIGUEZ due to his altered mental state and agitated behavior. Subsequently, NWMHH diagnosed RODRIGUEZ with a brain hemorrhage.

At approximately 7:43 p.m. CST, NWMHH transferred RODRIGUEZ to CDH for a neurosurgery consult to accommodate his diagnosis. RODRIGUEZ failed to respond during a neurological exam performed upon arrival at CDH. The attending neurosurgeon advised against surgery to treat RODRIGUEZ's chronic acute brain bleed because he had irreversible loss of all function of the brain and was unlikely to survive the surgery. CDH placed RODRIGUEZ on life support in the Intensive Care Unit.

At approximately 11:54 p.m. CST, ERO Chicago contacted the Mexican Consulate to inform them of RODRIGUEZ' medical status and to request assistance locating his next of kin.

On September 9, 2019, ERO Chicago contacted the Mexican Consulate who advised that they believed they have located a family member and requested to visit RODRIGUEZ in the hospital to verify his identity.

On September 10, 2019, at approximately 7:23 p.m. CST, the Mexican Consulate advised ERO Chicago that they believed they have identified the person under ERO custody. However, they stated there is no way to make a positive identification without having biometrics and/or DNA involved. For that course of action, they would need to get their Foreign Affairs Ministry involved. The Consulate mobilized its resources in the United States and in Mexico to locate a next of kin in order to make proper arrangements and a proper identification.

At approximately 8:00 p.m. CST, CDH commenced brain death testing to check the blood flow for RODRIGUEZ. The brain death testing results did not show any blood flow in RODRIGUEZ's brain.

At approximately 9:35 p.m. CST, CDH disconnected RODRIGUEZ from life support at which time RODRIGUEZ died. CDH notified the ERO Chicago officer on duty at the hospital of RODRIGUEZ's death. On the same date and time, the ERO Chicago officer notified ERO Chicago management of RODRIGUEZ's death.

At approximately 10:07 p.m. CST, the ERO Chicago Field Office Director notified ERO Headquarters, Assistant Director for Field Operations of RODRIGUEZ's death.

At approximately 10:08 p.m. CST, consistent with ICE policy, ERO Chicago telephonically notified the Office of Professional Responsibility (OPR) via the Joint Intake Center of RODRIGUEZ's death. OPR indicated they would notify the Office of the Inspector General of RODRIGUEZ's death.

At approximately 10:55 p.m. CST, ERO Chicago notified the Consulate of Mexico in Chicago, IL of RODRIGUEZ's death. The Mexican Consulate was advised that they have seven days to inform ERO Chicago if they are claiming the body. Mexican Consular officials stated that RODRIGUEZ did not have any known next of kin.

RODRIGUEZ is the eighth detainee to pass away in ICE custody in fiscal year 2019.

All media inquiries will be referred to the ICE Office of Public Affairs.

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The message below is distributed on behalf of Executive Associate Director Matthew T. Albence:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Gourgen MIRIMANIAN, A070 963 630.

ISSUE:

On April 10, 2018, ERO Dallas reported the death of ICE detainee **Gourgen MIRIMANIAN**, a 54-year-old citizen and national of Armenia who died at the Prairieland Detention Center (PDC) in Alvarado, Texas. Medical staff at Texas Health Huguley Hospital (THHH) notified PDC at approximately 9:15 CDT, with a preliminary cause of death unknown.

The Department of Homeland Security (DHS), Office of Inspector General (OIG), and Office of Professional Responsibility (OPR) were notified via the Joint Intake Center (JIC). ERO Dallas notified Removal and International Operations (RIO) of the death so that they can contact the Armenian Embassy in Washington DC. RIO left a message with the Embassy to contact the Acting AFOD.

MIRIMANIAN's next of kin was notified of his death.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On April 28, 1994, Customs Border Protection admitted MIRIMANIAN at Los Angeles, California on a B2 visitor visa.

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

On October 1, 2002, MIRIMANIAN filed an I-140, Immigrant Petition for Alien Worker. On June 6, 2003, United States Citizenship and Immigration Services (USCIS) approved the petition.

On May 5, 2005, MIRIMANIAN filed form I-485, Application to Register Permanent Residence or Adjust Status. The application was never adjudicated by USCIS.

On September 6, 2006, the Beverly Hills, California Municipal Court convicted MIRIMANIAN of possession or selling of a switch-blade knife and sentenced him to 24 months probation.

On July 30, 2013, the Southern District of New York convicted MIRIMANIAN of racketeering conspiracy and sentenced him to 60 months incarceration.

On December 12, 2017, ERO Dallas encountered MIRIMANIAN at the Federal Medical Center Bureau of Prisons facility in Fort Worth, Texas.

On February 7, 2018, ERO Dallas arrested and issued MIRIMANIAN a Notice to Appear (Form I-862), pursuant to INA § 237 (a)(2)(A)(iii), attempted or conspiracy to commit an offense described in section 101(a)(43).

On March 6, 2018, an immigration judge ordered MIRIMANIAN removed from the United States.

MIRIMANIAN was awaiting issuance of a travel document from the Embassy of Armenia.

On April 10, 2018, PDC staff found MIRIMANIAN unresponsive on his bed. Staff contacted emergency medical services which transported MIRIMANIAN to the Texas Health Huguley Hospital (THHH) in Fort Worth, Texas where he was pronounced dead at approximately 9:12 a.m. CDT.

The ICE Health Service Corps (IHSC) Field Medical Coordinator is awaiting autopsy results which will provide the cause of death.

MIRIMANIAN is the fourth detainee to pass away in ICE custody in fiscal year 2018.

From: (b)(6); (b)(7)(C)
Sent: Thursday, July 25, 2019 8:56 AM
To: #ERO Notification of Detainee Death (b)(7)(E) ice.dhs.gov>
Cc: #ERO CHIEFS OF STAFF (b)(7)(E) ice.dhs.gov>
Subject: Detainee Death Notification - Arriago-Santoya, Pedro
Importance: High

The message below is distributed on behalf of Executive Associate Director Nathalie R. Asher:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Pedro ARRIAGO-Santoya, A216 428 457.

ISSUE:

On July 24, 2019, ICE Enforcement and Removal Operations (ERO) Atlanta reported the death of ICE detainee Pedro ARRIAGO-Santoya (a.k.a. Fabian Valdovinos-Salgado, Antonio Valdez-Baldera, Fortino Mendiola, Pedro Santivilla-Aroba, Pedro Santoya, and Pedro Carillo-Santos), A216 428 457, a 44-year-old citizen of Mexico, at the Piedmont Midtown Medical Center (PMMC) in Columbus, GA. Medical staff at PMMC pronounced ARRIAGO deceased on July 24, 2019, at 3:10 p.m. EDT. The medical staff identified the preliminary cause of death as cardio-pulmonary arrest secondary to multi-organ system failure, endocarditis, dilated cardiomyopathy with a low ejection fraction and respiratory failure.

Consistent with ICE policy, ERO Atlanta notified the DHS Office of Inspector General (OIG), and the ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO Atlanta also provided telephonic notification of ARRIAGO's death to the Consulate General of Mexico in Atlanta, GA. Currently, neither ERO Atlanta nor the Consulate General of Mexico in Atlanta, GA, has identified next of kin for ARRIAGO.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On an unknown date and location, ARRIAGO entered the United States without being admitted or paroled after inspection by an immigration official.

On March 5, 2004, the Okeechobee County, FL, Sheriff's Office arrested ARRIAGO for disorderly intoxication (unknown disposition).

On January 1, 2006, the Suwannee County, FL, Sheriff's Office arrested ARRIAGO for disorderly intoxication (unknown disposition).

On May 14, 2006, the Lafayette County, FL, Sheriff's Office arrested ARRIAGO for grand theft in the first degree.

On February 18, 2013, the Suwannee County, FL, State Attorney's Office dismissed charges of grand theft in the first degree.

On April 21, 2015, the Savannah Chatham County, GA, Metro Police Department arrested ARRIAGO for disorderly conduct.

On May 7, 2015, the Chatham County Recorder's Court in Savannah, GA, convicted ARRIAGO of disorderly conduct and the court sentenced him to time served.

On March 30, 2019, the Appling County, GA, Sheriff's Office arrested ARRIAGO for public drunkenness and violation of probation in reference to disorderly conduct.

On April 1, 2019, ERO Atlanta encountered ARRIAGO at the Appling County Jail (ACJ) in Baxley, GA. ERO Atlanta issued and served ARRIAGO a Notice to Appear, Form I-862, charging inadmissibility pursuant to Section 212(a)(6)(A)(i) of the Immigration and Nationality Act, as an alien present in the United States without being admitted or paroled by an immigration officer, or who arrived in the United States at any time or place other than as designated by the Attorney General. ERO Atlanta also lodged an Immigration Detainer – Notice of Action, Form I-247, and a Warrant of Arrest of Alien, Form I-200, with the ACJ.

On April 24, 2019, the ACJ released ARRIAGO to ICE custody and ERO Atlanta detained him at the Folkston ICE Processing Center in Folkston, GA.

On April 25, 2019, ERO Atlanta filed Form I-862 with the Atlanta Executive Office for Immigration Review.

On June 6, 2019, an immigration judge ordered ARRIAGO removed to Mexico. ARRIAGO reserved his right to appeal which was due to be filed on or before July 8, 2019.

On July 8, 2019, ARRIAGO failed to file an appeal with the Board of Immigration Appeals.

On July 10, 2019, ERO Atlanta transferred ARRIAGO to the Stewart Detention Center (SDC) for removal processing.

On July 20, 2019, at 12:57 p.m. EDT, Core Civic Medical called a medical emergency due to ARRIAGO's complaints of severe abdominal pain. Core Civic brought ARRIAGO into the triage room and a nurse and a nurse practitioner conducted a medical assessment on him. A physician authorized ARRIAGO to be sent via emergency medical service (EMS) transport to a hospital for evaluation.

At approximately 1:43 p.m. EDT, Core Civic contacted the Stewart County Fire & EMS via 911 to transport ARRIAGO to the Southwest Georgia Regional Hospital (SGRH).

At approximately 1:55 p.m. EDT, EMS arrived at the SDC.

At approximately 2:13 p.m. EDT, EMS departed the SDC for the SGRH.

At approximately 2:45 p.m. EDT, EMS arrived at the SGRH.

At approximately 6:00 p.m., EDT, the SGRH in Cuthbert, GA, admitted ARRIAGO for nausea and stomach pains. ERO Atlanta submitted the required Significant Incident Report for a hospital admission under report number: 2019SIR0013761.

On July 21, 2019, at 1:30 p.m. EDT, the SGRH medical staff transferred ARRIAGO to the PMMC in Columbus, GA for surgery consultation for suspected gall bladder disease.

On July 22, 2019, at 3:57 a.m. EDT, ARRIAGO went into cardiac arrest. The PMMC medical staff performed life saving measures by administering three rounds of epinephrine. The PMMC medical staff performed cardiopulmonary resuscitation (CPR) using an Automated External Defibrillator. Once ARRIAGO had normal system rhythm with a pulse, medical staff placed a ventilator on ARRIAGO and maintained his fraction of inspired oxygen (FiO2) level at 100%.

PMMC placed ARRIAGO in the intensive care unit under medical care where he remained intubated, on mechanical ventilation, and comatose. PMMC placed ARRIAGO on three different types of medication to maintain his blood pressure. Core Civic officers from SDC maintained security and custody of ARRIAGO during his admission to the medical care facility.

On July 22, 2019, ERO Atlanta contacted the Consulate General of Mexico in Atlanta, GA, to notify them of ARRIAGO's condition and to seek assistance in locating next of kin.

On July 24, 2019, at approximately 2:40 p.m. EDT, ARRIAGO again went into cardiac arrest and the PMMC staff initiated CPR.

At approximately 3:10 p.m. EDT, the attending physician at PMMC pronounced ARRIAGO deceased.

At approximately 3:15 p.m. EDT, Core Civic personnel notified ERO Atlanta of ARRIAGO's death.

At approximately 3:18 p.m. EDT, the ERO Atlanta Field Office Director notified ERO Headquarters, Assistant Director for Field Operations of ARRIAGO's death.

At approximately 3:35 p.m. EDT, ERO Atlanta telephonically notified OPR through the JIC of ARRIAGO's death.

At approximately 3:39 p.m. EDT, ERO Atlanta telephonically contacted the Consulate General of Mexico in Atlanta, GA, and provided notification of ARRIAGO's death.

At approximately 4:30 p.m. EDT, ERO Atlanta telephonically notified the OIG duty agent of ARRIAGO's death.

At approximately 5:10 p.m. EDT, the PMMC notified the Muscogee County Coroner and the Columbus Police Department.

ARRIAGO is the seventh detainee to pass away in ICE custody in fiscal year 2019.

NOTICE: This communication may contain privileged or otherwise confidential information. If you are not an intended recipient or believe you have received this communication in error, please do not print, copy, retransmit, disseminate, or otherwise use this information. Please inform the sender that you received this message in error and delete the message from your system.

From: (b)(6); (b)(7)(C)
Sent: Monday, July 1, 2019 9:59 AM
To: #ERO Notification of Detainee Death (b)(7)(E) ice.dhs.gov>
Cc: #ERO CHIEFS OF STAFF (b)(7)(E) ice.dhs.gov>
Subject: Detainee Death Notification - Yimi Alexis BALDERRAMOS-Torres
Importance: High

The message below is distributed on behalf of Executive Associate Director Nathalie R. Asher:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Yimi Alexis BALDERRAMOS-Torres, A206 179 679.

ISSUE:

On June 30, 2019, ICE Enforcement and Removal Operations (ERO) Houston reported the death of ICE detainee Yimi Alexis BALDERRAMOS-Torres a.k.a. Yimi BALDERAMO-Torres, A206 179 679, a 30-year-old citizen of Honduras, at the Memorial Hermann Northeast Hospital (MHNH) in Humble, TX. Medical staff at MHNH pronounced BALDERRAMOS deceased on June 30, 2019, at 6:45 a.m. CDT. The medical staff identified the preliminary cause of death as unknown.

Consistent with ICE policy, ERO Houston notified the DHS Office of Inspector General (OIG), and the ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO Houston also provided telephonic notification of BALDERRAMOS' death to the Consulate General of Honduras in Houston, TX, who has notified BALDERRAMOS' next of kin.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On July 25, 2013, BALDERRAMOS entered the United States near Hidalgo, TX without inspection, admission or parole by an immigration officer.

On August 5, 2013, the U.S. Border Patrol (USBP) arrested BALDERRAMOS near Falfurrias, TX 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 Nationality Act (INA), as immigrant without an immigrant visa.

On August 9, 2013, the USBP transferred BALDERRAMOS to ERO San Antonio at the Brooks County Jail in Falfurrias, TX.

On August 14, 2013, ERO San Antonio removed BALDERRAMOS from the United States to Honduras.

On May 17, 2019, BALDERRAMOS entered the United States with his minor son (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) a 13-year-old citizen of Honduras, near the Paso Del Norte Bridge in El Paso, TX.

On the same date, the USBP arrested BALDERRAMOS and his son and issued them each a Notice to Appear, Form I-862, charging removability pursuant to section 212(a)(7)(A)(i)(I) of the INA. (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) The USBP returned BALDERRAMOS and his son to Mexico under the Migration Protection Protocol program to await a hearing before an immigration judge scheduled for September 30, 2019.

On or about May 27, 2019, BALDERRAMOS entered the United States near Hidalgo, TX without having been admitted or paroled by an immigration officer. BALDERRAMOS made this entry without his child.

On June 6, 2019, the Montgomery County, TX Sheriff's Office (MCSO) conducted a traffic stop on a vehicle traveling northbound on Interstate 59. The MCSO deputies found BALDERRAMOS along with 10 other individuals in the vehicle. The MCSO suspected that these individuals were being smuggled into the United States and contacted ICE Homeland Security Investigations (HSI). HSI responded and arrested BALDERRAMOS and the other occupants of the vehicle. HSI issued BALDERRAMOS a Notice of Intent/Decision to Reinstate a Prior Order, Form I-871, pursuant to section 241(a)(5). During processing, BALDERRAMOS did not make a claim to having a fear of persecution if returned to Honduras.

On June 7, 2019, HSI transferred BALDERRAMOS to ERO Houston at the Montgomery Processing Center in Conroe, TX. BALDERRAMOS reported no medical issues upon intake.

On June 18, 2019, ERO Houston transferred BALDERRAMOS to the Houston Contract Detention Facility (HCDF) in Houston, TX. ICE Health Service Corps (IHSC) found no derogatory medical information on BALDERRAMOS upon his medical screening.

On June 30, 2019, at approximately 5:38 a.m. CDT, CoreCivic personnel at HCDF discovered BALDERRAMOS lying on his bunk in his dorm unresponsive and not breathing. CoreCivic personnel immediately called a medical emergency. IHSC personnel responded and immediately began administering cardiopulmonary resuscitation (CPR) and administered an automated external defibrillator (AED). CoreCivic personnel contacted emergency medical services (EMS) via a call to 911.

At approximately 5:55 a.m. CDT, Houston Fire Department EMS arrived at the HCDF and relieved IHSC staff performing CPR and continued AED efforts.

At approximately 6:15 a.m. CDT, EMS transported BALDERRAMOS to MHNH via ambulance.

At approximately 6:31 a.m. CDT, CoreCivic personnel notified the ERO Contracting Officer Representative (COR) of the hospital transport.

At approximately 6:37 a.m. CDT, EMS arrived at MHNH .

At approximately 6:39 a.m. CDT, MHNH staff continued CPR on BALDERRAMOS.

At approximately 6:40 a.m. CDT, MHNH staff checked BALDERRAMOS for signs of life.

At approximately 6:41 a.m. CDT, MHNH staff resumed CPR on BALDERRAMOS.

At approximately 6:45 a.m. CDT, the attending physician at MHNH pronounced BALDERRAMOS deceased.

At approximately 7:20a.m. CDT, CoreCivic personnel notified ERO COR of BALDERRAMOS' death.

At approximately 7:32 a.m. CDT, the ERO COR notified ERO Houston of BALDERRAMOS' death.

At approximately 8:09 a.m. CDT, the ERO Houston Field Office Director notified ERO Headquarters, Assistant Director for Field Operations of BALDERRAMOS' death.

At approximately 8:45 a.m. CDT, ERO Houston telephonically contacted the Consulate General of Honduras in Houston, TX and provided notification of BALDERRAMOS' death.

At approximately 9:41 a.m. CDT, ERO Houston telephonically notified OPR through the JIC of BALDERRAMOS' death.

At approximately 9:42 a.m. CDT, ERO Houston telephonically notified the OIG duty agent of BALDERRAMOS' death.

On June 30, 2019, at approximately 11:25 a.m. CDT, the Honduran Consulate notified BALDERRAMOS' next of kin. The Consulate has indicated that the next of kin advised them that BALDERRAMOS' son has returned to Honduras. The consulate is verifying this information.

BALDERRAMOS is the sixth detainee to pass away in ICE custody in fiscal year 2019.

NOTICE: This communication may contain privileged or otherwise confidential information. If you are not an intended recipient or believe you have received this communication in error, please do not print, copy, retransmit, disseminate, or otherwise use this information. Please inform the sender that you received this message in error and delete the message from your system.

From: ERO CRCL
Sent: 24 Jul 2018 12:06:23 +0000
To: (b)(6); (b)(7)(C)

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

Cc: ERO CRCL
Subject: FW: Detainee Death Notice - Efrain Romero DE LA ROSA (b)(6); (b)(7)(C)

Please find notice of detainee death. I am not sure if this was previously sent to all.

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

HQ Custody Programs
Section Chief
Enforcement and Removal Operations
Immigration and Customs Enforcement

Desk: 631-8 (b)(6); (b)(7)(C)
Cell: 917-65 (b)(6); (b)(7)(C)

From: (b)(6); (b)(7)(C)
Sent: Wednesday, July 11, 2018 9:54 PM
To: #CPDSenior Staff (b)(7)(E) @ice.dhs.gov>
Subject: FW: Detainee Death Notice - Efrain Romero DE LA ROSA

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

Deputy Assistant Director
ICE Child Welfare and LGBTI Coordinator
DHS/ICE/ERO/Custody Programs
202.43 (b)(6); (b)(7)(C)

Sent with BlackBerry Work
(www.blackberry.com)

From: (b)(6); (b)(7)(C) @ice.dhs.gov>
Date: Wednesday, Jul 11, 2018, 9:17 PM
To: #ERO DEPUTY ASSISTANT DIRECTORS (b)(7)(E) @ice.dhs.gov>, #ERO EAD Front Office (b)(7)(E) @ice.dhs.gov>, #HSI CHIEFS OF STAFF (b)(7)(E) @ice.dhs.gov>, #ICE COS Staff (b)(7)(E) @ice.dhs.gov>, #ICE DD STAFF (b)(7)(E) @ice.dhs.gov>, #MASTAFF (b)(7)(E) @ice.dhs.gov> (b)(6); (b)(7)(C) @ice.dhs.gov>, Benner, Derek N (b)(6); (b)(7)(C) @ice.dhs.gov>, Burke, Ryan P (b)(6); (b)(7)(C) @ice.dhs.gov>, Davis, Mike P (b)(6); (b)(7)(C) @ice.dhs.gov>, Elzea, Jennifer (b)(6); (b)(7)(C) @ice.dhs.gov>, Hackbarth, Sean M (b)(6); (b)(7)(C) @ice.dhs.gov>, JIOC-ICE (b)(7)(E) @ice.dhs.gov>, Kovacic, Raymond (b)(6); (b)(7)(C) @ice.dhs.gov>, Lanum, Scott (b)(6); (b)(7)(C) @ice.dhs.gov>, Loiacono, Adam V (b)(6); (b)(7)(C) @ice.dhs.gov>, Padilla, Kenneth (b)(6); (b)(7)(C) @ice.dhs.gov>, Trickler-McNulty, Claire (b)(6); (b)(7)(C) @ice.dhs.gov>, Barrera, Staci A (b)(6); (b)(7)(C) @ice.dhs.gov>, Velazquez, Ricardo

(b)(6); (b)(7)(C) @ice.dhs.gov (b)(6); (b)(7)(C) @ice.dhs.gov, (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C) @ice.dhs.gov (b)(6); (b)(7)(C) @ice.dhs.gov, (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C) @ice.dhs.gov, (b)(6); (b)(7)(C) @ice.dhs.gov
Cc: #ERO CHIEFS OF STAFF (b)(7)(E) @ice.dhs.gov
Subject: Detainee Death Notice - Efrain Romero DE LA ROSA

The message below is distributed on behalf of Executive Associate Director Matthew T. Albence

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Efrain Romero DE LA ROSA, A209 910 301.

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:

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, WCDC 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.

From: (b)(6); (b)(7)(C)
Sent: 18 May 2018 14:51:22 +0000
To: (b)(6); (b)(7)(C)

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

Subject: FW: Detainee Death Notice - Ronald CRUZ ((b)(6); (b)(7)(C))

Please see below concerning a recent detainee death while in ICE custody.

A share point site has been created see below. Once the information is received all information will be uploaded into the Share Point site and you will be advised.

Detainee Deaths:

(b)(7)(E)

Subfolder: Cruz, Ronald A078 963 293

(b)(7)(E)

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

HQ Custody Programs
Section Chief
Enforcement and Removal Operations
Immigration and Customs Enforcement

Desk: 63 (b)(6); (b)(7)(C)
Cell: 917 (b)(6); (b)(7)(C)

From: (b)(6); (b)(7)(C)
Sent: Friday, May 18, 2018 10:27 AM
To: #CPDSenior Staff <(b)(6); (b)(7)(C)>@ice.dhs.gov>
Subject: FW: Detainee Death Notice - Ronald CRUZ

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

Deputy Assistant Director
DHS/ICE/ERO/Custody Programs
202 (b)(6); (b)(7)(C)

Sent with BlackBerry Work
(www.blackberry.com)

From: (b)(6); (b)(7)(C)>@ice.dhs.gov>

Date: Friday, May 18, 2018, 8:19 AM

To: #ERO DEPUTY ASSISTANT DIRECTORS (b)(6); (b)(7)(C) #ERO EAD

Front Office (b)(6); (b)(7)(C) #HSI CHIEFS OF STAFF (b)(6); (b)(7)(C)

#ICE COS Staff (b)(6); (b)(7)(C), #ICE DD STAFF (b)(6); (b)(7)(C), #MASTAFF

(b)(6); (b)(7)(C) Benner, Derek N

(b)(6); (b)(7)(C), Burke, Ryan P (b)(6); (b)(7)(C) @ice.dhs.gov>, Davis, Mike P

(b)(6); (b)(7)(C) @ice.dhs.gov>, Elzea, Jennifer (b)(6); (b)(7)(C) @ice.dhs.gov>, Hackbarth, Sean M

(b)(6); (b)(7)(C) @ice.dhs.gov>, JIOC-ICE (b)(6); (b)(7)(C) Kovacic, Raymond

(b)(6); (b)(7)(C) @ice.dhs.gov>, (b)(6); (b)(7)(C) @ice.dhs.gov>, Loiacono, Adam V

(b)(6); (b)(7)(C) @ice.dhs.gov>, Padilla, Kenneth (b)(6); (b)(7)(C) @ice.dhs.gov>, Trickler-McNulty, Claire

(b)(6); (b)(7)(C) @ice.dhs.gov>, Valerio, Tracey A (b)(6); (b)(7)(C) @ice.dhs.gov>, Velazquez,

Ricardo L (b)(6); (b)(7)(C) @ice.dhs.gov> (b)(6); (b)(7)(C) @ice.dhs.gov>, (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) @ice.dhs.gov> (b)(6); (b)(7)(C) @ice.dhs.gov>, Rodriguez, Waldemar

(b)(6); (b)(7)(C) @ice.dhs.gov>

Cc: #ERO CHIEFS OF STAFF (b)(6); (b)(7)(C) @ice.dhs.gov>

Subject: Detainee Death Notice - Ronald CRUZ

The message below is distributed on behalf of Executive Associate Director Matthew T. Albence

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Ronald CRUZ, A078 963 293.

ISSUE:

On May 16, 2018, U.S. Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) San Antonio reported the death of ICE detainee Ronald CRUZ, A078 963 293, a 39-year-old citizen of Honduras, at the Valley Baptist Medical Center (VBMC) in Harlingen, TX. The medical staff pronounced CRUZ dead at 6:49 p.m. CDT. Medical staff identified the preliminary cause of death as cardiac arrest.

Consistent with ICE policy, ERO San Antonio 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 San Antonio also notified the Consulate of Honduras in McAllen, TX, of CRUZ's death. Honduran Consular officials notified CRUZ's next of kin.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On May 15, 2002, CRUZ entered the United States at an unknown place without being admitted or paroled by an immigration officer.

On May 15, 2002, U.S. Border Patrol (USBP) arrested CRUZ at Carricitos, TX and served him 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 having been admitted or paroled by an immigration officer. USBP released CRUZ from custody under an Order of Recognizance.

On September 24, 2002, an immigration judge (IJ) in Houston, TX ordered CRUZ removed to Honduras in absentia.

On January 14, 2016, Jackson County Circuit Court, Kansas City, MO convicted CRUZ for the offense of driving under the influence and sentenced him to two days confinement.

On January 20, 2016, ERO Chicago arrested CRUZ at the Jackson County Jail, Kansas City, MO as an alien with an outstanding removal order.

On January 29, 2016, ERO removed CRUZ to Honduras.

On May 9, 2018, USBP arrested CRUZ at Rio Grande City, TX upon his illegal reentry into the United States. USBP served CRUZ a Notice of Intent/Decision to Reinstate Prior Order, Form I-871, pursuant to Section 241(a)(5) of the INA.

On May 14, 2018, USBP transferred CRUZ to ERO San Antonio, Port Isabel Detention Center (PIDC).

On May 14, 2018, ICE Health Service Corps (IHSC) conducted an initial medical screening which concluded that CRUZ had no health issues. CRUZ reported that he was feeling well, and disclosed that he had no acute or chronic medical conditions.

On May 15, 2018 at approximately 9:00 a.m. CDT, CRUZ reported to the IHSC PIDC medical clinic for sick call services. Upon the initial evaluation, the nurse obtained an elevated body temperature and an elevated blood pressure when compared to the results from the day before. The nurse then referred CRUZ to an IHSC Advanced Practice Practitioner (APP).

CRUZ reported to the APP that while at a facility prior to PIDC, he had been treated with antibiotics for flu like symptoms and with ear drops for a left ear infection. CRUZ was transferred to ICE with no accompanying medical paperwork from USBP and this claim of previous treatment remains under review.

After learning of CRUZ's symptoms, the APP performed a random blood sugar test and a standard urinalysis. Results from both tests revealed several abnormal values, to include high glucose, ketones protein and a small amount of blood. Because of these abnormal findings, CRUZ was transferred to the PIDC Acute Care Room.

While in the Acute Care Room, IHSC medical staff administered IV fluids, initiated antibiotic treatment, repeated the urinalysis test, and obtained lab studies for send out. CRUZ remained in the Acute Care Room until staff transferred him to the PIDC Medical Housing Unit (MHU).

At approximately 1:55 p.m. CDT, CRUZ arrived at the MHU. CRUZ reported to the IHSC medical staff of feeling sick and complained of pain.

At approximately 4:28 p.m. CDT, IHSC provided care to CRUZ as an urgent referral for altered mental status. CRUZ required assistance to ambulate and appeared lethargic and confused.

At approximately 4:38 p.m. CDT, IHSC activated Emergency Medical Services (EMS).

At approximately 5:06 p.m. CDT, EMS departed PIDC with CRUZ to the Harlingen Medical Center. EMS then rerouted to VBMC.

At approximately 5:48 p.m. CDT, EMS arrived at VBMC with CRUZ. VBMC admitted CRUZ and began testing, including chest x-rays and a CT scan of the head.

At approximately 10:11 p.m. CDT, CRUZ was diagnosed with Sepsis and Diabetic Keto Acidosis. At that time, he was still awake but very confused and nonverbal.

On May 16, 2018 at approximately 12:55 a.m. CDT, CRUZ suffered cardiac arrest. VBMC staff initiated advanced life support protocols and resuscitated him.

At approximately 1:09 a.m. CDT, CRUZ suffered a second cardiac arrest. VBMC staff initiated advanced life support protocols and resuscitated him.

At approximately 2:35 a.m. CDT, VBMC admitted CRUZ into the intensive care unit. CRUZ remained unresponsive and unconscious on a ventilator.

At approximately 10:00 a.m. CDT, ERO San Antonio notified the Honduran consulate in McAllen, TX via telephone and email, regarding the hospitalization and condition of CRUZ.

At approximately 10:05 a.m. CDT, ERO San Antonio contacted CRUZ's brother and sister via telephone and provided notification regarding the hospitalization and condition of CRUZ. Both of CRUZ's relatives reside in Missouri.

At approximately 6:25 p.m. CDT, CRUZ suffered from another cardiac arrest. VBMC staff initiated advanced cardiac life support protocols for 20 minutes. VBMC staff determined that further medical interventions were futile.

At approximately 6:49 p.m. CDT, VBMC staff pronounced CRUZ dead. The suspected cause of death is cardiac arrest.

At approximately 7:48 p.m. CDT, ERO San Antonio notified the Consulate of Honduras of CRUZ's death.

CRUZ is the fifth detainee to pass away in ICE custody in fiscal year 2018.

From: (b)(6); (b)(7)(C)
To:
Cc:
Subject: FW: Detainee Death Notice -- Abel REYES-Clemente
Date: Friday, May 3, 2019 3:47:19 PM

(b)(6); (b)(7)(C) will be sending us whatever information he has on this death next week.

From: (b)(6); (b)(7)(C)
Sent: Friday, May 3, 2019 3:45 PM
To: (b)(6); (b)(7)(C) @ice.dhs.gov
Subject: FW: Detainee Death Notice -- Abel REYES-Clemente

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

Per our discussion, please see the below detainee death notification.

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

Field Operations
Enforcement and Removal Operations
U.S. Immigration and Customs Enforcement
Department of Homeland Security

500 12th Street SW | Washington, DC 20536 | 202-732-3 (b)(6) (office) | 202-210 (b)(6); (b)(7)(C) (cell)

(b)(6); (b)(7)(C) ice.dhs.gov Email
(b)(6); (b)(7)(C) hs.sgov.gov SIPRnet
(b)(6); (b)(7)(C) hs.ic.gov JWICS

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From: (b)(6); (b)(7)(C)
Sent: Wednesday, April 3, 2019 8:45 PM
Subject: Detainee Death Notice -- Abel REYES-Clemente

The message below is distributed on behalf of Acting Executive Associate Director Nathalie R. Asher

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Abel REYES-Clemente, A215 881 614.

ISSUE:

On April 3, 2019, ERO Phoenix reported the death of ICE detainee Abel REYES-Clemente, A215 881 614, a 54-year-old citizen of Mexico, at the Florence Service Processing Center (SPC) in Florence, AZ. A doctor at the Mountain Vista Medical Center in Mesa, AZ,

pronounced REYES deceased on April 3, 2019, at 6:33 a.m. MST. Medical staff have not yet identified the preliminary cause of death.

Consistent with ICE policy, ERO Phoenix notified the U.S. Department of Homeland Security, Office of Inspector General (OIG), and the ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO Phoenix also provided telephonic notification of REYES' death to the Consulate General of Mexico in Tucson, AZ, who will, in turn, notify REYES' next of kin.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On December 28, 1999, REYES entered the United States at or near Lukeville, AZ, without being admitted or paroled by an immigration officer. On this same date, the U.S. Border Patrol (USBP) arrested REYES at a checkpoint near Ajo, AZ. The USBP granted REYES voluntary return (VR) to Mexico. This was REYES' first VR.

On December 29, 1999, USBP arrested REYES at or near Coverde Wells, AZ. USBP granted REYES VR to Mexico the same day. This was REYES' second VR.

On December 31, 1999, REYES entered the United States at or near Sasabe, AZ, without being admitted or paroled into the United States by an immigration officer. USBP granted REYES VR to Mexico the same day. This was REYES' third VR.

On January 3, 2000, USBP arrested REYES near Arivaca, AZ. USBP granted REYES VR to Mexico the same day. This was REYES' fourth VR.

On April 10, 2000, REYES entered the United States at or near Nogales, AZ, without being admitted or paroled into the United States by an immigration officer. USBP granted REYES VR to Mexico the same day. This was REYES' fifth VR.

On an unknown date, REYES entered the United States at an unknown location, without being admitted or paroled by an immigration officer.

On June 12, 2008, the Peoria Police Department, in Peoria, AZ, arrested REYES for outstanding warrants for assault, disorderly conduct, and prevent/interference from telephoning emergency personnel. On the same date, HSI Phoenix lodged an Immigration Detainer – Notice of Action, Form I-247, against REYES under A086 848 070.

On June 23, 2008, REYES was turned over to ERO Phoenix following his release from the Maricopa County Sheriff's Office (MCSO), Lower Buckeye Jail, in Phoenix, AZ, after MCSO released him on his own recognizance. There is no record of the final disposition for these charges. ERO Phoenix granted REYES VR to Mexico the same day. This was his sixth VR.

On July 4, 2008, REYES entered the United States at or near Nogales, AZ, without being admitted or paroled by an immigration officer. On July 7, 2008, USBP arrested REYES near Nogales, AZ, and granted him VR to Mexico the same day. This was his seventh VR.

On an unknown date, REYES entered the United States at an unknown location, without being

admitted or paroled by an immigration officer.

On January 8, 2017, the Phoenix Police Department, in Phoenix, AZ, arrested REYES for driving under the influence (DUI), DUI with blood alcohol content (BAC) of .08 or more, extreme DUI with BAC of .15-.20, and extreme DUI with BAC greater than .20.

On September 19, 2017, the Phoenix Municipal Court, in Phoenix, AZ, convicted REYES of one count of DUI-liquor/drugs, with a sentence of 10 days of incarceration and 36 months of probation; and one count of extreme DUI, with a sentence of 135 days of incarceration and 36 months of probation.

On January 14, 2019, ERO Phoenix encountered REYES at the MCSO, Lower Buckeye Jail, in Phoenix, AZ, after he self-surrendered pursuant to a court order to serve a total of 80 days relating to his September 19, 2017 convictions. On the same date, ERO Phoenix lodged an Immigration Detainer – Notice of Action, Form I-247A, against REYES.

On February 26, 2019, REYES was turned over to ERO Phoenix pursuant to the immigration detainer. ERO Phoenix served REYES with a Notice to Appear, Form I-862, charging him with violating Section 212(a)(6)(A)(i) of the Immigration and Nationality Act, as an alien present in the United States without being admitted or paroled, or who arrived in the United States at any time or place other than as designated by the Attorney General. At the time of his processing, REYES advised processing officers that his medical conditions included diabetes and high blood pressure. Processing officers noted on the Record of a Deportable/Inadmissible Alien, Form I-213, that REYES did not have medication in his possession.

On February 27, 2019, during his medical intake screening at the Florence Staging Facility, REYES reported to ICE Health Service Corps (IHSC) staff that he took metformin for his diabetes. IHSC staff prescribed and provided REYES metformin the same day.

On February 28, 2019, REYES reported to IHSC staff during his physical examination that he also had high blood pressure. IHSC staff ordered labs and blood pressure checks. IHSC records reflect that REYES' blood pressure was within normal limits.

On March 12, 2019, an immigration judge continued REYES' case with the subsequent immigration hearing scheduled for April 8, 2019.

On April 1, 2019, REYES reported to the medical clinic at the Florence Service Processing Center with flu-like symptoms, fever, chills, sore throat, and a cough. IHSC assessed him and prescribed oseltamivir (Tamiflu) for five days. Asset Protection and Security Services (Asset) contract staff moved REYES to the administrative segregation unit for medical observation as all negative pressure beds were currently occupied. IHSC staff conducted daily checks and temperature checks as part of REYES' treatment plan.

On April 3, 2019, at approximately 6:12 a.m. MST, Asset staff called a medical emergency after discovering REYES was unresponsive and not breathing in his cell. Asset staff immediately began administering cardiopulmonary resuscitation (CPR) to REYES.

At 6:15 a.m. MST, IHSC medical staff responded to the unit and contacted emergency medical services (EMS). IHSC medical staff took over CPR efforts at that time.

At approximately 6:24 a.m. MST, American Medical Response Ambulance and the Florence Fire Department (FFD) arrived on scene. FFD determined that REYES did not have a pulse or heart rhythm.

At approximately 6:33 a.m. MST, FFD paramedics called the Mountain Vista Medical Center in Mesa, AZ, where (b)(6); (b)(7)(C) pronounced REYES' time of death at 6:33 a.m. MST.

At approximately 6:40 a.m. MST, ERO Phoenix notified ERO Headquarters, Acting Deputy Assistant Director for Field Operations – West, of REYES' death.

At approximately 7:29 a.m. MST, ERO Phoenix telephonically notified OPR through the JIC.

At approximately 8:03 a.m. MST, ERO Phoenix telephonically notified the OIG duty agent of REYES' death.

At approximately 8:15 a.m. MST, ERO Phoenix notified Vice-Consul Pedro de Velasco of the Consulate General of Mexico in Tucson, AZ, and provided notification of REYES' death telephonically.

REYES is the fourth detainee to pass away in ICE custody in fiscal year 2019.

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From: (b)(6); (b)(7)(C)
To: ERO CRCL
Subject: FW: Detainee Death Notice - Augustina RAMIREZ-Arreola
Date: Friday, July 27, 2018 1:43:34 PM

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

Acting Chief of Staff
Custody Management Division
Office of Enforcement and Removal Operations
U.S. Immigration and Customs Enforcement

(b)(6); (b)(7)(C) ce.dhs.gov
202.732.4505 Desk Phone
202.270.3600 Phone

From: (b)(6); (b)(7)(C)
Sent: Friday, July 27, 2018 1:36 PM
To: #ERO Notification of Detainee Death (b)(6); (b)(7)(C) @ice.dhs.gov (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C) @HQ.DHS.GOV> (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C) @HQ.DHS.GOV> (b)(6); (b)(7)(C) @HQ.DHS.GOV>
Subject: Detainee Death Notice - Augustina RAMIREZ-Arreola

The message below is distributed on behalf of Executive Associate Director Matthew T. Albence

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Augustina RAMIREZ-Arreola, A206 266 687.

ISSUE:

On July 26, 2018, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) San Diego reported the death of ICE detainee Augustina RAMIREZ-Arreola, A206 266 687, a 62-year-old citizen of Mexico, at the Alvarado Hospital (AH) in San Diego, CA. The medical staff pronounced RAMIREZ deceased at 10:45 p.m. PDT. Medical staff identified the preliminary cause of death as complications from surgery.

Consistent with ICE policy, ERO San Diego 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 San Diego also notified the Consulate of Mexico in San Diego, CA, of RAMIREZ's death, who, in turn, notified RAMIREZ's next of kin.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On November 20, 2013, RAMIREZ applied for admission into the United States at the San

Ysidro Port of Entry and requested political asylum. The primary Customs and Border Protection (CBP) officer referred RAMIREZ to the San Ysidro Admissibility Enforcement Unit (AEU) for further disposition. Upon further questioning, RAMIREZ stated she had no fear or concern of being returned to Mexico.

On November 22, 2013, CBP served RAMIREZ 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 an immigrant without immigrant visa. On that same date CBP removed RAMIREZ to Mexico.

On May 21, 2018, RAMIREZ applied for admission at the San Ysidro Port of Entry and requested asylum. The CBP officer escorted RAMIREZ to the San Ysidro Port of Entry AEU for further processing.

On May 22, 2018, CBP served RAMIREZ a Notice and Order of Expedited Removal, Form I-860 charging inadmissibility pursuant to section 212(a)(7)(A)(i)(I) of the INA as an immigrant without immigrant visa.

On June 3, 2018, CBP transferred RAMIREZ to ERO San Diego custody at the Otay Mesa Detention Center (OMDC). On the same date, ERO San Diego transferred RAMIREZ to AH due a chest CT scan indicating tuberculosis (TB) exposure. The hospital follow-up examination determined RAMIREZ was negative for active tuberculosis (TB). The hospital also diagnosed RAMIREZ with pneumonia and extended-spectrum beta-lactamases (ESBL) and provided antibiotics to combat these illnesses.

On June 7, 2018, ERO San Diego referred RAMIREZ's case to U.S. Citizenship and Immigration Services (b)(7)(E); (b)(3):Unspecified Statute

On June 12, 2016, medical staff initiated treatment for TB.

On June 19, 2018, AH medical staff stopped the treatment due to RAMIREZ having side effects from the treatment.

On June 26, 2018, AH reported that an echocardiogram revealed aortic stenosis and as a result, medical staff stopped the ethambutol treatment. RAMIREZ's liver enzymes were also elevated and not improving.

On July 3, 2018, the AH scheduled a cardiology evaluation and possible outpatient cardiac catheterization once RAMIREZ was out of respiratory isolation.

On July 4, 2018, AH discharged RAMIREZ and she returned to OMDC.

On July 7, 2018, RAMIREZ accessed sick call for complaints of itchy skin on her arms and legs. The ICE Health Service Corps (IHSC) nurse prescribed daily doses of Benadryl to combat the allergy.

On July 10, 2018, a cardiac surgeon saw RAMIREZ as an outpatient and recommended aortic valve replacement surgery. An IHSC nurse screened RAMIREZ upon her return to OMDC and cleared her to return to general population.

On July 17, 2018, the IHSC Clinical Director submitted a cardiac surgery referral requesting authorization for aortic valve replacement surgery.

(b)(7)(E); (b)(3): Unspecified Statute

On July 18, 2018, an IHSC nurse saw RAMIREZ for sick call for care of itchy skin. RAMIREZ's vital signs were all normal but a red rash was noted on both arms. The IHSC nurse provided daily doses of Benadryl to combat the allergy.

On July 19, 2018, RAMIREZ attended a follow up appointment to review the cardiac surgeon's recommendations. RAMIREZ reported that she had no idea she had a heart problem but tired easily. The cardiac surgeon scheduled aortic stenosis surgery for July 25, 2018 and scheduled a post-operative follow-up visit for a week after surgery.

(b)(7)(E); (b)(3): Unspecified Statute

On July 24, 2018, Core Civic staff at the OMDC notified ERO San Diego that they had transported RAMIREZ back to AH for her scheduled surgery to treat her heart abnormality. In the afternoon, AH reported RAMIREZ was stable, awake, alert and oriented.

On July 25, 2018, at approximately 5:00 a.m. PDT, AH provided a morning update that RAMIREZ continued to be stable and awaiting the procedure.

At approximately 6:20 a.m. PDT RAMIREZ underwent cardiac surgery to replace her aortic valve.

At approximately 2:50 p.m. PDT RAMIREZ's surgery was completed.

Upon recovery from surgery, AH medical staff observed that RAMIREZ was still bleeding and returned her to the operating room at 5:20 p.m. PDT. RAMIREZ died during this procedure, with a time of death of 10:45 p.m. PDT.

At approximately 11:15 p.m. PDT, AH notified ERO San Diego of RAMIREZ's passing.

On July 26, 2018, at approximately 12:30 a.m. PDT, ERO San Diego notified ERO Headquarters of RAMIREZ's death.

At approximately 1:00 a.m. PDT, ERO San Diego notified the Consulate of Mexico in San Diego, CA, of RAMIREZ's death.

On July 26, 2018, at 1:50 a.m. PDT, ERO San Diego telephonically notified the Joint Intake Center and the Office of Professional Responsibility duty agent of RAMIREZ's death.

At approximately 7:50 a.m. PDT, ERO San Diego emailed notification to the Office of Professional Responsibility duty agent as requested.

RAMIREZ is the ninth detainee to pass away in ICE custody in fiscal year 2018.

From: (b)(6); (b)(7)(C)
To:
Cc:
Subject: FW: Detainee Death Notice - Guerman VOLKOV
Date: Sunday, December 2, 2018 7:12:34 AM

Good morning. See below. Need to update the detainee death tracker and CPD should open a Sharepoint location to be shared with CRCL and OPR.

Thanks.

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

Acting Chief of Staff

Custody Management Division

Office of Enforcement and Removal Operations

U.S. Immigration and Customs Enforcement

(b)(6); (b)(7)(C) [ice.dhs.gov](mailto:(b)(6); (b)(7)(C)@ice.dhs.gov)
202.732 (b)(6); (b)(7)(C) Desk Phone
202.270 (b)(6); (b)(7)(C) Phone

From: (b)(6); (b)(7)(C)
Sent: Saturday, December 1, 2018 2:15 PM
To: #ERO Notification of Detainee Death (b)(7)(E)@ice.dhs.gov>
Cc: (b)(6); (b)(7)(C)@ice.dhs.gov>; (b)(6); (b)(7)(C)@ice.dhs.gov>; Jennings, David W (b)(6); (b)(7)(C)@ice.dhs.gov>; #ERO CHIEFS OF STAFF (b)(7)(E)@ice.dhs.gov>
Subject: Detainee Death Notice - Guerman VOLKOV

***The message below is distributed on behalf of Acting Executive Associate
Director Nathalie R. Asher***

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Guerman VOLKOV, A209 879 518.

ISSUE:

On November 30, 2018, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) Miami reported the death of ICE detainee Guerman VOLKOV, A209 879 518, a 56-year-old citizen of Russia, at the University of Florida Health Jacksonville (UFHJ) Hospital in Jacksonville, FL. The medical staff pronounced VOLKOV deceased on November 30, 2018, at approximately 1:59 p.m. EST. The official cause of death remains under investigation but is believed to be cardiac related.

Consistent with ICE policy, ERO Miami 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 Headquarters Removal and International Operations Unit (HQ-RIO) provided email notification to the Embassy of the Russian Federation in Washington, D.C., of VOLKOV's death who will, in turn, notify VOLKOV's next of kin.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On November 4, 1998, the Immigration and Naturalization Service admitted VOLKOV into the United States at Miami, FL as a B2 non-immigrant visitor for pleasure with authorization to remain in the United States for a temporary period not to exceed six months. VOLKOV remained in the United States beyond six months without authorization.

On September 8, 1999, the 13th Judicial Circuit Court in Hillsborough County, Tampa, FL convicted VOLKOV of disorderly conduct and sentenced him to time served and court costs.

On February 2, 2000, the 6th Judicial Circuit Court in Pasco County, New Port Richey, FL convicted VOLKOV of driving under the influence (DUI) and sentenced him to nine months' probation and a fine. There is no indication that ERO Miami was notified of this arrest.

On March 18, 2016, the 6th Judicial Circuit Court in Pasco County, New Port Richey, FL convicted VOLKOV for the offense of battery/domestic violence and sentenced him to 38 days confinement and one year of probation. There is no indication that ERO Miami was notified of this arrest.

On May 21, 2017, the 6th Judicial Circuit Court in Pasco County, New Port Richey, FL convicted VOLKOV of battery/domestic violence and sentenced him to 34 days confinement.

On June 26, 2017, ERO Miami encountered VOLKOV at the Pasco County Jail (PCJ) in Land O Lakes, FL, and lodged an Immigration Detainer Notice of Action, Form I-247A on VOLKOV with PCJ.

On June 26, 2017, PCJ released VOLKOV to ERO Miami who detained him at Baker County Detention Center (BCDC) in Macclenny, FL. On the same date, ERO Miami issued VOLKOV a Notice to Appear charging removability pursuant to Section 237(a)(1)(B) of the Immigration and Nationality Act, as a non-immigrant overstay.

On December 15, 2017, an immigration judge (IJ) in Orlando, FL ordered VOLKOV removed from the United States to Russia. VOLKOV reserved appeal but failed to file an appeal by the deadline of January 12, 2018.

On January 29, 2018, ERO Miami submitted an Electronic Travel Document Request (eTD) for VOLKOV with the Embassy of Russia.

On March 20, 2018, ERO Miami completed a 90-day Post Order Custody Review (POCR) and issued a decision to continue VOLKOV's detention pending the issuance of a travel document.

On April 16, 2018, ERO HQ RIO notified ERO Miami that the Embassy of Russia denied VOLKOV issuance of a travel document. Embassy officials stated that someone in Russia with the same name and date of birth had died in 2011, and believed that VOLKOV may be lying about his real name and date of birth.

On May 30, 2018, ERO Miami requested help from the Assistant Attaché for Removal (AAR) covering Russia area of responsibility.

On June 11, 2018, ERO Miami provided the AAR with VOLKOV's fingerprints, which are still pending results from the Russian government.

On June 28, 2018, ERO HQ RIO completed a 180-day POCR and issued a decision to continue VOLKOV's detention in ICE custody.

On September 11, 2018, ERO Miami submitted an HQ transfer checklist to HQ RIO for evaluation of the 270-day POCR.

On September 24, 2018, HQ RIO sent ERO Miami questions to be used during a sworn statement of VOLKOV.

On October 5, 2018, ERO Miami conducted a sworn statement on VOLKOV and provided his answers to HQ RIO.

On November 26, 2018, BCDC security staff found VOLKOV lying supine on the floor speaking slowly. BCDC medical staff responded and escorted VOLKOV to the medical department. VOLKOV appeared pale, diaphoretic with an altered mental state. VOLKOV's vital signs were taken and noted as being abnormal. BCDC transported VOLKOV to the Ed Fraser Memorial Hospital (EFMH) in Macclenny, FL for assessment and treatment.

On the same date, EFMH transferred VOLKOV to the Memorial Hospital in Jacksonville, FL via ambulance for further testing. Subsequently, the medical staff at the Memorial Hospital admitted VOLKOV for further evaluation and treatment for hypovolemia.

On November 28, 2018, staff at the Memorial Hospital in Jacksonville notified the Armor Correctional Medical Unit at BCDC that VOLKOV was refusing all treatment and they were discharging him.

On that same date, the Armor Correctional Medical Unit notified ERO Miami and IHSC that VOLKOV had returned to the BCDC and was being placed on medical observation.

On November 29, 2018, BCDC medical staff evaluated VOLKOV and continued medical observation.

On November 30, 2018, at approximately 11:48 a.m. EST, BCDC medical staff called the Emergency Medical Services (EMS) of Baker County due to VOLKOV experiencing increased abdominal distention, dyspnea, and hypoxia.

At approximately 12:05 p.m. EST, EMS arrived at the BCDC.

At approximately 12:10 p.m. EST, EMS departed the BCDC transporting VOLKOV to the

UFHJ.

At approximately 12:59 p.m. EST, EMS arrived at UFHJ.

At approximately 1:11 p.m. EST, hospital staff indicated VOLKOV went into cardiac arrest and staff began cardiopulmonary resuscitation, intubated VOLKOV, and performed advanced cardiac life support.

At approximately 1:59 p.m. EST, hospital staff pronounced VOLKOV deceased.

At approximately 2:04 p.m. EST, BCDC notified ERO Miami of VOLKOV's passing.

At approximately 2:09 p.m. EST, ERO Miami notified ERO Headquarters of VOLKOV's death.

At approximately 2:55 p.m. EST, ERO Miami telephonically notified the Joint Intake Center duty agent of VOLKOV's death.

At approximately 3:21 p.m. EST, HQ-RIO contacted the vice-consul of the Embassy of the Russian Federation and provided notification of VOLKOV's death.

VOLKOV is the third detainee to pass away in ICE custody in fiscal year 2019.

From: Lorenzen-Strait, Andrew R
To: #CPDSenior Staff
Subject: FW: Detainee Death Notice - Huy Chi TRAN
Date: Thursday, June 14, 2018 1:06:03 PM

Andrew R. Lorenzen-Strait
Deputy Assistant Director
DHS/ICE/ERO/Custody Programs
202.431 (b)(6); (b)(7)(C)

Sent with BlackBerry Work
(www.blackberry.com)

From: (b)(6); (b)(7)(C) @ice.dhs.gov
Date: Thursday, Jun 14, 2018, 1:00 PM
To: #ERO DEPUTY ASSISTANT DIRECTORS
(b)(7)(F) @ice.dhs.gov>, #ERO EAD Front Office
(b)(7)(E) @ice.dhs.gov>, #HSI CHIEFS OF STAFF (b)(7)(E) @ice.dhs.gov>,
#ICE COS Staff <ICECOS@ice.dhs.gov>, #ICE DD STAFF (b)(7)(E) @ice.dhs.gov>, #MASTAFF
<MASTAF@ice.dhs.gov>, Bassett, Cori W (b)(6); (b)(7)(C) @ice.dhs.gov>, Benner, Derek N
(b)(6); (b)(7)(C) @ice.dhs.gov>, Burke, Ryan P (b)(6); (b)(7)(C) @ice.dhs.gov>, Davis, Mike P
<(b)(6); (b)(7)(C) @ice.dhs.gov>, Elzea, Jennifer (b)(6); (b)(7)(C) @ice.dhs.gov>, Hackbarth, Sean M
(b)(6); (b)(7)(C) @ice.dhs.gov>, JIOC-ICE (b)(6); (b)(7)(C) @ice.dhs.gov>, Kovacic, Raymond
(b)(6); (b)(7)(C) @ice.dhs.gov>, Lanum, Scott <(b)(6); (b)(7)(C) @ice.dhs.gov>, Loiacono, Adam V
<(b)(6); (b)(7)(C) @ice.dhs.gov>, Padilla, Kenneth (b)(6); (b)(7)(C) @ice.dhs.gov>, Trickler-McNulty,
Claire <(b)(6); (b)(7)(C) @ice.dhs.gov>, Valerio, Tracey A (b)(6); (b)(7)(C) @ice.dhs.gov>,
Velazquez, Ricardo L (b)(6); (b)(7)(C) @ice.dhs.gov>, (b)(6); (b)(7)(C) @ice.dhs.gov>,
Russell, Ashly M <(b)(6); (b)(7)(C) @ice.dhs.gov>, (b)(6); (b)(7)(C) @ice.dhs.gov>,
Rodriguez, Waldemar <(b)(6); (b)(7)(C) @ice.dhs.gov>, Fenton, Jennifer M
(b)(6); (b)(7)(C) @ice.dhs.gov>
Cc: #ERO CHIEFS OF STAFF (b)(7)(E) @ice.dhs.gov>
Subject: Detainee Death Notice - Huy Chi TRAN

The message below is distributed on behalf of Executive Associate Director Matthew T. Albence

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Huy Chi TRAN, A037 949 945.

ISSUE:

On June 12, 2018, U.S. Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) Phoenix reported the death of ICE detainee Huy Chi TRAN, A37 949 945, a 47-year-old citizen of Vietnam, at the Banner Casa Grande Medical Center (BCGMC) in Casa Grande, AZ. The medical staff pronounced TRAN deceased at 9:20 a.m. MST. Medical staff identified the preliminary cause of death as cardiac arrest.

Consistent with ICE policy, ERO Phoenix notified the U.S. Department of Homeland Security, Office of Inspector General and ICE, Office of Professional Responsibility via the

Joint Intake Center. ERO Phoenix also notified the Consulate of Vietnam in Phoenix, AZ of TRAN's death. ERO Phoenix notified TRAN's next of kin of his death.

All media inquiries will be referred to the Office of Public Affairs.

BACKGROUND:

On June 25, 1984, the former U.S. Immigration and Naturalization Service (INS) admitted TRAN into the United States at San Francisco, CA, as a P-53 immigrant, child of alien classified as P-51 / P-56, brother or sister of U.S. citizen.

On October 25, 2000, the Superior Court of Arizona, County of Maricopa, convicted TRAN of two counts of aggravated assault, and sentenced him to three and a half years of incarceration and three years of probation with credit for 210 days of time served.

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

On March 29, 2003, the ADOC transferred TRAN to ERO Phoenix 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 is at least one year.

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

On June 16, 2003, TRAN filed an appeal with the Board of Immigration Appeals (BIA).

On October 31, 2003, the BIA remanded the case to the IJ for further proceedings.

On December 10, 2003, the IJ found all TRAN's applications for relief to be abandoned and again ordered him removed to Vietnam. TRAN reserved his right to appeal.

On January 8, 2004, TRAN filed an appeal with the BIA.

On June 14, 2004, the BIA sustained TRAN's appeal and remanded the case back to the IJ for a decision.

On September 21, 2004, the IJ denied all TRAN's applications for relief and ordered him removed to Vietnam. TRAN waived his right to appeal.

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 as required four times between January 27, 2005, to April 20, 2005.

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.

On July 28, 2005, TRAN failed to appear at ERO Phoenix as ordered. TRAN's case was then referred to the Fugitive Operations Team for location and arrest with no result.

On February 2, 2006, the Chandler, AZ Police Department (CPD) arrested TRAN for disorderly conduct and criminal damage. CPD released TRAN while his charges were pending, ERO Phoenix did not encounter TRAN after his release. TRAN failed to appear for court, and the court issued a bench warrant for his arrest.

On August 15, 2006, CPD arrested TRAN for shoplifting. On the same date, CPD cited TRAN and released him to ERO Phoenix custody.

On August 18, 2006, ERO Phoenix released TRAN under his original OSUP issued on January 10, 2005, to complete his criminal proceedings. There is no record of TRAN reporting to ERO Phoenix after this date.

On April 8, 2009, the Superior Court of Arizona, County of Maricopa, convicted TRAN for the offense of aggravated assault, a domestic violence offense, and sentenced him to five years of incarceration with credit for 224 days of time served.

On April 13, 2009, ERO Phoenix encountered TRAN at the ARC and lodged a Notice of Action-Immigration Detainer, Form I-247A.

On August 14, 2013, ADOC transferred TRAN to ERO Phoenix custody. ERO Phoenix released TRAN from custody under his original OSUP issued on January 10, 2005 because there was still no significant likelihood of removal. TRAN did not appear at ERO Phoenix for his first scheduled appointment on February 12, 2014.

On January 21, 2017, CPD arrested TRAN for disorderly conduct and domestic violence. On the same date, ERO Phoenix encountered TRAN at the Maricopa Sheriff's Office (MCSO) Jail and lodged a Notice of Action-Immigration Detainer, Form I-247A. TRAN remained in MCSO custody pending his criminal proceedings.

On July 10, 2017, the Superior Court of Arizona, Maricopa County, convicted TRAN for the offense of disorderly conduct, a domestic violence offense, and sentenced TRAN to one and a half years of incarceration with credit for 117 days of time served.

On July 12, 2017, a 287(g) Designated Immigration Officer encountered TRAN at the ARC, and lodged a Notice of Action - Immigration Detainer, Form I-247A.

On May 25, 2018, ADOC released TRAN to ERO Phoenix custody. ERO Phoenix served TRAN a Notice of Revocation of Release with the intention of reviewing TRAN's likelihood of removal.

On the same date, ERO Phoenix transferred TRAN to the Florence Detention Center (FDC) in Florence, AZ.

On May 26, 2018, ICE Health Service Corps (IHSC) conducted an initial screening at the FDC. During his initial intake, TRAN reported experiencing auditory verbal hallucinations (AVH) but stated medication controls his AVH. TRAN arrived at FDC with a prescription for Prozac and Haldol and IHSC continued his medication regimen as prescribed.

On May 28, 2018, ERO Phoenix transferred TRAN to the Eloy Detention Center (EDC) in Eloy, AZ, to pursue removal to Vietnam.

On June 5, 2018, an IHSC mental health provider evaluated TRAN and placed him on mental health observation with 15-minute staggered security checks.

At approximately 4:15 p.m. MST, CoreCivic personnel while performing a security check discovered TRAN unresponsive in his cell. CoreCivic called a medical emergency and began cardiopulmonary resuscitation (CPR) on TRAN.

At approximately 4:18 p.m. MST, IHSC arrived to assist with CPR and applied an Automated External Defibrillator (AED) while awaiting the arrival of EMS. CPR was performed for approximately 17 minutes before EMS arrived.

At approximately 4:35 p.m. MST, EMS arrived and administered Narcan pursuant to their protocols. The Narcan had no effect. EMS then administered epinephrine, which enabled them to find a sinus rhythm.

At approximately 4:53 p.m. MST, EMS transported TRAN to the BCGMC in Casa Grande, AZ, for continued treatment and evaluation.

At approximately 5:21 p.m. MST, the BCGMC placed TRAN on a ventilator.

At approximately 5:50 p.m. MST, the BCGMC admitted TRAN for further care.

On June 6, 2018, at 5:59 a.m. MST, CT results returned negative with some abnormal lab values.

At approximately, at 12:15 p.m., MST, BCGMC hospital staff advised IHSC that TRAN's condition remained unchanged. His pupils were dilated and nonreactive, and he had no gag reflex. TRAN continued a ventilator with hypothermia therapy, and per protocol, a rewarming process was scheduled.

On June 7, 2018, at approximately 2:53 p.m., MST, BCGMC hospital staff advised IHSC that TRAN's condition remained largely unchanged. TRAN remained essentially unresponsive, with some sluggish pupillary reflex but still no pain response and no signs of waking.

On June 8, 2018 at approximately 7:02 a.m., MST, BCGMC hospital staff advised IHSC that TRAN's condition remained unchanged, but there was some evidence of kidney disfunction.

On June 11, 2018, BCGMC hospital staff conducted an EEG and brain stem test.

On June 12, 2018, at approximately 12:04 p.m., MST, BCGMC hospital staff advised IHSC that the results of the EEG and brain stem scan resulted in a diagnosis of code arrest and brain

anoxia. The test showed no brain activity.

At approximately 12:17 p.m., MST, BCGMC hospital staff notified ERO Phoenix that they had confirmed the findings of the EEG and brain stem scan, and declared TRAN brain dead with a time of death of 9:20 a.m., MST and a preliminary cause of death of cardiac arrest. BCGMC kept TRAN on the ventilator until his mother, father and three sisters arrived for a final visit.

At approximately 2:39 p.m., MST, TRAN's family, in consultation with the attending physician, made the decision to remove TRAN from the ventilator. TRAN's family was present at the time BCGMC extubated TRAN.

The IHSC Field Medical Coordinator is awaiting autopsy results which will provide the official cause of death. An autopsy will be performed on June 14, 2018.

TRAN is the seventh detainee to pass away in ICE custody in fiscal year 2018.

From: (b)(6); (b)(7)(C)
To: (b)(6); (b)(7)(C)
Cc:
Subject: FW: Detainee Death Notice - Wilfredo PADRON
Date: Friday, November 2, 2018 8:26:32 AM

Good morning. See below. Need to update the detainee death tracker and CPD should open a Sharepoint location to be shared with CRCL and OPR.

Thanks.

Sent with BlackBerry Work
(www.blackberry.com)

From: (b)(6); (b)(7)(C) <(b)(6); (b)(7)(C)@ice.dhs.gov>
Date: Friday, Nov 02, 2018, 8:02 AM
To: #ERO Notification of Detainee Death (b)(7)(E) <(b)(7)(E)@ice.dhs.gov>
Cc: Price, Corey A <(b)(6); (b)(7)(C)@ice.dhs.gov>, Asher, Nathalie R <(b)(6); (b)(7)(C)@ice.dhs.gov>, Jennings, David W <(b)(6); (b)(7)(C)@ice.dhs.gov>, #ERO CHIEFS OF STAFF <(b)(7)(E)@ice.dhs.gov>
Subject: Detainee Death Notice - Wilfredo PADRON

***The message below is distributed on behalf of Acting Executive Associate
Director Nathalie R. Asher***

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Wilfredo PADRON, A022 776 291.

ISSUE:

On November 1, 2018, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) Miami reported the death of ICE detainee Wilfredo PADRON, A022 776 291, a 58-year-old citizen of Cuba, at the Lower Keys Medical Center (LKMC) in Key West, FL. The medical staff at LKMC pronounced PADRON deceased at approximately 7:17 a.m. EDT. The official cause of death remains under investigation but is believed to be cardiac related.

Consistent with ICE policy, ERO Miami 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 Miami also notified the ERO Headquarters Removal and International Operations Unit for proper notification to the Government of Cuba as per current protocols. Next of kin notification is pending.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On May 16, 1980, the United States Immigration and Naturalization Service (INS) paroled PADRON into the United States near Key West, Florida during the “Mariel Boat Lift”.

On January 20, 1987, the Eleventh Judicial Circuit Court in Miami-Dade County, FL convicted PADRON of grand theft of vehicle and cocaine possession. The Eleventh Judicial Circuit Court sentenced him to two years probation.

On April 20, 1992, the Eleventh Judicial Circuit Court in Miami-Dade County, FL convicted PADRON of aggravated assault, carrying a concealed weapon, cocaine possession, and destroying evidence, and sentenced him to 11 months and 29 days confinement.

On October 10, 1992, PADRON filed an Application to Register Permanent Residence or Adjust Status, Form I-485 with the INS.

On August 16, 1995, INS adjusted PADRON’s status to that of a lawful permanent resident retroactive to October 10, 1992.

On January 7, 1999, the Eleventh Judicial Circuit Court in Miami-Dade County, FL convicted PADRON of resisting officer, fraud, and habitual driving while license suspended and sentenced him to two years of probation.

On July 17, 2000, INS arrested PADRON at the Florida Department of Corrections Probation Office in Miami, FL and issued him a Notice to Appear charging removability pursuant to Section 237(a)(2)(A)(ii) of the Immigration and Nationality Act (INA), as an alien convicted of two crimes involving moral turpitude after admission.

On November 15, 2000, the Miami INS Office of District Counsel filed additional charges of removability pursuant to Section 237(a)(1)(A) of the INA, as an alien inadmissible at the time of entry and or procuring by fraud a visa or admission into the United States, and Section 237(a)(2)(A)(i) of the INA, as an alien convicted of a crime involving moral turpitude within five years after admission or adjustment.

On November 29, 2001, an immigration judge in Miami, FL ordered PADRON removed from the United States to Cuba.

On May 15, 2002, INS in Miami, FL released PADRON on an Order of Supervision (OSUP) with a reporting date of June 15, 2002.

Between May 15, 2002 and August 15, 2018, PADRON reported on OSUP to ERO Miami annually.

On September 26, 2006, the Palm Beach County Court, West Palm Beach, FL convicted PADRON of not utilizing proper equipment in conjunction with a traffic offense. Disposition unknown.

On September 21, 2007, the Suwanee County Court, Live Oak, FL convicted PADRON of a traffic offense. Disposition unknown.

On October 23, 2008, the Suwanee County Court, Live Oak, FL convicted PADRON of a traffic offense. Disposition unknown.

On October 23, 2008, the Palm Beach County Court convicted PADRON of failing to have a driver's license in conjunction with a traffic offense. Disposition unknown.

On October 7, 2010, the 216th District Court in Kerr County, Kerrville, TX convicted PADRON of possession of a controlled substance and sentenced him to two years confinement with three years probation.

On October 5, 2013, the Palm Beach County Court, West Palm Beach, FL convicted PADRON of failing to pay a toll. Disposition unknown.

On March 22, 2018, PADRON reported to ERO Miami as required. ERO Miami requested that PADRON provide a medical summary and a list of medications due to being on the Cuban repatriation list. ERO Miami scheduled PADRON's next report date for August 15, 2018.

On August 15, 2018, ERO Miami arrested PADRON at the ERO Miami, Miramar Sub-Office due to his Significant Likelihood of Removal in the Reasonable Foreseeable Future, revoked PADRON's OSUP and detained him at the Krome Service Processing Center, Miami, FL.

On the same date, PADRON informed IHSC during intake screening that he had a history of hypertension, pancreatitis, and a left leg fracture due to a vehicular accident.

On August 17, 2018, ERO Miami transferred PADRON to the Monroe County Detention Center (MCDC) in Key West, FL.

On August 18, 2018, ERO Miami submitted a presentation package to HQ RIO for presentation to the Cuban Embassy for repatriation efforts.

On August 31, 2018, HQ RIO nominated PADRON to the Government of Cuba for repatriation.

On October 26, 2018, MCDC staff referred PADRON to the LKMC due to chest pain. LKMC staff evaluated PADRON and diagnosed him with constipation and released him on the same date back to MCDC.

On November 1, 2018, at approximately 6:41 a.m. EDT, PADRON's cellmate informed MCDC staff that PADRON would not wake up. MCDC staff found PADRON unresponsive in his cell and began cardiopulmonary resuscitation (CPR) and attached an Automated External Defibrillator.

At approximately 6:43 a.m. EDT, MCDC staff contacted Emergency Medical Services (EMS) and continued with CPR while awaiting the arrival of EMS.

At approximately 6:49 a.m. EDT, the Key West Fire Department (KWFD), Key West, FL arrived at MCDC and took over CPR.

At approximately 7:09 a.m. EDT, KWFD continued CPR and transported PADRON to LKMC.

At approximately 7:17 a.m. EDT, LKMC medical staff pronounced PADRON deceased.

At approximately 7:30 a.m., MCDC staff notified ERO Miami that PADRON had been transported to LKMC.

At approximately 7:47 a.m. EDT, LKMC medical staff notified MCDC staff on site at LKMC that PADRON had been pronounced deceased.

At approximately 8:10 a.m. EDT, MCDC notified ERO Miami that PADRON was pronounced deceased by LKMC.

At approximately 8:13 a.m. EDT, ERO Miami notified ERO Headquarters of PADRON's death.

At approximately 8:28 a.m. EDT, ERO Miami telephonically notified the Office of Professional Responsibility duty agent of PADRON's death.

At approximately 8:37 a.m. EDT, ERO Miami emailed the Joint Intake Center of

PADRON's death.

On November 1, 2018, HQ RIO notified the Embassy of Cuba of PADRON's death.

ERO Miami is in the process of providing notification to PADRON's next of kin.

PADRON is the first detainee to die in ICE custody in fiscal year 2019.

From: (b)(6); (b)(7)(C)
To:
Subject: FW: Detainee Death Notification - Alberto HERNANDEZ-Fundora
Date: Monday, January 27, 2020 11:21:30 PM

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

Unit Chief, SDDO
ICE/ERO Custody Reporting & Strategy
202-732-5154

From: (b)(6); (b)(7)(C) @ice.dhs.gov>
Date: Monday, Jan 27, 2020, 6:22 PM
Subject: Detainee Death Notification - Alberto HERNANDEZ-Fundora

The message below is distributed on behalf of Acting Executive Associate Director Timothy S. Robbins:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Alberto HERNANDEZ-Fundora, A022 804 402.

ISSUE:

On January 27, 2020, ICE Enforcement and Removal Operations (ERO) Miami, reported the death of ICE detainee Alberto HERNANDEZ-Fundora, a 63-year-old citizen of Cuba, at the Larkin Community Hospital (LCH) in Miami, FL. Doctors declared HERNANDEZ deceased at 9:32 am. Eastern Standard Time (EST), on January 27, 2020. The preliminary cause of death is cardiac arrest.

ERO Miami notified the Department of Homeland Security Office of Inspector General and ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO Miami staff attempted to notify HERNANDEZ's next-of-kin but has been unable to make contact. The ERO acting Assistant Attaché of Removals in Havana, Cuba, notified the Embassy of Cuba on January 27, 2020.

All media inquiries will be referred to ICE Office of Public Affairs.

BACKGROUND:

On May 14, 1980, the former U.S. Immigration and Naturalization Service (INS) paroled HERNANDEZ under Section 212(d)(5) of the Immigration and Naturalization Act (INA) into the United States at Key West, FL.

On February 2, 1984, the Mercer County Superior Court (MCSC) in Trenton, NJ convicted HERNANDEZ of heroin-sell, heroin, and heroin-possession. The court sentenced HERNANDEZ to 10 years of incarceration.

On the same date, MCSC convicted HERNANDEZ of aggravated assault-weapon and sentenced him to seven years of incarceration.

On December 26, 1990, Morris County Jail in Morristown, NJ released HERNANDEZ to INS Newark custody.

On February 4, 1991, INS Newark served HERNANDEZ with a Notice To Applicant for Admission Detained for Hearing Before an Immigration Judge, Form I-122, charging removability pursuant to Section 212(a)(20) of the INA, as an immigrant who at time of application for admission is not in possession of an unexpired immigrant visa, re-entry permit, border crossing card or other valid documents required for entry. The charging documents were not filed with the immigration court.

On February 26, 1991, INS Newark transferred HERNANDEZ to the custody of INS New York who detained him at the Ray Brook Federal Correctional Institution in Ray Brook, NY.

On April 16, 1996, INS New York transferred HERNANDEZ to the custody of INS New Orleans who detained him at the Talladega Federal Correctional Institution in Talladega, AL.

On May 19, 1997, INS New Orleans transferred HERNANDEZ to the custody of INS Los Angeles who detained him at Lompoc Federal Bureau of Prisons in Lompoc, CA.

On May 17, 2000, INS Los Angeles issued HERNANDEZ a Notice to Alien to Appear, Form I-862, charging excludability pursuant to Section 212(a)(2)(B) of the INA, as having two or more convictions and sentenced to at least 5 years in aggregate, and Section 212(a)(20) of the INA, as an immigrant without an immigrant visa.

On July 19, 2000, an immigration judge ordered HERNANDEZ excluded from the United States and order him removed to Cuba.

On February 5, 2003, INS Los Angeles released HERNANDEZ on parole.

On March 29, 2005, the Lawrence Township Municipal Court in Lawrence Township, NJ convicted HERNANDEZ of disorderly conduct-improper behavior and sentenced him to two years of probation.

On May 26, 2007, ERO Newark mailed a Call-in Letter, Form G-56 to HERNANDEZ's resident address instructing him to report on May 31, 2007, to the ERO Marlton, NJ Sub-office.

On May 31, 2007, ERO Newark served HERNANDEZ an Order of Supervision (OSUP), Form I-220B.

On November 17, 2009, MCSC convicted HERNANDEZ of unlawful possession of a weapon and sentenced him to 18 months of incarceration.

On August 25, 2010, the West Windsor Municipal Court in West Windsor Township, NJ convicted HERNANDEZ of theft and sentenced him to a fine.

On August 31, 2010, the Bucks County District Court in Levittown, PA convicted HERNANDEZ of retail theft and sentenced him to a fine.

On July 9, 2011, HERNANDEZ was arrested for Burglary, Burglary Tools, and Unlawful Possession of Weapon, and was detained at the Mercer County Jail (MCJ) in Lambertville, NJ.

On July 12, 2011, ERO Newark lodged an Immigration Detainer – Notice of Action, Form I-247, on HERNANDEZ with MCJ.

On October 6, 2011, the Hamilton Township Municipal Court in Trenton, NJ convicted HERNANDEZ of shoplifting-conceal merchandise and sentenced him to 60 days incarceration.

On October 26, 2011, MCSC in Trenton, NJ convicted HERNANDEZ of criminal trespass-unlicensed and sentenced him to three years of probation and a fine.

On December 27, 2011, MCJ released HERNANDEZ to the custody of ERO Newark who detained him at the Essex County Jail in Newark, NJ. On the same date, ERO Newark revoked HERNANDEZ's OSUP status.

On January 6, 2012, ERO Newark released HERNANDEZ on an OSUP.

On June 30, 2014, MCSC convicted HERNANDEZ of possession of a controlled drug substance and sentenced him to three years of probation.

On May 31, 2016, the Cumberland County Court in Carlisle, PA convicted HERNANDEZ of retail theft and sentenced him to three months' incarceration.

On November 7, 2016, the Burlington Municipal Court in Burlington, NJ convicted HERNANDEZ of shoplifting-conceal merchandise and sentenced him to 90 days of incarceration.

On November 21, 2016, the Ewing Township Municipal Court in Ewing Township, NJ convicted HERNANDEZ of shoplifting-conceal merchandise and sentenced him to 90 days of incarceration.

On January 3, 2018, MCSC convicted HERNANDEZ of shoplifting-conceal merchandise and sentenced him to 180 days of incarceration, three years of probation, and a fine.

On May 24, 2018, the Hamilton Township Municipal Court in Trenton, NJ convicted HERNANDEZ of shoplifting-conceal merchandise and sentenced him to six months of incarceration and a fine.

On June 23, 2019, the 11th Judicial Circuit Court (ECC), in and for Miami Dade County, FL convicted HERNANDEZ of petit theft and sentenced him to time served.

On January 2, 2020, ERO Miami encountered HERNANDEZ at the Turner Gilford Knight Correctional Center (TGK) in Miami, FL and lodged an Immigration Detainer – Notice of Action, Form I-247A.

On January 3, 2020, ECC convicted HERNANDEZ of petit theft and sentenced him to 15 days of incarceration.

On January 14, 2020, TGK released HERNANDEZ to the custody of ERO Miami who detained him at Krome Service Processing Center (KSPC) in Miami, FL pending nomination to the Government of Cuba for repatriation.

On January 23, 2020, ICE Health Service Corps staff at KSPC notified ERO Miami that American Medical Response ambulance service transported HERNANDEZ to LCH due to a positive chest x-ray, bowel incontinence, and hypoglycemia,

On the same date, LCH admitted HERNANDEZ for further evaluation and treatment.

On January 27, 2020, at approximately 4:19 a.m. EST, HERNANDEZ became unresponsive. The LCH Doctor intubated HERNANDEZ.

At approximately 4:45 a.m. EST, LCH staff called a code blue and began resuscitation efforts on HERNANDEZ.

At approximately 4:55 a.m. EST, LCH revived HERNANDEZ and cleared the code blue.

At approximately 5:12 a.m. EST, LCH called a second code blue and began resuscitation efforts on HERNANDEZ.

At approximately 5:29 a.m. EST, LCH revived HERNANDEZ and cleared the code blue.

At approximately 5:42 a.m. EST, LCH called a third code blue and began resuscitation efforts on HERNANDEZ.

At approximately 5:57 a.m. EST, during the time of compression and assessing, LCH called a fourth code blue.

At approximately 6:10 a.m. EST, LCH revived HERNANDEZ and cleared the code blue.

At approximately 7:01 a.m. EST, LCH called a fifth code blue and began resuscitation efforts on HERNANDEZ.

At approximately 7:09 a.m. EST, LCH revived HERNANDEZ and cleared the code blue.

At approximately 7:30 a.m. EST, LCH called a sixth code blue and began resuscitation efforts on HERNANDEZ.

At approximately 7:46 a.m. EST, LCH revived HERNANDEZ and cleared the code blue.

At approximately 8:11 am EST, LCH called a seventh code blue and began resuscitation efforts on HERNANDEZ.

At approximately 8:15 LCH revived HERNANDEZ and cleared the code blue.

At approximately 8:23 am EST, LCH called an eighth code blue and began resuscitation efforts on HERNADEZ.

At approximately 8:37 am EST, LCH revived HERNANDEZ and cleared the code blue.

At approximately 9:02 am EST, LCH called a ninth code blue and began resuscitation efforts on HERNADEZ.

At approximately 9:05 am EST, LCH revived HERNANDEZ and cleared the code blue. HERNANDEZ was placed on an echocardiogram machine.

At approximately 9:32 am EST, the LCH Doctor pronounced HERNANDEZ deceased after echocardiogram no longer showed heart activity.

At approximately, 9:45 a.m. EST, the Field Office Director for ERO Miami notified HQ ERO Field Operations of HERNANDEZ's death.

At approximately, 10:00 a.m. EST, an ERO Miami Supervisory Detention and Deportation Officer (SDDO) notified the OPR of HERNANDEZ's death.

At approximately, 10:15 a.m. EST, an ERO Miami SDDO notified the JIC of HERNANDEZ's death.

On January 27, 2020, ERO Miami made multiple unsuccessful attempts to identify the next of kin for notification of HERNANDEZ's death. ERO Miami will continue attempting to locate and make contact with the next of kin.

HERNANDEZ is the sixth detainee to pass away in ICE custody in Fiscal Year 2020.

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From: ERO CRCL
To: (b)(6); (b)(7)(C)
Cc: (b)(6); (b)(7)(C) ERO CRCL
Subject: FW: Detainee Death Notification - Anthony Oluseye AKINYEMI - A201 576 988 - 20-CRCL-2439 - DD (BAL)
Date: Monday, December 23, 2019 9:06:31 AM

Good morning,

CPD received a notification of the death of an ICE detainee, Anthony Oluseye AKINYEMI - A201 576 988. CPD reached out to ERO Baltimore Field Office for information/documents related to detainee Akinyemi.

CPD created a folder labeled (b)(6); (b)(7)(C) - Akinyemi, Anthony. We will let you know as soon as we receive more information from ERO Baltimore Field Office.

Thank you,

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

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

ICE | PCN - Washington, DC 20024
U.S. Department of Homeland Security

O: 202-(b)(6); : 202-(b)(6); (b)(7)(C) @ice.dhs.gov

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From: (b)(6); (b)(7)(C) @ice.dhs.gov>
Sent: Saturday, December 21, 2019 8:06 PM
To: (b)(6); (b)(7)(C) @ice.dhs.gov>
Subject: FW: Detainee Death Notification - Anthony Oluseye AKINYEMI

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

Unit Chief, SDDO
ICE/ERO Custody Reporting & Strategy
202-(b)(6); (b)(7)(C)

From: (b)(6); (b)(7)(C) @ice.dhs.gov>
Date: Saturday, Dec 21, 2019, 4:28 PM
Subject: Detainee Death Notification - Anthony Oluseye AKINYEMI

The message below is distributed on behalf of Acting Executive Associate Director Timothy S. Robbins:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Anthony Oluseye AKINYEMI, A201 576 988.

ISSUE:

-
On December 21, 2019, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) Baltimore, reported the death of ICE detainee, Anthony Oluseye AKINYEMI, a 56-year-old citizen of Nigeria, at Worcester County Jail (WCJ) in Snow Hill, MD. The paramedics contacted the on-call doctor at Peninsula Regional Medical Center in Salisbury, MD and the doctor declared AKINYEMI deceased at 5:23 a.m. Eastern Standard Time (EST), on December 21, 2019. The preliminary cause of death is asphyxiation due to hanging.

ERO Baltimore notified the Department of Homeland Security Office of Inspector General and ICE Office of Professional Responsibility via the Joint Intake Center. ERO Baltimore staff notified AKINYEMI's next-of-kin. ERO Baltimore notified the Consulate General of Nigeria in Washington, DC on December 21, 2019.

-
All media inquiries will be referred to ICE Office of Public Affairs.

BACKGROUND:

On December 13, 2017, U.S. Customs and Border Protection admitted AKINYEMI into the United States at New York City, NY as a B2 nonimmigrant with authorization to remain in the United States until June 12, 2018.

On July 23, 2019, ERO Baltimore lodged an Immigration Detainer-Notice of Action, I-247, on AKINYEMI with the Baltimore City (MD) Police Department after his arrest for sex abuse of a minor. AKINYEMI sexually abused his 12-year-old step-granddaughter.

On December 19, 2019, the Circuit Court for Baltimore City, MD, convicted AKINYEMI of sex offense in the fourth degree and assault in the second degree and sentenced him to eight years' incarceration.

On December 20, 2019, the Baltimore City Jail in Baltimore, MD released AKINYEMI to ERO Baltimore pursuant to the immigration detainer.

On the same date, ERO Baltimore served AKINYEMI a Notice to Appear, Form I-862, charging removability pursuant to Section 237(a)(1)(B) of the Immigration and Nationality Act, as an alien who has remained in the United States for a time longer than permitted. ERO Baltimore transferred AKINYEMI to WCJ for housing.

On December 21, 2019, at approximately 4:43 a.m. EST, a WCJ correctional officer conducted his rounds of the holding cells and confirmed that AKINYEMI was in bed and appeared to be asleep.

At approximately 5:03 a.m. EST, a WCJ correctional officer conducted his rounds of the holding cells and found AKINYEMI hanging off the ground with one end of a sheet wrapped around his neck and the other end tied to a vent in his cell. The correctional officer radioed to their control center for the 911 tool (this is an emergency tool used for cutting).

At approximately 5:04 a.m. EST, a WCJ supervisor arrived with the WCJ nurse, and proceeded to cut AKINYEMI down and began cardio-pulmonary resuscitation (CPR).

At approximately 5:05 a.m. EST, paramedics arrived on the scene and took over performing CPR.

At approximately 5:23 a.m. EST, the paramedics onsite made telephonic contact with Dr. (b)(6); [REDACTED] the on-call doctor at Peninsula Regional Medical Center in Salisbury, MD, who advised the paramedics they could cease performing CPR. The paramedics advised the WCJ that AKINYEMI was deceased.

At approximately, 5:30 a.m. EST, the WCJ Warden notified ERO Baltimore of the death.

At approximately, 6:06 a.m. EST, ERO Baltimore field office director notified HQ ERO Field Operations of AKINYEMI's death.

At approximately, 6:20 a.m. EST, ERO Baltimore assistant field office director for ERO Baltimore in Salisbury, MD, arrived at WCJ to obtain AKINYEMI's personal effects as well as the preliminary paperwork on the death.

At approximately, 7:45 a.m. EST, ERO Baltimore deputy field office director (DFOD) notified the Joint Intake Center of the AKINYEMI's death.

At approximately, 9:09 a.m. EST, ERO Baltimore DFOD notified the next of kin of AKINYEMI's death.

AKINYEMI is the third detainee to pass away in ICE custody in fiscal year 2020.

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From: [Nugent, Samuel](#)
To: [Lee, Louie](#)
Subject: FW: Detainee Death Notification - Ben James OWEN
Date: Monday, January 27, 2020 5:46:19 AM

Samuel A. Nugent

Unit Chief, SDDO
ICE/ERO Custody Reporting & Strategy
[202-732-5154](tel:202-732-5154)

From: (b)(6); (b)(7)(C) <[REDACTED]@ice.dhs.gov>
Date: Sunday, Jan 26, 2020, 9:37 PM
Subject: Detainee Death Notification - Ben James OWEN

The message below is distributed on behalf of Acting Executive Associate Director Timothy S. Robbins:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Ben James OWEN, A219 403 429.

ISSUE:

On January 25, 2020, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) Miami, reported the death of ICE detainee, Ben James OWEN, a 39-year-old citizen of the United Kingdom (UK), at the Baker County Detention Center (BCDC) in Macclenny, FL. Paramedics declared OWEN deceased at 7:52p.m. Eastern Standard Time (EST), on January 25, 2020. The preliminary cause of death is asphyxiation due to hanging.

ERO Miami notified the Department of Homeland Security Office of Inspector General and ICE Office of Professional Responsibility via the Joint Intake Center. ERO Miami staff attempted to notify OWEN's next-of-kin but has been unable to make contact. ERO Miami notified the Consulate General of the United Kingdom's out-of-hours emergency contact team, in London, England on January 26, 2020.

All media inquiries will be referred to ICE Office of Public Affairs.

BACKGROUND:

On July 23, 2019, U.S. Customs and Border Protection (CBP) admitted OWEN into the United States at Minneapolis, MN, as an O2 nonimmigrant (individuals who will accompany an O1, artist, or athlete, to assist in a specific event or performance), with authorization to remain in the United States until December 10, 2019. July 23, 2019 is listed as OWEN's most recent entry into the United States, with the O2 visa being issued on January 10, 2017. The O1 sponsor is identified as (b)(6); (b)(7)(C) [REDACTED] CTK Management LLC, who employed

OWEN as a sound and lighting engineer for multiple performing artists.

On September 18, 2019, the Daytona Beach (FL) Police Department (DBPD) arrested OWEN for felony aggravated battery on a pregnant person.

On September 19, 2019, ERO Miami Interoperability Response Center received notification regarding the aforementioned arrest and did not take an enforcement action since OWEN was not amenable to removal.

On October 22, 2019, the Florida State Attorney's Office dropped the aforementioned charge.

On November 17, 2019, DBPD arrested OWEN for misdemeanor domestic battery. This case is currently pending with the court.

On December 9, 2019, (b)(6); (b)(7)(C), OWEN's United States citizen spouse, filed a Petition for Alien Relative, Form I-130, with U.S. Citizenship and Immigration Services (USCIS) on behalf of OWEN which is pending adjudication.

On the same date, OWEN filed an Application to Register Permanent Residence or Adjust Status, Form I-485, and an Application for Travel Document, Form I-131, with USCIS; both applications are pending adjudication.

On January 12, 2020, the Port Orange (FL) Police Department arrested OWEN for misdemeanor domestic assault, felony aggravated stalking after injunction, felony false imprisonment and violation of condition of pre-trial release. This case is currently pending with the court.

On the same date, ERO Miami lodged an Immigration Detainer-Notice of Action, Form I-247A, on OWEN with the Volusia County Jail (VCJ) in Daytona Beach, FL.

On January 15, 2020, VCJ released OWEN to ERO Miami custody pursuant to the immigration detainer.

On the same date, ERO Miami served OWEN a Notice to Appear, Form I-862, charging removability pursuant to Section 237(a)(1)(B) of the Immigration and Nationality Act, as an alien who has remained in the United States for a time longer than permitted. ERO Miami transferred OWEN to BCDC pending a hearing in the Immigration Court in Orlando, FL.

On January 25, 2020, at approximately 7:29 p.m. EST, ICE detainee (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) citizen and national of Ecuador, discovered OWEN hanging in their shared cell and alerted other detainees of the emergency. Another ICE detainee pushed the emergency call button to alert BCDC deputies.

At approximately 7:30 p.m. EST, a BCDC deputy responded to the alert and found OWEN hanging from a bed sheet that was wrapped around his neck and the other end tied to a pillar that separates the shower and toilet in his cell.

At approximately 7:31 p.m. EST, the BCDC deputy radioed for medical support, then began cardio-pulmonary resuscitation (CPR).

At approximately 7:33 p.m. EST, BCDC medical staff arrived on-scene and continued to administer CPR. In addition, they used an automated external defibrillator in an attempt to resuscitate OWEN.

At approximately 7:36 p.m. EST, a BCDC main control operator, notified the paramedics.

At approximately 7:52 p.m. EST, paramedics arrived on the scene and advised BCDC that OWEN was deceased. They did not attempt any lifesaving procedures or take over CPR.

At approximately, 8:00 p.m. EST, BCDC notified ERO Miami of the death.

At approximately, 8:30 p.m. EST, the Field Office Director for ERO Miami notified HQ ERO Field Operations of OWEN's death.

At approximately, 9:03 p.m. EST, an ERO Miami Supervisory Detention and Deportation Officer notified the Joint Intake Center of OWEN's death.

At approximately, 10:35 p.m. EST, an ERO Miami Assistant Field Office Director in Jacksonville, FL, arrived at BCDC to obtain OWEN's personal effects as well as the preliminary paperwork on the death.

On January 26, 2020, ERO Miami attempted contact with the next of kin at 10:30 a.m. EST, 12:45 p.m. EST, and 1:45 p.m. EST, without having made contact. ERO Miami will continue to attempt to contact the next of kin for notification of OWEN's death.

OWEN is the fifth detainee to pass away in ICE custody in fiscal year 2020.

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From: ERO CRCL
To: (b)(6); (b)(7)(C)
Cc: ERO CRCL
Subject: FW: Detainee Death Notification - Carlos Ernesto ESCOBAR-Mejia - A089 345 062 (b)(6); (b)(7)(C) DD (SND)
Date: Wednesday, May 6, 2020 7:18:48 PM

Dear CRCL,

Please see below notification of the death of an ICE detainee Carlos Ernesto ESCOBAR-Mejia - A089 345 062

CPD created a folder labeled (b)(6); (b)(7)(C) - Escobar Mejia, Carlos in the CRCL SP site and coordinating with ERO San Diego Field Office for the information/documents related to Mr. Escobar-Mejia.

Thank you,

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

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

ICE | PCN - Washington, DC 20024

U.S. Department of Homeland Security

O: 202 (b)(6); (b)(7)(C) C: 202 (b)(6); (b)(7)(C) @ice.dhs.gov

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From: (b)(6); (b)(7)(C) @ice.dhs.gov>
Sent: Wednesday, May 6, 2020 6:43 PM
To: (b)(6); (b)(7)(C) @ice.dhs.gov>; (b)(6); (b)(7)(C) Lee@ice.dhs.gov>; (b)(6); (b)(7)(C) @ice.dhs.gov>
Subject: FW: Detainee Death Notification - Carlos Ernesto ESCOBAR-Mejia

From: (b)(6); (b)(7)(C) @ice.dhs.gov>
Sent: Wednesday, May 6, 2020 6:24 PM
Subject: Detainee Death Notification - Carlos Ernesto ESCOBAR-Mejia

The message below is distributed on behalf of Executive Associate Director Enrique M. Lucero:

-
Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Carlos Ernesto ESCOBAR-Mejia, A089 345 062.

ISSUE:

On May 6, 2020, U.S. Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) San Diego reported the death of ICE detainee Carlos Ernesto ESCOBAR-Mejia, A89 345 062, a 57-year-old citizen of El Salvador, at the Paradise Valley Hospital (PVH) in National City, CA. The medical staff pronounced ESCOBAR deceased at 2:15 a.m. Pacific Daylight Time (PDT). Medical staff has not identified the preliminary cause of death.

Consistent with ICE policy, ERO San Diego notified the DHS Office of Inspector General (OIG), and the ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO San Diego also provided telephonic notification of ESCOBAR's death to the Consulate General of El Salvador in Washington, DC. ERO San Diego also provided information about ESCOBAR's next of kin. The Consulate General will notify the next of kin about ESCOBAR's death.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On May 1, 1980, ESCOBAR entered the United States near San Diego, CA without having been admitted or paroled by an immigration officer.

On October 24, 1989, the Municipal Court of California, County of Los Angeles, convicted ESCOBAR for the offense of grand theft and sentenced him to 60 days in jail.

On December 5, 1989, the Superior Court of California, County of Los Angeles, convicted ESCOBAR for the offense of possession of a controlled substance and sentenced him to 110 days in jail.

On May 30, 1990, the Superior Court of California, County of Los Angeles, CA, convicted ESCOBAR of receiving known stolen property and sentenced him to 365 days in jail.

On August 17, 1993, the Municipal Court of California, County of Los Angeles, CA, convicted ESCOBAR of driving under the influence (DUI) and sentenced him to 20 days in jail.

On February 1, 2012, the Compton Police Department in Compton, CA arrested ESCOBAR for possession of controlled substance. The court dismissed ESCOBAR's case.

On February 2, 2012, the Los Angeles Sheriff's Department (LASD), in Los Angeles, CA, arrested ESCOBAR for possession of a controlled substance. On the same date, the Southern California Secure Communities Support Center (SC3) in Laguna Niguel, CA received an Immigration Alien Response (IAR) from the Law Enforcement Support Center (LESC) in Williston, VT, concerning ESCOBAR's arrest and lodged an Immigration Detainer, Form I-247 with the LASD.

On March 28, 2012, ESCOBAR entered ERO Los Angeles custody. On the same date, ERO Los Angeles served ESCOBAR 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.

On March 28, 2012, ERO Los Angeles transferred ESCOBAR to the Adelanto ICE Processing Center in Adelanto, CA, pending removal proceedings.

On April 9, 2012, an immigration judge (IJ) reset ESCOBAR's hearing.

On May 1, 2012, the IJ continued ESCOBAR's case to May 15, 2012.

On May 8, 2012, the IJ reset ESCOBAR's case. The court set ESCOBAR's bond at \$5,000.

On May 15, 2012, the IJ set the case for June 5, 2012.

On June 4, 2012, ERO Los Angeles released ESCOBAR and placed him on the non-detained docket after he posted \$5,000 delivery bond.

On January 3, 2020, the United States Border Patrol (USBP) arrested ESCOBAR near Campo, CA, on suspicion of alien smuggling. On the same date, USBP presented ESCOBAR before the Assistant United States Attorney's Office (AUSA) for criminal prosecution. The AUSA declined criminal prosecution and USBP served ESCOBAR a Notice to Appear, Form I-862, charging removability pursuant to Section 212(a)(6)(A)(i) of the 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.

On January 7, 2020, ERO Los Angeles cancelled ESCOBAR's bond.

On January 9, 2020, the USBP cancelled their Notice to Appear because ESCOBAR was already in removal proceedings in Los Angeles, CA.

On January 10, 2020, ESCOBAR entered ERO San Diego custody at the Otay Mesa Detention Center pending a motion for a change of venue and an IJ hearing.

On January 11, 2020, ICE Health Service Corp (IHSC) medical staff saw ESCOBAR and noted that he had primary hypertension. ESCOBAR also self-identified as having diabetes.

On January 13, 2020, the San Diego Office of Chief Counsel (OCC) filed a motion for change of venue from Los Angeles, CA to San Diego, CA.

On January 24, 2020, an IJ continued ESCOBAR's case.

On February 14, 2020, an IJ continued ESCOBAR's case.

On March 20, 2020, an IJ continued ESCOBAR's case.

On April 15, 2020, an IJ found ESCOBAR to be a flight risk and denied bond. ESCOBAR reserved appeal.

On April 24, 2020, at approximately 5:30 p.m. PDT, ERO San Diego transferred ESCOBAR to the PVH in National City, CA due to ESCOBAR having COVID-19 symptoms (hypoxia).

On the same date, IHSC administered a test for COVID-19. The results returned that day indicating that ESCOBAR did have COVID-19. ERO San Diego reported the positive test result and hospital admission via the significant event network (SEN) in report

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

On April 27, 2020, at approximately 12:25 p.m. PDT, medical personnel at the PVH placed ESCOBAR on a ventilator and transferred him to the Intensive Care Unit (ICU) due to COVID-19 complications.

On April 29, 2020, the IJ reset ESCOBAR's next hearing for October 19, 2020.

On April 29, 2020, at approximately 9:08 a.m. PDT, ERO San Diego contacted ESCOBAR's next of kin (sister), (b)(6); (b)(7)(C) and provided her with the hospital contact information.

At approximately 10:58 a.m. PDT, ERO San Diego informed ESCOBAR's attorney of record, (b)(6); (b)(7)(C) of ESCOBAR's status.

At approximately 5:28 p.m. PDT, a do not resuscitate (DNR) order went into effect at the request of ESCOBAR's family.

On May 6, 2020, staff at the PVH notified ERO San Diego that medical staff had pronounced ESCOBAR deceased at 2:15 a.m. Medical staff have not identified an official cause of death.

At approximately 9:26 a.m. PDT, ERO San Diego notified the El Salvador Consulate of ESCOBAR's death.

At approximately 10:17 a.m. PDT, ERO San Diego notified the Joint Intake Center of ESCOBAR's death.

ESCOBAR is the eleventh detainee to pass away in ICE custody in fiscal year 2020.

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ICE Significant Incident Report

Submitted Date and Time of Report: 9/11/2019 1554 EST

Incident Date: 9/11/2019	Incident Time: 2135	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Field Operations Division	Area: Eastern Operations
Case Number: No Case Involved	Office: XI - FOD CHICAGO - CHI	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	☐ Unaccompanied Children		☐ COVID19
☐ Loss or Theft of Firearm or Body Armor	☐ COVID19 Disruptions		

Principal Subject: Person
Date of Birth: 1/3/1982

Last Name: Rodriguez Espinosa
Country of Birth: Mexico

First Name: Roberto
Citizenship: Mexico

Alien ID: 215809440

Narrative

Report Title: Detainee Death - Chicago Field Office

The message below is distributed on behalf of Acting Executive Associate Director Timothy S. Robbins

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Roberto RODRIGUEZ-Espinoza, A215 809 440.
ERO Chicago-Roberto RODRIGUEZ-Espinoza A215 809 440

ISSUE:

Enforcement and Removal Operations (ERO) Chicago reported the death of ICE detainee Roberto RODRIGUEZ-Espinoza, A215 809 440, a 37-year-old citizen of Mexican in removal proceedings. On September 10, 2019, Northwestern Medicine Central DuPage Hospital (CDH) in Winfield, IL. Medical staff pronounced RODRIGUEZ dead at 9:35 p.m. Central Standard Time (CST) today. CDH identified the preliminary cause of death as subdural hematoma.

BACKGROUND:

On an unknown date, RODRIGUEZ entered the United States at an unknown location without admission or parole by an immigration officer.

On May 29, 2008, the Circuit Court of Cook County (CCCC) in Chicago, IL convicted RODRIGUEZ of theft and sentenced him to six months' probation. ERO Chicago did not have any contact with RODRIGUEZ at this time.

On September 21, 2016, CCCC convicted RODRIGUEZ of burglary and sentenced him to 324 days in custody with credit for time served and two years' probation. ERO Chicago did not have any contact with RODRIGUEZ at this time.

On September 3, 2019, Homeland Security Investigations (HSI) Gang and Safety Unit Chicago encountered RODRIGUEZ in Chicago, IL as (b)(7)(E)

(b)(7)(E) with the Chicago Police Department. HSI had RODRIGUEZ under (b)(7)(E) HSI Chicago arrested RODRIGUEZ and detained him at McHenry County Adult Correctional Facility (MCACF) in Woodstock, IL.

On September 3, 2019, MCACF medically screened RODRIGUEZ during the intake process and he claimed no medical or mental health history nor current intake of medications; however, he admitted to drinking a six pack of alcohol daily. RODRIGUEZ had not yet undergone a complete physical exam at MCACF, which is normally required within 14 days of intake.

On September 4, 2019, ERO Chicago transported RODRIGUEZ to Broadview Service Staging Area (BSSA) in Broadview, IL and issued him a Notice to Appear, Form I-862, charging inadmissibility pursuant to Section 212(a)(6)(A)(i) of the Immigration and Nationality Act (INA), as an alien who is present in the United States without admission or parole by an immigration officer. ERO Chicago returned RODRIGUEZ to MCACF after completing processing.

On September 7, 2019, at approximately 3:30 p.m. CST, MCACF correctional staff observed RODRIGUEZ acting confused and unfamiliar with his surroundings. MCACF contacted MCACF medical regarding RODRIGUEZ' behavior. At this time, MCACF medical staff completed a medical re-evaluation to include vital signs and coordinated RODRIGUEZ's movement to the medical housing unit for further observation. MCACF medical staff indicated that RODRIGUEZ could be detoxing and commenced an alcohol detoxing treatment per the physician's order.

At approximately 10:47 p.m. CST, the MCACF physician ordered RODRIGUEZ transported to the Northwestern Medicine Woodstock Hospital (NWMWH) in Woodstock, IL, emergency room for further evaluation due to his altered mental status as a result of reported history of alcohol abuse.

On September 8, 2019, at approximately 4:58 a.m. CST, NWMWH transferred RODRIGUEZ via ambulance to Northwestern Medicine Huntley Hospital (NWMHH), in Huntley, IL, due to his continuous erratic behavior and his severe altered mental status. On the same date, NWMHH sedated and intubated RODRIGUEZ due to his altered mental state and agitated behavior. Subsequently, NWMHH diagnosed RODRIGUEZ with a brain hemorrhage.

At approximately 7:43 p.m. CST, NWMHH transferred RODRIGUEZ to CDH for a neurosurgery consult to accommodate his diagnosis. RODRIGUEZ failed to respond during a neurological exam performed upon arrival at CDH. The attending neurosurgeon advised against surgery to treat RODRIGUEZ's chronic acute brain bleed because he had irreversible loss of all function of the brain and was unlikely to survive the surgery. CDH placed RODRIGUEZ on life support in the Intensive Care Unit.

At approximately 11:54 p.m. CST, ERO Chicago contacted the Mexican Consulate to inform them of RODRIGUEZ' medical status and to request assistance locating his next of kin.

On September 9, 2019, ERO Chicago contacted the Mexican Consulate who advised that they believed they have located a family member and requested to visit RODRIGUEZ in the hospital to verify his identity.

On September 10, 2019, at approximately 7:23 p.m. CST, the Mexican Consulate advised ERO

Chicago that they believed they have identified the person under ERO custody. However, they stated there is no way to make a positive identification without having biometrics and/or DNA involved. For that course of action, they would need to get their Foreign Affairs Ministry involved. The Consulate mobilized its resources in the United States and in Mexico to locate a next of kin in order to make proper arrangements and a proper identification.

At approximately 8:00 p.m. CST, CDH commenced brain death testing to check the blood flow for RODRIGUEZ. The brain death testing results did not show any blood flow in RODRIGUEZ's brain.

At approximately 9:35 p.m. CST, CDH disconnected RODRIGUEZ from life support at which time RODRIGUEZ died. CDH notified the ERO Chicago officer on duty at the hospital of RODRIGUEZ's death. On the same date and time, the ERO Chicago officer notified ERO Chicago management of RODRIGUEZ's death.

At approximately 10:07 p.m. CST, the ERO Chicago Field Office Director notified ERO Headquarters, Assistant Director for Field Operations of RODRIGUEZ's death.

At approximately 10:08 p.m. CST, consistent with ICE policy, ERO Chicago telephonically notified the Office of Professional Responsibility (OPR) via the Joint Intake Center of RODRIGUEZ's death. OPR indicated they would notify the Office of the Inspector General of RODRIGUEZ's death.

At approximately 10:55 p.m. CST, ERO Chicago notified the Consulate of Mexico in Chicago, IL of RODRIGUEZ's death. The Mexican Consulate was advised that they have seven days to inform ERO Chicago if they are claiming the body. Mexican Consular officials stated that RODRIGUEZ did not have any known next of kin.

RODRIGUEZ is the eighth detainee to pass away in ICE custody in fiscal year 2019.

All media inquiries will be referred to the ICE Office of Public Affairs.

Violations of Law:

Action Taken:

Other Agencies Notified:

Name	Agency	Phone	Date	Time
none				

Injuries:	Injuries (Names and Extent of Injury):
Fatalities:	
Damage:	
Unaccompanied	
Child Count:	

Locations:

Type	Address	City	State	Zip
	101 W Ida B Wells Drive	Chicago	Illinois	60605

Reported to ICE Operations Center via Phone:

Public Affairs Notified: Yes

Officer Notified: (b)(6); (b)(7)(C)

Date: 9/11/2019

Time: 1500

Comments:

Reported By: (b)(6); (b)(7)(C)

Phone: 312-347-(b)(6); (b)(7)(C)

Cell/Pager: 312-29-(b)(6); (b)(7)(C)

Supervisor:

Phone: 312-347-(b)(6); (b)(7)(C)

Cell/Pager: 312-29-(b)(6); (b)(7)(C)

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

Detention and Deportation Officer
HQ ERO Domestic Operations
Office-(202) 71 (b)(6);
Cell-(202) 321 (b)(7)(C)

-----Original Message-----

From: National SCO Support-ICE <nsco-ice@ice.dhs.gov>

Sent: Wednesday, October 2, 2019 3:21 PM

To: (b)(6); (b)(7)(C)@ice.dhs.gov; Albence, Matthew (b)(6); (b)(7)(C)@ice.dhs.gov;
(b)(6); (b)(7)(C)@ice.dhs.gov; (b)(6); (b)(7)(C)@ice.dhs.gov;
(b)(6); (b)(7)(C)@ice.dhs.gov; (b)(6); (b)(7)(C)@ice.dhs.gov; (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C)@ice.dhs.gov; (b)(6); (b)(7)(C)@ice.dhs.gov; Wong, Ricardo
(b)(6); (b)(7)(C)@ice.dhs.gov; (b)(6); (b)(7)(C)@ice.dhs.gov; (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C)@ice.dhs.gov; (b)(6); (b)(7)(C)@ice.dhs.gov; (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C)@ice.dhs.gov; (b)(6); (b)(7)(C)@ice.dhs.gov; (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C)@ice.dhs.gov; (b)(6); (b)(7)(C)@ice.dhs.gov; Robbins, Timothy S
(b)(6); (b)(7)(C)@ice.dhs.gov; (b)(6); (b)(7)(C)@ice.dhs.gov; (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C)@ice.dhs.gov; (b)(6); (b)(7)(C)@ice.dhs.gov; Lucero, Enrique M
(b)(6); (b)(7)(C)@ice.dhs.gov; (b)(6); (b)(7)(C)@ice.dhs.gov; Estrada, Rafael
(b)(6); (b)(7)(C)@ice.dhs.gov; Archambeault, Gregory J (b)(6); (b)(7)(C)@ice.dhs.gov; (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C)@ice.dhs.gov; (b)(6); (b)(7)(C)@ice.dhs.gov; (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C)@ice.dhs.gov; (b)(6); (b)(7)(C)@ice.dhs.gov;
(b)(6); (b)(7)(C)@ice.dhs.gov

Subject: SEN Report Notification

INCIDENT NBR: (b)(7)(E)

INCIDENT DATE/TIME: 10/01/2019 12:05

INCIDENT END DATE/TIME: 00:00

EVENT STATUS: Routine

REPORT TITLE: Detainee Death-San Diego Field Office

TECS CASE NUMBER: (none)

RELATED CASE NUMBER: (none)

RELATED SEN NUMBER: (none)

OFFICE: FOD SAN DIEGO - SND

LEAD AGENCY: DHS / ICE

ICE COMPONENT: Enforcement & Removal Operations

DIVISION: Detention Management Division

AREA: Detention Monitoring

LOCATION:

SUSPECT: Nebane ABIENWI;

ALIEN NUMBER: 213 187 584

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

619-661 (b)(6); (b)(7)(C) (office)

619-455 (b)(6); (b)(7)(C) (cell/pager)

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

619-661 (b)(6) (office)

619-57 (b)(6); (b)(7)(C) (cell/pager)

REPORT NARRATIVE:

The message below is distributed on behalf of Acting Executive Associate Director Timothy S. Robbins:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Nebane ABIENWI, A213 187 584.

ISSUE:

On October 1, 2019, ICE Enforcement and Removal Operations (ERO) San Diego reported the death of ICE detainee Nebane ABIENWI, A213 187 584, a 37-year-old citizen of Cameroon, at the Sharp Chula Vista Medical Center in Chula Vista, CA. The medical staff pronounced ABIENWI deceased at 12:05 p.m. PDT. Medical staff identified the preliminary cause of death as brain death secondary to herniation secondary to basal ganglia hemorrhage.

Consistent with ICE policy, ERO San Diego notified the DHS Office of Inspector General (OIG), and the ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO San Diego also provided telephonic notification of ABIENWI's death to the Consulate General of Cameroon in Washington, DC. The Consulate General of Cameroon in Washington identified next of kin for ABIENWI. All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On September 5, 2019, U.S. Customs and Border Protection (CBP) encountered ABIENWI as he applied for admission into the United States at the San Ysidro, CA, Port of Entry. During an oral interview, and in a sworn statement, ABIENWI admitted to being a citizen and national of Cameroon by virtue of birth in Bameda, Cameroon on October 28, 1981. CBP served ABIENWI with a Notice and Order of Expedited Removal, Form I-860, charging inadmissibility under section 212(a)(7)(A)(i)(I) of the Immigration and Nationality Act (INA), as an immigrant without a valid visa. ABIENWI claimed fear of persecution during processing.

On September 19, 2019, CBP transferred ABIENWI to the custody of ERO San Diego at the Otay Mesa Detention Center (OMDC) in San Diego, CA.

On September 20, 2019, ERO San Diego referred ABIENWI's case to U.S. Citizenship and Immigration Services for a credible fear interview.

On September 26, 2019, at approximately 3:28 a.m. PDT, ICE Health Service Corp (IHSC) staff at OMDC responded to a medical emergency in a housing unit. Other detainees in ABIENWI's housing unit observed him fall off his bunk to the floor.

At 3:50 a.m. PDT, OMDC staff contacted Emergency Medical Services (EMS).

At 4:12 a.m. PDT, EMS arrived at OMDC and began treatment of ABIENWI.

At 4:34 a.m. PDT, EMS departed OMDC with ABIENWI for the Sharp Chula Vista Medical Center. Medical staff at the hospital admitted ABIENWI because he was nonresponsive to questions and commands, had jerky movements, and showed left side paralysis. Medical staff intubated ABIENWI.

At approximately 9:55 a.m. PDT, a CoreCivic detention officer notified ERO San Diego a doctor from the Sharp Chula Vista Medical Center needed ABIENWI's family contact information because he was hemorrhaging in the brain and might succumb to his injuries within the next 24 hours.

At approximately 2:27 p.m. PDT, ERO San Diego called (b)(6); (b)(7)(C) friend of ABIENWI listed in ABIENWI's alien file. ERO San Diego requested assistance from (b)(6); with providing contact information for ABIENWI's family.

On September 27, 2019, at approximately 2:00 a.m. PDT, a CoreCivic detention officer reported that medical staff at the Sharp Chula Vista Medical Center described ABIENWI's neurological functioning as getting worse, and a CT scan was scheduled. IHSC reported ABIENWI was unresponsive and had a fever throughout the night which finally broke in the morning.

At approximately 10:44 a.m. PDT, ERO San Diego left a voicemail for (b)(6); (b)(7)(C) at the Consulate of Cameroon requesting assistance with notifying any next of kin for ABIENWI.

At approximately 11:13 a.m. PDT, ERO San Diego emailed the Consulate of Cameroon with ABIENWI's alien number, date of birth, and copies of his Cameroon ID card and birth certificate.

At approximately 12:42 p.m. PDT, ERO San Diego contacted (b)(6); from the Consulate of Cameroon. ERO San Diego informed (b)(6); of ABIENWI's medical status. (b)(6); said his office would try to locate family members for ABIENWI.

At approximately 3:00 p.m. PDT, ERO staff located medical certificates in ABIENWI's property. The medical certificates indicate that ABIENWI received treatment for hypertension/high blood pressure on August 30, 2019, in Tijuana, Mexico at a hospital named Centro De Salud Tijuana. ABIENWI was prescribed Captopril and Ranitidine medications.

At approximately 3:22 p.m. PDT, ERO San Diego provided (b)(6); (b)(7)(C) additional information about ABIENWI's injury.

On September 29, 2019, at approximately 5:01 a.m. PDT, IHSC notified ERO San Diego that ABIENWI remained comatose, unresponsive, and received tube feeding.

On September 30, 2019, at approximately 5:03 a.m. PDT, IHSC notified ERO San Diego that there were no changes to ABIENWI's status.

On September 30, 2019, at approximately 12:22 p.m. PDT, ERO San Diego called (b)(6); (b)(7)(C) and he provided the phone number to ABIENWI's brother, Ambe Elvis, living in South Africa. ERO San Diego contacted (b)(6); (b)(7)(C) and related his brother's condition. (b)(6); identified ABIENWI's wife as Susan Manja, living in Cameroon. Mr. (b)(6); provided her contact information.

At approximately 2:13 p.m. PDT, ERO San Diego and IHSC called ABIENWI's wife in Cameroon. During this phone call, OMDC personnel and IHSC medical staff answered (b)(6); question regarding her husband. OMDC staff provided Ms. Manja the phone number to the hospital so she could speak to the attending physician for an update on her husband.

At approximately 9:24 p.m. PDT, IHSC notified ERO San Diego there were no reported changes to ABIENWI's status, the prognosis was grim to poor.

On October 1, 2019, at approximately 6:07 a.m. PDT, IHSC notified ERO San Diego there were no reported changes to ABIENWI's status.

At approximately 12:05 p.m., medical staff at the Sharp Chula Vista Medical Center pronounced ABIENWI brain dead.

At approximately 12:38 p.m. PDT, ERO San Diego called ABIENWI's wife, Susan Manja. During this phone call IHSC notified Susan Manja that her husband passed.

At approximately 1:06 p.m. PDT, IHSC notified ERO San Diego that medical staff at the Sharp Chula Vista Medical Center pronounced ABIENWI dead at 12:05 p.m. PDT. Medical staff identified the cause of death as brain death secondary to herniation secondary to basal ganglia hemorrhage.

At approximately 2:37 p.m. PDT, medical staff at the Sharp Chula Vista Medical Center discontinued the use of the ventilator. ABIENWI's cardiac function stopped shortly thereafter.

At approximately 3:06 p.m. PDT, ERO San Diego notified the Consulate General of Cameroon of ABIENWI's death.

ABIENWI is the first detainee to pass away in ICE custody in fiscal year 2020.

ICE Significant Incident Report

Submitted Date and Time of Report: 10/16/2019 1620 EST

Incident Date: 10/15/2019	Incident Time: 1404	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Field Operations Division	Area: Eastern Operations
Case Number: No Case Involved	Office: XN - FOD NEW ORLEANS - NOL	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	☐ Unaccompanied Children		
☐ Loss or Theft of Firearm or Body Armor			

Principal Subject: Person	Last Name: Royland	First Name: HERNANDEZ-Diaz	Alien ID: 203637060
Date of Birth: 9/25/1976	Country of Birth: Cuba	Citizenship: Cuba	

Narrative

Report Title: New Orleans Field Office - Detainee Suicide

ISSUE:

On October 15, 2019, ICE Enforcement and Removal Operations (ERO) New Orleans reported the death of ICE detainee Roylan HERNANDEZ-Diaz, A203 637 060, a 43-year old citizen of Cuba, at the Richwood Correctional Center (RCC), Richwood, LA. RCC medical staff pronounced HERNANDEZ deceased at 2:21p.m. CDT and identified the preliminary cause of death as suicide.

Consistent with ICE policy, ERO New Orleans notified DHS Office of Inspector General, and the ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO New Orleans also provided electronic notifications of HERNANDEZ's death to the Acting Assistant Attorney General of Removal in Cuba for notification to the Government of Cuba, as well as for him to provide notification to next of kin with information obtained from HERNANDEZ's file.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On May 19, 2019, U.S. Customs and Border Patrol (CBP) encountered HERNANDEZ as he applied for admission into the United States at the El Paso, TX Paso Del Norte, Port of Entry. CBP served HERNANDEZ with 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 Nationality Act (INA), as an immigrant without a valid visa. During initial interview, HERNANDEZ made a claim of fear of returning to Cuba.

On May 20, 2019, CBP transferred HERNANDEZ into the custody of ERO El Paso.

On May 23, 2019, ERO El Paso transferred HERNANDEZ to the Tallahatchie County Correctional Facility, Tutwiler, MS, located within the ERO New Orleans Field Office.

On May 24, 2019, ERO New Orleans referred HERNANDEZ's case to U.S. Citizenship and Immigration Service (USCIS) for a credible fear interview.

On June 5, 2019, USCIS determined HERNANDEZ had made a positive credible fear claim and served him a Notice to Appear, Form I-862, charging inadmissibility pursuant to section 212(a)(7)(A)(i)(I) of the INA, as an immigrant without a valid visa.

On June 13, 2019, HERNANDEZ was transferred to RCC.

On August 5, 2019, HERNANDEZ filed a request for parole with ERO New Orleans.

On August 20, 2019, ERO New Orleans denied the request for parole.

On August 21, 2019, an immigration judge (IJ) in Richwood, LA, found HERNANDEZ removable and provided him with an Application for Asylum and for Withholding of Removal, Form I-589. The IJ reset the case for an individual hearing on October 9, 2019 to address the I-589.

On September 16, 2019, HERNANDEZ filed a request for a parole redetermination.

On September 27, 2019, HERNANDEZ filed an I-589 with the Executive Office for Immigration Review.

On October 8, 2019, ERO New Orleans denied HERNANDEZ's request for parole redetermination.

On October 9, 2019, an IJ reset the case for January 30, 2020.

On October 10, 2019, RCC placed HERNANDEZ in administrative segregation for observation and monitoring due to threatening a hunger strike.

On October 11, 2019, RCC observed HERNANDEZ eating his dinner meal.

On October 12, 2019, RCC observed HERNANDEZ eating his breakfast meal.

On October 15, 2019, RCC notified ERO New Orleans that HERNANDEZ had missed his ninth consecutive meal and declared a hunger strike, citing

ICE Significant Incident Report

Submitted Date and Time of Report: 12/21/2019 1713 EST

Incident Date: 12/21/2019	Incident Time: 0523	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Field Operations Division	Area: Eastern Operations
Case Number: No Case Involved	Office: ET - FOD BALTIMORE - BAL	Lead Agency: B - DHS / ICE
SEN Incident Number: (b)(7)(F)	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	☐ Unaccompanied Children		☐ COVID19
☐ Loss or Theft of Firearm or Body Armor	☐ COVID19 Disruptions		

Principal Subject: Person
Date of Birth: 3/6/1963

Last Name: AKINYEMI
Country of Birth: Nigeria

First Name: Anthony
Citizenship: Nigeria

Alien ID: 201 576 988

Narrative

Report Title: Detainee Death Notification - Anthony Oluseye AKINYEMI

The message below is distributed on behalf of Acting Executive Associate Director Timothy S. Robbins:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Anthony Oluseye AKINYEMI, A201 576 988.

ISSUE:

On December 21, 2019, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) Baltimore, reported the death of ICE detainee, Anthony Oluseye AKINYEMI, a 56-year-old citizen of Nigeria, at Worcester County Jail (WCJ) in Snow Hill, MD. The paramedics contacted the on-call doctor at Peninsula Regional Medical Center in Salisbury, MD and the doctor declared AKINYEMI deceased at 5:23 a.m. Eastern Standard Time (EST), on December 21, 2019. The preliminary cause of death is asphyxiation due to hanging.

ERO Baltimore notified the Department of Homeland Security Office of Inspector General and ICE Office of Professional Responsibility via the Joint Intake Center. ERO Baltimore

staff notified AKINYEMI's next-of-kin. ERO Baltimore notified the Consulate General of Nigeria in Washington, DC on December 21, 2019.

All media inquiries will be referred to ICE Office of Public Affairs.

BACKGROUND:

On December 13, 2017, U.S. Customs and Border Protection admitted AKINYEMI into the United States at New York City, NY as a B2 nonimmigrant with authorization to remain in the United States until June 12, 2018.

On July 23, 2019, ERO Baltimore lodged an Immigration Detainer-Notice of Action, I-247, on AKINYEMI with the Baltimore City (MD) Police Department after his arrest for sex abuse of a minor. AKINYEMI sexually abused his 12-year-old step-granddaughter.

On December 19, 2019, the Circuit Court for Baltimore City, MD, convicted AKINYEMI of sex offense in the fourth degree and assault in the second degree and sentenced him to eight years' incarceration.

On December 20, 2019, the Baltimore City Jail in Baltimore, MD released AKINYEMI to ERO Baltimore pursuant to the immigration detainer.

On the same date, ERO Baltimore served AKINYEMI a Notice to Appear, Form I-862, charging removability pursuant to Section 237(a)(1)(B) of the Immigration and Nationality Act, as an alien who has remained in the United States for a time longer than permitted. ERO Baltimore transferred AKINYEMI to WCJ for housing.

On December 21, 2019, at approximately 4:43 a.m. EST, a WCJ correctional officer conducted his rounds of the holding cells and confirmed that AKINYEMI was in bed and appeared to be asleep.

At approximately 5:03 a.m. EST, a WCJ correctional officer conducted his rounds of the holding cells and found AKINYEMI hanging off the ground with one end of a sheet wrapped around his neck and the other end tied to a vent in his cell. The correctional officer radioed to their control center for the 911 tool (this is an emergency tool used for cutting).

At approximately 5:04 a.m. EST, a WCJ supervisor arrived with the WCJ nurse, and proceeded to cut AKINYEMI down and began cardio-pulmonary resuscitation (CPR).

At approximately 5:05 a.m. EST, paramedics arrived on the scene and took over performing CPR.

At approximately 5:23 a.m. EST, the paramedics onsite made telephonic contact with Dr. (b)(6); the on-call doctor at Peninsula Regional Medical Center in Salisbury, MD, who advised the paramedics they could cease performing CPR. The paramedics advised the WCJ that AKINYEMI was deceased.

At approximately, 5:30 a.m. EST, the WCJ Warden notified ERO Baltimore of the death.

At approximately, 6:06 a.m. EST, ERO Baltimore field office director notified HQ ERO Field Operations of AKINYEMI's death.

At approximately, 6:20 a.m. EST, ERO Baltimore assistant field office director for ERO Baltimore in Salisbury, MD, arrived at WCJ to obtain AKINYEMI's personal effects as well as the preliminary paperwork on the death.

At approximately, 7:45 a.m. EST, ERO Baltimore deputy field office director (DFOD) notified the Joint Intake Center of the AKINYEMI's death.

At approximately, 9:09 a.m. EST, ERO Baltimore DFOD notified the next of kin of AKINYEMI's death.

AKINYEMI is the third detainee to pass away in ICE custody in fiscal year 2020.

This SIR was reviewed and approved by FOD Diane L. Witte

Violations of Law:

Action Taken:

Other Agencies Notified:

Name	Agency	Phone	Date	Time
none				

Injuries:	Injuries (Names and Extent of
Fatalities:	Injury):
Damage:	
Unaccompanied	
Child Count:	

Locations:

Type	Address	City	State	Zip
Business	Worcester County Jail	Snow Hill	Maryland	

Reported to ICE Operations Center via Phone:

Public Affairs Notified: No - Without comments

Comments:

Reported	(b)(6); (b)(7)(C)	Phone: 410-	(b)(6); (b)(7)(C)	Cell/Pager: 202	(b)(6); (b)(7)(C)
Supervisor		Phone: 4106		Cell/Pager: 202	

ICE Significant Incident Report

Submitted Date and Time of Report: 12/31/2019 1644 EST

Incident Date: 12/29/2019	Incident Time: 1220	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Detention Management Division	Area: Detention Monitoring
Case Number: No Case Involved	Office: E1 - Albuquerque, NM - ABQ	Lead Agency: B - DHS / ICE
SEN Incident Number: (b)(7)(E)	Initial/Follow-Up: Follow-Up	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	☐ Unaccompanied Children		☐ COVID19
☐ Loss or Theft of Firearm or Body Armor	☐ COVID19 Disruptions		

Principal Subject: Person	Last Name: MAVINGA	First Name: Samuelino	Alien ID: 213 171 482
Date of Birth: 6/29/1979	Country of Birth: Angola	Citizenship: France	

Narrative

Report Title: ERO El Paso - Death of ICE Detainee

The message below is distributed on behalf of Acting Executive Associate Director Timothy S. Robbins:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Samuelino MAVINGA, A213 171 482.

ISSUE:

On December 29, 2019, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) El Paso, reported the death of ICE detainee, Samuelino MAVINGA, a 40-year-old citizen of France, at the Presbyterian Hospital (PH) in Albuquerque, NM. The on-call physician declared MAVINGA deceased at 12:20 p.m. Mountain Standard Time (MST), on December 29, 2019. The preliminary cause of death is cardiac arrest.

ERO El Paso notified the Department of Homeland Security Office of Inspector General and ICE Office of Professional Responsibility via the Joint Intake Center. ERO El Paso staff

was unable to locate any family members for MAVINGA as he was homeless when he was encountered by U.S. Customs and Border Protection. ERO El Paso notified the Consulate General of France in Washington, DC on December 29, 2019.

All media inquiries will be referred to ICE Office of Public Affairs.

BACKGROUND:

On November 28, 2018, U.S. Customs and Border Protection Officers admitted MAVINGA into the United States at the John F. Kennedy International Airport in New York, NY as a visitor for pleasure under the Visa Waiver Program until February 27, 2019.

On November 11, 2019, U.S. Border Patrol (USBP) encountered MAVINGA at a USBP checkpoint in Sierra Blanca, TX while conducting passenger bus inspections. USBP determined that MAVINGA remained in the United States for a period longer than authorized and is in violation of his immigration status. USBP processed MAVINGA for a removal pursuant to Section 237 of the Immigration and Nationality Act (INA), as a Visa Wavier Program Violator (overstay).

On November 12, 2019, USBP released MAVINGA to ERO El Paso custody. ERO El Paso transferred MAVINGA to the Otero County Processing Center, in Chaparral, NM pending his removal from the United States.

On November 15, 2019, MAVINGA claimed fear of returning to his country and requested asylum. ERO El Paso submitted a Notice of Referral to Immigration Judge, Form I-863 to the Executive Office for Immigration Review to initiate asylum proceedings.

On December 5, 2019, an immigration judge issued an oral decision granting MAVINGA's request to withdraw his application for asylum, withholding of removal under INA 241 and withholding of removal under convention against torture.

On December 11, 2019, ERO El Paso transferred MAVINGA to the Torrance County Detention Facility (TCDF) in Estancia, NM pending removal from the United States.

On December 12, 2019, TCDF medical staff advised ERO El Paso that TCDF staff transported MAVINGA, to PH for treatment and evaluation of emaciation, low body mass index, low blood pressure, scleral jaundice, frequent unproductive cough, slow mentation, tangential speech, left anterior chest with diminished, adventitious lung sounds, decreased reflexes, potential sepsis and sigmoid volvulus (twisting of the large intestines, causing large bowel obstruction).

On December 16, 2019, PH medical staff conducted a colectomy surgical procedure on MAVINGA.

On December 18, 2019, ERO El Paso contacted the Consulate of France, via telephone, and notified them of MAVINGA's hospital admission and requested the issuance of a travel document (TD).

On December 19, 2019, ERO El Paso contacted the Consulate of France, via email, for issuance of a TD and uploaded proof of French citizenship.

On December 20, 2019, ERO El Paso received an email from the Consulate of France indicating that they would issue the TD once an itinerary was issued. ERO El Paso began working on travel arrangements for MAVINGA to provide to the Consulate of France for TD issuance.

On December 25, 2019, PH medical staff transferred MAVINGA into the Intensive Care Unit after he went into respiratory distress during an intubation procedure which required Cardiopulmonary Resuscitation (CPR). PH physicians stabilized MAVINGA, but he remained in critical condition.

On December 29, 2019, at approximately 3:00 a.m., MST, MAVINGA went into cardiac arrest and needed to be resuscitated through CPR., PH medical staff stabilized MAVINGA, but he remained in critical condition.

On December 29, 2019, at approximately 4:00 a.m. MST, MAVINGA went into cardiac arrest for the second time and needed to be resuscitated through CPR. PH medical staff stabilized MAVINGA, but he remained in critical condition. PH medical staff determined that if MAVINGA went into cardiac arrest again they would not resuscitate.

On December 29, 2019, at approximately 12:20 p.m. MST, MAVINGA went into cardiac arrest for the third time and was pronounced deceased by a PH on call physician.

At approximately 12:35 p.m. MST, the TCDF warden notified ERO El Paso of MAVINGA's death.

At approximately, 12:52 p.m. MST, ERO El Paso acting deputy field office director (DFOD) notified HQ ERO Field Operations of MAVINGA's death.

At approximately, 2:20 p.m. MST, ERO El Paso acting DFOD notified the Joint Intake Center of the MAVINGA's death.

At approximately, 2:38 p.m. MST, ERO El Paso assistant field office director for ERO El Paso in Albuquerque, NM, arrived at PH to obtain MAVINGA's personal effects as well as the preliminary paperwork on the death.

MAVINGA is the fourth detainee to pass away in ICE custody in fiscal year 2020.

Violations of Law: Section 237 (a) (1) (B) of the Immigration and Nationality Act (INA).

Action Taken: Report of ICE detainee death.

Other Agencies Notified:

Name	Agency	Phone	Date	Time
none				

Injuries: No
 Fatalities: No
 Damage: No
 Unaccompanied
 Child Count: 0

Injuries (Names and Extent of N/A Injury):

Locations:

Type	Address	City	State	Zip
Other	209 County Road AO49	Estancia	New Mexico	87016

Hospital Narrative: N/A

Hospital Address: Presbyterian Hospital
 1100 Central Ave SE
 Albuquerque, NM 87106
 Phone: (505) 841-1234

Reported to ICE Operations Center via Phone:

Public Affairs Notified: No - Without comments

Comments:

Reported By: (b)(6); (b)(7)(C)	Phone: 915 (b)(6); (b)(7)(C)	Cell/Pager: 915 (b)(6); (b)(7)(C)
Supervisor:	Phone: 915	Cell/Pager: 915

ICE Significant Incident Report

Submitted Date and Time of Report: 1/26/2020 2222 EST

Incident Date: 1/25/2020	Incident Time: 1952	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Field Operations Division	Area: Eastern Operations
Case Number: No Case Involved	Office: EI - FOD MIAMI - MIA	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	☐ Unaccompanied Children		
☐ Loss or Theft of Firearm or Body Armor			

Principal Subject: Person	Last Name: OWENS	First Name: Ben	Alien ID: 219403429
Date of Birth: 9/16/1980	Country of Birth: United Kingdom	Citizenship: United Kingdom	

Narrative

Report Title: ERO Miami detainee death notification

The message below is distributed on behalf of Acting Executive Associate Director Timothy S. Robbins:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Ben James OWEN, A219 403 429.

ISSUE:

On January 25, 2020, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) Miami, reported the death of ICE detainee, Ben James OWEN, a 39-year-old citizen of the United Kingdom (UK), at the Baker County Detention Center (BCDC) in Macclenny, FL. Paramedics declared OWEN deceased at 7:52p.m. Eastern Standard Time (EST), on January 25, 2020. The preliminary cause of death is asphyxiation due to hanging.

ERO Miami notified the Department of Homeland Security Office of Inspector General and ICE Office of Professional Responsibility via the Joint Intake Center. ERO Miami staff attempted to notify OWEN's next-of-kin but has been unable to make contact. ERO Miami notified the Consulate General of the United Kingdom's out-of-hours emergency contact team, in London, England on January 26, 2020.

All media inquiries will be referred to ICE Office of Public Affairs.

BACKGROUND:

On July 23, 2019, U.S. Customs and Border Protection (CBP) admitted OWEN into the United States at Minneapolis, MN, as an O2 nonimmigrant (individuals who will accompany an O1, artist, or athlete, to assist in a specific event or performance), with authorization to remain in the United States until December 10, 2019. July 23, 2019 is listed as OWEN's most recent entry into the United States, with the O2 visa being issued on January 10, 2017. The O1 sponsor is identified as (b)(6); (b)(7)(C) CTK Management LLC, who employed OWEN as a sound and lighting engineer for multiple performing artists.

On September 18, 2019, the Daytona Beach (FL) Police Department (DBPD) arrested OWEN for felony aggravated battery on a pregnant person.

On September 19, 2019, ERO Miami Interoperability Response Center received notification regarding the aforementioned arrest and did not take an enforcement action since OWEN was not amenable to removal.

On October 22, 2019, the Florida State Attorney's Office dropped the aforementioned charge.

On November 17, 2019, DBPD arrested OWEN for misdemeanor domestic battery. This case is currently pending with the court.

On December 9, 2019, (b)(6); (b)(7)(C)'s United States citizen spouse, filed a Petition for Alien Relative, Form I-130, with U.S. Citizenship and Immigration Services (USCIS) on behalf of OWEN which is pending adjudication.

On the same date, OWEN filed an Application to Register Permanent Residence or Adjust Status, Form I-485, and an Application for Travel Document, Form I-131, with USCIS; both applications are pending adjudication.

On January 12, 2020, the Port Orange (FL) Police Department arrested OWEN for misdemeanor domestic assault, felony aggravated stalking after injunction, felony false imprisonment and violation of condition of pre-trial release. This case is currently pending with the court.

On the same date, ERO Miami lodged an Immigration Detainer-Notice of Action, Form I-247A, on OWEN with the Volusia County Jail (VCJ) in Daytona Beach, FL.

On January 15, 2020, VCJ released OWEN to ERO Miami custody pursuant to the immigration detainer.

On the same date, ERO Miami served OWEN a Notice to Appear, Form I-862, charging removability pursuant to Section 237(a)(1)(B) of the Immigration and Nationality Act, as an alien who has remained in the United States for a time longer than permitted. ERO Miami transferred OWEN to BCDC pending a hearing in the Immigration Court in Orlando, FL.

On January 25, 2020, at approximately 7:29 p.m. EST, ICE detainee Angel MOROCHO-Cuaman, A208 158 909, a citizen and national of Ecuador, discovered OWEN hanging in their shared cell and alerted other detainees of the emergency. Another ICE detainee pushed the emergency call button to alert EROC deputies.

ICE Significant Incident Report

Submitted Date and Time of Report: 1/28/2020 0944 EST

Incident Date: 1/27/2020	Incident Time: 0932	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Detention Management Division	Area: Detention Monitoring
Case Number: No Case Involved	Office: EI - FOD MIAMI - MIA	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	☐ Unaccompanied Children		☐ COVID19
☐ Loss or Theft of Firearm or Body Armor	☐ COVID19 Disruptions		

Principal Subject: Person	Last Name: HERNANDEZ-Fundora	First Name: Alberto	Alien ID: 022 804 402
Date of Birth: 8/5/1956	Country of Birth: Cuba	Citizenship: Cuba	

Narrative

Report Title: ERO Miami Detainee Death

The message below is distributed on behalf of Acting Executive Associate Director Timothy S. Robbins:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Alberto HERNANDEZ-Fundora, A022 804 402.

ISSUE:

On January 27, 2020, ICE Enforcement and Removal Operations (ERO) Miami, reported the death of ICE detainee Alberto HERNANDEZ-Fundora, a 63-year-old citizen of Cuba, at the Larkin Community Hospital (LCH) in Miami, FL. Doctors declared HERNANDEZ deceased at 9:32 am. Eastern Standard Time (EST), on January 27, 2020. The preliminary cause of death is cardiac arrest.

ERO Miami notified the Department of Homeland Security Office of Inspector General and ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO Miami staff attempted to notify HERNANDEZ's next-of-kin but has been unable to make

contact. The ERO acting Assistant Attaché of Removals in Havana, Cuba, notified the Embassy of Cuba on January 27, 2020.

All media inquiries will be referred to ICE Office of Public Affairs.

BACKGROUND:

On May 14, 1980, the former U.S. Immigration and Naturalization Service (INS) paroled HERNANDEZ under Section 212(d)(5) of the Immigration and Naturalization Act (INA) into the United States at Key West, FL.

On February 2, 1984, the Mercer County Superior Court (MCSC) in Trenton, NJ convicted HERNANDEZ of heroin-sell, heroin, and heroin-possession. The court sentenced HERNANDEZ to 10 years of incarceration.

On the same date, MCSC convicted HERNANDEZ of aggravated assault-weapon and sentenced him to seven years of incarceration.

On December 26, 1990, Morris County Jail in Morristown, NJ released HERNANDEZ to INS Newark custody.

On February 4, 1991, INS Newark served HERNANDEZ with a Notice To Applicant for Admission Detained for Hearing Before an Immigration Judge, Form I-122, charging removability pursuant to Section 212(a)(20) of the INA, as an immigrant who at time of application for admission is not in possession of an unexpired immigrant visa, re-entry permit, border crossing card or other valid documents required for entry. The charging documents were not filed with the immigration court.

On February 26, 1991, INS Newark transferred HERNANDEZ to the custody of INS New York who detained him at the Ray Brook Federal Correctional Institution in Ray Brook, NY.

On April 16, 1996, INS New York transferred HERNANDEZ to the custody of INS New Orleans who detained him at the Talladega Federal Correctional Institution in Talladega, AL.

On May 19, 1997, INS New Orleans transferred HERNANDEZ to the custody of INS Los Angeles who detained him at Lompoc Federal Bureau of Prisons in Lompoc, CA.

On May 17, 2000, INS Los Angeles issued HERNANDEZ a Notice to Alien to Appear, Form I-862, charging excludability pursuant to Section 212(a)(2)(B) of the INA, as having two or more convictions and sentenced to at least 5 years in aggregate, and Section 212(a)(20) of the INA, as an immigrant without an immigrant visa.

On July 19, 2000, an immigration judge ordered HERNANDEZ excluded from the United States and order him removed to Cuba.

On February 5, 2003, INS Los Angeles released HERNANDEZ on parole.

On March 29, 2005, the Lawrence Township Municipal Court in Lawrence Township, NJ convicted HERNANDEZ of disorderly conduct-improper behavior and sentenced him to two years of probation.

On May 26, 2007, ERO Newark mailed a Call-in Letter, Form G-56 to HERNANDEZ's resident address instructing him to report on May 31, 2007, to the ERO Marlton, NJ Sub-office.

On May 31, 2007, ERO Newark served HERNANDEZ an Order of Supervision (OSUP), Form I-220B.

On November 17, 2009, MCSC convicted HERNANDEZ of unlawful possession of a weapon and sentenced him to 18 months of incarceration.

On August 25, 2010, the West Windsor Municipal Court in West Windsor Township, NJ convicted HERNANDEZ of theft and sentenced him to a fine.

On August 31, 2010, the Bucks County District Court in Levittown, PA convicted HERNANDEZ of retail theft and sentenced him to a fine.

On July 9, 2011, HERNANDEZ was arrested for Burglary, Burglary Tools, and Unlawful Possession of Weapon, and was detained at the Mercer County Jail (MCJ) in Lambertville, NJ.

On July 12, 2011, ERO Newark lodged an Immigration Detainer - Notice of Action, Form I-247, on HERNANDEZ with MCJ.

On October 6, 2011, the Hamilton Township Municipal Court in Trenton, NJ convicted HERNANDEZ of shoplifting-conceal merchandise and sentenced him to 60 days incarceration.

On October 26, 2011, MCSC in Trenton, NJ convicted HERNANDEZ of criminal trespass-unlicensed and sentenced him to three years of probation and a fine.

On December 27, 2011, MCJ released HERNANDEZ to the custody of ERO Newark who detained him at the Essex County Jail in Newark, NJ. On the same date, ERO Newark revoked HERNANDEZ's OSUP status.

On January 6, 2012, ERO Newark released HERNANDEZ on an OSUP.

On June 30, 2014, MCSC convicted HERNANDEZ of possession of a controlled drug substance and sentenced him to three years of probation.

On May 31, 2016, the Cumberland County Court in Carlisle, PA convicted HERNANDEZ of retail theft and sentenced him to three months' incarceration.

On November 7, 2016, the Burlington Municipal Court in Burlington, NJ convicted HERNANDEZ of shoplifting-conceal merchandise and sentenced him to 90 days of incarceration.

On November 21, 2016, the Ewing Township Municipal Court in Ewing Township, NJ convicted HERNANDEZ of shoplifting-conceal merchandise and sentenced him to 90 days of incarceration.

On January 3, 2018, MCSC convicted HERNANDEZ of shoplifting-conceal merchandise and sentenced him to 180 days of incarceration, three years of probation, and a fine.

On May 24, 2018, the Hamilton Township Municipal Court in Trenton, NJ convicted HERNANDEZ of shoplifting-conceal merchandise and sentenced him to six months of incarceration and a fine.

On June 23, 2019, the 11th Judicial Circuit Court (ECC), in and for Miami Dade County, FL convicted HERNANDEZ of petit theft and sentenced him to time served.

On January 2, 2020, ERO Miami encountered HERNANDEZ at the Turner Gilford Knight Correctional Center (TGK) in Miami, FL and lodged an Immigration Detainer - Notice of Action, Form I-247A.

On January 3, 2020, ECC convicted HERNANDEZ of petit theft and sentenced him to 15 days of incarceration.

On January 14, 2020, TGK released HERNANDEZ to the custody of ERO Miami who detained him at Krome Service Processing Center (KSPC) in Miami, FL pending nomination to the Government of Cuba for repatriation.

On January 23, 2020, ICE Health Service Corps staff at KSPC notified ERO Miami that American Medical Response ambulance service transported HERNANDEZ to LCH due to a positive chest x-ray, bowel incontinence, and hypoglycemia,

On the same date, LCH admitted HERNANDEZ for further evaluation and treatment.

On January 27, 2020, at approximately 4:19 a.m. EST, HERNANDEZ became unresponsive. The LCH Doctor intubated HERNANDEZ.

At approximately 4:45 a.m. EST, LCH staff called a code blue and began resuscitation efforts on HERNANDEZ.

At approximately 4:55 a.m. EST, LCH revived HERNANDEZ and cleared the code blue.

At approximately 5:12 a.m. EST, LCH called a second code blue and began resuscitation efforts on HERNADEZ.

At approximately 5:29 a.m. EST, LCH revived HERNANDEZ and cleared the code blue.

At approximately 5:42 a.m. EST, LCH called a third code blue and began resuscitation efforts on HERNADEZ.

At approximately 5:57 a.m. EST, during the time of compression and assessing, LCH called a fourth code blue.

At approximately 6:10 a.m. EST, LCH revived HERNANDEZ and cleared the code blue.

At approximately 7:01 a.m. EST, LCH called a fifth code blue and began resuscitation efforts on HERNADEZ.

At approximately 7:09 a.m. EST, LCH revived HERNANDEZ and cleared the code blue.

At approximately 7:30 a.m. EST, LCH called a sixth code blue and began resuscitation efforts on HERNADEZ.

At approximately 7:46 a.m. EST, LCH revived HERNANDEZ and cleared the code blue.

At approximately 8:11 am EST, LCH called a seventh code blue and began resuscitation efforts on HERNADEZ.

At approximately 8:15 LCH revived HERNANDEZ and cleared the code blue.

At approximately 8:23 am EST, LCH called an eighth code blue and began resuscitation efforts on HERNADEZ.

At approximately 8:37 am EST, LCH revived HERNANDEZ and cleared the code blue.

At approximately 9:02 am EST, LCH called a ninth code blue and began resuscitation efforts on HERNADEZ.

At approximately 9:05 am EST, LCH revived HERNANDEZ and cleared the code blue. HERNANDEZ was placed on an echocardiogram machine.

At approximately 9:32 am EST, the LCH Doctor pronounced HERNANDEZ deceased after echocardiogram no longer showed heart activity.

At approximately, 9:45 a.m. EST, the Field Office Director for ERO Miami notified HQ ERO Field Operations of HERNANDEZ's death.

At approximately, 10:00 a.m. EST, an ERO Miami Supervisory Detention and Deportation Officer (SDDO) notified the OPR of HERNANDEZ's death.

At approximately, 10:15 a.m. EST, an ERO Miami SDDO notified the JIC of HERNANDEZ's death.

On January 27, 2020, ERO Miami made multiple unsuccessful attempts to identify the next of kin for notification of HERNANDEZ's death. ERO Miami will continue attempting to locate and make contact with the next of kin.

HERNANDEZ is the sixth detainee to pass away in ICE custody in Fiscal Year 2020.

The ERO Miami Field Office Director, Michael W. Meade reviewed and approved this SIR.

Violations of Law:

Action Taken:

Other Agencies Notified:

Name	Agency	Phone	Date	Time
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none

Injuries: Injuries (Names and Extent of
Fatalities: Injury):
Damage:
Unaccompanied
Child Count:

Locations:

Type	Address	City	State	Zip
Other	7031 SW 62 Ave	South Miami	Florida	33143

Reported to ICE Operations Center via Phone: No

Public Affairs Notified: No - Without comments

Comments:

Reported By:	(b)(6); (b)(7)(C)	Phone: 305	(b)(6); (b)(7)(C)	Cell/Pager: 786	(b)(6); (b)(7)(C)
Supervisor:		Phone: 305	(b)(7)(C)	Cell/Pager: 786	

ICE Significant Incident Report

Submitted Date and Time of Report: 2/20/2020 2236 EST

Incident Date: 2/20/2020	Incident Time: 0149	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Field Operations Division	Area: Eastern Operations
Case Number: No Case Involved	Office: D1 - Cleveland, OH - CLE	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	☐ Unaccompanied Children		
☐ Loss or Theft of Firearm or Body Armor			

Principal Subject: Person	Last Name: HERNANDEZ Colula	First Name: David	Alien ID: 206 652 911
Date of Birth: 1/23/1986	Country of Birth: Mexico	Citizenship: Mexico	

Narrative

Report Title: ICE Detainee Death by Suicide- ERO Detroit

The message below is distributed on behalf of Executive Associate Director Enrique M. Lucero:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: David HERNANDEZ-Colula, A206 652 911.

ISSUE:

On February 20, 2020, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) Detroit, reported the death of ICE detainee David HERNANDEZ-Colula, a 34-year-old citizen of Mexico, at St. Elizabeth Hospital in Youngstown, OH. Doctors declared HERNANDEZ deceased at 1:49 a.m. Eastern Standard Time (EST), on February 20, 2020. The preliminary cause of death is suicide by hanging.

ERO Detroit notified the Department of Homeland Security Office of Inspector General and ICE Office of Professional Responsibility via the Joint Intake Center. ERO Detroit staff advised that next-of-kin notification was made by the Assistant Warden of the Northeast Ohio Correctional Center (NEOCC). The local Mexican Consulate was notified telephonically on February 20, 2020.

All media inquiries will be referred to ICE Office of Public Affairs.

BACKGROUND:

On an unknown date and location, HERNANDEZ entered the United States without admission or parole by an immigration officer.

On December 4, 2014, the U.S. Border Patrol (USBP) arrested HERNANDEZ near Rochester, NY, during Greyhound Bus transportation check duties. USBP served HERNANDEZ 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 admission or parole.

On December 5, 2014, USBP transferred HERNANDEZ to ERO Buffalo custody for removal proceedings. On the same date, ERO Buffalo granted HERNANDEZ a \$5000 bond.

On December 8, 2014, HERNANDEZ was released from ICE custody upon posting bond.

On May 18, 2016, an immigration judge (IJ) in Buffalo, NY, consolidated HERNANDEZ's case with his spouse (b)(6); (b)(7)(C) [REDACTED]
(b)(6); (b)(7)(C) [REDACTED]

On September 27, 2016, an IJ in Buffalo, NY, granted a change of venue to Cleveland, OH, after HERNANDEZ moved to Ohio.

On or about July 16, 2018, the Sturgis, MI, Police Department (Sturgis PD) arrested HERNANDEZ for domestic assault. There is no disposition on this case.

On May 8, 2018, an IJ in Cleveland, OH, continued the case to December 12, 2019.

On December 4, 2019, the Sturgis PD encountered HERNANDEZ during a civil dispute with his spouse. Sturgis PD arrested HERNANDEZ for outstanding warrants from his previous domestic assault arrests and booked him into the St. Joseph County Jail (SJCJ) in Centreville, MI.

On December 5, 2019, the Pacific Enforcement Response Center in Laguna Niguel, CA, lodged an Immigration Detainer- Notice of Action, Form I-247A, on HERNANDEZ.

On December 6, 2019, ERO Detroit arrested HERNANDEZ upon release from the SJCJ and booked him into ICE custody at the Calhoun County Jail in Battle Creek, MI.

On December 10, 2019, ERO Detroit transferred HERNANDEZ to the Northeast Ohio Correctional Center (NEOCC) in Youngstown, OH.

On December 12, 2019, ERO Detroit cancelled HERNANDEZ's bond.

On December 13, 2019, a NEOCC correctional officer conducting population count witnessed HERNANDEZ begin to place a blanket around his neck. Upon noticing the officer, HERNANDEZ quickly removed the blanket. Upon arrival to NEOCC Health Services, medical staff observed small abrasions to HERNANDEZ's left wrist. NEOCC staff placed HERNANDEZ on continuous medical watch.

On December 16, 2019, NEOCC medical staff cleared HERNANDEZ from Medical watch/observation, following an assessment in which HERNANDEZ denied present suicidal ideation. HERNANDEZ was transferred to general population.

On February 19, 2020, NEOCC medical staff conducted a mental health evaluation on HERNANDEZ. Notes from the evaluation state detainee cited no current needs, concerns, or problems. Security reported no unusual or problematic behaviors.

On the same date, an IJ in Cleveland, OH, continued HERNANDEZ's case to February 25, 2020.

On February 20, 2020, at approximately 1:09 a.m. (EST), an NEOCC officer conducting a security check discovered HERNANDEZ hanging from the top bunk of his cell, identified as cell #B-5-121. The officer immediately called for Emergency Response Team (ERT) assistance.

At approximately 1:10 a.m. (EST), ERT staff responded to the scene, assisted HERNANDEZ to the ground, and began performing cardio-pulmonary resuscitation (CPR). Staff called for emergency services.

At approximately 1:12 a.m. (EST), NEOCC Health Services arrived at the scene and continued to conduct CPR while applying an automatic external defibrillator.

At approximately 1:24 a.m. (EST), outside emergency services arrived at the facility, responded to the scene, and continued CPR.

At approximately 1:26 a.m. (EST), emergency medical technicians (EMT) took over life saving measures.

At approximately 1:45 a.m. (EST), the ambulance exited the facility with HERNANDEZ.

At approximately 1:49 a.m. (EST), medical providers at St. Elizabeth's Hospital pronounced HERNANDEZ deceased.

At approximately 2:16 a.m. (EST), NEOCC staff provided telephonic notification to ERO Detroit via a voicemail message.

At approximately 4:30 a.m. (EST), the assistant warden from NEOCC notified the next of kin, (b)(6); (b)(7)(C) is currently in removal proceedings and on the alternatives to detention program.

At approximately 6:04 a.m. (EST), an Assistant Field Office Director (AFOD) for ERO Detroit received the voicemail message from NEOCC regarding the detainee death.

At approximately 6:33 a.m. (EST), the Deputy Field Office Director (DFOD) for ERO Detroit notified ERO HQ Field Operations of HERNANDEZ's death.

At approximately 8:28 a.m. (EST), ERO Detroit notified the Joint Intake Center of HERNANDEZ's death.

At approximately 8:30 a.m. (EST), ERO Detroit notified the local Office of the Principal Legal Advisor and the local ICE Office of Public Affairs.

At approximately 9:22 a.m. (EST), ERO Detroit notified the Office of Professional Responsibility.

HERNANDEZ is the seventh detainee to pass away in ICE custody in Fiscal Year 2020.

Violations of Law:

Action Taken:

Other Agencies Notified:

Name	Agency	Phone	Date	Time
none				

Injuries:	Injuries (Names and Extent of Injury):
Fatalities:	
Damage:	
Unaccompanied	
Child Count:	

Locations:

Type	Address	City	State	Zip
Other	NEOCC, 2240 Hubbard Rd.	Youngstown	Ohio	44505

Reported to ICE Operations Center via Phone:

Public Affairs Notified: Yes		
Officer Notified: Khaalid Walls	Date: 2/20/2020	Time: 0830
Comments:		

Reported by (b)(6); (b)(7)(C)

Supervisor

Phone: 216 (b)(6);

Phone: 520 (b)(7)(C)

Cell/Pager: 216 (b)(6);

Cell/Pager: 520 (b)(7)(C)

ICE Significant Incident Report

Submitted Date and Time of Report: 3/8/2020 1634 EST

Incident Date: 3/8/2020	Incident Time: 0842	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Detention Management Division	Area: Detention Monitoring
Case Number: No Case Involved	Office: XD - FOD DALLAS	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: (b)(7)(E)	

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	☐ Unaccompanied Children		
☐ Loss or Theft of Firearm or Body Armor			

Principal Subject: Person
Date of Birth: 8/10/1997Last Name: Ochoa-Yoc De Ramirez
Country of Birth: GuatemalaFirst Name: Maria
Citizenship: Guatemala

Alien ID: 213441658

Narrative

Report Title: Detainee Death Notification - Maria Celeste OCHOA-Yoc de Ramirez

ISSUE:

On March 8, 2020, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) Dallas, reported the death of ICE detainee Maria Celeste OCHOA- Yoc de Ramirez, a 22-year-old female citizen of Guatemala, at the Texas Health Downtown Fort Worth Hospital (THDFW) in Fort Worth, Texas. Doctors declared OCHOA deceased at 8:42 a.m. Central Time (CT), on March 8, 2020. THDFW has not established an official cause of death.

ERO Dallas notified the Department of Homeland Security Office of Inspector General and the ICE Office of Professional Responsibility via the Joint Intake Center. The local Guatemalan Consulate notified the next-of-kin on March 8, 2020.

All media inquiries will be referred to ICE Office of Public Affairs.

BACKGROUND:

On September 4, 2019, the U.S. Border Patrol (USBP) arrested OCHOA upon her illegal entry into the United States near Hidalgo, TX.

On September 5, 2019, USBP served OCHOA a Notice and Order of Expedited Removal, Form I-860, charging her with removability pursuant to Section 212(a)(7)(A)(i)(I) of the Immigration and Nationality Act (INA), as an immigrant without a valid, unexpired immigrant visa or other document required for admission. On the same date, OCHOA claimed fear of returning to Guatemala.

AMERICAN
OVERSIGHT

(b)(7)(E)

DHS-20-0638-F-000147

2020-ICLI-00057 2205

On September 6, 2019, USBP transferred OCHOA to the custody of ERO San Antonio at the El Valle Detention Facility in Raymondville, TX.

On September 12, 2019, ERO San Antonio transferred OCHOA to ERO Dallas for detention at the Kay County Detention Center (KCDC) in Newkirk, OK.

On September 14, 2019, ERO Dallas referred OCHOA's case to U.S. Citizenship and Immigration Services (USCIS) for a credible fear determination.

On September 23, 2019, USCIS issued a positive credible fear finding for OCHOA.

On October 8, 2019, ERO Dallas served OCHOA a Notice to Appear, Form I-862, charging her with removability pursuant to Section 212(a)(7)(A)(i)(I) of the INA.

On December 16, 2019 and January 27, 2020, an immigration judge (IJ) in El Paso, TX continued OCHOA's case so she could file an Application for Asylum and for Withholding of Removal, Form I-589.

On February 7, 2020, KCDC transported OCHOA to the Alliance Health Hospital (AHH) in Ponca City, OK for evaluation. The AHH admitted OCHOA for a gall bladder procedure.

On February 9, 2020, OCHOA had her gall bladder surgically removed.

On February 10, 2020, OCHOA returned to the KCDC following medical discharge from AHH.

On February 13, 2020, ERO Dallas transferred OCHOA to the Prairieland Detention Center (PDC) in Alvarado, TX.

On February 18, 2020, the PDC contract staff transported OCHOA to the Texas Health Huguley Hospital (THHH) in Burleson, TX for abdominal pain related to her gall bladder removal.

On February 24, 2020, the IJ continued OCHOA's scheduled hearing due to her hospitalization.

On February 28, 2020, THHH transferred OCHOA to THDFW for specialty treatment of her conditions.

On March 5, 2020, at approximately 7:45 p.m. CT, THDFW transferred OCHOA to high level cardiac care for a heartrate of 168 and elevated lactic acid. THDFW reported OCHOA to be alert and oriented but had difficulty breathing.

At approximately 9:10 p.m. CT, THDFW diagnosed OCHOA's condition as "worsening sepsis."

At approximately 9:25 p.m. CT, THDFW initiated a code blue for respiratory distress and respiratory failure, which resulted in OCHOA being intubated. The physician also administered Ativan.

At approximately 11:50 p.m. CT, OCHOA had a seizure. THDFW reported her condition as life threatening and placed her in a medically induced coma.

At approximately 11:52 p.m. CT, chest scans revealed aspiration pneumonia in the lower portion of OCHOA's lungs. Medical staff provided OCHOA with plasma due to continued blood ooze. OCHOA showed significantly abnormal bloodwork results.

On March 6, 2020, at approximately 7:23 a.m. CT, THDFW reported a new diagnosis of pneumonia with organ failure. THDFW listed OCHOA in a life-threatening condition.

On March 8, 2020, at approximately 8:42 a.m. CT, medical providers at THDFW pronounced OCHOA deceased.

At approximately 9:02 a.m. CT, the Field Office Director (FOD) for ERO Dallas notified ERO HQ Domestic Operations of OCHOA's death.

At approximately 9:20 a.m. CT, ERO Dallas notified the Joint Intake Center of OCHOA's death.

At approximately 9:54 a.m. CT, the FOD for ERO Dallas notified ERO HQ Custody Operations of OCHOA's death.

At approximately 9:54 a.m. CT, ERO Dallas notified the local ICE Office of the Principal Legal Advisor and the local ICE Office of Public Affairs of OCHOA's death.

DHS-20-0638-F-000148

At approximately 9:54 a.m. CT, ERO Dallas notified the ICE Office of the Congressional Relations of OCHOA's death.

At approximately 9:58 a.m. CT, ERO Dallas notified the ICE Office of Professional Responsibility of OCHOA's death.

At approximately 10:25 a.m. CT, ERO Dallas notified the Consulate of Guatemala Consul General, Ricardo Montes of OCHOA's death. Consul General Montes confirmed he would notify the next-of-kin, Jimmy and Estuardo Ochoa (brothers).

OCHOA is the eighth detainee to pass away in ICE custody in Fiscal Year 2020.

Violations of Law:

Action Taken:

Other Agencies Notified:

Name	Agency	Phone	Date	Time
none				

Injuries: Injuries (Names and Extent of Injury):
 Fatalities:
 Damage:
 Unaccompanied
 Child Count:

Locations:

Type	Address	City	State	Zip
Other	1301 Pennsylvania Ave	Fort Worth	Texas	76104

Reported to ICE Operations Center via Phone: No

Public Affairs Notified: Yes

Officer Notified: Leticia Zamarripa

Date: 3/8/2020

Time: 1436

Comments:

Reported By: (b)(6); (b)(7)(C)

Phone: 405 (b)(6); (b)(7)(C)

Cell/Pager: 405 (b)(6); (b)(7)(C)

Supervisor:

Phone: 214

Cell/Pager: 432

ICE Significant Incident Report

Submitted Date and Time of Report: 3/19/2020 1034 EST

Incident Date: 3/18/2020	Incident Time: 0055	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Detention Management Division	Area: Juvenile and Family Residence Management
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: 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	☐ Unaccompanied Children		
☐ Loss or Theft of Firearm or Body Armor			

Principal Subject: Person	Last Name: Carcamo-Navarro	First Name: Orlan Ariel	Alien ID: 213 563 372
Date of Birth: 6/16/1992	Country of Birth: Honduras	Citizenship: Honduras	

Narrative

Report Title: Detainee Death Notification - Orlan Ariel CARCAMO-Navarro

The message below is distributed on behalf of Executive Associate Director Enrique M. Lucero:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Orlan Ariel CARCAMO-Navarro, A213 563 372.

ISSUE:

On March 18, 2020, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) San Antonio, reported the death of ICE detainee Orlan Ariel CARCAMO-Navarro, a 27-year-old citizen of Honduras, at Karnes County Residential Center (KCRC) in Karnes City, TX. Karnes County Emergency Medical Services (EMS) declared CARCAMO deceased at 12:55 a.m. Central Standard Time (CST), on March 18, 2020. The preliminary cause of death is asphyxiation due to hanging.

ERO San Antonio notified the Department of Homeland Security Office of Inspector General and ICE Office of Professional Responsibility via the Joint Intake Center. ERO San

Antonio has been unable to make notification to the next-of-kin. ERO San Antonio notified the Honduran Consulate telephonically on March 18, 2020.

All media inquiries will be referred to ICE Office of Public Affairs.

BACKGROUND:

On February 19, 2020, CARCAMO applied for admission as a member of a family unit at the Presidio Texas Port of Entry and requested asylum. U.S. Customs and Border Protection (CBP) served CARCAMO a Notice and Order of Expedited Removal, Form I-860, charging removability pursuant to Section 212(a)(7)(A)(i)(I) of the Immigration and Nationality Act (INA), as an immigrant without a valid, unexpired immigrant visa or other document required for admission.

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

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

On March 11, 2020, an IJ in San Antonio, TX affirmed the negative APSO decision and returned the case to ICE for removal of the family unit.

On March 18, 2020, at approximately 12:30 a.m. CST, a GEO Residential Advisor (RA) conducting a routine security check discovered CARCAMO hanging from the shower rod in his room. The RA immediately called for emergency medical assistance.

At approximately 12:32 a.m. CST, GEO medical and security staff responded to the scene, began performing cardio-pulmonary resuscitation (CPR), and called for Emergency Medical Services (EMS) via a call to 911.

At approximately 12:42 a.m. CST, Karnes County EMS arrived at the facility, responded to the scene, and continued CPR.

At approximately 12:47 a.m. CST, GEO staff provided telephonic notification to ERO San Antonio.

At approximately 12:48 a.m. CST, an Assistant Field Office Director (AFOD) for ERO San Antonio received the call from GEO regarding the detainee suicide attempt.

At approximately 12:52 a.m. CST, the Deputy Field Office Director (DFOD) for ERO San Antonio notified ERO HQ Field Operations of CARCAMO'S suicide attempt.

At approximately 12:55 a.m. CST, Karnes County EMS terminated CPR. EMS contacted Precinct 2 Justice of the Peace, (b)(6); (b)(7)(C) Justice of the Peace (b)(6); established CARCAMO'S time of death as 12:30 a.m.

At approximately 1:35 a.m. CST, ERO San Antonio notified the Joint Intake Center of CARCAMO'S death.

At approximately 1:41 a.m. CST, ERO San Antonio notified the Office of Professional Responsibility of CARCAMO'S death.

At approximately 5:57 a.m. CST, Rhodes Funeral Home arrived at the facility.

At approximately 6:16 a.m. CST, Rhodes Funeral Home exited the facility with CARCAMO.

At approximately 7:00 a.m. CST, ERO San Antonio notified the local ICE Office of Public Affairs of CARCAMO'S death.

At approximately 8:21 a.m. CST, ERO San Antonio notified the Honduran Consulate. The Honduran Consulate is attempting to locate and notify the next of kin.

At approximately 9:29 a.m. CST, ERO San Antonio notified the local Office of the Principal Legal Advisor.

CARCAMO is the ninth detainee to pass away in ICE custody in Fiscal Year 2020.

NOTICE: This communication may contain privileged or otherwise confidential information. If you are not an intended recipient or believe you have received this communication in error, please do not print, copy, retransmit, disseminate, or otherwise use this information. Please inform the sender that you received this message in error and delete the message from your system.

Violations of Law:

Action Taken:

Other Agencies Notified:

Name	Agency	Phone	Date	Time
none				

Injuries: No	Injuries (Names and Extent of
Fatalities: Yes	Injury):
Damage: No	
Unaccompanied	
Child Count: 1	

Weapon Type: ZZZ - OTHER

Locations:

Type	Address	City	State	Zip
Other	409 FM 1144	Karnes City	Texas	78118

Reported to ICE Operations Center via Phone:

Public Affairs Notified: Yes**Officer Notified:** Nina Pruneda**Date:** 3/18/2020**Time:** 0730**Comments:**

Reported By: (b)(6); (b)(7)(C)**Phone:** 830-(b)(7)(E)**Cell/Pager:** 210-(b)(6); (b)(7)(C)**Supervisor:****Phone:** 830-**Cell/Pager:** 210-

ICE Significant Incident Report

Submitted Date and Time of Report: 3/22/2020 1258 EST

Incident Date: 3/22/2020	Incident Time: 1150	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: 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	☐ Unaccompanied Children		
☐ Loss or Theft of Firearm or Body Armor			

Principal Subject: Person	Last Name: HERNANDEZ-Ibarra	First Name: Ramiro	Alien ID: A097743041
Date of Birth: 3/11/1978	Country of Birth: Mexico	Citizenship: Mexico	

Narrative

Report Title: ICE Detainee Death - ERO/SNA (PIDC)

ISSUE:

On March 21, 2020, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) San Antonio, reported the death of ICE detainee Ramiro HERNANDEZ-Ibarra, a 42-year-old citizen of Mexico, at the Valley Baptist Medical Center (VPMC) in Harlingen, TX. VPMC declared HERNANDEZ deceased at 5:46 a.m. Central Daylight Time (CDT), on March 21, 2020. The preliminary cause of death is septic shock.

ERO San Antonio notified the Department of Homeland Security Office of the of Inspector General and the ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO San Antonio notified the Mexican Consulate telephonically at 6:27 a.m. CDT. The Mexican Consulate notified the next-of-kin at 6:28 a.m. CDT.

All media inquiries will be referred to ICE Office of Public Affairs.

BACKGROUND:

On June 23, 1999, HERNANDEZ entered the United States near Pharr, TX without having been admitted or paroled by an immigration officer. The U.S. Border Patrol (USBP) arrested HERNANDEZ at that time and granted him a voluntarily return (VR) to Mexico.

On June 27, 1999, HERNANDEZ re-entered the United States near Hidalgo, TX without having been admitted or paroled by an immigration officer. The USBP arrested HERNANDEZ at that time and granted him a VR to Mexico the same day.

On July 3, 2000, HERNANDEZ re-entered the United States near Pharr, TX without having been admitted or paroled by an immigration officer. The USBP arrested HERNANDEZ near Alamo, TX the same day and granted him a VR to Mexico the same day.

On May 7, 2001, HERNANDEZ re-entered the United States near Hidalgo, TX without having been admitted or paroled by an immigration officer. The USBP arrested HERNANDEZ at that time and granted him a VR to Mexico the same day.

On May 12, 2001, HERNANDEZ re-entered the United States near Pharr, TX without having been admitted or paroled by an immigration officer. The USBP arrested HERNANDEZ at that time and granted him a VR to Mexico the same day.

On an unknown date at an unknown time, HERNANDEZ entered the United States without having been admitted or paroled by an immigration officer.

On October 29, 2003, the Texas Department of Public Safety arrested HERNANDEZ on charges of driving while intoxicated (DWI).

On December 29, 2003, the Texas County Court at Law No. 2 at Edinburg, TX convicted HERNANDEZ of DWI and imposed a sentence of 30 days of confinement.

On December 30, 2003, the USBP encountered HERNANDEZ at the Hidalgo County Jail (HCJ) in Edinburg, TX subsequent to his arrest for DWI. The USBP lodged an Immigration Detainer-Notice of Action, Form I-247 with HCJ.

On December 31, 2003, HCJ released HERNANDEZ to USBP. On the same day, the U.S. District Court for the Southern District of Texas convicted HERNANDEZ of violating 8 USC 1325 Illegal Entry and imposed a sentence of time served and returned HERNANDEZ to the custody of the USBP. The USBP granted HERNANDEZ a VR to Mexico the same day.

On an unknown date at an unknown time, HERNANDEZ entered the United States without having been admitted or paroled by an immigration officer.

On May 7, 2010, USBP arrested HERNANDEZ near McAllen, TX and issued a him a Notice to Appear (NTA), 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 admission or parole by an immigration officer.

On May 9, 2010, USBP transferred HERNANDEZ to ERO San Antonio at the Harlingen Staging Facility in Harlingen, TX.

On May 10, 2010, ERO San Antonio transferred HERNANDEZ to the Willacy County Detention Center in Raymondville, TX.

ICE Significant Incident Report

Submitted Date and Time of Report: 5/7/2020 0422 EST

Incident Date: 5/6/2020 ICE Component: Enforcement & Removal Operations Case Number: No Case Involved	Incident Time: 0215 Division: Detention Management Division Office: WE - FOD SAN DIEGO - SND	Incident Location: Area: Detention Monitoring Lead Agency: B - DHS / ICE
SEN Incident Number: (b)(7)(E) Related SEN Number: Intel Number:	Initial/Follow-Up: Initial Related Case Number: ----- ENFORCE Number:	Event Status: Priority SEACATS 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	☐ Unaccompanied Children		☒ COVID19
☐ Loss or Theft of Firearm or Body Armor	☐ COVID19 Disruptions		

Principal Subject: Person	Last Name: ESCOBAR-Mejia	First Name: Carlos Ernesto	Alien ID: 089 345 062
Date of Birth: 5/27/1962	Country of Birth: El Salvador	Citizenship: El Salvador	

Narrative

Report Title: SEN Narrative ICE ERO San Diego-Detainee Death

The message below is distributed on behalf of Executive Associate Director Enrique M. Lucero:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Carlos Ernesto ESCOBAR-Mejia, A089 345 062.

ISSUE:

On May 6, 2020, U.S. Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) San Diego reported the death of ICE detainee Carlos Ernesto ESCOBAR-Mejia, A89 345 062, a 57-year-old citizen of El Salvador, at the Paradise Valley Hospital (PVH) in National City, CA. The medical staff pronounced ESCOBAR deceased at 2:15 a.m. Pacific Daylight Time (PDT). Medical staff has not identified the preliminary cause of death.

Consistent with ICE policy, ERO San Diego notified the DHS Office of Inspector General (OIG), and the ICE Office of Professional Responsibility (OPR) via the Joint Intake

Center (JIC). ERO San Diego also provided telephonic notification of ESCOBAR's death to the Consulate General of El Salvador in Washington, DC. ERO San Diego also provided information about ESCOBAR's next of kin. The Consulate General will notify the next of kin about ESCOBAR's death.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On May 1, 1980, ESCOBAR entered the United States near San Diego, CA without having been admitted or paroled by an immigration officer.

On October 24, 1989, the Municipal Court of California, County of Los Angeles, convicted ESCOBAR for the offense of grand theft and sentenced him to 60 days in jail.

On December 5, 1989, the Superior Court of California, County of Los Angeles, convicted ESCOBAR for the offense of possession of a controlled substance and sentenced him to 110 days in jail.

On May 30, 1990, the Superior Court of California, County of Los Angeles, CA, convicted ESCOBAR of receiving known stolen property and sentenced him to 365 days in jail.

On August 17, 1993, the Municipal Court of California, County of Los Angeles, CA, convicted ESCOBAR of driving under the influence (DUI) and sentenced him to 20 days in jail.

On February 1, 2012, the Compton Police Department in Compton, CA arrested ESCOBAR for possession of controlled substance. The court dismissed ESCOBAR's case.

On February 2, 2012, the Los Angeles Sheriff's Department (LASD), in Los Angeles, CA, arrested ESCOBAR for possession of a controlled substance. On the same date, the Southern California Secure Communities Support Center (SC3) in Laguna Niguel, CA received an Immigration Alien Response (IAR) from the Law Enforcement Support Center (LESC) in Williston, VT, concerning ESCOBAR's arrest and lodged an Immigration Detainer, Form I-247 with the LASD.

On March 28, 2012, ESCOBAR entered ERO Los Angeles custody. On the same date, ERO Los Angeles served ESCOBAR 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.

On March 28, 2012, ERO Los Angeles transferred ESCOBAR to the Adelanto ICE Processing Center in Adelanto, CA, pending removal proceedings.

On April 9, 2012, an immigration judge (IJ) reset ESCOBAR's hearing.

On May 1, 2012, the IJ continued ESCOBAR's case to May 15, 2012.

On May 8, 2012, the IJ reset ESCOBAR's case. The court set ESCOBAR's bond at \$5,000.

On May 15, 2012, the IJ set the case for June 5, 2012.

On June 4, 2012, ERO Los Angeles released ESCOBAR and placed him on the non-detained docket after he posted \$5,000 delivery bond.

On January 3, 2020, the United States Border Patrol (USBP) arrested ESCOBAR near Campo, CA, on suspicion of alien smuggling. On the same date, USBP presented ESCOBAR before the Assistant United States Attorney's Office (AUSA) for criminal prosecution. The AUSA declined criminal prosecution and USBP served ESCOBAR a Notice to Appear, Form I-862, charging removability pursuant to Section 212(a)(6)(A)(i) of the 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.

On January 7, 2020, ERO Los Angeles cancelled ESCOBAR's bond.

On January 9, 2020, the USBP cancelled their Notice to Appear because ESCOBAR was

already in removal proceedings in Los Angeles, CA.

On January 10, 2020, ESCOBAR entered ERO San Diego custody at the Otay Mesa Detention Center pending a motion for a change of venue and an IJ hearing.

On January 11, 2020, ICE Health Service Corp (IHSC) medical staff saw ESCOBAR and noted that he had primary hypertension. ESCOBAR also self identified as having diabetes.

On January 13, 2020, the San Diego Office of Chief Counsel (OCC) filed a motion for change of venue from Los Angeles, CA to San Diego, CA.

On January 24, 2020, an IJ continued ESCOBAR's case.

On February 14, 2020, an IJ continued ESCOBAR's case.

On March 20, 2020, an IJ continued ESCOBAR's case.

On April 15, 2020, an IJ found ESCOBAR to be a flight risk and denied bond. ESCOBAR reserved appeal.

On April 24, 2020, at approximately 5:30 p.m. PDT, ERO San Diego transferred ESCOBAR to the PVH in National City, CA due to ESCOBAR having COVID-19 symptoms (hypoxia). On the same date, IHSC administered a test for COVID-19. The results returned that day indicating that ESCOBAR did have COVID-19. ERO San Diego reported the positive test result and hospital admission via the significant event network (SEN) in report

(b)(7)(E)

On April 27, 2020, at approximately 12:25 p.m. PDT, medical personnel at the PVH placed ESCOBAR on a ventilator and transferred him to the Intensive Care Unit (ICU) due to COVID-19 complications.

On April 29, 2020, the IJ reset ESCOBAR's next hearing for October 19, 2020.

On April 29, 2020, at approximately 9:08 a.m. PDT, ERO San Diego contacted ESCOBAR's next of kin (sister), (b)(6); (b)(7)(C) and provided her with the hospital contact information.

At approximately 10:58 a.m. PDT, ERO San Diego informed ESCOBAR's attorney of record, Susana Beltran, of ESCOBAR's status.

At approximately 5:28 p.m. PDT, a do not resuscitate (DNR) order went into effect at the request of ESCOBAR's family.

On May 6, 2020, staff at the PVH notified ERO San Diego that medical staff had pronounced ESCOBAR deceased at 2:15 a.m. Medical staff have not identified an official cause of death.

At approximately 9:26 a.m. PDT, ERO San Diego notified the El Salvador Consulate of ESCOBAR's death.

At approximately 10:17 a.m. PDT, ERO San Diego notified the Joint Intake Center of ESCOBAR-Mejia's death.

Violations of Law:

Action Taken: The Consulate of El Salvador was notified at 0926 hours.
The Joint Intake Center was notified at 1017 hours.

Other Agencies Notified:

Name	Agency	Phone	Date	Time
none				

Injuries:	Injuries (Names and Extent of
Fatalities:	Injury):
Damage:	

Unaccompanied
Child Count:

Locations:

Type	Address	City	State	Zip
	7488 Calzada de la Fuente	San Diego	California	92154

Hospital Narrative: On April 24, 2020, ESCOBAR was admitted to Paradise Valley Hospital for Hypoxia. At that time, ESCOBAR tested positive for the COVID-19 virus. On April 27, 2020, ESCOBAR was placed on a ventilator and transferred to the Intensive Care Unit. On April 29, 2020, a Do Not Resuscitate (DNR) was placed at the request of ESCOBAR's family. On May 6, 2020, @ 0215 hours, ESCOBAR was pronounced dead.

Hospital Address: Paradise Valley Hospital
2400 E 4th St
National City, CA 91950

Reported to ICE Operations Center via Phone:

Public Affairs Notified: Yes

Officer Notified: Lauren Mack

Date: 5/6/2020

Time: 0935

Comments:

Reported By: (b)(6); (b)(7)(C)

Phone: 619- (b)(6);
(b)(7)(C)

Cell/Pager: 619- (b)(6);
(b)(7)(C)

Supervisor:

Phone: 619-

Cell/Pager: 619-

ICE Significant Incident Report

Submitted Date and Time of Report: 5/18/2020 2048 EST

Incident Date: 5/17/2020	Incident Time: 2152	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Field Operations Division	Area: Western Operations
Case Number: No Case Involved	Office: WF - FOD SAN FRANCISCO - SFR	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	☐ Unaccompanied Children		☐ COVID19
☐ Loss or Theft of Firearm or Body Armor	☐ COVID19 Disruptions		

Principal Subject: Person
 Date of Birth: 6/2/1945

Last Name: AHN
 Country of Birth: Korea, South

First Name: Choung
 Citizenship: Korea, South

Alien ID: A042 028 791

Narrative

Report Title: ERO San Francisco - ICE Detainee Death

ISSUE:

On May 17, 2020, U.S. Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) San Francisco reported the death of ICE detainee Choung Woong AHN, A42 028 791, a 74-year-old citizen of South Korea at the Mesa Verde ICE Processing Facility (MVIPI) in Bakersfield, CA. Emergency Medical Services (EMS) pronounced AHN deceased at 9:52 p.m. Pacific Daylight Time (PDT). Medical staff has not identified the preliminary cause of death.

Consistent with ICE policy, ERO San Francisco notified the DHS Office of Inspector General (OIG), and the ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO San Francisco provided telephonic notification of AHN's death to the Consulate General of South Korea in San Francisco, CA. ERO San Francisco also provided information about AHN's next of kin. The Consulate General will notify the next of kin about AHN's death.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On November 3, 1988, the former Immigration and Naturalization Service at San Francisco, CA admitted AHN into the U.S. as a lawful permanent resident (P-51, sibling of an adult U.S. Citizen).

On June 25, 2013, the Superior Court of California, County of Alameda, convicted AHN for the offense of attempted murder in violation of California Penal Code (CPC) Section 187(a) with an enhancement for using a firearm in violation of CPC Section 12022.5. The court imposed a sentence of seven years in prison for the offense of attempted murder with an additional three years for the firearms enhancement.

On February 21, 2020, ERO San Francisco arrested AHN upon his release from Solano State Prison in Vacaville, CA. On the same date, ERO San Francisco served AHN a Notice to Appear, Form I-862, charging AHN as being a removable alien under 237 (a)(2)(A)(iii) of the Immigration and Nationality Act, as an alien whom after admission is convicted of an aggravated felony.

On March 12, 2020, the Mercy Truxtun Hospital admitted AHN for cough with history of right hilar mass.

On March 18, 2020, the Mercy Truxtun Hospital discharged AHN and he returned to the MVIPI. On the same day, an immigration judge (IJ) continued AHN's case due to his hospitalization.

On March 24, 2020, the IJ reset AHN's case to allow more time for him to obtain an attorney.

On April 2, 2020, the IJ reset AHN's case in order to allow more time for him to obtain an attorney.

On April 14, 2020, the IJ reset AHN's case in order to allow more time for him to obtain an attorney.

On April 15, 2020, the Office of the Principal Legal Advisor received notice of a habeas and incoming Temporary Restraining Order (TRO) for release based on AHN's possible vulnerability to COVID-19.

On April 28, 2020, ERO San Francisco reviewed AHN's custody status to determine risk status due to the COVID-19 pandemic. ERO San Francisco determined AHN was a member of the risk factor 1 due to his age and medical history. ERO San Francisco found that AHN was not amenable to release due to his violent criminal history. On the same date, an IJ continued AHN's case.

On May 4, 2020, the U.S. District Court for the Northern District of California denied AHN's motion for a temporary restraining order in the case AHN, et al. v. Barr, et al., 3:20-cv-02604-JD

On May 12, 2020, MVIPI staff escorted AHN to the facility medical unit after AHN complained of chest pains. At approximately 3:13 p.m. PDT, the Memorial Hospital in Bakersfield, CA admitted AHN for chest pain. On the same date, the IJ reset AHN's case to May 19, 2020, due to his hospitalization.

On May 13, 2020, the U.S. District Court for the Northern District of California denied AHN's request for bail.

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ICE Significant Incident Report

Submitted Date and Time of Report: 5/24/2020 1826 EST

Incident Date: 5/24/2020	Incident Time: 0503	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	☐ Unaccompanied Children		☐ COVID19
☐ Loss or Theft of Firearm or Body Armor	☐ COVID19 Disruptions		

Principal Subject: Person
 Date of Birth: 7/13/1985
 Last Name: Baten-Oxlaj
 Country of Birth: Guatemala
 First Name: Santiago
 Citizenship: Guatemala
 Alien ID: 216635071

Narrative

Report Title: ERO Atlanta - Detainee Death Notification

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Santiago BATEN-Oxlaj, A216 635 071.

ISSUE:

On May 24, 2020, ICE Enforcement and Removal Operations (ERO) Atlanta, reported the death of ICE detainee Santiago BATEN-Oxlaj, a 34-year-old citizen of Guatemala, at the Piedmont Columbus Regional Hospital (PCRH) in Columbus, GA. Doctors pronounced BATEN deceased at 5:03 a.m. Eastern Daylight Time (EDT). The preliminary cause of death is Coronavirus disease (COVID-19).

Consistent with ICE policy, ERO Atlanta notified the DHS Office of Inspector General (OIG), and the ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO Atlanta staff attempted to notify BATEN's next-of-kin but has been unable to make contact. ERO Atlanta provided telephonic notification of BATEN's death to the Consulate General of Guatemala in Atlanta, GA. ERO Atlanta also provided information about BATEN's next-of-kin.

All media inquiries will be referred to ICE Office of Public Affairs.

BACKGROUND:

On an unknown date, BATEN entered the United States at an unknown location without being admitted or paroled after inspection by an immigration officer.

On June 18, 2019, the Kennesaw Municipal Court in Kennesaw, GA convicted BATEN of driving without a valid license and sentenced him to two days of confinement.

On February 19, 2020, the Marietta Municipal Court in Marietta, GA convicted BATEN of driving under the influence and sentenced him to one day of confinement and 11 months and 28 days of probation.

On March 2, 2020, ERO Atlanta arrested BATEN at the Marietta Municipal Probation Office and served him with a Notice to Appear, Form I-862, charging inadmissibility pursuant to Section 212(a)(6)(A)(i) of the Immigration and Nationality Act (INA), as an alien present in the United States without admission or parole by an immigration officer.

On March 18, 2020, an immigration judge (IJ) denied BATEN's request for release on an immigration bond.

On March 26, 2020, an IJ granted BATEN voluntary departure under safeguards to Guatemala with instructions to depart on or before April 27, 2020.

On April 17, 2020, the Stewart Detention Center Medical Director informed ERO Atlanta that BATEN had been admitted to the PCRH in Columbus, GA for evaluation and treatment of decreased oxygen saturation levels. The hospital subsequently informed ERO Atlanta that BATEN tested positive for COVID-19 and began utilizing treatment regimens including convalescent plasma donation, Hydroxychloroquine, and Remdesivir.

On May 24, 2020, at approximately 4:45 a.m. EDT, BATEN went into cardiopulmonary arrest and the PCRH medical staff initiated advance life support.

At approximately 5:03 a.m. EDT, the PCRH Doctor pronounced BATEN deceased after echocardiogram no longer showed heart activity.

At approximately, 5:56 a.m. EDT, the Acting Field Office Director for ERO Atlanta notified HQ ERO Field Operations of BATEN's death.

At approximately, 6:56 a.m. EDT, ERO Atlanta, notified the Consulate General of Guatemala in Atlanta of BATEN's death and requested that they notify the next-of-kin.

At approximately, 6:58 a.m. EDT, the Acting Field Office Director for ERO Atlanta notified the Joint Intake Center (JIC) and the JIC OPR duty agent of BATEN's death.

At approximately, 7:45 a.m. EDT, the Consulate General of Guatemala in Atlanta contacted BATEN's spouse and notified of BATEN's death.

ICE Significant Incident Report

Submitted Date and Time of Report: 4/11/2018 1518 EST

Incident Date: 4/10/2018	Incident Time: 0915	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Detention Management Division	Area: Detention Standards Compliance
Case Number: No Case Involved	Office: XD - FOD DALLAS	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	Last Name: Mirimanian	First Name: Gourgen	Alien ID: 070963630
Date of Birth: 3/16/1964	Country of Birth: Armenia	Citizenship: Armenia	

Narrative

Report Title: ERO Dallas- Detainee Death

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Gourgen MIRIMANIAN, A70 963 630.

ISSUE:

On April 10, 2018, ERO Dallas reported the death of ICE detainee Gourgen MIRIMANIAN, A70 963 630, a 54 year-old citizen of Armenia, at the Texas Health Huguley Hospital (THHH) in Fort Worth, TX. On April 10, 2018, medical staff at THHH declared MIRIMANIAN deceased at 9:12 am CDT with a preliminary cause of death being unknown.

Consistent with ICE Policy, ERO Dallas notified the Department of Homeland Security Office of Inspector General and Office of Professional Responsibility via the Joint Intake Center. ERO Dallas notified the HQ ERO Removal Division of the death. HQ ERO Removal Division has notified the Armenian Embassy in Washington D.C. of MIRIMANIAN's death. ERO Dallas notified the next of kin, Anna Mirimanian, his spouse, via telephone at 9:22 am CDT on April 10, 2018.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On April 28, 1994, the former Immigration and Naturalization Service (INS) admitted

MIRIMANIAN into the United States at Los Angeles, CA as a nonimmigrant visitor for pleasure (B2) for a period of six months.

On July 28, 1994, MIRIMANIAN submitted an Application for Asylum and Withholding of Removal, Form I-589 and an Application for Employment Authorization, Form I-765 with the INS.

On August 31, 1994, INS approved the I-765.

On August 25, 1995, MIRIMANIAN filed another I-765 with the INS.

On September 1, 1995, INS approved the I-765.

On March 28, 1997, MIRIMANIAN withdrew his I-589.

On September 24, 1997, MIRIMANIAN filed another I-765 with the INS.

On November 8, 1997, the INS approved MIRIMANIAN's I-765.

On October 1, 2002, MIRIMANIAN filed Immigrant Petition for Alien Worker, Form I-140 with the INS.

On June 6, 2003, United States Citizenship and Immigration Services (USCIS) approved the I-140.

On May 5, 2005, MIRIMANIAN filed an Application to Register Permanent Residence or Adjust Status, Form I-485, and another I-765 with USCIS. USCIS has not adjudicated the I-485.

On May 30, 2005, USCIS approved the I-765.

On September 6, 2006, the Beverly Hills Municipal Court in Beverly Hills, CA convicted MIRIMANIAN of possession or selling of a switch-blade knife and sentenced him to 24 months of probation.

On March 8, 2007, MIRIMANIAN submitted another I-765 to USCIS.

On May 18, 2007, USCIS approved the I-765.

On July 30, 2013, the U.S. District Court for the Southern District of New York convicted MIRIMANIAN for racketeering conspiracy, in violation of 18 USC 1962(d), and sentenced him to 60 months incarceration.

On October 3, 2013, ERO San Francisco encountered MIRIMANIAN at the Taft Community Correctional Facility in Taft, CA and lodged an Immigration Detainer - Notice of Action, Form I-247 on MIRIMANIAN with the facility.

On December 12, 2017, ERO Dallas encountered MIRIMANIAN at the Federal Bureau of Prisons Federal Medical Center in Fort Worth, TX and lodged an Immigration Detainer - Notice of Action, Form I-247A on MIRIMANIAN with the facility.

On December 18, 2017, MIRIMANIAN submitted an Application for Waiver of Grounds of Inadmissibility, Form I-601, with USCIS. USCIS has not adjudicated that application.

On February 6, 2018, the Bureau of Prisons released MIRIMANIAN to ERO Dallas custody. ERO Dallas detained MIRIMANIAN at the Bedford City, TX jail.

On February 7, 2018, ERO Dallas transferred MIRIMANIAN to the Prairieland Detention Center (PDC) in Alvarado, TX.

On February 7, 2018, ERO Dallas served MIRIMANIAN a Notice to Appear, Form I-862, charging removability pursuant to Section 237(a)(1)(B) of the Immigration and Nationality Act (INA), as a nonimmigrant overstay and Section 237(a)(2)(A)(iii) of the INA as an alien who, at any time after admission, has been convicted of an aggravated felony.

On March 6, 2018, an immigration judge ordered MIRIMANIAN removed to Armenia. Both DHS and MIRIMANIAN waived appeal.

On March 26, 2018, ERO Dallas forwarded MIRIMANIAN's travel document application to the Armenian Consulate where it is currently pending.

On April 10, 2018 at 8:00 am CDT facility staff at PDC found MIRIMANIAN unresponsive on his bunk. PDC medical staff performed cardio pulmonary resuscitation (CPR) and contacted emergency medical services (EMS). EMS transported MIRIMANIAN to the THHH. At 9:12 am CDT medical staff at THHH declared MIRIMANIAN deceased.

MIRIMANIAN is the fourth detainee to pass away in ICE custody in fiscal year 2018. HQ ERO Removal Division has notified the Armenian Embassy in Washington D.C. of MIRIMANIAN's death.

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	1209 Sunflower Lane	alvarado	Texas	76009

Hospital**Narrative:**

Hospital Address: 11801 South Fwy, Burleson, TX 76028

Reported to ICE Operations Center via Phone:

Public Affairs Notified: No - Without comments

Comments:

Reported By: (b)(6); (b)(7)(C)

Phone: 817- (b)(6); (b)(7)(C)

Cell/Pager: 214- (b)(6); (b)(7)(C)

Supervisor: S

Phone: 817- (b)(6); (b)(7)(C)

Cell/Pager: 2067 (b)(6); (b)(7)(C)

ICE Significant Incident Report

Submitted Date and Time of Report: 5/18/2018 1143 EST

Incident Date: 5/16/2018	Incident Time: 1849	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	☐ Unaccompanied Children		☐ COVID19
☐ Loss or Theft of Firearm or Body Armor	☐ COVID19 Disruptions		

Principal Subject: Person	Last Name: CRUZ	First Name: Roland	Alien ID: 078 963 293
Date of Birth: 2/28/1979	Country of Birth: Honduras	Citizenship: Honduras	

Narrative

Report Title: ICE notification of the death of an ICE detainee:- San Antonio Field Office (PIDC, Los Fresnos, TX)

ISSUE:

On May 16, 2018, U.S. Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) San Antonio reported the death of ICE detainee Ronald CRUZ, A078 963 293, a 39-year-old citizen of Honduras, at the Valley Baptist Medical Center (VBMC) in Harlingen, TX. The medical staff pronounced CRUZ dead at 6:49 p.m. CDT. Medical staff identified the preliminary cause of death as cardiac arrest.

Consistent with ICE policy, ERO San Antonio 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 San Antonio also notified the Consulate of Honduras in McAllen, TX, of CRUZ's death. Honduran Consular officials notified CRUZ's next of kin.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On May 15, 2002, CRUZ entered the United States at an unknown place without being admitted or paroled by an immigration officer.

On May 15, 2002, U.S. Border Patrol (USBP) arrested CRUZ at Carricitos, TX and served him 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 having been admitted or paroled by an immigration officer. USBP released CRUZ from custody under an Order of Recognizance.

On September 24, 2002, an immigration judge (IJ) in Houston, TX ordered CRUZ removed to Honduras in absentia.

On January 14, 2016, Jackson County Circuit Court, Kansas City, MO convicted CRUZ for the offense of driving under the influence and sentenced him to two days confinement.

On January 20, 2016, ERO Chicago arrested CRUZ at the Jackson County Jail, Kansas City, MO as an alien with an outstanding removal order.

On January 29, 2016, ERO removed CRUZ to Honduras.

On May 9, 2018, USBP arrested CRUZ at Rio Grande City, TX upon his illegal reentry into the United States. USBP served CRUZ a Notice of Intent/Decision to Reinstate Prior Order, Form I-871, pursuant to Section 241(a)(5) of the INA.

On May 14, 2018, USBP transferred CRUZ to ERO San Antonio, Port Isabel Detention Center (PIDC).

On May 14, 2018, ICE Health Service Corps (IHSC) conducted an initial medical screening which concluded that CRUZ had no health issues. CRUZ reported that he was feeling well, and disclosed that he had no acute or chronic medical conditions.

On May 15, 2018 at approximately 9:00 a.m. CDT, CRUZ reported to the IHSC PIDC medical clinic for sick call services. Upon the initial evaluation, the nurse obtained an elevated body temperature and an elevated blood pressure when compared to the results from the day before. The nurse then referred CRUZ to an IHSC Advanced Practice Practitioner (APP).

CRUZ reported to the APP that while at a facility prior to PIDC, he had been treated with antibiotics for flu like symptoms and with ear drops for a left ear infection. CRUZ was transferred to ICE with no accompanying medical paperwork from USBP and this claim of previous treatment remains under review.

After learning of CRUZ's symptoms, the APP performed a random blood sugar test and a standard urinalysis. Results from both tests revealed several abnormal values, to include high glucose, ketones protein and a small amount of blood. Because of these abnormal findings, CRUZ was transferred to the PIDC Acute Care Room.

While in the Acute Care Room, IHSC medical staff administered IV fluids, initiated antibiotic treatment, repeated the urinalysis test, and obtained lab studies for send out. CRUZ remained in the Acute Care Room until staff transferred him to the PIDC Medical Housing Unit (MHU).

At approximately 1:55 p.m. CDT, CRUZ arrived at the MHU. CRUZ reported to the IHSC medical staff of feeling sick and complained of pain.

At approximately 4:28 p.m. CDT, IHSC provided care to CRUZ as an urgent referral for altered mental status. CRUZ required assistance to ambulate and appeared lethargic and confused.

At approximately 4:38 p.m. CDT, IHSC activated Emergency Medical Services (EMS).

At approximately 5:06 p.m. CDT, EMS departed PIDC with CRUZ to the Harlingen Medical Center. EMS then rerouted to VBMC.

At approximately 5:48 p.m. CDT, EMS arrived at VBMC with CRUZ. VBMC admitted CRUZ and began testing, including chest x-rays and a CT scan of the head.

At approximately 10:11 p.m. CDT, CRUZ was diagnosed with Sepsis and Diabetic Keto Acidosis. At that time, he was still awake but very confused and nonverbal.

On May 16, 2018 at approximately 12:55 a.m. CDT, CRUZ suffered cardiac arrest. VBMC staff initiated advanced life support protocols and resuscitated him.

At approximately 1:09 a.m. CDT, CRUZ suffered a second cardiac arrest. VBMC staff initiated advanced life support protocols and resuscitated him.

At approximately 2:35 a.m. CDT, VBMC admitted CRUZ into the intensive care unit. CRUZ remained unresponsive and unconscious on a ventilator.

At approximately 10:00 a.m. CDT, ERO San Antonio notified the Honduran consulate in McAllen, TX via telephone and email, regarding the hospitalization and condition of CRUZ.

At approximately 10:05 a.m. CDT, ERO San Antonio contacted CRUZ's brother and sister via telephone and provided notification regarding the hospitalization and condition of CRUZ. Both of CRUZ's relatives reside in Missouri.

At approximately 6:25 p.m. CDT, CRUZ suffered from another cardiac arrest. VBMC staff initiated advanced cardiac life support protocols for 20 minutes. VBMC staff determined that further medical interventions were futile.

At approximately 6:49 p.m. CDT, VBMC staff pronounced CRUZ dead. The suspected cause of death is cardiac arrest.

At approximately 7:48 p.m. CDT, ERO San Antonio notified the Consulate of Honduras of CRUZ's death.

CRUZ is the is the fifth 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 Injury):
Fatalities:	
Damage:	
Unaccompanied	
Child Count:	

Locations:

Type	Address	City	State	Zip
Other	2101 Pease Street	Harlingen	Texas	78550

Reported to ICE Operations Center via Phone:

Public Affairs Notified: Yes

Officer Notified: (b)(6); (b)(7)(C)

Date: 5/17/2018

Time: 1029

Comments:

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

Phone: 956- (b)(6); (b)(7)(C)

Cell/Pager: 956 (b)(6); (b)(7)(C)

Supervise

Phone: 956- (b)(6); (b)(7)(C)

Cell/Pager: 202 (b)(6); (b)(7)(C)

ICE Significant Incident Report

Submitted Date and Time of Report: 6/14/2018 1733 EST

Incident Date: 6/12/2018	Incident Time: 0920	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Field Operations Division	Area: Western Operations
Case Number: No Case Involved	Office: X1 - Eloy Det. Ctr., AZ - EAZ	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	Last Name: Tran	First Name: Huy Chi	Alien ID: 037 949 945
Date of Birth: 8/7/1970	Country of Birth: Vietnam	Citizenship: Vietnam	

Narrative

Report Title: Detainee Death - Eloy Detention Center - Eloy, Arizona

ISSUE:

On June 12, 2018, U.S. Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) Phoenix reported the death of ICE detainee Huy Chi TRAN, A37 949 945, a 47-year-old citizen of Vietnam, at the Banner Casa Grande Medical Center (BCGMC) in Casa Grande, AZ. The medical staff pronounced TRAN deceased at 9:20 a.m. MST. Medical staff identified the preliminary cause of death as cardiac arrest.

Consistent with ICE policy, ERO Phoenix notified the U.S. Department of Homeland Security, Office of Inspector General and ICE, Office of Professional Responsibility via the Joint Intake Center. ERO Phoenix also notified the Consulate of Vietnam in Phoenix, AZ of TRAN's death. ERO Phoenix notified TRAN's next of kin of his death.

All media inquiries will be referred to the Office of Public Affairs.

BACKGROUND:

On June 25, 1984, the former U.S. Immigration and Naturalization Service (INS) admitted TRAN into the United States at San Francisco, CA, as a P-53 immigrant, child of alien classified as P-51 / P-56, brother or sister of U.S. citizen.

On October 25, 2000, the Superior Court of Arizona, County of Maricopa, convicted TRAN of two counts of aggravated assault, and sentenced him to three and a half years of incarceration and

three years of probation with credit for 210 days of time served.

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

On March 29, 2003, the ADOC transferred TRAN to ERO Phoenix 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 is at least one year.

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

On June 16, 2003, TRAN filed an appeal with the Board of Immigration Appeals (BIA).

On October 31, 2003, the BIA remanded the case to the IJ for further proceedings.

On December 10, 2003, the IJ found all TRAN's applications for relief to be abandoned and again ordered him removed to Vietnam. TRAN reserved his right to appeal.

On January 8, 2004, TRAN filed an appeal with the BIA.

On June 14, 2004, the BIA sustained TRAN's appeal and remanded the case back to the IJ for a decision.

On September 21, 2004, the IJ denied all TRAN's applications for relief and ordered him removed to Vietnam. TRAN waived his right to appeal.

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 as required four times between January 27, 2005, to April 20, 2005.

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.

On July 28, 2005, TRAN failed to appear at ERO Phoenix as ordered. TRAN's case was then referred to the Fugitive Operations Team for location and arrest with no result.

On February 2, 2006, the Chandler, AZ Police Department (CPD) arrested TRAN for disorderly conduct and criminal damage. CPD released TRAN while his charges were pending, ERO Phoenix did not encounter TRAN after his release. TRAN failed to appear for court, and the court issued a bench warrant for his arrest.

On August 15, 2006, CPD arrested TRAN for shoplifting. On the same date, CPD cited TRAN and released him to ERO Phoenix custody.

On August 18, 2006, ERO Phoenix released TRAN under his original OSUP issued on January 10, 2005, to complete his criminal proceedings. There is no record of TRAN reporting to ERO Phoenix after this date.

On April 8, 2009, the Superior Court of Arizona, County of Maricopa, convicted TRAN for the offense of aggravated assault, a domestic violence offense, and sentenced him to five years of incarceration with credit for 224 days of time served.

On April 13, 2009, ERO Phoenix encountered TRAN at the ARC and lodged a Notice of Action-Immigration Detainer, Form I-247A.

On August 14, 2013, ADOC transferred TRAN to ERO Phoenix custody. ERO Phoenix released TRAN from custody under his original OSUP issued on January 10, 2005 because there was still no significant likelihood of removal. TRAN did not appear at ERO Phoenix for his first scheduled appointment on February 12, 2014.

On January 21, 2017, CPD arrested TRAN for disorderly conduct and domestic violence. On the same date, ERO Phoenix encountered TRAN at the Maricopa Sheriff's Office (MCSO) Jail and lodged a Notice of Action-Immigration Detainer, Form I-247A. TRAN remained in MCSO custody.

pending his criminal proceedings.

On July 10, 2017, the Superior Court of Arizona, Maricopa County, convicted TRAN for the offense of disorderly conduct, a domestic violence offense, and sentenced TRAN to one and a half years of incarceration with credit for 117 days of time served.

On July 12, 2017, a 287(g) Designated Immigration Officer encountered TRAN at the ARC, and lodged a Notice of Action - Immigration Detainer, Form I-247A.

On May 25, 2018, ADOC released TRAN to ERO Phoenix custody. ERO Phoenix served TRAN a Notice of Revocation of Release with the intention of reviewing TRAN's likelihood of removal.

On the same date, ERO Phoenix transferred TRAN to the Florence Detention Center (FDC) in Florence, AZ.

On May 26, 2018, ICE Health Service Corps (IHSC) conducted an initial screening at the FDC. During his initial intake, TRAN reported experiencing auditory verbal hallucinations (AVH) but stated medication controls his AVH. TRAN arrived at FDC with a prescription for Prozac and Haldol and IHSC continued his medication regimen as prescribed.

On May 28, 2018, ERO Phoenix transferred TRAN to the Eloy Detention Center (EDC) in Eloy, AZ, to pursue removal to Vietnam.

On June 5, 2018, an IHSC mental health provider evaluated TRAN and placed him on mental health observation with 15-minute staggered security checks.

At approximately 4:15 p.m. MST, CoreCivic personnel while performing a security check discovered TRAN unresponsive in his cell. CoreCivic called a medical emergency and began cardiopulmonary resuscitation (CPR) on TRAN.

At approximately 4:18 p.m. MST, IHSC arrived to assist with CPR and applied an Automated External Defibrillator (AED) while awaiting the arrival of EMS. CPR was performed for approximately 17 minutes before EMS arrived.

At approximately 4:35 p.m. MST, EMS arrived and administered Narcan pursuant to their protocols. The Narcan had no effect. EMS then administered epinephrine, which enabled them to find a sinus rhythm.

At approximately 4:53 p.m. MST, EMS transported TRAN to the BCGMC in Casa Grande, AZ, for continued treatment and evaluation.

At approximately 5:21 p.m. MST, the BCGMC placed TRAN on a ventilator.

At approximately 5:50 p.m. MST, the BCGMC admitted TRAN for further care.

On June 6, 2018, at 5:59 a.m. MST, CT results returned negative with some abnormal lab values.

At approximately, at 12:15 p.m., MST, BCGMC hospital staff advised IHSC that TRAN's condition remained unchanged. His pupils were dilated and nonreactive, and he had no gag reflex. TRAN continued a ventilator with hypothermia therapy, and per protocol, a rewarming process was scheduled.

On June 7, 2018, at approximately 2:53 p.m., MST, BCGMC hospital staff advised IHSC that TRAN's condition remained largely unchanged. TRAN remained essentially unresponsive, with some sluggish pupillary reflex but still no pain response and no signs of waking.

On June 8, 2018 at approximately 7:02 a.m., MST, BCGMC hospital staff advised IHSC that TRAN's condition remained unchanged, but there was some evidence of kidney disfunction.

On June 11, 2018, BCGMC hospital staff conducted an EEG and brain stem test.

On June 12, 2018, at approximately 12:04 p.m., MST, BCGMC hospital staff advised IHSC that the results of the EEG and brain stem scan resulted in a diagnosis of code arrest and brain anoxia. The test showed no brain activity.

At approximately 12:17 p.m., MST, BCGMC hospital staff notified ERO Phoenix that they had confirmed the findings of the EEG and brain stem scan, and declared TRAN brain dead with a time of death of 9:20 a.m., MST and a preliminary cause of death of cardiac arrest. BCGMC kept TRAN on the ventilator until his mother, father and three sisters arrived for a final visit.

At approximately 2:39 p.m., MST, TRAN's family, in consultation with the attending physician, made the decision to remove TRAN from the ventilator. TRAN's family was present at the time BCGMC extubated TRAN.

The IHSC Field Medical Coordinator is awaiting autopsy results which will provide the official cause of death. An autopsy will be performed on June 14, 2018.

TRAN is the seventh detainee to pass away in ICE custody in fiscal year 2018.

Violations of Law:

Action Taken: ICE death notifications made and protocols initiated.

Other Agencies Notified:

Name	Agency	Phone	Date	Time
none				

Injuries: Injuries (Names and Extent of Injury):
Fatalities:
Damage:

Locations:

Type	Address	City	State	Zip
Business	1705 E Hanna Road	Eloy	Arizona	85131

Reported to ICE Operations Center via Phone:**Public Affairs Notified: Yes**

Officer Notified: (b)(6); (b)(7)(C)

Date: 6/13/2018

Time: 1325

Comments:

Reported By: (b)(6); (b)(7)(C)

Phone: 520.464 (b)(6); (b)(7)(C)

Cell/Pager: 520.4 (b)(6); (b)(7)(C)

Supervisor:

Phone: 520-464

Cell/Pager: 520-4

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	Last Name: DE LA ROSA	First Name: Efrain	Alien ID: 209910301
Date of Birth: 9/17/1977	Country of Birth: Mexico	Citizenship: Mexico	

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:

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 Injury):
Fatalities:	
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: (b)(6); (b)(7)(C)

Date: 7/10/2018

Time: 0000

Comments:

Reported By: (b)(6); (b)(7)(C)

Phone: 229-83

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

Cell/Pager: 229-3

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

Supervisor:
Phone: 229-83

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

Cell/Pager: 229-5

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

ICE Significant Incident Report

Submitted Date and Time of Report: 7/27/2018 1656 EST

Incident Date: 7/25/2018	Incident Time: 2245	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Detention Management Division	Area: Detention Standards Compliance
Case Number: No Case Involved	Office: WE - FOD SAN DIEGO - SND	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	☐ Unaccompanied Children		☐ COVID19
☐ Loss or Theft of Firearm or Body Armor	☐ COVID19 Disruptions		

Principal Subject: Person	Last Name: Agustina	First Name: Ramirez-Arreola	Alien ID: 206266687
Date of Birth: 5/30/1956	Country of Birth: Mexico	Citizenship: Mexico	

Narrative

Report Title: ICE ERO San Deigo Report of Detainee death

ISSUE:

On July 26, 2018, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) San Diego reported the death of ICE detainee Agustina RAMIREZ-Arreola, A206 266 687, a 62-year-old citizen of Mexico, at the Alvarado Hospital (AH) in San Diego, CA. The medical staff pronounced RAMIREZ deceased at 10:45 p.m. PDT. Medical staff identified the preliminary cause of death as complications from surgery.

Consistent with ICE policy, ERO San Diego 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 San Diego also notified the Consulate of Mexico in San Diego, CA, of RAMIREZ's death, who, in turn, notified RAMIREZ's next of kin.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On November 20, 2013, RAMIREZ applied for admission into the United States at the San Ysidro Port of Entry and requested political asylum. The primary Customs and Border Protection (CBP) officer referred RAMIREZ to the San Ysidro Admissibility Enforcement Unit (AEU) for further disposition. Upon further questioning, RAMIREZ stated she had no fear or concern of being returned to Mexico.

On November 22, 2013, CBP served RAMIREZ 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 an immigrant without immigrant visa. On that same date CBP removed RAMIREZ to Mexico.

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

On May 22, 2018, CBP served RAMIREZ a Notice and Order of Expedited Removal, Form I-860 charging inadmissibility pursuant to section 212(a)(7)(A)(i)(I) of the INA as an immigrant without immigrant visa.

On June 3, 2018, CBP transferred RAMIREZ to ERO San Diego custody at the Otay Mesa Detention Center (OMDC). On the same date, ERO San Diego transferred RAMIREZ to AH due a chest CT scan indicating tuberculosis (TB) exposure. The hospital follow-up examination determined RAMIREZ was negative for active tuberculosis (TB). The hospital also diagnosed RAMIREZ with pneumonia and extended-spectrum beta-lactamases (ESBL) and provided antibiotics to combat these illnesses.

On June 7, 2018, ERO San Diego referred RAMIREZ's case to U.S. Citizenship and Immigration Services Asylum Pre-screening Officer (APSO) for a credible fear interview.

On June 12, 2016, medical staff initiated treatment for TB.

On June 19, 2018, AH medical staff stopped the treatment due to RAMIREZ having side effects from the treatment.

On June 26, 2018, AH reported that an echocardiogram revealed aortic stenosis and as a result, medical staff stopped the ethambutol treatment. RAMIREZ's liver enzymes were also elevated and not improving.

On July 3, 2018, the AH scheduled a cardiology evaluation and possible outpatient cardiac catheterization once RAMIREZ was out of respiratory isolation.

On July 4, 2018, AH discharged RAMIREZ and she returned to OMDC.

On July 7, 2018, RAMIREZ accessed sick call for complaints of itchy skin on her arms and legs. The ICE Health Service Corps (IHSC) nurse prescribed daily doses of Benadryl to combat the allergy.

On July 10, 2018, a cardiac surgeon saw RAMIREZ as an outpatient and recommended aortic valve replacement surgery. An IHSC nurse screened RAMIREZ upon her return to OMDC and cleared her to return to general population.

On July 17, 2018, the IHSC Clinical Director submitted a cardiac surgery referral requesting authorization for aortic valve replacement surgery.

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

On July 18, 2018, an IHSC nurse saw RAMIREZ for sick call for care of itchy skin. RAMIREZ's vital signs were all normal but a red rash was noted on both arms. The IHSC nurse provided daily doses of Benadryl to combat the allergy.

On July 19, 2018, RAMIREZ attended a follow up appointment to review the cardiac

surgeon's recommendations. RAMIREZ reported that she had no idea she had a heart problem but tired easily. The cardiac surgeon scheduled aortic stenosis surgery for July 25, 2018 and scheduled a post-operative follow-up visit for a week after surgery.

On July 23, 2018, an IJ in San Diego affirmed the APSO finding and returned the case to ICE for removal.

On July 24, 2018, Core Civic staff at the OMDC notified ERO San Diego that they had transported RAMIREZ back to AH for her scheduled surgery to treat her heart abnormality. In the afternoon, AH reported RAMIREZ was stable, awake, alert and oriented.

On July 25, 2018, at approximately 5:00 a.m. PDT, AH provided a morning update that RAMIREZ continued to be stable and awaiting the procedure.

At approximately 6:20 a.m. PDT RAMIREZ underwent cardiac surgery to replace her aortic valve.

At approximately 2:50 p.m. PDT RAMIREZ's surgery was completed.

Upon recovery from surgery, AH medical staff observed that RAMIREZ was still bleeding and returned her to the operating room at 5:20 p.m. PDT. RAMIREZ died during this procedure, with a time of death of 10:45 p.m. PDT.

At approximately 11:15 p.m. PDT, AH notified ERO San Diego of RAMIREZ's passing.

On July 26, 2018, at approximately 12:30 a.m. PDT, ERO San Diego notified ERO Headquarters of RAMIREZ's death.

At approximately 1:00 a.m. PDT, ERO San Diego notified the Consulate of Mexico in San Diego, CA, of RAMIREZ's death.

On July 26, 2018, at 1:50 a.m. PDT, ERO San Diego telephonically notified the Joint Intake Center and the Office of Professional Responsibility duty agent of RAMIREZ's death.

At approximately 7:50 a.m. PDT, ERO San Diego emailed notification to the Office of Professional Responsibility duty agent as requested.

RAMIREZ is the ninth 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 Injury):
Fatalities:	
Damage:	
Unaccompanied	
Child Count:	

Locations:

Type	Address	City	State	Zip
Business	7488 Calzada De La Fuente	San Diego	California	92154

Reported to ICE Operations Center via Phone:

Public Affairs Notified: No - Without comments

Comments:

Reported By: (b)(6); (b)(7)(C) **Phone:** 619-574-(b)(6); **Cell/Pager:** 61957-(b)(6);

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

Phone: (619)557 (b)(6); (b)(7)(C)

Cell/Pager: 619572 (b)(6); (b)(7)(C)

ICE Significant Incident Report

Submitted Date and Time of Report: 11/2/2018 1009 EST

Incident Date: 11/1/2018	Incident Time: 0717	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Detention Management Division	Area: Detention Monitoring
Case Number: No Case Involved	Office: M3 - Krome North SPC, FL - KRO	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	☐ Unaccompanied Children		☐ COVID19
☐ Loss or Theft of Firearm or Body Armor	☐ COVID19 Disruptions		

Principal Subject: Person	Last Name: PADRON	First Name: WILFREDO	Alien ID: 022 776 291
Date of Birth: 9/3/1960	Country of Birth: Cuba	Citizenship: Cuba	

Narrative

Report Title: ERO Miami Detainee Death

The below information is provided by ERO Miami.

On November 1, 2018, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) Miami reported the death of ICE detainee Wilfredo PADRON, A022 776 291, a 58-year-old citizen of Cuba, at the Lower Keys Medical Center (LKMC) in Key West, FL. The medical staff at LKMC pronounced PADRON deceased at approximately 7:17 a.m. EDT. The official cause of death remains under investigation but is believed to be cardiac related.

Consistent with ICE policy, ERO Miami 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 Miami also notified the ERO Headquarters Removal and International Operations Unit for proper notification to the Government of Cuba as per current protocols.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On May 16, 1980, the United States Immigration and Naturalization Service (INS) paroled PADRON into the United States near Key West, Florida during the "Mariel Boat Lift".

On January 20, 1987, the Eleventh Judicial Circuit Court in Miami-Dade County, FL convicted PADRON of grand theft of vehicle and cocaine possession. The Eleventh Judicial Circuit Court sentenced him to two years probation.

On April 20, 1992, the Eleventh Judicial Circuit Court in Miami-Dade County, FL convicted PADRON of aggravated assault, carrying a concealed weapon, cocaine possession, and destroying evidence, and sentenced him to 11 months and 29 days confinement.

On October 10, 1992, PADRON filed an Application to Register Permanent Residence or Adjust Status, Form I-485 with the INS.

On August 16, 1995, INS adjusted PADRON's status to that of a lawful permanent resident retroactive to October 10, 1992.

On January 7, 1999, the Eleventh Judicial Circuit Court in Miami-Dade County, FL convicted PADRON of resisting officer, fraud, and habitual driving while license suspended and sentenced him to two years of probation.

On July 17, 2000, INS arrested PADRON at the Florida Department of Corrections Probation Office in Miami, FL and issued him a Notice to Appear charging removability pursuant to Section 237(a)(2)(A)(ii) of the Immigration and Nationality Act (INA), as an alien convicted of two crimes involving moral turpitude after admission.

On November 15, 2000, the Miami INS Office of District Counsel filed additional charges of removability pursuant to Section 237(a)(1)(A) of the INA, as an alien inadmissible at the time of entry and or procuring by fraud a visa or admission into the United States, and Section 237(a)(2)(A)(i) of the INA, as an alien convicted of a crime involving moral turpitude within five years after admission or adjustment.

On November 29, 2001, an immigration judge in Miami, FL ordered PADRON removed from the United States to Cuba.

On May 15, 2002, INS in Miami, FL released PADRON on an Order of Supervision (OSUP) with a reporting date of June 15, 2002.

Between May 15, 2002 and August 15, 2018, PADRON reported on OSUP to ERO Miami annually.

On September 26, 2006, the Palm Beach County Court, West Palm Beach, FL convicted PADRON of not utilizing proper equipment in conjunction with a traffic offense. Disposition unknown.

On September 21, 2007, the Suwanee County Court, Live Oak, FL convicted PADRON of a traffic offense. Disposition unknown.

On October 23, 2008, the Suwanee County Court, Live Oak, FL convicted PADRON of a traffic offense. Disposition unknown.

On October 23, 2008, the Palm Beach County Court convicted PADRON of failing to have a driver's license in conjunction with a traffic offense. Disposition unknown.

On October 7, 2010, the 216th District Court in Kerr County, Kerrville, TX convicted PADRON of possession of a controlled substance and sentenced him to two years confinement with three years probation.

On October 5, 2013, the Palm Beach County Court, West Palm Beach, FL convicted PADRON of failing to pay a toll. Disposition unknown.

On March 22, 2018, PADRON reported to ERO Miami as required. ERO Miami requested that

PADRON provide a medical summary and a list of medications due to being on the Cuban repatriation list. ERO Miami scheduled PADRON's next report date for August 15, 2018.

On August 15, 2018, ERO Miami arrested PADRON at the ERO Miami, Miramar Sub-Office due to his Significant Likelihood of Removal in the Reasonable Foreseeable Future, revoked PADRON's OSUP and detained him at the Krome Service Processing Center, Miami, FL.

On the same date, PADRON informed IHSC during intake screening that he had a history of hypertension, pancreatitis, and a left leg fracture due to a vehicular accident.

On August 17, 2018, ERO Miami transferred PADRON to the Monroe County Detention Center (MCDC) in Key West, FL.

On August 18, 2018, ERO Miami submitted a presentation package to HQ RIO for presentation to the Cuban Embassy for repatriation efforts.

On August 31, 2018, HQ RIO nominated PADRON to the Government of Cuba for repatriation.

On October 26, 2018, MCDC staff referred PADRON to the LKMC due to chest pain. LKMC staff evaluated PADRON and diagnosed him with constipation and released him on the same date back to MCDC.

On November 1, 2018, at approximately 6:41a.m. EDT, PADRON's cellmate informed MCDC staff that PADRON would not wake up. MCDC staff found PADRON unresponsive in his cell and began cardiopulmonary resuscitation (CPR) and attached an Automated External Defibrillator.

At approximately 6:43 a.m. EDT, MCDC staff contacted Emergency Medical Services (EMS) and continued with CPR while awaiting the arrival of EMS.

At approximately 6:49 a.m. EDT, the Key West Fire Department (KWFD), Key West, FL arrived at MCDC and took over CPR.

At approximately 7:09 a.m. EDT, KWFD continued CPR and transported PADRON to LKMC.

At approximately 7:17 a.m. EDT, LKMC medical staff pronounced PADRON deceased.

At approximately 7:30 a.m., MCDC staff notified ERO Miami that PADRON had been transported to LKMC.

At approximately 7:47 a.m. EDT, LKMC medical staff notified MCDC staff on site at LKMC that PADRON had been pronounced deceased.

At approximately 8:10 a.m. EDT, MCDC notified ERO Miami that PADRON was pronounced deceased by LKMC.

At approximately 8:13 a.m. EDT, ERO Miami notified ERO Headquarters of PADRON's death.

At approximately 8:28 a.m. EDT, ERO Miami telephonically notified the Office of Professional Responsibility duty agent of PADRON's death.

At approximately 8:37 a.m. EDT, ERO Miami emailed the Joint Intake Center of PADRON's death.

On November 1, 2018, HQ RIO notified the Embassy of Cuba of PADRON's death.

ERO Miami is in the process of providing notification to PADRON's next of kin.

PADRON is the first detainee to die in ICE custody in fiscal year 2019.

The ERO Miami Acting Deputy Field Office Director, Joel T. Mikelson reviewed and approved this SIR.

Violations of Law:

Action Taken:

Other Agencies Notified:

Name	Agency	Phone	Date	Time
none				

Injuries:	Injuries (Names and Extent of
Fatalities:	Injury):
Damage:	
Unaccompanied	
Child Count:	

Locations:

Type	Address	City	State	Zip
Other	5900 College Road	Key West	Florida	33040

Reported to ICE Operations Center via Phone: No

Public Affairs Notified: Yes

Officer Notified: (b)(6); (b)(7)(C)

Date: 11/1/2018

Time: 0815

Comments: .

Reported By: (b)(6); (b)(7)(C)

Phone: 305-207 (b)(6); (b)(7)(C)

Cell/Pager: 786-760 (b)(6); (b)(7)(C)

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

Phone: 305-207 (b)(6); (b)(7)(C)

Cell/Pager: 7896-4 (b)(6); (b)(7)(C)

ICE Significant Incident Report

Submitted Date and Time of Report: 12/1/2018 1712 EST

Incident Date: 11/30/2018	Incident Time: 1359	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Detention Management Division	Area: Detention Monitoring
Case Number: No Case Involved	Office: EI - FOD MIAMI - MIA	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: (b)(7)(E)	

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: Guerman	First Name: Volkov	Alien ID: 209879518
Date of Birth: 2/16/1962	Country of Birth: Russia	Citizenship: Russia	

Narrative

Report Title: ERO Miami Detainee Death

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Guerman VOLKOV, A209 879 518.

ISSUE:

On November 30, 2018, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) Miami reported the death of ICE detainee Guerman VOLKOV, A209 879 518, a 56-year-old citizen of Russia, at the University of Florida Health Jacksonville (UFHJ) Hospital in Jacksonville, FL. The medical staff pronounced VOLKOV deceased on November 30, 2018, at approximately 1:59 p.m. EST. The official cause of death remains under investigation but is believed to be cardiac related.

Consistent with ICE policy, ERO Miami 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 Headquarters Removal and International Operations Unit (HQ-RIO) provided email notification to the Embassy of the Russian Federation in Washington, D.C., of VOLKOV's death who will, in turn, notify VOLKOV's next of kin.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On November 4, 1998, the Immigration and Naturalization Service admitted VOLKOV into the United States at Miami, FL as a B2 non-immigrant visitor for pleasure with authorization to remain in the United States for a temporary period not to exceed six months. VOLKOV remained in the United States beyond six months without authorization.

On September 8, 1999, the 13th Judicial Circuit Court in Hillsborough County, Tampa, FL convicted VOLKOV of disorderly conduct and sentenced him to time served and court costs.

On February 2, 2000, the 6th Judicial Circuit Court in Pasco County, New Port Richey, FL convicted VOLKOV of driving under the influence (DUI) and sentenced him to nine months' probation and a fine. There is no indication that ERO Miami was notified of this arrest.

On March 18, 2016, the 6th Judicial Circuit Court in Pasco County, New Port Richey, FL convicted VOLKOV for the offense of battery/domestic violence and sentenced him to 38 days confinement and one year of probation. There is no indication that ERO Miami was notified of this arrest.

On May 21, 2017, the 6th Judicial Circuit Court in Pasco County, New Port Richey, FL convicted VOLKOV of battery/domestic violence and sentenced him to 34 days confinement.

On June 26, 2017, ERO Miami encountered VOLKOV at the Pasco County Jail (PCJ) in Land O Lakes, FL, and lodged an Immigration Detainer Notice of Action, Form I-247A on VOLKOV with PCJ.

On June 26, 2017, PCJ released VOLKOV to ERO Miami who detained him at Baker County Detention Center (BCDC) in Macclenny, FL. On the same date, ERO Miami issued VOLKOV a Notice to Appear charging removability pursuant to Section 237(a)(1)(B) of the Immigration and Nationality Act, as a non-immigrant overstay.

On December 15, 2017, an immigration judge (IJ) in Orlando, FL ordered VOLKOV removed from the United States to Russia. VOLKOV reserved appeal but failed to file an appeal by the deadline of January 12, 2018.

On January 29, 2018, ERO Miami submitted an Electronic Travel Document Request (eTD) for VOLKOV with the Embassy of Russia.

On March 20, 2018, ERO Miami completed a 90-day Post Order Custody Review (POCR) and issued a decision to continue VOLKOV's detention pending the issuance of a travel document.

On April 16, 2018, ERO HQ RIO notified ERO Miami that the Embassy of Russia denied VOLKOV issuance of a travel document. Embassy officials stated that someone in Russia with the same name and date of birth had died in 2011, and believed that VOLKOV may be lying about his real name and date of birth.

On May 30, 2018, ERO Miami requested help from the Assistant Attaché for Removal (AAR) covering Russia area of responsibility.

On June 11, 2018, ERO Miami provided the AAR with VOLKOV's fingerprints, which are still pending results from the Russian government.

On June 28, 2018, ERO HQ RIO completed a 180-day POCR and issued a decision to continue VOLKOV's detention in ICE custody.

On September 11, 2018, ERO Miami submitted an HQ transfer checklist to HQ RIO for evaluation of the 270-day POCR.

On September 24, 2018, HQ RIO sent ERO Miami questions to be used during a sworn statement of VOLKOV.

On October 5, 2018, ERO Miami conducted a sworn statement on VOLKOV and provided his answers to HQ RIO.

On November 26, 2018, BCDC security staff found VOLKOV lying supine on the floor speaking slowly. BCDC medical staff responded and escorted VOLKOV to the medical department. VOLKOV appeared pale, diaphoretic with an altered mental state. VOLKOV's vital signs were taken and noted as being abnormal. BCDC transported VOLKOV to the Ed Fraser Memorial Hospital (EFMH) in Macclenny, FL for assessment and treatment.

On the same date, EFMH transferred VOLKOV to the Memorial Hospital in Jacksonville, FL via ambulance for further testing. Subsequently, the medical staff at the Memorial Hospital admitted VOLKOV for further evaluation and treatment for hypovolemia.

On November 28, 2018, staff at the Memorial Hospital in Jacksonville notified the Armor Correctional Medical Unit at BCDC that VOLKOV was refusing all treatment and they were discharging him.

On that same date, the Armor Correctional Medical Unit notified ERO Miami and IHSC that VOLKOV had returned to the BCDC and was being placed on medical observation.

On November 29, 2018, BCDC medical staff evaluated VOLKOV and continued medical observation.

On November 30, 2018, at approximately 11:48 a.m. EST, BCDC medical staff called the Emergency Medical Services (EMS) of Baker County due to VOLKOV experiencing increased abdominal distention, dyspnea, and hypoxia.

At approximately 12:05 p.m. EST, EMS arrived at the BCDC.

At approximately 12:10 p.m. EST, EMS departed the BCDC transporting VOLKOV to the UFHJ.

At approximately 12:59 p.m. EST, EMS arrived at UFHJ.

At approximately 1:11 p.m. EST, hospital staff indicated VOLKOV went into cardiac arrest and staff began cardiopulmonary resuscitation, intubated VOLKOV, and performed advanced cardiac life support.

At approximately 1:59 p.m. EST, hospital staff pronounced VOLKOV deceased.

At approximately 2:04 p.m. EST, BCDC notified ERO Miami of VOLKOV's passing.

At approximately 2:09 p.m. EST, ERO Miami notified ERO Headquarters of VOLKOV's death.

At approximately 2:55 p.m. EST, ERO Miami telephonically notified the Joint Intake Center duty agent of VOLKOV's death.

At approximately 3:21 p.m. EST, HQ-RIO contacted the vice-consul of the Embassy of the Russian Federation and provided notification of VOLKOV's death.

VOLKOV is the third detainee to pass away in ICE custody in fiscal year 2019.

ERO Miami Acting DFOD Joel Mikelson reviewed and approved this SIR.

Violations of Law:

Action Taken:

Other Agencies Notified:

Name	Agency	Phone	Date	Time
none				

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

Locations:

Type	Address	City	State	Zip
Other	1010 McDuff Avenue N	Jacksonville	Florida	32254

Hospital**Narrative:****Hospital Address:** 1010 McDuff Ave N, Jacksonville, FL 32254

Reported to ICE Operations Center via Phone: No

Public Affairs Notified: No - With comments**Comments:**

Reported By:	(b)(6); (b)(7)(C)	Phone: 904-288	(b)(6); (b)(7)(C)	Cell/Pager: 202-3	(b)(6); (b)(7)(C)
Supervisor:		Phone: 407-440		Cell/Pager: 202-5	

ICE Significant Incident Report

Submitted Date and Time of Report: 4/4/2019 1640 EST

Incident Date: 4/3/2019	Incident Time: 0633	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Field Operations Division	Area: Western Operations
Case Number: No Case Involved	Office: X2 - Florence SPC, AZ - FLO	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	☐ Unaccompanied Children		☐ COVID19
☐ Loss or Theft of Firearm or Body Armor	☐ COVID19 Disruptions		

Principal Subject: Person
Date of Birth: 8/5/1964

Last Name: REYES-Clemente
Country of Birth: Mexico

First Name: Abel
Citizenship: Mexico

Alien ID: 215 881 614

Narrative

Report Title: ERO Phoenix - Detainee Death

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Abel REYES-Clemente, A215 881 614.

ISSUE:

On April 3, 2019, ERO Phoenix reported the death of ICE detainee Abel REYES-Clemente, A215 881 614, a 54-year-old citizen of Mexico, at the Florence Service Processing Center (SPC) in Florence, AZ. A doctor at the Mountain Vista Medical Center in Mesa, AZ, pronounced REYES deceased on April 3, 2019, at 6:33 a.m. MST. Medical staff have not yet identified the preliminary cause of death.

Consistent with ICE policy, ERO Phoenix notified the U.S. Department of Homeland Security, Office of Inspector General (OIG), and the ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO Phoenix also provided telephonic notification of REYES' death to the Consulate General of Mexico in Tucson, AZ, who will, in turn, notify REYES' next of kin.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On December 28, 1999, REYES entered the United States at or near Lukeville, AZ, without being admitted or paroled by an immigration officer. On this same date, the U.S. Border Patrol (USBP) arrested REYES at a checkpoint near Ajo, AZ. The USBP granted REYES voluntary return (VR) to Mexico. This was REYES's first VR.

On December 29, 1999, USBP arrested REYES at or near Coverde Wells, AZ. USBP granted REYES VR to Mexico the same day. This was REYES' second VR.

On December 31, 1999, REYES entered the United States at or near Sasabe, AZ, without being admitted or paroled into the United States by an immigration officer. USBP granted REYES VR to Mexico the same day. This was REYES' third VR.

On January 3, 2000, USBP arrested REYES near Arivaca, AZ. USBP granted REYES VR to Mexico the same day. This was REYES' fourth VR.

On April 10, 2000, REYES entered the United States at or near Nogales, AZ, without being admitted or paroled into the United States by an immigration officer. USBP granted REYES VR to Mexico the same day. This was REYES' fifth VR.

On an unknown date, REYES entered the United States at an unknown location, without being admitted or paroled by an immigration officer.

On June 12, 2008, the Peoria Police Department, in Peoria, AZ, arrested REYES for outstanding warrants for assault, disorderly conduct, and prevent/interference from telephoning emergency personnel. On the same date, HSI Phoenix lodged an Immigration Detainer - Notice of Action, Form I-247, against REYES under A086 848 070.

On June 23, 2008, REYES was turned over to ERO Phoenix following his release from the Maricopa County Sheriff's Office (MCSO), Lower Buckeye Jail, in Phoenix, AZ, after MCSO released him on his own recognizance. There is no record of the final disposition for these charges. ERO Phoenix granted REYES VR to Mexico the same day. This was his sixth VR.

On July 4, 2008, REYES entered the United States at or near Nogales, AZ, without being admitted or paroled by an immigration officer. On July 7, 2008, USBP arrested REYES near Nogales, AZ, and granted him VR to Mexico the same day. This was this seventh VR.

On an unknown date, REYES entered the United States at an unknown location, without being admitted or paroled by an immigration officer.

On January 8, 2017, the Phoenix Police Department, in Phoenix, AZ, arrested REYES for driving under the influence (DUI), DUI with blood alcohol content (BAC) of .08 or more, extreme DUI with BAC of .15-.20, and extreme DUI with BAC greater than .20.

On September 19, 2017, the Phoenix Municipal Court, in Phoenix, AZ, convicted REYES of one count of DUI-liquor/drugs, with a sentence of 10 days of incarceration and 36 months of probation; and one count of extreme DUI, with a sentence of 135 days of incarceration and 36 months of probation.

On January 14, 2019, ERO Phoenix encountered REYES at the MCSO, Lower Buckeye Jail, in Phoenix, AZ, after he self-surrendered pursuant to a court order to serve a total of 80 days relating to his September 19, 2017 convictions. On the same date, ERO Phoenix lodged an Immigration Detainer - Notice of Action, Form I-247A, against REYES.

On February 26, 2019, REYES was turned over to ERO Phoenix pursuant to the immigration detainer. ERO Phoenix served REYES with a Notice to Appear, Form I-862, charging him with violating Section 212(a)(6)(A)(i) of the Immigration and Nationality Act, as an alien present in the United States without being admitted or paroled, or who arrived in the United States at any time or place other than as designated by the Attorney General. At the time of his processing, REYES advised processing officers that his medical conditions included diabetes and high blood pressure. Processing officers noted on the Record of a

Deportable/Inadmissible Alien, Form I-213, that REYES did not have medication in his possession.

On February 27, 2019, during his medical intake screening at the Florence Staging Facility, REYES reported to ICE Health Service Corps (IHSC) staff that he took metformin for his diabetes. IHSC staff prescribed and provided REYES metformin the same day.

On February 28, 2019, REYES reported to IHSC staff during his physical examination that he also had high blood pressure. IHSC staff ordered labs and blood pressure checks. IHSC records reflect that REYES' blood pressure was within normal limits.

On March 12, 2019, an immigration judge continued REYES' case with the subsequent immigration hearing scheduled for April 8, 2019.

On April 1, 2019, REYES reported to the medical clinic at the Florence Service Processing Center with flu-like symptoms, fever, chills, sore throat, and a cough. IHSC assessed him and prescribed oseltamivir (Tamiflu) for five days. Asset Protection and Security Services (Asset) contract staff moved REYES to the administrative segregation unit for medical observation as all negative pressure beds were currently occupied. IHSC staff conducted daily checks and temperature checks as part of REYES' treatment plan.

On April 3, 2019, at approximately 6:12 a.m. MST, Asset staff called a medical emergency after discovering REYES was unresponsive and not breathing in his cell. Asset staff immediately began administering cardiopulmonary resuscitation (CPR) to REYES.

At 6:15 a.m. MST, IHSC medical staff responded to the unit and contacted emergency medical services (EMS). IHSC medical staff took over CPR efforts at that time.

At approximately 6:24 a.m. MST, American Medical Response Ambulance and the Florence Fire Department (FFD) arrived on scene. FFD determined that REYES did not have a pulse or heart rhythm.

At approximately 6:33 a.m. MST, FFD paramedics called the Mountain Vista Medical Center in Mesa, AZ, where Dr. Amanda Winter pronounced REYES' time of death at 6:33 a.m. MST.

At approximately 6:40 a.m. MST, ERO Phoenix notified ERO Headquarters, Acting Deputy Assistant Director for Field Operations - West, of REYES' death.

At approximately 7:29 a.m. MST, ERO Phoenix telephonically notified OPR through the JIC.

At approximately 8:03 a.m. MST, ERO Phoenix telephonically notified the OIG duty agent of REYES' death.

At approximately 8:15 a.m. MST, ERO Phoenix notified Vice-Consul Pedro de Velasco of the Consulate General of Mexico in Tucson, AZ, and provided notification of REYES' death telephonically.

REYES is the fourth 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:	
Unaccompanied	
Child Count:	

Locations:

Type	Address	City	State	Zip
Other	3250 North Pinal Parkway	Florence	Arizona	85123

Reported to ICE Operations Center via Phone:

Public Affairs Notified: Yes

Officer Notified: (b)(6); (b)(7)(C)

Date: 4/3/2019

Time: 0700

Comments:

Reported By: (b)(6); (b)(7)(C)

Phone: 520-464-(b)(6); (b)(7)(C)

Cell/Pager: 520-840-(b)(6); (b)(7)(C)

Supervisor:

Phone: 520-864-(b)(6); (b)(7)(C)

Cell/Pager: 520-483-(b)(6); (b)(7)(C)

ICE Significant Incident Report

Submitted Date and Time of Report: 5/4/2019 1120 EST

Incident Date: 5/3/2019	Incident Time: 0158	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Field Operations Division	Area: Western Operations
Case Number: No Case Involved	Office: WX - FOD PHOENIX - PHO	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	☐ Unaccompanied Children		☐ COVID19
☐ Loss or Theft of Firearm or Body Armor	☐ COVID19 Disruptions		

Principal Subject: Person
Date of Birth: 1/29/1998

Last Name: SINGH
Country of Birth: India

First Name: Simratpal
Citizenship: India

Alien ID: 201432202

Narrative

Report Title: ERO Phoenix - Detainee Death

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Simratpal SINGH, A201 432 202.

ISSUE:

On May 3, 2019, U.S. Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO) Phoenix reported the death of ICE detainee Simratpal SINGH, A201 432 202, a 21-year-old citizen of India at the Abrazo West Campus Hospital in Goodyear, AZ. Medical staff at the hospital pronounced SINGH deceased on May 3, 2019, at 1:58 a.m. MST. The medical staff identified the preliminary cause of death as cardiopulmonary arrest caused by a suicide attempt.

Consistent with ICE policy, ERO Phoenix notified the U.S. Department of Homeland Security, Office of Inspector General (OIG), and the ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO Phoenix also provided telephonic notification of SINGH's death to the Consulate General of India in San Francisco, CA, who will, in turn, notify SINGH's next of kin.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On February 5, 2019, the U.S. Border Patrol (USBP) arrested SINGH near Otay Mesa, CA, immediately after his illegal entry into the United States. The USBP served SINGH 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 Nationality Act (INA), as an immigrant not in possession of a valid unexpired immigrant visa, reentry permit, border crossing card, or other valid document required by the INA. On the same date, (b)(3):Unspecified Statute; (b)(7)(E); (b)(3):Unspecified Statute

On February 9, 2019, the USBP turned SINGH over to ERO Phoenix at the San Luis Regional Detention Center.

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

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

On the same date, ERO Phoenix granted SINGH a bond in the amount of \$73,500.

On April 29, 2019, SINGH posted his bond and ERO Phoenix released him from custody.

On April 30, 2019, the La Paz County Sheriff's Office (LPCSO) arrested SINGH near Ehrenberg, AZ for assault and sexual assault. On the same date, LPCSO booked SINGH into the La Paz County Jail.

On May 1, 2019, ERO Phoenix received an ACRIME notification of SINGH's arrest and book-in at the La Paz County Jail. ERO Phoenix lodged an Immigration Detainer - Notice of Action, Form I-247A against SINGH with the facility.

On May 2, 2019, the Quartzsite Justice Court in Quartzsite, AZ granted SINGH a bond in the amount of \$5,000.

On the same date, the Executive Office for Immigration Review (EOIR) in Tucson, AZ scheduled SINGH for a master hearing on May 17, 2019.

On the same date, at approximately 3:45 p.m. MST, La Paz County Jail personnel contacted the ERO Phoenix, Yuma Sub-Office to confirm ICE would take custody of SINGH. ERO Phoenix submitted another Immigration Detainer - Notice of Action, Form I-247A and a Warrant for Arrest of Alien, Form I-200, for SINGH. ERO Phoenix also submitted an Order to Detain, Form I-203A, and made arrangements to transport SINGH to the ERO Yuma Sub-Office the following day for further processing.

At approximately 4:30 p.m. MST, SINGH posted bond in his criminal case and SINGH became an ERO Phoenix detainee at the La Paz County Jail.

At approximately 5:56 p.m. MST, La Paz County Jail personnel called a medical emergency after discovering SINGH in his cell with what appeared to be socks tied around his neck and attached to the bed post. SINGH was lying on the ground unresponsive and not breathing. La Paz County Jail personnel immediately began administering cardiopulmonary resuscitation (CPR).

At approximately 5:59 p.m. MST, La Paz County Jail personnel contacted the Parker, AZ Fire Department (PFD) and River Medical Emergency Medical Services (EMS).

At approximately 6:15 p.m. MST, EMS and PFD personnel arrived on scene and determined that SINGH did not have a pulse or heart rhythm. EMS and PFD personnel took over CPR

efforts at that time.

At approximately 6:20 p.m. MST, EMS transported SINGH via ambulance to the La Paz Regional Hospital in Parker, AZ.

At approximately 6:58 p.m. MST, La Paz Regional Hospital medical staff regained SINGH's pulse and heart rhythm.

At approximately 9:53 p.m. MST, Air Methods Careflight EMS air lifted SINGH to the Abrazo West Campus Hospital in Goodyear, AZ.

At approximately 10:43 p.m. MST, SINGH arrived at Abrazo West Campus Hospital. SINGH arrived in a deep comatose state with a pulse and heartbeat. Shortly after arrival, SINGH experienced sudden cardiac arrest which required life-saving measures. Medical staff were able to resuscitate and re-stabilize SINGH. However, SINGH experienced another sudden cardiac event and despite the best efforts of medical staff, they were unable to resuscitate SINGH.

On May 3, 2019, at approximately 1:58 a.m. MST, the attending physician pronounced SINGH dead at 1:58 a.m. MST.

At approximately 7:46 a.m. MST, ERO Phoenix notified ERO Headquarters, Acting Deputy Assistant Director for Domestic Operations of SINGH's death.

At approximately 8:30 a.m. MST, ERO Phoenix telephonically notified OPR through the JIC.

At approximately 10:00 a.m. MST, ERO Phoenix telephonically notified the OIG duty agent of SINGH's death.

At approximately 10:30 a.m. MST, ERO Phoenix telephonically contacted the Consul General of India in San Francisco, CA and provided notification of SINGH's death.

SINGH is the fifth 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:	
Unaccompanied	
Child Count:	

Locations:

Type	Address	City	State	Zip
Other	7431 E, 30TH STREET, SUITE 2	YUMA	Arizona	85365

Reported to ICE Operations Center via Phone: No

Public Affairs Notified: Yes

Officer Notified: (b)(6); (b)(7)(C)

Date: 5/3/2019

Time: 1000

Comments:

Reported By: (b)(6); (b)(7)(C)

Phone: 928-341-(b)(6); (b)(7)(C)

Cell/Pager: 619-57-(b)(6); (b)(7)(C)

Supervisor:

Phone: (520) 295-(b)(6); (b)(7)(C)

Cell/Pager: 520-25-(b)(6); (b)(7)(C)

ICE Significant Incident Report

Submitted Date and Time of Report: 7/1/2019 1106 EST

Incident Date: 6/30/2019	Incident Time: 0539	Incident Location:
ICE Component: Enforcement & Removal Operations	Division: Detention Management Division	Area: Detention Standards Compliance
Case Number: No Case Involved	Office: XO - FOD HOUSTON	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	☐ Unaccompanied Children		☐ COVID19
☐ Loss or Theft of Firearm or Body Armor	☐ COVID19 Disruptions		

Principal Subject: Person	Last Name: BALDERRAMOS	First Name: Yimi	Alien ID: A206 179 679
Date of Birth: 5/2/1989	Country of Birth: Honduras	Citizenship: Honduras	

Narrative

Report Title: ERO Houston Detainee Death

The message below is distributed on behalf of Executive Associate Director Nathalie R. Asher:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Yimi Alexis BALDERRAMOS-Torres, A206 179 679.

ISSUE:

On June 30, 2019, ICE Enforcement and Removal Operations (ERO) Houston reported the death of ICE detainee Yimi Alexis BALDERRAMOS-Torres a.k.a. Yimi BALDERAMO-Torres, A206 179 679, a 30-year-old citizen of Honduras, at the Memorial Hermann Northeast Hospital (MHNH) in Humble, TX. Medical staff at MHNH pronounced BALDERRAMOS deceased on June 30, 2019, at 6:45 a.m. CDT. The medical staff identified the preliminary cause of death as unknown.

Consistent with ICE policy, ERO Houston notified the DHS Office of Inspector General (OIG), and the ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO Houston also provided telephonic notification of BALDERRAMOS' death to

the Consulate General of Honduras in Houston, TX, who has notified BALDERRAMOS' next of kin.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On July 25, 2013, BALDERRAMOS entered the United States near Hidalgo, TX without inspection, admission or parole by an immigration officer.

On August 5, 2013, the U.S. Border Patrol (USBP) arrested BALDERRAMOS near Falfurrias, TX 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 Nationality Act (INA), as immigrant without an immigrant visa.

On August 9, 2013, the USBP transferred BALDERRAMOS to ERO San Antonio at the Brooks County Jail in Falfurrias, TX.

On August 14, 2013, ERO San Antonio removed BALDERRAMOS from the United States to Honduras.

On May 17, 2019, BALDERRAMOS entered the United States with his minor son Yimi Samuel BALDERRAMOS-Munguia, A203 744 590, a 13-year-old citizen of Honduras, near the Paso Del Norte Bridge in El Paso, TX.

On the same date, the USBP arrested BALDERRAMOS and his son and issued them each a Notice to Appear, Form I-862, charging removability pursuant to section 212(a)(7)(A)(i)(I) of the INA. During processing, BALDERRAMOS claimed that both he and his son held a fear of persecution if returned to Honduras. The USBP returned BALDERRAMOS and his son to Mexico under the Migration Protection Protocol program to await a hearing before an immigration judge scheduled for September 30, 2019.

On or about May 27, 2019, BALDERRAMOS entered the United States near Hidalgo, TX without having been admitted or paroled by an immigration officer. BALDERRAMOS made this entry without his child.

On June 6, 2019, the Montgomery County, TX Sheriff's Office (MCSO) conducted a traffic stop on a vehicle traveling northbound on Interstate 59. The MCSO deputies found BALDERRAMOS along with 10 other individuals in the vehicle. The MCSO suspected that these individuals were being smuggled into the United States and contacted ICE Homeland Security Investigations (HSI). HSI responded and arrested BALDERRAMOS and the other occupants of the vehicle. HSI issued BALDERRAMOS a Notice of Intent/Decision to Reinstate a Prior Order, Form I-871, pursuant to section 241(a)(5). During processing, BALDERRAMOS did not make a claim to having a fear of persecution if returned to Honduras.

On June 7, 2019, HSI transferred BALDERRAMOS to ERO Houston at the Montgomery Processing Center in Conroe, TX. BALDERRAMOS reported no medical issues upon intake.

On June 18, 2019, ERO Houston transferred BALDERRAMOS to the Houston Contract Detention Facility (HCDF) in Houston, TX. ICE Health Service Corps (IHSC) found no derogatory medical information on BALDERRAMOS upon his medical screening.

On June 30, 2019, at approximately 5:38 a.m. CDT, CoreCivic personnel at HCDF discovered BALDERRAMOS lying on his bunk in his dorm unresponsive and not breathing. CoreCivic personnel immediately called a medical emergency. IHSC personnel responded and immediately began administering cardiopulmonary resuscitation (CPR) and administered an automated external defibrillator (AED). CoreCivic personnel contacted emergency medical services (EMS) via a call to 911.

At approximately 5:55 a.m. CDT, Houston Fire Department EMS arrived at the HCDF and relieved IHSC staff performing CPR and continued AED efforts.

At approximately 6:15 a.m. CDT, EMS transported BALDERRAMOS to MHNH via ambulance.

At approximately 6:31 a.m. CDT, CoreCivic personnel notified the ERO Contracting Officer Representative (COR) of the hospital transport.

At approximately 6:37 a.m. CDT, EMS arrived at MHNH .

At approximately 6:39 a.m. CDT, MHNH staff continued CPR on BALDERRAMOS.

At approximately 6:40 a.m. CDT, MHNH staff checked BALDERRAMOS for signs of life.

At approximately 6:41 a.m. CDT, MHNH staff resumed CPR on BALDERRAMOS.

At approximately 6:45 a.m. CDT, the attending physician at MHNH pronounced BALDERRAMOS deceased.

At approximately 7:20a.m. CDT, CoreCivic personnel notified ERO COR of BALDERRAMOS' death.

At approximately 7:32 a.m. CDT, the ERO COR notified ERO Houston of BALDERRAMOS' death.

At approximately 8:09 a.m. CDT, the ERO Houston Field Office Director notified ERO Headquarters, Assistant Director for Field Operations of BALDERRAMOS' death.

At approximately 8:45 a.m. CDT, ERO Houston telephonically contacted the Consulate General of Honduras in Houston, TX and provided notification of BALDERRAMOS' death.

At approximately 9:41 a.m. CDT, ERO Houston telephonically notified OPR through the JIC of BALDERRAMOS' death.

At approximately 9:42 a.m. CDT, ERO Houston telephonically notified the OIG duty agent of BALDERRAMOS' death.

On June 30, 2019, at approximately 11:25 a.m. CDT, the Honduran Consulate notified BALDERRAMOS' next of kin. The Consulate has indicated that the next of kin advised them that BALDERRAMOS' son has returned to Honduras. The consulate is verifying this information.

BALDERRAMOS is the sixth detainee to pass away in ICE custody in fiscal year 2019.

Violations of Law:

Action Taken: Notified chain of command.

Other Agencies Notified:

Name	Agency	Phone	Date	Time
none				

Injuries:	Injuries (Names and Extent of Injury):
Fatalities:	
Damage:	
Unaccompanied	
Child Count:	

Locations:

Type	Address	City	State	Zip
	15850 Export Plaza Ddrive	Houston	Texas	77032

Hospital Narrative: Time of death 0645 CST on June 30, 2018.

Hospital Address: 18951 N Memorial Dr, Humble, TX 77338

Reported to ICE Operations Center via Phone: 6/30/2019 At: 0942 CST - Central Standard Time (GMT-6hrs)

Public Affairs Notified: Yes

Officer Notified: (b)(6); (b)(7)(C)

Date: 6/30/2019

Time: 0755

Comments:

Reported By: (b)(6); (b)(7)(C)

Phone: 281-98 (b)(6);
(b)(7)(C)Cell/Pager: 832-3 (b)(6);
(b)(7)(C)

Supervisor:

Phone: 83243

Cell/Pager: 83243

ICE Significant Incident Report

Submitted Date and Time of Report: 7/25/2019 0925 EST

Incident Date: 7/24/2019	Incident Time: 1510	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	☐ Unaccompanied Children		
☐ Loss or Theft of Firearm or Body Armor			

Principal Subject: Person Last Name: ARRIAGO-Santoya First Name: Pedro Alien ID: 216428457
 Date of Birth: 7/15/1975 Country of Birth: Mexico Citizenship: Mexico

Narrative

Report Title: ERO Atlanta - Detainee Death Notification

The message below is distributed on behalf of Executive Associate Director Nathalie R. Asher:

Pursuant to ICE policy, I am providing notification of the death of an ICE detainee: Pedro ARRIAGO-Santoya, A216 428 457.

ISSUE:

On July 24, 2019, ICE Enforcement and Removal Operations (ERO) Atlanta reported the death of ICE detainee Pedro ARRIAGO-Santoya (a.k.a. Fabian Valdovinos-Salgado, Antonio Valdez-Baldera, Fortino Mendiola, Pedro Santivilla-Arroba, Pedro Santoya, and Pedro Carillo-Santos), A216 428 457, a 44-year-old citizen of Mexico, at the Piedmont Midtown Medical Center (PMMC) in Columbus, GA. Medical staff at PMMC pronounced ARRIAGO deceased on July 24, 2019, at 3:10 p.m. EDT. The medical staff identified the preliminary cause of death as cardio-pulmonary arrest secondary to multi-organ system failure, endocarditis, dilated cardiomyopathy with a low ejection fraction and respiratory failure.

Consistent with ICE policy, ERO Atlanta notified the DHS Office of Inspector General (OIG), and the ICE Office of Professional Responsibility (OPR) via the Joint Intake Center (JIC). ERO Atlanta also provided telephonic notification of ARRIAGO's death to the Consulate General of Mexico in Atlanta, GA. Currently, neither ERO Atlanta nor the Consulate General of Mexico in Atlanta, GA, has identified next of kin for ARRIAGO.

All media inquiries will be referred to the ICE Office of Public Affairs.

BACKGROUND:

On an unknown date and location, ARRIAGO entered the United States without being admitted or paroled after inspection by an immigration official.

AMERICAN
OVERSIGHT

DHS-20-0638-F-000198

2020-ICLI-00057 2256

9/6/2019 9:00:11 AM]

On March 5, 2004, the Okeechobee County, FL, Sheriff's Office arrested ARRIAGO for disorderly intoxication (unknown disposition).

On January 1, 2006, the Suwannee County, FL, Sheriff's Office arrested ARRIAGO for disorderly intoxication (unknown disposition).

On May 14, 2006, the Lafayette County, FL, Sheriff's Office arrested ARRIAGO for grand theft in the first degree.

On February 18, 2013, the Suwannee County, FL, State Attorney's Office dismissed charges of grand theft in the first degree.

On April 21, 2015, the Savannah Chatham County, GA, Metro Police Department arrested ARRIAGO for disorderly conduct.

On May 7, 2015, the Chatham County Recorder's Court in Savannah, GA, convicted ARRIAGO of disorderly conduct and the court sentenced him to time served.

On March 30, 2019, the Appling County, GA, Sheriff's Office arrested

ARRIAGO for public drunkenness and violation of probation in reference to disorderly conduct.

On April 1, 2019, ERO Atlanta encountered ARRIAGO at the Appling County Jail (ACJ) in Baxley, GA. ERO Atlanta issued and served ARRIAGO a Notice to Appear, Form I-862, charging inadmissibility pursuant to Section 212(a)(6)(A)(i) of the Immigration and Nationality Act, as an alien present in the United States without being admitted or paroled by an immigration officer, or who arrived in the United States at any time or place other than as designated by the Attorney General. ERO Atlanta also lodged an Immigration Detainer - Notice of Action, Form I-247, and a Warrant of Arrest of Alien, Form I-200, with the ACJ.

On April 24, 2019, the ACJ released ARRIAGO to ICE custody and ERO Atlanta detained him at the Folkston ICE Processing Center in Folkston, GA.

On April 25, 2019, ERO Atlanta filed Form I-862 with the Atlanta Executive Office for Immigration Review.

On June 6, 2019, an immigration judge ordered ARRIAGO removed to Mexico. ARRIAGO reserved his right to appeal which was due to be filed on or before July 8, 2019.

On July 8, 2019, ARRIAGO failed to file an appeal with the Board of Immigration Appeals.

On July 10, 2019, ERO Atlanta transferred ARRIAGO to the Stewart Detention Center (SDC) for removal processing.

On July 20, 2019, at 12:57 p.m. EDT, Core Civic Medical called a medical emergency due to ARRIAGO's complaints of severe abdominal pain. Core Civic brought ARRIAGO into the triage room and a nurse and a nurse practitioner conducted a medical assessment on him. A physician authorized ARRIAGO to be sent via emergency medical service (EMS) transport to a hospital for evaluation.

At approximately 1:43 p.m. EDT, Core Civic contacted the Stewart County Fire & EMS via 911 to transport ARRIAGO to the Southwest Georgia Regional Hospital (SGRH).

At approximately 1:55 p.m. EDT, EMS arrived at the SDC.

At approximately 2:13 p.m. EDT, EMS departed the SDC for the SGRH.

At approximately 2:45 p.m. EDT, EMS arrived at the SGRH.

At approximately 6:00 p.m., EDT, the SGRH in Cuthbert, GA, admitted ARRIAGO for nausea and stomach pains. ERO Atlanta submitted the required Significant Incident Report for a hospital admission under report number: 2019SIR0013761.

On July 21, 2019, at 1:30 p.m. EDT, the SGRH medical staff transferred ARRIAGO to the PMMC in Columbus, GA for surgery consultation for suspected gall bladder disease.

On July 22, 2019, at 3:57 a.m. EDT, ARRIAGO went into cardiac arrest. The PMMC medical staff performed life saving measures by administering three rounds of epinephrine. The PMMC medical staff performed cardiopulmonary resuscitation (CPR) using an Automated External Defibrillator. Once ARRIAGO had normal system rhythm with a pulse, medical staff placed a ventilator on ARRIAGO and maintained his fraction of inspired oxygen (FiO2) level at 100%. PMMC placed ARRIAGO in the intensive care unit under medical care where he remained intubated, on mechanical ventilation, and comatose. PMMC placed ARRIAGO on three different types of medication to maintain his blood pressure. Core Civic officers from SDC maintained security and custody of ARRIAGO during his admission to the medical care facility.

On July 22, 2019, ERO Atlanta contacted the Consulate General of Mexico in Atlanta, GA, to notify them of ARRIAGO's condition and to seek assistance in locating next of kin.

On July 24, 2019, at approximately 2:40 p.m. EDT, ARRIAGO again went into cardiac arrest and the PMMC staff initiated CPR.

At approximately 3:10 p.m. EDT, the attending physician at PMMC pronounced ARRIAGO deceased.

At approximately 3:15 p.m. EDT, Core Civic personnel notified ERO Atlanta of ARRIAGO's death.

At approximately 3:18 p.m. EDT, the ERO Atlanta Field Office Director notified ERO Headquarters, Assistant Director for Field Operations of ARRIAGO's death.

At approximately 3:35 p.m. EDT, ERO Atlanta telephonically notified OPR through the JIC of ARRIAGO's death.

At approximately 3:39 p.m. EDT, ERO Atlanta telephonically contacted the Consulate General of Mexico in Atlanta, GA, and provided notification of ARRIAGO's death.

At approximately 4:30 p.m. EDT, ERO Atlanta telephonically notified the OIG duty agent of ARRIAGO's death.

AMERICAN
OVERSIGHT

DHS-20-0638-F-000199

At approximately 5:10 p.m. EDT, the PMMC notified the Muscogee County Coroner and the Columbus Police Department.

ARRIAGO is the seventh 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:
Unaccompanied
Child Count:

Locations:

Type	Address	City	State	Zip
Other	146 CCA Road	Lumpkin	Georgia	31815

Hospital Narrative:

Hospital Address: 710 Center St
Columbus, GA 31901

Reported to ICE Operations Center via Phone: 7/24/2019 At: 1535 EST - Eastern Standard Time (GMT-5hrs)

Public Affairs Notified: Yes

Officer Notified (b)(6); (b)(7)(C) Date: 7/24/2019 Time: 1536

Comments:

Reported By (b)(6); (b)(7)(C) Phone: 229838 (b)(6); (b)(7)(C) Cell/Pager: 229724 (b)(6); (b)(7)(C)
Supervisor: f Phone: 229-83 (b)(7)(C) Cell/Pager: 229-32 (b)(7)(C)



U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: ESCOBAR Mejia, Carlos Ernesto

General Demographic/Background Information

- **Date of Birth:** May 27, 1962
- **Date of Death:** May 6, 2020
- **Age:** 57
- **Gender:** Male
- **Country of Citizenship:** El Salvador
- **Marital Status:** Single
- **Children:** N/A

Immigration History

- On February 2, 2012, U.S. Immigration and Customs Enforcement (ICE) received notification of Mr. ESCOBAR's arrest in Los Angeles, California (CA) and lodged an Immigration Detainer (Form I-247) with the Los Angeles Sheriff's Department (LASD).
- On March 28, 2012, an ICE Enforcement and Removal Operations (ERO) officer assigned to the Criminal Alien Program took custody of Mr. ESCOBAR from the LASD. On the same date, ERO Los Angeles served Mr. ESCOBAR a Notice to Appear (Form I-862) and transferred Mr. ESCOBAR to the Adelanto ICE Processing Center in Adelanto, CA.
- On June 4, 2012, Mr. ESCOBAR posted bond and was released from ICE custody.
- On January 3, 2020, the U.S. Border Patrol (USBP) encountered and arrested Mr. ESCOBAR near Campo, CA, on suspicion of smuggling aliens.
- On January 10, 2020, ERO San Diego took custody of Mr. ESCOBAR and transferred him to the Otay Mesa Detention Center (OMDC) in San Diego, CA.

Criminal History

- On October 24, 1989, Mr. ESCOBAR was convicted of Grand Theft, in violation of Section 487.3 of the California Penal Code (CA PC), and was sentenced to 60 days in jail.
- On December 5, 1989, Mr. ESCOBAR was convicted of Possession of a Controlled Substance, in violation of Section 11350(A) of the California Health and Safety Code, and was sentenced to 110 days in jail.
- On May 30, 1990, Mr. ESCOBAR was convicted of Receiving Known Stolen Property, in violation of Section 496.1 of the CA PC, and was sentenced to 365 days in jail.
- On August 17, 1993, Mr. ESCOBAR was convicted of Driving Under the Influence, in violation of Section 23152(B) of the California Vehicle Code, and was sentenced to 20 days in jail.
- On February 2, 2012, the LASD arrested Mr. ESCOBAR for possession of a controlled substance.

Medical History

OMDC Medical Records

- **On January 10, 2020**, a registered nurse (RN) completed Mr. ESCOBAR's pre-screening and intake screening, and noted a history of hypertension (HTN), type II insulin dependent diabetes mellitus (T2DM), Vitamin D deficiency, hypercholesterolemia (elevated cholesterol level), and



surgical amputation of his right foot three months prior to detention due to T2DM complications. The RN issued Mr. ESCOBAR a wheelchair to aid his mobility, and scheduled a complex physical exam.

- **On January 11, 2020**, an advanced practice provider (APP) completed Mr. ESCOBAR's physical exam, prescribed Mr. ESCOBAR medications to treat his HTN, T2DM, and hyperlipidemia (elevated lipids in the blood), and ordered laboratory testing. The APP also scheduled a follow-up visit in two weeks.
- **From January 12 to April 20, 2020**, OMDC medical, dental, and nursing staff routinely evaluated Mr. ESCOBAR, including a referral to a prosthetic clinic for an evaluation and fitting of a right foot prosthesis.
- **On April 21, 2020**, an APP evaluated Mr. ESCOBAR for complaints of chills, cough, sore throat, and shortness of breath for several days. The APP did not identify abnormal findings, diagnosed a viral infection, and ordered a SARS-CoV-2, NAA (COVID-19 test).
- **On April 24, 2020**, OMDC received positive results on Mr. ESCOBAR's COVID-19 test and reassigned him to a designated housing unit for patients with positive COVID-19.
 - An RN assessed Mr. ESCOBAR noting a temperature (T) of 98.7 degrees Fahrenheit (F), pulse (P) of 106 beats per minute (bpm), respiratory rate (R) of 22 breaths/minute, blood pressure (BP) of 130/94 millimeters of mercury (mmHG), and oxygen saturation (SpO2) of 90 percent (%).
 - On examination, the RN documented sore throat, fatigue, assistance needed with ambulation, shortness of breath with exertion, skin warm and dry to touch, positive non-productive cough, and his SpO2 did not improve with activity or deep breaths.
 - The RN notified the APP on duty and obtained orders to transfer Mr. ESCOBAR, via emergency medical services (EMS), to the Paradise Valley Hospital (PVH) emergency department (ED) for evaluation. The RN placed Mr. ESCOBAR in a wheelchair, administered oxygen (six liters/minute via face mask), and his SpO2 level improved from 90% to 96%.
 - EMS personnel assumed care upon their arrival to OMDC. Mr. ESCOBAR's disposition was calm, cooperative, conversing with staff, alert, and oriented prior to departure.
 - Per OMDC's hospital update, PVH admitted Mr. ESCOBAR as an inpatient with diagnoses of T2DM, HTN, COVID-19 infection, and pneumonia.
- **From April 24 to April 26, 2020**, PVH assigned Mr. ESCOBAR to a regular room and initiated treatment for each of his admitting diagnoses with no appreciable changes in his condition.
- **On April 27, 2020**, PVH transferred Mr. ESCOBAR to the intensive care unit due to Mr. ESCOBAR becoming increasingly hypoxic, an increased respiratory rate (33 breaths/minute), and a decreased SpO2 level of 87%.
- **On April 28, 2020**, Mr. ESCOBAR experienced hypotension (low BP) and his respiratory rate averaged 26 breaths/minute. As a result, Mr. ESCOBAR was sedated and placed on a mechanical ventilator. Hospital staff inserted two central venous catheters and initiated hemodialysis (mechanical filtering of waste products from the blood).
- **On April 29, 2020**, Mr. ESCOBAR developed a pneumothorax (collapsed lung) and a chest tube was inserted to aid breathing. Although Mr. ESCOBAR was aggressively treated, his condition continued to worsen.
- **On April 30, 2020**, PVH physicians continued his current treatments and ICE ERO notified Mr. ESCOBAR's family of his health status.



U.S. Immigration and Customs Enforcement
Enforcement and Removal Operations

- **On May 2, 2020**, PVH decreased Mr. ESCOBAR's sedation to assess his cognition and noted he remained unresponsive. Mr. ESCOBAR received a feeding tube to provide nutritional supplementation.
- **On May 3, 2020**, Mr. ESCOBAR's condition continued to deteriorate.
- **From May 4 to May 5, 2020**, Mr. ESCOBAR's condition remained unchanged.

Synopsis of Death

- **On May 6, 2020**, PVH's physician pronounced Mr. ESCOBAR dead at 2:15 a.m., PST. The preliminary cause of death is complications due to COVID-19.



**U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: HERNANDEZ Diaz, Roylan**

General Demographic/Background Information

- **Date of Birth:** September 25, 1976
- **Date of Death:** October 15, 2019
- **Age:** 43
- **Gender:** Male
- **Country of Citizenship:** Cuba
- **Marital Status:** Single
- **Children:** N/A

Immigration History

- On May 18, 2019, Mr. HERNANDEZ applied for admission at the El Paso, Texas (TX), Paso Del Norte Port of Entry. U.S. Customs and Border Patrol (CBP) served Mr. HERNANDEZ with a Notice and Order of Expedited Removal, Form I-860, based on his inadmissibility under section 212(a)(7)(A)(i)(I) of the Immigration and Nationality Act.
- On May 20, 2019, CBP transferred Mr. HERNANDEZ into ICE Enforcement and Removal Operations (ERO) custody at the El Paso Service Processing Center in El Paso, TX.
- From May 21 to 23, 2019, Mr. HERNANDEZ was housed at the West Texas Detention Facility (WTDF) in Sierra Blanca, TX, before being transferred to the Tallahatchie County Correctional Facility (TCCF) in Tutwiler, Mississippi (MS). Mr. HERNANDEZ remained at TCCF until his transfer to Richwood Correctional Center (RCC) in Monroe, LA, on June 13, 2019.

Criminal History

- N/A

Medical History

El Paso Service Processing Center, El Paso, TX

- On May 20, 2019, Mr. HERNANDEZ arrived and was processed at the El Paso Service Processing Center before transferring to WTDF.

West Texas Detention Facility, Sierra Blanca, TX

- From May 21 to 22, 2019, ERO housed Mr. HERNANDEZ at WTDF. His intake screening at WTDF was unremarkable, except for his reported history of irritable bowel syndrome (IBS), which was being treated with ondansetron, 4 milligram (mg) tablet, three times a day and lacinex, one tablet each morning. On May 22, 2019, a registered nurse (RN) evaluated Mr. HERNANDEZ in a nursing sick call for abdominal pain, and treated him with acetaminophen 500 mg tablet, one tablet three times a day or as needed for pain; simethicone, two 80 mg tablets, twice a day or as needed for abdominal distention/gas; and sodium bicarbonate, two 650 mg tablets twice a day.

Tallahatchie County Correctional Facility, Tutwiler, MS



- From May 23 to June 12, 2019, ERO housed Mr. HERNANDEZ at TCCF. While at TCCF, his intake screening, mental health evaluation, and physical exam were unremarkable, except for his reported history of IBS. TCCF continued Mr. HERNANDEZ' medications for IBS until he was transferred to RCC on June 13, 2019.

Richwood Correctional Center, Monroe, LA

- **On June 13, 2019:**
 - At 11:05 a.m., an RN evaluated Mr. HERNANDEZ and cleared him for placement in the general population.
 - At 2:05 p.m., an advanced practice provider (APP) completed Mr. HERNANDEZ' mental health screening and documented normal findings, except for a history of physical abuse in Cuba. Mr. HERNANDEZ reportedly refused a mental health referral.
 - At 2:15 p.m., a medical doctor (MD) completed Mr. HERNANDEZ' intake screening and reviewed his accompanying TCCF transfer summary. The transfer summary indicated Mr. HERNANDEZ had IBS as well as recent mumps exposure and ongoing cohort status until June 26, 2019. The summary also stated that Mr. HERNANDEZ was taking dicyclomine (10 milligrams [mg], by mouth, two times daily) and senna glycoside (8.6 mg, two tablets, by mouth, at bedtime). The MD completed Mr. HERNANDEZ' physical exam and documented normal findings except for left lower abdominal tenderness consistent with IBS. The MD continued Mr. HERNANDEZ' medications and cleared him for placement in general population.
- **On June 18, 2019**, Mr. HERNANDEZ submitted a sick call request for abdominal pain unrelieved with his current medications.
- **On June 19, 2019**, an RN attempted to evaluate Mr. HERNANDEZ for his abdominal pain, but he refused the evaluation and refused to sign the refusal of care form. The RN also reported that Mr. HERNANDEZ had refused six consecutive meals and refused his medications for two days.
- **On June 20, 2019**, after Mr. HERNANDEZ was observed to have missed nine consecutive meals, an RN completed Mr. HERNANDEZ' pre-segregation health evaluation prior to placement in administrative segregation for hunger strike monitoring.
- **On June 21, 2019:**
 - An RN evaluated Mr. HERNANDEZ and documented his blood pressure and his pulse. The RN observed Mr. HERNANDEZ drinking two cups of juice and gave him a bottle of Ensure (nutritional supplement).
 - A licensed practical nurse (LPN) evaluated Mr. HERNANDEZ during segregation rounds, including checking his vital signs and weight and collecting a urine specimen for analysis. The LPN documented Mr. HERNANDEZ' intake of an eight-ounce bottle of Ensure, and consumption of 25 – 30 percent of his lunch.
 - An MD evaluated Mr. HERNANDEZ during segregation rounds, documented normal exam findings except for left lower abdominal tenderness, diagnosed Mr. HERNANDEZ with IBS and depression (not suicidal), ordered him a bland diet, and discharged him to general population.
 - An LPN spoke to an APP, who approved Mr. HERNANDEZ to remain in the segregation unit over the weekend for continued food and fluid intake monitoring.
- **On June 23, 2019**, an LPN documented that Mr. HERNANDEZ refused his medications (dicyclomine and senna glycoside) and refused to sign a refusal form.



- **On June 24, 2019**, an MD evaluated Mr. HERNANDEZ for his dietary complaints. The MD documented normal exam findings, except for a high blood pressure (BP) reading of 160/85 mmHg. The MD ordered Mr. HERNANDEZ a bland diet, psyllium fiber powder laxative, and to recheck his BP.
- **On June 30, 2019**, an LPN administered Mr. HERNANDEZ a measles, mumps, and rubella vaccination.
- **On July 5, 2019:**
 - Mr. HERNANDEZ submitted a sick call request for an MD/APP evaluation because he thought the dicyclomine was worsening his symptoms.
 - An MD evaluated Mr. HERNANDEZ and documented the following findings: abdomen soft and non-tender to palpation. The MD diagnosed Mr. HERNANDEZ with “chronic worry about colon cancer and inflamed colon,” discontinued his dicyclomine, and ordered stool testing.
- **On August 6, 2019**, an RN evaluated Mr. HERNANDEZ during sick call for persistent abdominal pain that he rated 7/10 and for his request to change dicyclomine to an alternative treatment. The RN documented normal vital signs and referred Mr. HERNANDEZ to the MD/APP for further evaluation.
- **On August 8, 2019**, an APP evaluated Mr. HERNANDEZ, documented normal findings, diagnosed him with abdominal pain, again ordered stool testing, and scheduled Mr. HERNANDEZ for a follow-up appointment. The stool testing yielded normal results.
- **On August 26, 2019**, an APP completed Mr. HERNANDEZ’ scheduled follow-up visit, documented normal exam findings except for left lower abdominal tenderness, and diagnosed him with chronic IBS. The APP discontinued the senna glycoside medication, ordered pinaverium bromide (one tablet, by mouth, two times daily), instructed Mr. HERNANDEZ to follow up as needed, and recommended a referral to the mental health provider. Mr. HERNANDEZ refused the mental health referral, and the APP instead provided education on stress relieving techniques.
- **On September 4, 2019**, an RN triaged Mr. HERNANDEZ’ sick call request for a mental health consult and submitted a referral to mental health.
- **On September 10, 2019**, an LPN evaluated Mr. HERNANDEZ during sick call for persistent abdominal pain since the discontinuation of his senna glycoside medication, and as a result of his failure to take the pinaverium bromide medication as prescribed. The LPN referred him to the MD/APP for further evaluation.
- **On September 13, 2019**, an MD evaluated Mr. HERNANDEZ for his complaint of persistent abdominal pain. The MD documented normal exam findings and vital signs except for tenderness to the lower half of Mr. HERNANDEZ’ abdomen. The MD diagnosed Mr. HERNANDEZ with chronic constipation and abdominal pain, discontinued the pinaverium bromide medication, and re-prescribed senna glycoside.
- **On September 14, 2019**, Mr. HERNANDEZ refused his mental health appointment and an RN obtained a signed refusal.
- **On October 10, 2019**, an RN completed Mr. HERNANDEZ’ pre-segregation health evaluation for threatening a hunger strike. Mr. HERNANDEZ refused his vital signs and weight assessment. The RN documented a normal physical and mental health assessment, except for a withdrawn emotional state, and cleared Mr. HERNANDEZ for administrative segregation housing placement.



- **On October 11, 2019**, an RN noted Mr. HERNANDEZ refused his vital signs check, did not report any complaints, and did not appear in distress.
- **On October 12, 2019**, an RN documented Mr. HERNANDEZ did not voice any complaints or requests and appeared stable. Security staff confirmed Mr. HERNANDEZ ate dinner the previous night (October 11, 2019) and his morning breakfast.
- **On October 13, 2019**, an RN noted Mr. HERNANDEZ was resting, not in any distress, and responsive to verbal stimuli, but was non-communicative with staff. An unknown author documented Mr. HERNANDEZ refused lunch and dinner on October 12, 2019, and all three meals on October 13, 2019.
- **On October 14, 2019**, an RN documented Mr. HERNANDEZ was awake, alert, oriented, and did not appear in distress. Mr. HERNANDEZ refused his vital signs assessment and refused to sign the hunger strike treatment consent form.

Synopsis of Death

- **On October 15, 2019:**
 - At 12:00 p.m., an RN documented Mr. HERNANDEZ refused his breakfast, lunch, medical assessment, shower, and blood work for laboratory testing. The RN notified ERO and ICE Health Service Corps that Mr. HERNANDEZ had missed 10 consecutive meals.
 - At 1:55 p.m., a security officer completed segregation rounds.
 - At 2:04 p.m., a security captain walked by Mr. HERNANDEZ' cell, smelled an odor, looked through the cell door window, but did not see Mr. HERNANDEZ.
 - At 2:05 p.m., the security captain returned to Mr. HERNANDEZ' cell, opened the door, and found Mr. HERNANDEZ hanging unresponsive from his bunk. Via radio transmission, the captain requested his supervisor and the warden to respond to Mr. HERNANDEZ' cell.
 - At 2:14 p.m., the warden instructed the captain to call for an ambulance and announced a medical emergency. Medical staff responded, found Mr. HERNANDEZ hanging by a sheet, unresponsive, and pulseless.
 - At 2:20 p.m., emergency medical services (EMS) arrived, cut down Mr. HERNANDEZ, and performed vital signs checks and cardiac monitoring. Mr. HERNANDEZ did not have electrical activity in his heart and his vital signs were unobtainable, thus EMS did not initiate CPR.
 - At 2:30 p.m., the Ouachita Parish Sheriff's Department was notified.
 - At 3:09 p.m., the Sheriff's Deputies arrived, completed their investigation, and notified the coroner's office. The deputy coroner arrived and pronounced Mr. HERNANDEZ deceased at an unknown time.
- On November 7, 2019, the State of Louisiana issued Mr. HERNANDEZ' death certificate documenting hanging as the cause of death.



U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: HERNANDEZ Ibarra, Ramiro

General Demographic/Background Information

- **Date of Birth:** March 11, 1978
- **Date of Death:** March 21, 2020
- **Age:** 42
- **Gender:** Male
- **Country of Citizenship:** Mexico
- **Marital Status:** Married
- **Children:** N/A

Immigration History

- On June 23, 1999; June 27, 1999; July 3, 2000; May 7, 2001; and May 12, 2001; the U.S. Border Patrol (USBP) encountered and arrested Mr. HERNANDEZ after illegally entering the United States via the Mexico-Texas border. Each time, USBP granted him a voluntary return (VR) to Mexico.
- On December 30, 2003, USBP encountered Mr. HERNANDEZ at the Hidalgo County Jail (HCJ) in Edinburg, Texas (TX), and lodged an I-247 (Immigration Detainer – Notice of Action). USBP took custody of Mr. HERNANDEZ and granted him a VR to Mexico on December 31, 2003.
- On May 7, 2010, USBP apprehended Mr. HERNANDEZ near McAllen, TX and issued him a form I-862 (Notice to Appear). An immigration judge granted Mr. HERNANDEZ a Voluntary Departure on June 8, 2010, and Enforcement and Removal Operations (ERO) San Antonio witnessed his return to Mexico on June 9, 2010.
- On December 21, 2019, ERO San Antonio encountered Mr. HERNANDEZ at HCJ, served him with form I-862 (Notice to Appear), and lodged an I-247 (Immigration Detainer – Notice of Action) with HCJ.
- On January 15, 2020, HCJ released Mr. HERNANDEZ to ERO San Antonio. ERO served Mr. HERNANDEZ with form I-200 (Warrant for Arrest of Alien) and transferred him to Port Isabel Detention Center (PIDC) for housing.

Criminal History

- On October 29, 2003, the Texas Department of Public Safety arrested Mr. HERNANDEZ on charges of driving while intoxicated (DWI). Mr. HERNANDEZ was convicted and imposed a sentence of 30 days of confinement.
- On December 20, 2019, Hidalgo County Sheriff's Office arrested Mr. HERNANDEZ on charges of assault, which caused bodily injury to a family member. He was convicted on January 14, 2020, and imposed a sentence of 24 days of confinement (time served).

Medical History

PIDC Medical Records

- **On January 15, 2020**, a licensed vocational nurse (LVN) completed Mr. HERNANDEZ's medical intake screening. Mr. HERNANDEZ reported a history of diabetes, hypertension (HTN), and taking medications, but was unable to recall the names of the medications. Mr.



HERNANDEZ denied any pain, discomfort, mental health or suicide history. The LVN referred Mr. HERNANDEZ to a medical provider for evaluation of his chronic medical history.

- **On January 16, 2020**, an advanced practice provider (APP) completed Mr. HERNANDEZ's physical examination. Mr. HERNANDEZ reported a five-year history of diabetes and HTN, taking metformin (anti-diabetic medication), but again unable to recall the name of his HTN medication. The APP prescribed Mr. HERNANDEZ's medication and ordered an electrocardiogram (ECG) and laboratory tests.
- **On February 7, 2020**, an APP evaluated Mr. HERNANDEZ during a chronic care appointment and reviewed his laboratory results, which were normal except for elevated lipids, glucose, hemoglobin A1C, and trace protein and ketones in his urine. Mr. HERNANDEZ complained of left flank pain, reported past kidney issues, and not drinking water. The APP prescribed atorvastatin (treats elevated cholesterol and triglyceride levels) 10 mg, one tablet by mouth, daily; Pedialyte; and instructed him to increase his water intake.
- **On February 13, 2020**, a registered nurse (RN) evaluated Mr. HERNANDEZ for acute left flank pain, radiating to his lower back. Mr. HERNANDEZ reported a history of kidney disease, taking medications, and admitted to limited water intake. Mr. HERNANDEZ requested over the counter medication for pain. The RN referred Mr. HERNANDEZ to a provider for further evaluation.
- **On February 15, 2020**, an APP evaluated Mr. HERNANDEZ for left flank pain. Mr. HERNANDEZ reported a history of kidney problems, gastritis (inflammation in the stomach lining), and decreased water intake. A urine dipstick showed positive ketones and proteins in his urine. The APP noted positive left flank tenderness and prescribed and ordered the following: ibuprofen (pain medication), tamsulosin (used to treat urine retention), omeprazole (treats heartburn), Pedialyte, sliding scale insulin, and additional laboratory studies, including a urine culture.
- **On February 17, 2020**, an RN evaluated Mr. HERNANDEZ for left flank pain, radiating to his lower back. Mr. HERNANDEZ reported pain with ambulation, movement, and no relief with pain medication. The RN noted Mr. HERNANDEZ had difficulty ambulating, notified the on-call provider, and received an order to transfer Mr. HERNANDEZ to Valley Baptist Medical Center (VBMC) emergency department (ED) in Harlingen, TX, via emergency medical services (EMS) for evaluation.
- **On February 18, 2020**, at approximately 1:52 a.m., a VBMC medical doctor (MD) discharged Mr. HERNANDEZ with a diagnosis of low back pain and a urinary tract infection on the following medications: cephalexin (antibiotic), cyclobenzaprine (muscle relaxer), and ibuprofen.
 - At approximately 4:50 a.m., an RN evaluated Mr. HERNANDEZ after he returned to the facility, reviewed his VBMC ED discharge summary, and contacted the on-call provider. An APP issued a telephonic order for sulfamethoxazole/trimethoprim (antibiotic), ibuprofen for pain, and to house Mr. HERNANDEZ in the medical housing unit (MHU) for observation.
 - At approximately 2:26 p.m., an APP evaluated Mr. HERNANDEZ in the MHU. Mr. HERNANDEZ requested to return to the dorms with self-administered medications versus pill line administration due to difficulty ambulating. He denied back pain, dysuria, hematuria, chills, or sweats. The APP discharged Mr. HERNANDEZ from the MHU with keep on person medications.



- **On March 18, 2020**, an RN evaluated Mr. HERNANDEZ for nausea and vomiting. Mr. HERNANDEZ reported he last ate a bag of Hot Cheetos, had diarrhea, and denied other symptoms. He admitted to metformin non-compliance and had not taken it for the past few days. The RN noted normal vital signs, except for a slightly elevated heart rate of 109 beats per minute (bpm) (normal 60 – 100 bpm) and an elevated blood sugar of 205 mg/dl (normal 60 – 100 mg/dl). The RN notified the on-call provider, received telephone orders for an MHU admission, ondansetron (treats nausea and vomiting) 8 mg, by mouth, as needed, and to provide a promethazine injection (treats nausea and vomiting) 25 mg, intramuscular now, and to encourage oral hydration.
- **On March 19, 2020**, at approximately 5:25 a.m., while viewing the video monitor, an RN observed Mr. HERNANDEZ fall while going to the bathroom. The RN noted normal vital signs, except for a slightly elevated BP (140/82), and no injuries. The RN notified the on-call provider, received a telephone order to notify EMS, and to transfer Mr. HERNANDEZ to VBMC.
 - At approximately 5:45 a.m., EMS personnel arrived, noted Mr. HERNANDEZ as alert and oriented with flank and lower back pain, and transported him to VBMC ED.
 - At approximately 6:30 a.m., VBMC ED personnel evaluated Mr. HERNANDEZ and admitted him for hypotension (low blood pressure).
 - At approximately 8:10 a.m., during a daily hospital update, a PIDC RN provided Mr. HERNANDEZ's keep on person medication list, and noted empty bottles of metformin, lisinopril, and ibuprofen.
 - At approximately 10:50 a.m., a VBMC RN reported that Mr. HERNANDEZ was hypotensive (84/55), hypothermic (rectal temperature of 88.6), confused, sedated, intubated, and pending transfer to the intensive care unit (ICU). The RN also reported that Mr. HERNANDEZ was on antibiotics and vasopressors (anti-hypotensive drugs).
 - At approximately 4:12 p.m., VBMC transferred Mr. HERNANDEZ to ICU.
 - At approximately 6:42 p.m., a VBMC MD ordered emergent dialysis for Mr. HERNANDEZ due to acute kidney failure.
- **On March 20, 2020**, at approximately 1:15 a.m., a VBMC RN reported Mr. HERNANDEZ's condition had improved with increased BP readings; however, he remained on antibiotics, epinephrine (for blood pressure support), and received dialysis.
 - At approximately 5:15 a.m., a VBMC RN reported Mr. HERNANDEZ's condition was worsening.
 - At approximately 9:15 a.m., a VBMC RN reported Mr. HERNANDEZ remained in critical condition, unresponsive, in kidney failure, and death was imminent. The RN stated his diagnosis was related to a suspected metformin overdose.
 - At approximately 1:15 p.m., a VBMC RN reported Mr. HERNANDEZ remained in critical condition, unresponsive, in kidney failure, currently receiving dialysis, and on ventilatory (breathing) support.
 - At approximately 4:20 p.m., a VBMC MD notified ICE Health Service Corps (IHSC) that Mr. HERNANDZ was in organ failure and advised them to contact his next of kin. Mr. HERNANDEZ remained unresponsive in ICU.
 - At approximately 5:30 p.m., Mr. HERNANDEZ's wife invoked a do not resuscitate order.

Synopsis of Death



- **On March 21, 2020**, at approximately 12:30 a.m., a VBMC RN reported Mr. HERNANDEZ remained unresponsive in critical condition, his condition was worsening, and he was no longer tolerating dialysis treatments.
 - At approximately 4:30 a.m., a VBMC RN reported Mr. HERNANDEZ's condition continued to deteriorate.
 - At approximately 5:46 a.m., Mr. HERNANDEZ expired on ventilatory support and a VBMC MD pronounced Mr. HERNANDEZ dead.
 - ICE requested an autopsy from the county medical examiner and an independent medical examiner, but the requests were denied.



U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: HERNANDEZ-Colula, David

General Demographic/Background Information

- **Date of Birth:** January 23, 1986
- **Date of Death:** February 20, 2020
- **Age:** 34
- **Gender:** Male
- **Country of Citizenship:** Mexico
- **Marital Status:** Married
- **Children:** Yes (3)

Immigration History

- On December 4, 2014, the U.S. Border Patrol (BP) encountered Mr. HERNANDEZ-Colula while conducting transportation check duties in Rochester, New York (NY). HERNANDEZ-Colula was arrested for being illegally present in the United States and transported to the Rochester Border Patrol Station for further interview and processing. He was then processed for removal proceedings, served with Forms I-862, I-200, I-286, and I-826, and detained at the Buffalo Federal Detention Facility in Batavia, NY.
- On December 8, 2014, HERNANDEZ-Colula was released on bond.
- On December 5, 2019, the Pacific Enforcement Response Center in Laguna Niguel, California, lodged an Immigration Detainer – Notice of Action for Mr. HERNANDEZ-Colula.
- On December 6, 2019, ICE Enforcement and Removal Operations (ERO) in Detroit, Michigan (MI), arrested Mr. HERNANDEZ-Colula upon his release from St. Joseph County Jail (SJCJ), and booked him in to ICE custody at the Calhoun County Jail (CCJ) in Battle Creek, MI.
- On December 10, 2019, ERO transferred Mr. HERNANDEZ-Colula to the Northeast Ohio Correctional Center (NEOCC).

Criminal History

- On December 4, 2019, Sturgis Police Department in Sturgis, MI, encountered Mr. HERNANDEZ-Colula during a civil dispute with his spouse, arrested him for an outstanding warrant for domestic assault, and booked him in to SJCJ in Centerville, MI.

Medical History

CCJ Medical Records

- **On December 6, 2019**, a CCJ custody officer completed Mr. HERNANDEZ-Colula's intake screening; he denied any medical or mental health concerns. A nurse reviewed and signed the intake screening. Mr. HERNANDEZ-Colula did not seek any further medical care while at CCJ.

NEOCC Medical Records

- **On December 10, 2019**, a licensed practical nurse (LPN) completed Mr. HERNANDEZ-Colula's intake screening; he denied any medical or mental health concerns. The LPN submitted routine referrals to a medical provider, dentist, and mental health provider (MHP).
- **On December 11, 2019**, an MHP completed Mr. HERNANDEZ-Colula's mental health evaluation; he denied any current mental health concerns.



- **On December 12, 2019**, at approximately 12:20 a.m., a custody officer called a medical emergency after finding Mr. HERNANDEZ-Colula with a blanket tied around his neck. An LPN responded, assessed Mr. HERNANDEZ-Colula, and contacted the psychiatrist. The psychiatrist ordered Mr. HERNANDEZ-Colula be placed on one-on-one suicide “constant watch” and ordered a follow-up appointment with an MHP.
- **On December 13, 2019**, an MHP evaluated Mr. HERNANDEZ-Colula, who claimed that he had a panic attack the previous day but denied further thoughts of self-harm. The MHP completed a suicide risk assessment, recommended continuation of constant observation, and scheduled a follow-up appointment for December 16, 2019.
- **Between December 14 and 16, 2019**, in addition to constant observation as ordered, the NEOCC nursing staff completed twice-daily mental health nursing checks for Mr. HERNANDEZ-Colula, who denied further thoughts of self-harm.
- **On December 16, 2019**, an MHP evaluated Mr. HERNANDEZ-Colula, completed a suicide risk assessment, found he presented without risk factors, and recommended discontinuing his constant observation and that he return to general population. The MHP notified the psychiatrist, who agreed with the recommendation.
- **Between December 16 and 20, 2019**, while in general population, the MHP conducted daily visits with Mr. HERNANDEZ-Colula.
- **On January 3, 2020**, an MHP evaluated Mr. HERNANDEZ-Colula, who reported difficulty sleeping and feeling anxious at times and referred Mr. HERNANDEZ-Colula to the psychiatrist.
- **On January 8, 2020**, the psychiatrist evaluated Mr. HERNANDEZ-Colula for sleeplessness and anxiety, and prescribed hydroxyzine (a medication to treat anxiety).
- **On January 22, 2020**, mental health staff evaluated Mr. HERNANDEZ-Colula. He reported improvement with his medications and denied any mental health concerns.
- **On January 29**, mental health staff evaluated Mr. HERNANDEZ-Colula and discussed his medications.
- **On February 19, 2020**, mental health staff evaluated Mr. HERNANDEZ-Colula and offered him supportive counseling. Mr. HERNANDEZ-Colula reportedly denied the offer for counseling but remained compliant with his medications and denied having any suicidal ideations. When questioned, custody staff also denied observing any concerning behaviors from Mr. HERNANDEZ-Colula.

Synopsis of Death

- **On February 20, 2020**, at approximately 1:09 a.m., a custody officer found Mr. HERNANDEZ-Colula hanging from the bunk in his cell and called a medical emergency.
 - At approximately 1:10 a.m., NEOCC’s emergency response team arrived in the unit, cut the ligature, and began lifesaving measures including cardiopulmonary resuscitation (CPR).
 - At approximately 1:12 a.m., medical staff arrived, applied an automatic electronic defibrillator, and continued CPR.
 - At approximately 1:24 a.m., emergency medical services (EMS) arrived and assumed care of Mr. HERNANDEZ-Colula.
 - At approximately 1:45 a.m., EMS transported Mr. HERNANDEZ-Colula to St. Elizabeth Youngstown Hospital (SEYH) in Youngstown, OH.



- At approximately 1:49 a.m., while en route to the hospital, a SEYH physician pronounced Mr. HERNANDEZ-Colula deceased.



**U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: HERNANDEZ-Fundora, Alberto**

General Demographic/Background Information

- **Date of Birth:** August 5, 1956
- **Date of Death:** January 27, 2020
- **Age:** 63
- **Gender:** Male
- **Country of Citizenship:** Cuba
- **Marital Status:** Single
- **Children:** N/A

Immigration History

- On May 14, 1980, Mr. HERNANDEZ, entered the United States (U.S.) at Key West, Florida (FL) and was granted parole as a part of what is commonly referred to as the "Mariel boatlift."
- On April 4, 1985, Mr. HERNANDEZ's parole status was revoked due to criminal convictions.
- On May 17, 2000, ICE (then called Immigration and Naturalization Service) encountered Mr. HERNANDEZ at the Federal Correctional Institution in Lompoc, California and served him with a Form I-862, Notice to Appear, charging him as deportable under section 212(a)(2)(A)(i)(II) and 212(a)(2)(A)(i)(I) of the Immigration and Nationality Act.
- On July 19, 2000, an immigration judge ordered Mr. HERNANDEZ removed to Cuba.
- On December 27, 2011, ICE revoked Mr. HERNANDEZ's Order of Supervision (OSUP) and booked him into Essex County Jail. He was again released on OSUP 10 days later.
- On January 2, 2020, Enforcement and Removal Operations (ERO) Miami encountered Mr. HERNANDEZ at the Turner Gilford Knight Correctional Center (TGKCC) in Miami, FL, and served him an Immigration Detainer-Notice of Action, Form I-247A.
- On January 14, 2020, TGKCC released Mr. HERNANDEZ into ERO Miami custody. ERO transferred Mr. HERNANDEZ to Krome North Service Processing Center (KNSPC) in Miami, FL, pending nomination to the Government of Cuba for repatriation.

Criminal History

- Mr. HERNANDEZ has numerous criminal convictions while in the U.S.:
 - October 8, 1982 – Heroin-Sell (NCIC Code 3510)
 - July 26, 1983 – Aggravated Assault-Weapon (1315)
 - September 11, 1993 – Aggravated Assault-Weapon (1315)
 - March 29, 2005 – Disorderly Conduct (5311) and Morals-Decency Crimes (7299)
 - February 23, 2010 – Possession of Weapon (5212)
 - August 31, 2010 – Shoplifting (2303)
 - October 6, 2011 – Shoplifting (2303)
 - December 22, 2011 – Burglary (2299)
 - September 9, 2014 – Drug Trafficking (35AB)
 - May 31, 2016 – Shoplifting (2303)
- On January 3, 2020, a judicial circuit court convicted Mr. HERNANDEZ of petit theft and sentenced him to 15 days of incarceration.



Medical History

- **On January 14, 2020**, a registered nurse (RN) at KNSPC completed Mr. HERNANDEZ's intake screening. Mr. HERNANDEZ reported having mild fatigue, difficulty breathing with exertion, moderate shortness of breath, bilateral lower extremity edema (a condition characterized by an excess of fluid collected in the cavities or tissues of the body), and bilateral lower extremity weakness. Mr. HERNANDEZ's vital signs were normal, except for his elevated finger stick blood sugar (FSBS) level of 350 milligrams per deciliter (normal range: 70 to 100 mg/dl).
 - Mr. HERNANDEZ's transfer summary listed the following medical conditions: congestive heart failure (CHF), asthma, diabetes, hypertension (HTN), Hepatitis C, dyslipidemia, and chronic kidney disease. The transfer summary also listed his current medications; however, Mr. HERNANDEZ arrived at KNSPC with an inhaler.
 - The intake RN called the on-call advanced practice provider (APP) and received orders to house Mr. HERNANDEZ in the medical housing unit (MHU), to administer regular insulin (four units), and to recheck his FSBS in one hour. The RN scheduled Mr. HERNANDEZ's physical examination for the next day, and cleared him for custody, pending his chest x-ray results.
 - Approximately one hour later, the RN rechecked Mr. HERNANDEZ's FSBS and recorded an elevated FSBS of 457 mg/dl. The RN contacted the on-call provider, who gave a verbal order to administer seven (7) units of regular insulin, which she provided.
- **On January 15, 2020**, an APP completed Mr. HERNANDEZ's physical examination. Mr. HERNANDEZ reported having multiple chronic conditions and special needs to include: HTN, type 2 diabetes, asthma, hyperlipidemia (high blood cholesterol), onychomycosis (nail fungus), poor dental hygiene, pleurectomy (surgical procedure to remove part of the linings that surround the lung), cardiac catheterization, pitting edema, episodes of fecal incontinence, chronic lower extremity weakness, use of a wheelchair, fall precautions, and homelessness. Mr. HERNANDEZ reported a history of smoking one to five cigarettes daily and drinking one to two beers daily. Mr. HERNANDEZ denied having pain or discomfort, shortness of breath, chest pain, dizziness, palpitations, headache, or nausea and vomiting.
 - Mr. HERNANDEZ's vital signs were within normal limits, except for his elevated FSBS of 219 mg/dl.
 - The APP diagnosed Mr. HERNANDEZ with type 2 diabetes, CHF, asthma, HTN, coronary artery disease, mixed hyperlipidemia, fecal urgency, chronic kidney disease, chronic pain, and onychomycosis.
 - Mr. Hernandez's chest x-ray results showed findings consistent with tuberculosis (TB),
 - The APP admitted Mr. HERNANDEZ into KNSPC's MHU respiratory isolation room due to his x-ray results and ordered fall precautions, a wheelchair to assist with ambulation, and baseline laboratory studies.
- **On January 21, 2020**, the APP again evaluated Mr. HERNANDEZ and submitted an infectious disease consultation request, due to Mr. HERNANDEZ's positive chest x ray results.
 - The ICE Health Service Corps' (IHSC) infectious disease consultant recommended to defer ordering anti-TB medications and requested the following: a copy of Mr. HERNANDEZ's previous hospital records; a computed tomography (CT) scan of the chest; a right upper quadrant ultrasound with doppler to assess for any underlying cirrhosis and/or pulmonary HTN (unless done already in the last year); laboratory studies; and routine vaccinations.



- The IHSC infectious disease consultant also recommended adding Mr. HERNANDEZ to IHSC's list of detainees with serious illness for additional medical monitoring.
- **On January 22, 2020**, an APP evaluated Mr. HERNANDEZ and documented his history of a right pleurectomy at Jackson Hospital (2019) in Miami, FL, taking TB medication for six months (1986), and 10-year homelessness in Miami, FL.
 - Mr. HERNANDEZ self-reported feeling fine, eating and sleeping well, and having regular bowel movements. He denied having shortness of breath, nausea and vomiting, abdominal pain, fevers, chills, diarrhea, or constipation.
- **On January 23, 2020**, an APP evaluated Mr. HERNANDEZ and noted feces on his bed and on the floor. Mr. HERNANDEZ reported feeling hungry most of the time, fecal incontinence for the past three years (etiology unknown), intermittent diarrhea without blood or mucous, musculoskeletal weakness, leg swelling, foot problems, and shyness regarding his incontinence. He reported eating and sleeping well and denied having chest pain, shortness of breath, nausea or vomiting, fever, chills, abdominal pain, and homicidal or suicidal ideations. The APP referred Mr. HERNANDEZ to the Larkin Community Hospital (LCH) emergency department for further evaluation.
 - At approximately 11:00 a.m., an RN completed Mr. HERNANDEZ's FSBS (38 mg/dl) and notified the APP that it was low. The APP gave an order to give Mr. HERNANDEZ oral glucose gel and recheck his level in 30 minutes.
 - At approximately 11:50 a.m., the RN documented Mr. HERNANDEZ's condition as "stable," and rechecked his FSBS (144 mg/dl).
 - At approximately 12:15 p.m., emergency medical services arrived at KNSPC and transferred Mr. HERNANDEZ to LCH emergency department for further evaluation per the APP's referral.
- **On January 24, 2020**, LCH's medical doctor (MD) diagnosed Mr. HERNANDEZ with CHF, a low ejection fraction of 20 – 25 percent (%) (normal range: 55 – 70%), bilateral pleural effusions (excess fluid that accumulates in the pleural cavity, the fluid-filled space that surrounds the lungs), cough, hyperkalemia (increased potassium level), diarrhea, diabetes, HTN, hyperlipidemia, acute kidney injury, and neuropathy. The MD transferred Mr. HERNANDEZ to the intensive care unit (ICU) due to his low ejection fraction results.
 - The MD ordered the following treatment: milrinone drip (medication used for blood pressure support and treatment of heart failure), a low sodium diet, continuation of some of his current medications, and heparin (a blood thinner).
 - Mr. HERNANDEZ denied having fever, chills, nausea and vomiting, headache, chest pain, palpitations, syncope, or urinary symptoms. His vital signs were normal.
 - Mr. HERNANDEZ had two ultrasounds completed:
 - 1) Right upper quadrant: mild abdominal ascites (accumulation of fluid causing abdominal swelling), hepatomegaly (abnormal enlargement of the liver), and cholelithiasis (formation of gallstones).
 - 2) Renal (kidney) and bladder: suggestive of possible renal disease, 1cm right renal cyst, and mild abdominal ascites.
- **On January 25, 2020**, an MD noted Mr. HERNANDEZ experienced worsening respiratory symptoms, requiring his placement on a ventilator, a Foley catheter, and medications to prevent edema. Mr. HERNANDEZ's chest x-ray showed cardiomegaly (enlarged heart), moderate to severe edema, and bilateral pleural effusions.



- An MD performed Mr. HERNANDEZ's thoracentesis (a procedure in which a needle is inserted into the pleural space between the lungs to remove excess fluid), due to a large pleural effusion.
- **On January 26, 2020**, during medical rounds, Mr. HERNANDEZ reported feeling hungry, but in no acute distress. The MD diagnosed him with hyperkalemia and ordered kayexalate (medication used to lower potassium levels). Mr. HERNANDEZ's chest x-ray showed improvement of his pleural effusions and the MD ordered continued medical care services and no cardiothoracic surgery.
 - Later in the afternoon, Mr. HERNANDEZ complained of blurred vision, became lethargic, and hypotensive (low blood pressure). As a result, the MD discontinued milrinone and added albumin to increase his blood volume.

Synopsis of Death

- **On January 27, 2020**, between 4:40 a.m. and 8:23 a.m., Mr. HERNANDEZ experienced eight cardiac arrests. A code blue and advanced cardiac life support measures were initiated each time, with successful resuscitation.
 - During Mr. HERNANDEZ's eighth code, an LCH representative contacted KNSPC's ICE representative to notify Mr. HERNANDEZ's next of kin to make the final treatment decisions for Mr. HERNANDEZ. ICE attempted but could not identify a family member to serve as proxy and LCH's medical personnel made decisions consistent with hospital policies and procedures.
 - At approximately 9:02 a.m., Mr. HERNANDEZ experienced a ninth cardiac arrest. LCH called a code blue, checked Mr. HERNANDEZ's cardiac activity with an echocardiogram, and found no cardiac activity.
 - At approximately 9:32 a.m., an LCH physician pronounced Mr. HERNANDEZ deceased.



**U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: MAVINGA, Samuelino Pitchout**

General Demographic/Background Information

- **Date of Birth:** June 29, 1979
- **Date of Death:** December 29, 2019
- **Age:** 40
- **Gender:** Male
- **Country of Citizenship:** France
- **Marital Status:** Single
- **Children:** N/A

Immigration History

- On November 28, 2018, Mr. MAVINGA entered the United States (U.S.) at John F. Kennedy International airport, in New York City via application for the electronic system for travel authorization visa waiver program, which expired on February 24, 2019.
- On November 11, 2019, at the Sierra Blanca U.S. Border Patrol (BP) checkpoint, Mr. MAVINGA was arrested by BP for remaining in the U.S. beyond his visa expiration date.
- On November 12, 2019, BP transferred Mr. MAVINGA into U.S. Immigration and Customs Enforcement (ICE) custody at El Paso Service Processing Center (EPC), with a subsequent transfer to Otero County Processing Center (OCPC).

Criminal History

- N/A

Medical History

- **On November 12, 2019** at 5:45 p.m., a registered nurse (RN) completed Mr. MAVINGA's medical intake screening. Mr. MAVINGA denied a history of medical or mental health conditions, taking medication, illicit drugs, or alcohol use. His vital signs were within normal limits, and he weighed 160 pounds (lbs.). His mental health screening and observations were normal, and the RN cleared Mr. MAVINGA for general population.
 - At 7:20 p.m., an RN completed Mr. MAVINGA's physical examination. Mr. MAVINGA again denied a history of medical or mental health conditions, his vital signs were within normal limits, and no significant findings were noted.
 - Two chest x-rays were completed for tuberculosis (TB) screening and comparison. Both results were negative for TB.
- **On November 13, 2019** at 10:45 a.m., the OCPC director of nursing/RN informed Mr. MAVINGA of his chest x-ray results.
 - The chest x-ray findings showed central haziness with vascular prominence and borderline cardiomegaly (enlarged heart), consistent with interstitial edema related to early congestive heart failure; grossly distended splenic flexure (abrupt turn of the colon beneath the lower end of the spleen) beneath elevated left hemidiaphragm, obstructions cannot be excluded; correlate clinically with further evaluation and follow up using computer tomography (CT). No evidence of TB. The OCPC medical doctor (MD) reviewed and signed the results.



- Again, Mr. MAVINGA denied having a history of medical conditions or current symptoms.
 - Mr. MAVINGA refused any follow-up diagnostic testing and requested to speak to the immigration judge.
- **On November 17, 2019** at 6:00 p.m., a custody officer escorted Mr. MAVINGA to the medical clinic due to complaints received by other detainees in his dorm about Mr. MAVINGA's behavior. An RN evaluated Mr. MAVINGA, referred Mr. MAVINGA to the mental health provider (MHP), and placed him in the medical observation unit (MOU) pending a mental health evaluation.
- **On November 18, 2019** at 12:30 p.m., a licensed professional clinical counselor (LPCC) evaluated Mr. MAVINGA for his behavior. He reported, "I feel well," eating and sleeping well, and denied hallucinations or suicidal/homicidal ideations. Mr. MAVINGA reported he did not need mental health treatment. He denied having a history of mental health conditions or treatment. The LPCC completed Mr. MAVINGA's mental health exam and noted, "altered mental status exam, rule out possible psychotic disorder, need further evaluation," and ordered "mental health treatment as needed/accordingly."
- **On November 19, 2019** at 1:00 p.m., an LPCC performed Mr. MAVINGA's follow-up evaluation in the MOU and documented Mr. MAVINGA reports of feeling well and denial of symptoms of depression, anxiety, and hallucinations. The LPCC referred Mr. MAVINGA to the advanced practice provider (APP) for a medical evaluation.
 - At 5:10 p.m., during an APP evaluation, Mr. MAVINGA reported not eating for the past four weeks, but that claim was unsubstantiated, and he denied any declaration of a hunger strike. His weight was 153 lbs. and vital signs and examination were normal, except his eyes were slightly icteric (yellow). The APP ordered to continue medical observation, follow up with the MHP, and laboratory tests: complete blood count, comprehensive metabolic panel, thyroid stimulating hormone, hepatitis panel, human immune-deficiency virus, urine dipstick, and a peripheral smear.
- **On November 20, 2019, at approximately 11:45 a.m.**, an LPCC evaluated Mr. MAVINGA, who reported, "I am well" and denied symptoms of depression, anxiety, hallucinations, or suicidal/homicidal ideations. The LPCC ordered continued medical observation.
 - At 5:00 p.m., an RN evaluated Mr. MAVINGA in the MOU. The RN observed Mr. MAVINGA in the bathroom, covering himself with his mattress. The custody officer instructed Mr. MAVINGA to return the mattress to the bed frame, and he complied with that instruction. The RN documented that Mr. MAVINGA did not appear in distress, but he refused the nursing assessment and refused to sign the refusal form.
- **On November 20 through 22, 2019**, Mr. MAVINGA consistently refused to allow medical staff to monitor his vital signs, and nursing assessments. He refused to sign the refusal forms.
- **On November 23, 2019 at 12:47 p.m.**, the MD evaluated Mr. MAVINGA in the MOU for abnormal behavior. Mr. MAVINGA admitted he only consumed fruits and vegetables in his diet. Mr. MAVINGA denied any history of medical or mental health conditions and denied having suicidal/homicidal ideations. The MD assessed that Mr. MAVINGA had adjustment disorder versus anti-social disorder. The MD discharged Mr. MAVINGA to general population, documenting there were no risk of harm to self or others. The MD ordered a vegetarian/kosher diet and referred Mr. MAVINGA to the MHP as needed.



- At 4:06 p.m. his vital signs were within normal limits, weight was 150.2 lbs., and he refused pulse and oxygen saturation monitoring. His examination was normal, except for “moments of flight of ideas.”
- **On December 8, 2019, at 4:20 p.m.**, a licensed vocational nurse (LVN) evaluated Mr. MAVINGA after a dorm officer informed that Mr. MAVINGA was “acting weird.” The LVN documented that Mr. MAVINGA stated he will refuse all lab work, urine samples, and intravenous (IV) fluids. The LVN submitted a telephone encounter to the MD regarding Mr. MAVINGA’s current status. The MD ordered placement in MOU (due to unstable vital signs), a vegetarian diet with bottled water, and instructions to notify the field medical coordinator (FMC) regarding Mr. MAVINGA’s status and treatment plan pending an evaluation.
 - At 5:05 p.m., per a custody officer, Mr. MAVINGA returned an empty dinner tray; however, during security rounds, the food was found in the cell’s toilet.
 - At 8:22 p.m., an MD evaluated Mr. MAVINGA for weight loss, secondary to not eating and unusual behavior. Mr. MAVINGA did not report any complaints but refused to drink anything not bottled. The MD documented Mr. MAVINGA’s weight as 131.9 lbs. The MD contacted ICE for recommendations regarding Mr. MAVINGA’s transfer to another facility versus nutritional supplementation, and the MD ordered Ensure (a nutritional supplement).
 - At 9:00 p.m., Mr. MAVINGA’s vital signs were normal, except a pulse of 107 beats per minute (bpm).
 - Per the FMC, the MD reported Mr. MAVINGA had capacity to exercise his right to refuse medical care. The MD recommended sending Mr. MAVINGA to the local emergency department; however, Mr. MAVINGA refused. The FMC informed the MD that Mr. MAVINGA’s case would be discussed during the next ICE Field Office Director’s meeting.
- **On December 9, 2019**, Mr. MAVINGA continued to refuse to eat food or drink any fluids. His weight was 134.3 lbs. and vital signs were normal except a pulse range of 100-110 bpm.
- **On December 10, 2019**, Mr. MAVINGA continued to refuse to eat food or drink any fluids. His weight was 131.9 and vital signs were normal except pulse of 102 and oxygen saturation of 95%.
- **On December 11, 2019**, an RN medically cleared Mr. MAVINGA for transfer to Torrance County Detention Facility (TCDF) with a transfer summary that outlined his current medical problems of adjustment versus antisocial disorder.
- **On December 12, 2019**, at approximately 12:22 a.m., an RN completed Mr. MAVINGA’s intake screening. Mr. MAVINGA denied having a history of medical and mental health problems, tobacco, drug or alcohol use. On observation, he was disheveled, experiencing difficulty breathing and his sclera appeared jaundice. His vital signs were: temperature of 99.1, pulse of 107 bpm, blood pressure 98/67, oxygen saturation of 96 %, and his weight was 130 lbs. The RN completed an urgent referral (to be evaluated within 24 hours) to an APP.
 - At 10:47 a.m., an APP completed Mr. MAVINGA’s physical examination. Mr. MAVINGA reported “feeling well.” He denied having a history of medical or mental health conditions, fever, chills, night sweats, or drug, alcohol, and tobacco use. His vital signs were within normal limits except: temperature - 99.1, pulse - 107, oxygen saturation - 96%. His exam findings were: appearance unkempt and emaciated, frequent non-productive cough, slow mentation with some tangential speech, rambling, difficult to understand, mucous membranes pale with yellow crusted flakes to outer nose,



prominent xiphoid process with positive skin tenting indicating dehydration, lung sounds diminished with adventitious sounds to left anterior chest, and diminished extremity reflexes (1+ where normal is 2+).

- The APP referred Mr. MAVINGA to Presbyterian Hospital (PH) emergency department via the facility's transport van to rule out sepsis.
- PH admitted Mr. MAVINGA as an in-patient, diagnosed with sigmoid volvulus (twisting of the large intestines, causing a large bowel obstruction) and requiring surgery: detorsion (emergency treatment to correct the twist of intestine).
- **On December 13, 2019** at 2:34 p.m., Mr. MAVINGA consented to a detorsion procedure to correct a large intestinal obstruction and was in the operating room.
- **On December 14, 2019**, Mr. MAVINGA was scheduled for a colectomy (surgical removal of all or part of the colon); his surgery was rescheduled in order to conduct bowel preparation and complete abdominal films.
- **On December 15, 2019**, Mr. MAVINGA's oxygen saturation levels decreased to mid to high 80s and he was placed on two liters of oxygen. Mr. MAVINGA refused to complete the bowel preparation for surgery and oxygen administration.
- **On December 16, 2019** at 11:45 a.m., Mr. MAVINGA's surgery (colectomy) was performed. Post operatively, his vital signs were stable and there were no surgical complications.
- **On December 17, 2019**, Mr. MAVINGA became mildly confused, removed the nasogastric tube (NGT), refused the peripherally inserted central catheter (PICC), and nursing care. The PH attending MD spoke to the TCDF MD about Mr. MAVINGA's psychiatric history, ordered a psychiatric consult and contacted PH's legal department to obtain a consent to do a colostomy (surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall to bypass the damaged part of the colon) "to rest his bowel."
 - At approximately 8:40 p.m., Mr. MAVINGA continued to refuse insertion of a PICC line and pulled out his NGT. The nurse noted "detainee not letting bowel rest by having NGT and receiving medicines through PICC line, so he will most likely require a colostomy." The MHP evaluated Mr. MAVINGA and explained the importance of treatment, but he continued to refuse. The PH nurse spoke to the TCDF custody officer about and requested that Mr. MAVINGA be placed in four-point restraints due to Mr. MAVINGA's continuous removal of his NGT. The officer advised the nurse that Mr. MAVINGA can only be placed in two-point restraints and an MD's order will be required to apply the four-point restraints.
- **On December 18 and 19, 2019**, Mr. MAVINGA refused all care, including the mental health evaluation and PICC line insertion. The MD documented, "patient is competent enough to refuse all care." However, the PH's Patient Care Manager reported "two of the hospital MDs feel detainee is not competent and suggested progressing for court order and use of restraints."
- **On December 20, 2019**, the MD completed the required order for use of four-point restraints. Mr. MAVINGA continued to be uncooperative and refused urinary catheter placement. The NGT and peripheral IV access remained in place. Mr. MAVINGA did ambulate in the hall for the first time.
- **On December 21, 2019**, Mr. MAVINGA was transferred to a higher level of care due to an elevated temperature and tachycardia (fast heart rate).
- **On December 22, 2019**, per the PH nurse, Mr. MAVINGA experienced pulmonary edema (abnormal swelling of tissue in the lungs because of fluid build-up) and his IV fluids were discontinued. His heart rate remained between 120-130 bpm and respirations of 20-30s breaths



per minute. A CT scan was ordered to evaluate for another bowel or biliary obstruction due to elevated bilirubin levels and the appearance of jaundice in his eyes.

- **On December 23, 2019**, Mr. MAVINGA removed his NGT which was not reinserted.
- **On December 24, 2019**, the CT scan results revealed abdominal distention and fluid filled pouches without confirmation of an obstruction. A second CT scan was ordered to further evaluate the fluid pockets due to the uncertainty if fluid is pus in the abdomen or possible fluid in the lower lungs. The FMC spoke to the MD regarding the status of obtaining proxy consent. The MD informed the FMC that PH medical and legal staff are in the process of pursuing an incompetency determination.
- **On December 25, 2019**, Mr. MAVINGA's status elevated to critical condition. He experienced respiratory distress in the early morning, requiring intubation (insertion of a tube into the lungs to keep the airway open and deliver oxygen). During the sedation for intubation, Mr. MAVINGA experienced a heart block causing bradycardia (slow heart rate) and doctors initiated cardio-pulmonary resuscitation (CPR) and administered two doses of epinephrine. Mr. MAVINGA was transferred to the intensive care unit with an elevated heart rate and respirations, and a very firm, distended abdomen. There were no plans for new surgeries.
- **On December 26 and 27, 2019**, Mr. MAVINGA remained intubated and sedated. His abdomen remained firm and distended, and a nephrology consult was ordered due to low urinary output.
- **On December 28, 2019**, dialysis (process of removing excess water, solutes and toxins from the blood) was initiated for continuous renal replacement therapy.

Synopsis of Death

- **On December 29, 2019**, Mr. MAVINGA went into cardiac arrest twice with successful resuscitations. The dialysis was discontinued. His vital signs were: temperature 99.0, pulse 100, respirations 40 (normal range 12- 18 breaths per minute), BP of 60/44, and oxygen saturation of 89%. The FMC documented, "if Mr. MAVINGA coded again, he would not be resuscitated."
 - At 12:20 p.m., Mr. MAVINGA's blood pressure became non-existent and his pulse was bradycardic. His heart rhythm became asystole and Mr. MAVINGA was pronounced dead.
- The preliminary cause of death is cardiac arrest related to septic shock.



**U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: MIRIMANIAN, Gourgen**

General Demographic/Background Information

- **Date of Birth:** March 16, 1964
- **Date of Death:** April 10, 2018
- **Age:** 54
- **Sex:** Male
- **Country of Citizenship:** Armenia
- **Marital Status:** The deceased reported that his spouse is a lawful permanent resident of the United States who lives in Glendale, California.
- **Children:** None reported

Immigration History

- Mr. MIRIMANIAN entered the United States via the Los Angeles, CA Port of Entry (POE) on April 27, 1994 as a B2 visitor for pleasure.
- Mr. MIRIMANIAN submitted an application for adjustment of status to that of a Lawful Permanent Resident prior to his Federal criminal sentence.
- On December 12, 2017, ICE Enforcement and Removal Operations (ERO) encountered Mr. MIRIMANIAN in Bureau of Prisons (BOP) custody and lodged an immigration detainer.
- On February 6, 2018, Mr. MIRIMANIAN entered ERO custody and was housed at Bedford City Jail in Dallas, TX.
- On February 7, 2018, ERO transferred Mr. MIRIMANIAN to Prairieland Detention Center in Alvarado, TX.
- On March 6, 2018, Mr. MIRIMANIAN was issued a Final Order of Removal.
- On March 26, 2018, ICE requested travel documents from the Armenian consulate.

Criminal History

- On September 30, 2010, the Federal Bureau of Investigations (FBI) arrested Mr. MIRIMANIAN as part of a large FBI operation, "Diagnosis Dollars." He was indicted for Racketeering Conspiracy (Racketeer Influenced and Corrupt Organizations Act (RICO)).
- Mr. MIRIMANIAN was convicted on July 30, 2013, and sentenced to a term of 60 months in federal prison.

Medical History

- The BOP transfer summary, dated **January 29, 2018**, noted Mr. MIRIMANIAN had a history of essential hypertension (high blood pressure). His daily medications were aspirin 81 mg and lisinopril (anti-hypertensive) 20 mg. His last chest x-ray on August 13, 2017, was negative.
- **On February 8, 2018**, a registered nurse (RN) completed Mr. MIRIMANIAN's ICE intake screening. Based on this screening, the RN referred Mr. MIRIMANIAN for a chronic care evaluation and provided him medication (aspirin and lisinopril, an anti-hypertensive) to keep on his person in general population housing. At his chronic care evaluation, the advanced practice provider (APP) noted that Mr. MIRIMANIAN's vital signs were stable, and ordered his medications to continue. Mr. MIRIMANIAN reported a three pack-per-day history of



smoking with frequent consumption of alcohol. The APP educated Mr. MIRIMANIAN on exercise, diet, and blood pressure control, and ordered a heart healthy diet, an EKG, and laboratory work.

- **On February 14, 2018**, a physician (MD) again evaluated Mr. MIRIMANIAN for hypertension and hyperlipidemia, among other minor conditions. The doctor noted Mr. MIRIMANIAN's blood pressure had been well controlled, and added a prescription for simvastatin to treat the hyperlipidemia. The doctor further ordered additional laboratory tests, encouraged Mr. MIRIMANIAN to exercise, and scheduled a one-month follow up.
- **On March 7, 2018**, an APP evaluated Mr. MIRIMANIAN as a walk-in for what Mr. MIRIMANIAN described as "burning, squeezing chest pain that started 10 days ago, and lasts 30 to 40 seconds." Mr. MIRIMANIAN denied a history of heart disease. The APP documented no abnormal physical findings or acute distress, but noted that an EKG was minimally abnormal and referred Mr. MIRIMANIAN to cardiology.
- **On March 21, 2018**, an APP evaluated Mr. MIRIMANIAN for complaints of "runny nose, chills, fever, and cough starting yesterday." Vital signs were stable and the exam was within normal limits. The APP diagnosed Mr. MIRIMANIAN with a common cold and treated him with cold relief, cold and flu, two tablets, by mouth, twice daily for five days.
- **On March 22, 2018**, Mr. MIRIMANIAN refused his daily medications.
- **On April 6, 2018**, an APP evaluated Mr. MIRIMANIAN for a follow-up chronic care appointment for hypertension, hyperlipidemia, and atypical chest pain. The APP noted Mr. MIRIMANIAN "denies further chest pain; however, has an upcoming cardiology consult [appointment date of April 13, 2018]. His blood pressure had been normal and has tolerated his meds well." The APP continued the current regimen, encouraged diet and exercise, and scheduled a two-month follow up or as necessary.

Synopsis of Death

- **On April 10, 2018**, at approximately 7:45 a.m., medical staff responded to a code blue for Mr. MIRIMANIAN. An APP noted Mr. MIRIMANIAN was found unresponsive, not breathing, and without a pulse. PDC staff initiated cardio-pulmonary resuscitation (CPR) and notified emergency medical services (EMS). After approximately 15 minutes, EMS arrived, continued CPR, and undertook advanced cardiac life support measures and medications. EMS departed with Mr. MIRIMANIAN. At approximately 9:15 a.m., Mr. MIRIMANIAN was pronounced dead.
- On April 13, 2018, the State of Texas Department of State Health Services issued a Certificate of Death documenting Mr. MIRIMANIAN's cause of death as hypertensive and atherosclerotic cardiovascular disease and the manner of death to be natural.



U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: OCHOA-Yoc de Ramirez, Maria Celeste

General Demographic/Background Information

- **Date of Birth:** August 10, 1997
- **Date of Death:** March 8, 2020
- **Age:** 22
- **Gender:** Female
- **Country of Citizenship:** Guatemala
- **Marital Status:** Single
- **Children:** N/A

Immigration History

- On September 5, 2019, U.S. Border Patrol (USBP) encountered Ms. OCHOA in the Rio Grande Valley, Texas (TX) and transported her to the Rio Grande Valley Sector Centralized Processing Center in McAllen, Texas for processing.
- On September 6, 2019, USBP transferred Ms. OCHOA to the custody of ICE Enforcement and Removal Operations (ERO) in San Antonio, TX.
- From September 6, 2019 to March 8, 2020, ERO housed Ms. OCHOA at three Intergovernmental agreement (IGSA) facilities:
 - September 6 - 12, 2019, El Valle Detention Facility (EVDC) in Raymondville, TX.
 - September 12, 2019 - February 13, 2020, Kay County Detention Center (KCDC) in Newkirk, Oklahoma (OK).
 - February 13 - 18, 2020, Prairieland Detention Center (PDC) in Alvarado, TX.
 - Referred to Texas Health Huguley Hospital (THHH) in Burleson, TX.

Criminal History

- N/A

Medical History

EVDC Medical Records

- **On September 6, 2019**, a registered nurse (RN) completed Ms. OCHOA's intake screening. Ms. OCHOA denied a history of medical or mental health conditions; however, she did report an allergy to gentamycin (antibiotic) and history of spousal physical abuse in 2015. Ms. OCHOA denied a history of sexual assault, her vital signs (VS) were normal, and the RN cleared her for general population (GP) with a referral to a mental health provider (MHP).
- **On September 11, 2019**, an RN completed Ms. OCHOA's transfer summary and cleared her for transfer.

KCDC Medical Records

- **On September 12, 2019**, a licensed vocational nurse (LVN) completed Ms. OCHOA's intake screening. Ms. OCHOA denied a medical history but reported a history of post-traumatic stress disorder (PTSD) from a sexual assault at age 19. Her VS were normal. The LVN submitted an urgent MHP referral for Ms. OCHOA and cleared her for GP.
- **On September 13, 2019**, an MHP evaluated Ms. OCHOA. Ms. OCHOA reported a history of sexual assault, admitted to disruptive nightmares, and resorted to excessive sleep during the



day to cope. She denied any current or history of suicidal or homicidal ideations. Her mental status exam noted a tearful, flat affect, and dysphoric/sad mood. The MHP diagnosed her with severe PTSD, ordered her a routine follow-up, and referred her to a medical provider for further evaluation.

- **On September 20, 2019**, a medical doctor (MD) prescribed Terazosin (used for lowering blood pressure or off-label usage for PTSD associated nightmares) 2 mg, one tablet, orally, at bedtime.
- **On September 21, 2019**, an RN completed Ms. OCHOA's physical examination. Ms. OCHOA denied a history of medical conditions; however, she reported a history of anxiety related tachycardia (fast heart rate), taking Terazosin 1 mg, two capsules, orally, every evening, and admitted to one hospitalization following a sexual assault at age 19. Her examination was unremarkable, and she was instructed to follow up as needed.
- **September 22 – January 31, 2020**, KCDC medical staff evaluated Ms. OCHOA for various complaints from dental pain, allergy related symptoms, cold symptoms, constipation, urinary symptoms, and right elbow injury.
- **On February 2, 2020**, an LVN evaluated Ms. OCHOA for vomiting, weight loss, muscle aches, and an episode of black stool. Her VS were normal, except a pulse (P) of 123 beats per minute [(bpm); normal, 60 – 100 bpm] and a loss of 14 pounds (lbs.) since November 20, 2019. The LVN documented the exam as normal and referred Ms. OCHOA to a medical provider.
- **On February 3, 2020**, an RN evaluated Ms. OCHOA for complaints of shortness of breath and nausea. Her VS were normal, except P of 110 bpm. Ms. OCHOA's exam was normal, except for diminished right lung sounds. The RN referred Ms. OCHOA to a medical provider for evaluation and a chest x-ray was ordered, which was negative.
- **On February 4, 2020**, an advanced practice provider (APP) evaluated Ms. OCHOA, who complained of a runny nose. The exam was unremarkable, except a P of 104. The APP ordered Flonase (allergy nasal spray) daily with routine follow up.
- **On February 5, 2020**, security staff reported that fellow detainees witnessed Ms. OCHOA self-induce vomiting after meals.
- **On February 6, 2020**, an RN assessed Ms. OCHOA for anxiety, poor sleep, and feeling as though her heart was stopping and she was dying. Her VS were normal, except for a P of 118 bpm. Her exam was unremarkable, except tachycardia, light straw tint to her eyes, and abnormal urinalysis (UA) dipstick results. The RN admitted Ms. OCHOA to medical housing for observation and referred her to an APP and MHP for evaluation.
 - The APP ordered Ensure (nutritional supplement) two times daily, weekly weight checks for thirty-days, and the following tests: complete blood count (CBC), comprehensive metabolic panel (CMP), and a hepatic panel (liver function tests). After receiving critical laboratory results, the APP referred Ms. OCHOA to Alliance Health Ponca City emergency department in Ponca City, OK, for further evaluation.
- **On February 7, 2020**, Ms. OCHOA was diagnosed with cholecystitis (inflammation of the gall bladder), acute biliary pancreatitis (inflammation of the pancreas), and transferred to Mercy Hospital in Oklahoma City, OK, for further testing.
- **On February 8, 2020**, Ms. OCHOA had a cholecystectomy (surgical removal of gall bladder).
- **On February 10, 2020**, Mercy Hospital discharged and released Ms. OCHOA to KCDC. Ms. OCHOA complained of not sleeping for thirty days. A nurse housed Ms. OCHOA in medical housing for observation pending a medical provider's evaluation. The MD prescribed



acetaminophen and ketorolac, as needed for pain. Prior to Ms. OCHOA's hospitalization, security staff discovered several pills – type unknown – under her mattress.

- **On February 11, 2020**, an APP evaluated Ms. OCHOA status post-cholecystectomy. Ms. OCHOA refused medications claiming they were making her crazy. Ms. OCHOA also reported that she wanted jail personnel to kill her and that she wanted to die, but had no plans or desire to self-inflict injury. Her VS were stable, except P of 120. The APP placed Ms. OCHOA in medical housing on suicide watch and referred her to mental health.
 - An MHP evaluated Ms. OCHOA. Ms. OCHOA voiced the desire for medication to the extent that she did not want to feel. The MHP diagnosed Ms. OCHOA with 1) eating disorder - rule out bulimia, 2) depressive disorder, 3) and personality disorder - not otherwise specified, and ordered continued suicide watch, consider referral to a higher level of care, and routine referral for psychiatrist evaluation.
- **On February 12, 2020**, ERO Dallas transferred Ms. OCHOA to PDC for further mental health evaluation of possible PTSD and bulimia.

PDC Medical Records.

- **On February 14, 2020**, an RN completed Ms. OCHOA's intake screening. Ms. OCHOA reported a recent cholecystectomy, four days ago; current medications: Terazosin (psychotropic), acetaminophen, amoxicillin, docusate sodium, multi-vitamins, and allergy medicine (nasal decongestant spray and cetirizine-D). Ms. OCHOA denied a history of other medical or mental health conditions; however, she reported receiving counseling six months ago for a history of spousal sexual and physical abuse, three years ago. The RN referred Ms. OCHOA to the MHP and APP.
 - A licensed marriage and family therapist (LMFT) completed Ms. OCHOA's initial mental health evaluation. Ms. OCHOA denied history of mental health and suicidal ideations; however, she reported an ex-husband raped her three years ago and complained of difficulty sleeping. The LMFT's assessment of Ms. OCHOA's mental status was PTSD and referred her to psychiatry.
 - An APP completed Ms. OCHOA's initial chronic disease evaluation due to her recent surgery. Ms. OCHOA complained of a poor appetite, dry mouth, weakness, and difficulty sleeping. Her VS and examination were normal, except jaundiced (yellow) sclera. The APP's assessment was unspecified jaundice, anorexia (lack of appetite), post cholecystectomy, PTSD; and ordered intravenous fluid hydration, continuance of medications, laboratory testing, and to maintain in medical for observation. The APP scheduled a next-day follow-up.
- **On February 17, 2020**, an MD evaluated Ms. OCHOA. Ms. OCHOA complained of a lack of appetite; however, she reported drinking Ensure (nutritional supplement) and eating from her food tray. Ms. OCHOA's laboratory results were abnormal, and the MD ordered repeat laboratory testing (CMP, amylase, lipase) for confirmation and considered a hospital referral for further diagnostic testing if repeat laboratory testing was abnormal.
- **On February 18, 2020**, an APP reviewed Ms. OCHOA laboratory results and referred her to Texas Health Huguley Hospital (THHH) in Burleson, TX, to rule out bile duct obstruction. THHH admitted Ms. OCHOA for elevated liver enzymes, abdominal pain with nausea and vomiting, and acute pancreatitis.
 - On this same date, Ms. OCHOA was scheduled for a psychiatrist evaluation; however, Ms. OCHOA was not seen because of her referral to the hospital.



THHH Medical Records

- **February 19 - 28, 2020**, Ms. OCHOA remained in inpatient care and received specialty consults and diagnostic testing.
- **On February 24 and 25, 2020**, THHH completed an abdominal computed tomography (CT) scan, liver biopsy, and a chest x-ray. CT scan results showed: possible pancreatitis; fatty, enlarged liver; abnormal uterine appendages, which could be related to a prominent ovarian cyst; and bilateral atelectasis (partial collapse of lung) with trace left pleural effusion (buildup of fluid in the lining of lungs). The liver biopsy showed a fatty liver with mild periportal hepatitis (inflammation of the liver) without fibrosis (scarring). The chest x-ray results showed mild atypical pneumonitis (inflammation of the lungs) and mild diffuse bilateral alveolar disease.
- **On February 29, 2020**, Ms. OCHOA was transferred to Texas Health Harris Methodist Hospital (THHMH) – Fort Worth for a hepatology (liver specialist) consult.

THHMH Medical Records

- **February 29 – March 3, 2020**, Ms. OCHOA's condition improved, her VS were stable, and discharge was anticipated on March 4, 2020. During this period, a gastroenterologist consulted and evaluated Ms. OCHOA. The MD noted an unremarkable exam, except positive jaundice and abnormal laboratory results (AST - 904, ALT - 112, Alk phosphate – 501, and bilirubin - 10), liver biopsy – moderate diffuse macro vesicular steatosis (accumulation of fat in the liver), and mild periportal hepatitis (inflammation of the liver).
- **On March 4, 2020**, during the hospital discharge process, Ms. OCHOA presented weak and incontinent of urine; therefore, the discharge was halted.
- **On March 5, 2020** at approximately 7:45 p.m., Ms. OCHOA had difficulty breathing, an elevated P of 168 bpm, and an elevated lactic acid (organic acid present normally in muscle tissue as a by-product of the breakdown of glucose). She was transferred to the intensive care unit (ICU) and cardiology was consulted. Later this day, Ms. OCHOA experienced seizure-like activity, and she was emergently transferred to Neuro Critical Care ICU.
 - At 10:45 p.m., Ms. OCHOA coded (medical emergency) for significant respiratory distress and was successfully resuscitated. There was no evidence of cardiac arrest.
- **On March 6, 2020** at 12:05 a.m., Ms. OCHOA required intubation and placement on a ventilator to assist with her breathing, and her condition worsened with persistent and worsening acidosis and hypotension.
 - At 9:53 a.m., Ms. OCHOA's active problem list included: septic shock, hyperbilirubinemia (excess of bilirubin in the blood), elevated liver enzymes, supraventricular tachycardia [(SVT); abnormal fast heart rate], acute respiratory failure, seizure, cardiomyopathy (enlarged, weak heart muscle), and thrombocytopenia (abnormally low platelets).
 - At 11:10 a.m., Ms. OCHOA's lactic acid level continued to increase.
 - At 2:53 p.m., Ms. OCHOA's urine culture was positive for staphylococcus aureus (bacteria) and abdominal CT scan results revealed ascites (accumulation of fluid in abdominal cavity). Ms. OCHOA was diagnosed with bacteremia (bacteria in the blood), pneumonia, and intravenous antibiotics were initiated.
 - At 9:10 p.m., Ms. OCHOA was diagnosed with widespread infection [(sepsis); a life-threatening condition when the body's response to infection causes injury to its own



tissues and organs] and placed on renal dialysis but was discontinued due to treatment failure.

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

Synopsis of Death

- **On March 8, 2020**, Ms. OCHOA experienced cardiac arrest three times with unsuccessful resuscitation.
 - At 8:45 a.m. CT, Ms. OCHOA was pronounced deceased. An autopsy was ordered and is pending for the official cause and manner of death.



**U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: OWEN, Ben James**

General Demographic/Background Information

- **Date of Birth:** September 16, 1980
- **Date of Death:** January 25, 2020
- **Age:** 39
- **Gender:** Male
- **Country of Citizenship:** United Kingdom
- **Marital Status:** Married
- **Children:** 2

Immigration History

- On July 23, 2019, U.S. Customs and Border Protection admitted Mr. OWEN into the United States (U.S.) at the Miami Sea Port, Florida (FL), as an O2 non-immigrant with authorization to remain in the U.S for a temporary period not to exceed December 10, 2019; however, he remained beyond that date without authorization.
- On January 14, 2020, Enforcement and Removal Operations (ERO), Orlando Federal Criminal Alien Program, encountered Mr. OWEN while he was detained at the Volusia County Branch Jail (VCBJ) in Daytona Beach, FL. ERO determined Mr. OWEN to be removable under Section 237(a)(1)(B) of the Immigration and Nationality Act and issued him a Notice to Appear, Form I-862.
- On January 15, 2020, VCBJ released Mr. OWEN to the custody of ERO Miami, pursuant to the immigration detainer. ERO brought Mr. OWEN to the Orlando Hold Room in Orlando, FL, where he was subsequently transferred to Baker County Detention Center (BCDC) for housing.

Criminal History

- On November 17, 2019, Mr. OWEN was charged with domestic violence (NCIC Code 13AB).
- On January 12, 2020, Mr. OWEN was arrested in Port Orange, Florida and charged with felony violation of a court order (5016), felony false imprisonment (10AA), misdemeanor simple assault (1313), and violating the conditions of his pre-trial release (5013).

Medical History

- **On January 16, 2020** at 12:56 a.m., a licensed practical nurse (LPN) completed Mr. OWEN's medical intake screening and reviewed the VCBJ transfer summary. Mr. OWEN's vital signs were normal, and he denied having any medical, mental health conditions, past suicide attempts, and/or current suicidal ideations.
 - The LPN scheduled Mr. OWEN's full physical assessment for January 24, 2020; however, he refused the evaluation.
- **During January 16 to 25, 2020**, Mr. OWEN did not submit any sick call requests and BCDC's medical staff did not conduct any further medical or mental health evaluations after his initial medical intake screening and refusal of further assessment.

Synopsis of Death

- **On January 25, 2020**, at approximately 5:39 p.m., Mr. OWEN made a telephone call to a female.



- At approximately 7:29 p.m., Mr. OWEN's cellmate discovered him hanging in their cell and alerted other detainees who pushed the emergency call button to alert BCDC custody staff.
- At approximately 7:30 p.m., a custody officer found Mr. OWEN in his dorm hanging from a bed sheet tied around his neck and anchored to a shower partition. The custody officer immediately radioed for all available staff to respond for a possible hanging. Additional custody staff arrived and removed the linens from Mr. OWEN's neck, placed him on the floor, and initiated cardiopulmonary resuscitation (CPR) to Mr. OWEN, who was unresponsive, pulseless, and was not breathing.
- As CPR continued, medical staff responded to the scene at approximately 7:33 p.m. and assisted custody staff with transferring Mr. OWEN to the booking area. A nurse evaluated Mr. OWEN, who remained unresponsive, pulseless, and not breathing. The nurse noted he had pale, cool skin and his pupils were fixed and dilated. The medical team started Mr. OWEN on supplemental oxygen, at 25 liters per minute, and applied an automated external defibrillator (AED) that advised "no shock."
- At approximately 7:35 p.m., a custody officer called for Emergency Medical Services (EMS). Staff continued CPR until EMS arrived.
- At approximately 7:48 p.m., EMS personnel arrived and evaluated Mr. OWEN's heart activity, which showed asystole (also known as flatline, a condition of cardiac arrest where there is no discernible electrical activity in the heart). The BCDC staff informed EMS personnel of their initiation of CPR and use of an AED, and that no shock was advised. EMS personnel determined that continued lifesaving efforts would not change Mr. OWEN's chance of survival and discontinued CPR.
- At approximately 7:52 p.m., the EMS personnel pronounced Mr. OWEN deceased.



**U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: PADRON, Wilfredo**

General Demographic/Background Information

- **Date of Birth:** September 3, 1960
- **Date of Death:** November 1, 2018
- **Age:** 58
- **Sex:** Male
- **Country of Citizenship:** Cuba
- **Marital Status:** Married
- **Children:** One minor child

Immigration History

- Mr. PADRON was paroled into the United States on or about 07/16/1980 at or near Key West, FL.
- Mr. PADRON adjusted his status to that of a Lawful Permanent Resident on or about 08/15/1995 as of 10/10/1992.
- On 11/29/2001 Mr. PADRON was ordered removed by an Immigration Judge at Miami, FL.
- On August 15, 2018, ICE Enforcement and Removal Operations (ERO) Miami Fugitive Operations encountered and arrested Mr. PADRON at the ERO Miami Miramar Sub-Office after reporting for a scheduled order of supervision appointment.
- On this same date, ERO Miami revoked Mr. PADRON's release and transferred him to Krome Service Processing Center (KSPC) for removal.
- On August 17, 2018, ERO Miami transferred Mr. PADRON to Monroe County Detention Center (MCDC) pending repatriation efforts.

Criminal History

- 12/11/1985-VEHICLE THEFT/COCAINE POSSESSION-Convicted
- 06/08/1989-CARRYING CONCEALED WEAPON-Convicted
- 08/19/1991-COCAINE POSSESSION-Convicted
- 12/18/1991-AGGRAVATED ASSAULT-Convicted
- 11/12/1998-DWLS-Convicted
- 01/26/2002-DISORDERLY CONDUCT-Dismissed
- 02/28/2010-DRUG POSSESSION-Convicted

Medical History

- **On August 15, 2018**, a registered nurse (RN) completed Mr. PADRON's receiving screening and noted Mr. PADRON had a chronic condition requiring prioritization.
- **On August 16, 2018**, a RN completed Mr. PADRON's intake screening and noted Mr. PADRON had hypertension, pancreatitis, and prior left leg fracture. The RN observed him walking with a slow, steady gait and limp, as his left leg was shorter than the right.
- **On August 17, 2018**, an advanced practice provider (APP) completed Mr. PADRON's initial chronic care assessment and confirmed his chronic care history. In addition, the APP noted Mr. PADRON had been using a wheelchair to ambulate and denied any other chronic or acute medical complaints.



- **On August 18, 2018**, a physician (MD) co-signed the APP's initial chronic care note adding that Mr. PADRON should be added to the disability list. A RN noted that a wheelchair would be provided to the detainee while at MCDC and his chronic care medications were continued in accordance with his August 17, 2018 KSPC transfer summary.
- **On August 20, 2018**, an RN conducted a sick call assessment for Mr. PADRON's chief complaint of a runny nose. The RN noted Mr. PADRON's medical history and medications and added Mr. PADRON's newly reported history of a stroke in 2014 and 2018, with his last hospitalization in Arizona from January 24-31, 2018.
- **On August 29, 2018**, an RN conducted Mr. PADRON's health assessment and noted that he wears a bridge for missing teeth, cardiomegaly, hypertension, and a spot on the liver (reportedly diagnosed years ago but did not receive treatment). RN also noted, "Patient states a history of six strokes in the past and takes a baby aspirin."
- **On August 31, 2018**, Mr. PADRON submitted a written sick call request in English, stating that he "receives blood pressure medication at night." An RN scheduled a chart review with the APP for September 6, 2018.
- **On September 6, 2018**, at 11:32 a.m., an APP performed a chart review. Mr. PADRON's problem list included: allergic rhinitis, chronic pain due to trauma, chronic pancreatitis, and hypertension. The APP noted Mr. PADRON's medication list and changed his amlodipine from morning to nightly.
- **On October 26, 2018**, Mr. PADRON presented to the medical clinic for chest pain complaints, describing sharp, radiating pain to the left arm and back. Mr. PADRON was observed gripping his chest. An electrocardiogram (EKG) was performed and showed normal sinus rhythm with depressed ST. The RN initiated a telephone consultation with the APP, who ordered a hospital transfer to the Lower Keys Medical Center (LKMC) in Key West, FL, via emergency medical services (EMS). He was released back to MCDC about three hours later. According to the LKMC medical record, Mr. PADRON's chest x-ray results were: no active disease in the chest but indicated there was gas scattered throughout non-dilated bowel in non-specific pattern. There was severe deformity of the left hip with flattening of the femoral head, sclerotic and cystic changes with severe degenerative changes and near total obliteration of the joint space. There may be old post traumatic deformity of the left superior and inferior pubic rami. There were vascular calcifications. The EKG results were: normal sinus rhythm with non-specific ST abnormality. Mr. PADRON was diagnosed and treated for constipation.
- **On October 29, 2018**, an LPN monitored Mr. PADRON's blood pressure three times due to chest pain complaints. The LPN consulted with the APP. The APP ordered Mr. PADRON's placement in the medical housing unit due to his elevated blood pressure.
- **On October 31, 2018**, an RN documented that Mr. PADRON believed his medications were administered at the wrong time, causing his "BP to be worse, chest pains, headache, and similar symptoms of having a stroke like he did in the past." Mr. PADRON was escorted to the medical clinic for a blood pressure check. Mr. PADRON stated he wished to take the amlodipine 10 mg, as prescribed at the previous facility. The RN reviewed Mr. PADRON's medication and explained to him that his BP medications remained the same from KSPC. Mr. PADRON disagreed with the RN multiple times as she explained his medications. The RN offered to schedule Mr. PADRON for a medical appointment. Mr. PADRON stated he wanted to see the MD only. The RN scheduled Mr. PADRON to see the MD on November 11, 2018. The RN noted that Mr. PADRON was stable, even though his blood pressure was elevated.



Synopsis of Death

- **On November 1, 2018**, Mr. PADRON's roommate attempted to wake him for breakfast, but he was unresponsive. A medical emergency was then called over the radio.
 - At approximately 6:41 a.m., a RN and LPN arrived at the scene and found Mr. PADRON lying on the floor. The security staff initiated cardio-pulmonary resuscitation (CPR) which was in progress when the nurses arrived at the scene. Mr. PADRON was unresponsive, without a pulse. The nursing staff applied the automated external defibrillator to Mr. PADRON's chest. No rhythm was detected, and CPR was continued. Security staff contacted EMS.
 - At 6:49 a.m., EMS arrived and assumed CPR.
 - At 7:09 a.m., EMS transported Mr. PADRON to LKMC. The RN provided EMS a copy of Mr. PADRON's current medications and his history and physical.
 - At 7:47 a.m., security staff received notification from the LKMC's emergency room staff indicating that Mr. PADRON was pronounced deceased at 7:17 a.m.
- On March 8, 2019, the Monroe County Medical Examiner documented Mr. PADRON's cause of death as thrombosis of the right coronary artery due to atherosclerotic cardiovascular disease.



U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: RAMIREZ-ARREOLA, Augustina

General Demographic/Background Information

- **Date of Birth:** May 30, 1956
- **Date of Death:** July 25, 2018
- **Age:** 62
- **Sex:** Female
- **Country of Citizenship:** Mexico
- **Marital Status:** Reported that she is separated
- **Children:** Reported having six (6) children with her former husband

Immigration History

- On or about November 20, 2013, Ms. RAMIREZ applied for admission into the United States at the San Ysidro Port of Entry. During an oral interview and sworn statement, Ms. RAMIREZ said she came to the United States because she had heard an announcement on the Michoacan radio station that the United States was giving out free passes to enter for people from Michoacan. She wanted to attain this pass to see her children in Modesto, California.
- On November 22, 2013, Ms. RAMIREZ was served an I-296 and I-860 (Final Order of Removal).
- On December 8, 2013, Ms. RAMIREZ was removed from the United States.
- On May 21, 2018, Ms. RAMIREZ applied for admission into the United States at the San Ysidro Port of Entry. Ms. RAMIREZ was processed as an expedited removal.
- On June 3, 2018, Ms. RAMIREZ was transferred to Otay Mesa Detention Center (OMDC).
- On July 17, 2018, Ms. RAMIREZ requested an immigration judge review.
- On July 23, 2018, an immigration judge issued an order of removal for Ms. RAMIREZ.

Criminal History

- None

Medical History

- **On June 3, 2018**, a registered nurse (RN) completed Ms. RAMIREZ' prescreening. Ms. RAMIREZ acknowledged having a current illness or health problems, but denied pain, taking medication, or mental health issues. The RN did not assign a priority to Ms. RAMIREZ' prescreening. Later that day, a RN completed the intake screening. Ms. RAMIREZ denied history of medical problems, but did report a cough and sore throat for three days. Ms. RAMIREZ also reported having right eye surgery, ten years ago, to remove a "piece of flesh." Her vital signs were within normal limits except for an elevated pulse and a mildly elevated blood pressure. The RN marked the intake screening as "normal."
- **On June 4, 2018**, the radiologist read Ms. RAMIREZ' chest x-ray and could not rule out active tuberculosis (TB). Ms. RAMIREZ was not cleared for general population housing, and the advanced practice provider (APP) ordered a two-view chest x-ray.
- **On June 5, 2018**, the radiologist read Ms. RAMIREZ' two-view chest x-ray as "confirmed findings of initial screen, positive study. The heart size is within normal limits." The APP



ordered Ms. RAMIREZ to be placed in negative pressure isolation, but because the OMDC medical housing unit (MHU) isolation rooms were full, the APP ordered Ms. RAMIREZ be transported to the Alvarado Hospital emergency room (ER).

- **On June 6, 2018**, Ms. RAMIREZ remained stable. Three sputum samples were collected and a purified protein derivative (PPD) was planted to determine if Ms. RAMIREZ was infected with TB.
- **On June 8, 2018**, the PPD results were reviewed and determined to be negative. A computer tomography (CT) scan of the chest with contrast showed bilateral lower lobes (LL) and left upper lobe (UL) pneumonia. Two of the sputum samples were found to be negative for acid-fast bacilli (AFB), but positive for extended spectrum beta-lactamases (ESBL).
- **On June 11, 2018**, Ms. RAMIREZ underwent a QuantiFERON-TB Gold test, a diagnostic test for latent TB infection, which yielded a positive result for TB.
- **On June 12, 2018**, Ms. RAMIREZ was started on rifampin, isoniazid, pyrazinamide, and ethambutol (RIPE), a medication regiment for TB treatment, with a plan to discharge Ms. RAMIREZ after five days of treatment. Ms. RAMIREZ also saw an infectious disease specialist who changed her administration of amoxicillin-clavulanic acid from oral to intravenous (IV) for seven days.
- **On June 14, 2018**, the third sputum samples came back negative.
- **On June 19, 2018**, Ms. RAMIREZ's RIPE treatment was discontinued due to elevated liver function enzymes.
- **On June 21, 2018**, Ms. RAMIREZ's RIPE treatment was re-initiated with only ethambutol. The following orders were also submitted: laboratory test and lipase in the morning.
- **On June 26, 2018**, Ms. RAMIREZ underwent an echocardiogram which showed aortic stenosis. Ms. RAMIREZ's liver enzymes remained elevated without improvement and ethambutol was discontinued.
- **On June 27, 2018**, ethambutol and rifampin were restarted.
- **On July 3, 2018**, Ms. RAMIREZ remained stable with the re-initiation of TB medications (day five of ethambutol/rifampin/pyridoxine and day three of isoniazid).
- **On July 4, 2018**, Ms. RAMIREZ was discharged to OMDC. A RN notified the APP of Ms. RAMIREZ' return. The APP ordered Ms. RAMIREZ to be admitted to MHU to screen for TB.
- **On July 5, 2018**, a medical doctor (MD) completed Ms. RAMIREZ' physical examination. The MD documented a review of Ms. RAMIREZ' hospital stay which revealed a diagnosis of heart murmur and aortic stenosis and that no surgery was performed. Ms. RAMIREZ's vital signs were stable, with a heart murmur audible over upper sternal border. Ms. RAMIREZ was told to continue her TB medications (RIPE) and omeprazole for heartburn. The MD also submitted a referral for a cardiac surgeon consult for severe asymptomatic aortic stenosis.
- **On July 7, 2018**, Ms. RAMIREZ requested to be seen in sick call for itching to her arms and legs. Per the RN Guidelines, an RN ordered diphenhydramine to treat her condition and instructed Ms. RAMIREZ to return to the clinic if the condition worsened and/or symptoms were not relieved by medication.
- **On July 10, 2018**, Ms. RAMIREZ returned from an off-site appointment with the cardiac surgeon, who recommended aortic valve replacement surgery. The RN scheduled a follow-up appointment with an APP.



- **On July 17, 2018**, a MD submitted a referral for surgery.
- **On July 18, 2018**, a RN obtained blood and urine samples for laboratory testing. Ms. RAMIREZ requested a sick call for continued itching. The RN re-ordered diphenhydramine and encouraged Ms. RAMIREZ to return to the clinic in three days, if symptoms persisted or worsened.
- **On July 19, 2018**, an APP evaluated Ms. RAMIREZ as a follow-up to the July 10, 2018 cardiologist visit. Ms. RAMIREZ denied a history of heart disease or problems. Ms. RAMIREZ' surgery was scheduled for July 25, 2018. The APP continued with diphenhydramine for itching, related to the TB medications. A follow-up appointment was scheduled for one week and the APP submitted a referral for an infectious disease consult.
- **On July 24, 2018**, Ms. RAMIREZ was pre-admitted to the hospital for her scheduled surgery.
- **On July 25, 2017**, Ms. RAMIREZ underwent aortic valve replacement surgery. Prior to the surgery, her vital signs were within normal limits. Post operation, Ms. RAMIREZ was admitted to the intensive care unit (ICU) for close monitoring.

Synopsis of Death

- **On July 26, 2018**, the day following her aortic valve replacement, bleeding was observed and Ms. RAMIREZ became unstable. Ms. RAMIREZ was diagnosed with cardiogenic shock and was returned to surgery to replace the aortic valve prosthesis. During the operation, Ms. RAMIREZ went into a cardiac arrhythmia and passed away.
- On September 20, 2018, the San Diego County Medical Examiner completed Ms. RAMIREZ' autopsy and documented an official cause of death of rheumatic heart disease, with coronary artery disease, pneumonia, and tuberculosis as contributing.



**U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: REYES-Clemente, Abel**

General Demographic/Background Information

- **Date of Birth:** August 5, 1964
- **Date of Death:** April 3, 2019
- **Age:** 54
- **Sex:** Male
- **Country of Citizenship:** Mexico
- **Marital Status:** Single
- **Children:** One son

Immigration History

- Mr. REYES-Clemente told a Deportation Officer during a January 14, 2019 interview that he entered the U.S. illegally on an unknown date, approximately nineteen (19) years ago via Nogales, Arizona.
- On December 28 and 29, 1999, January 3, 2000, June 23, 2008, and July 7, 2008, Mr. REYES-Clemente was encountered by DHS personnel and granted voluntary return to Mexico.
- On February 26, 2019, the Lower Buckeye Jail, in Maricopa County, AZ, released Mr. REYES-Clemente to ICE Enforcement and Removal Operations (ERO) Phoenix's custody. ERO Phoenix served him with a Notice to Appear, Form I-862, and transferred him to the Florence Staging Facility in Florence, AZ.
- On March 1, 2019, ERO Phoenix transferred Mr. REYES-Clemente to the Florence Service Processing Center (FSPC).

Criminal History

- June 12, 2008 - Arrested for outstanding warrants on Assault-Intent/Reckless/Injure (A.R.S. Section 13-1203A1), Disorderly Conduct-Fighting (A.R.S. Section 13-2904A1), and Prevent/Interfere Tele-Emerg (A.R.S. Section 13-2915A3).
- September 19, 2017 - Convicted of Driving Under Influence of Liquor

Medical History

- **On February 27, 2019**, a registered nurse (RN) documented the pre-screening of Mr. REYES-Clemente. Mr. REYES-Clemente reported a three-year history of Type 2 diabetes mellitus. The RN measured Mr. REYES-Clemente's blood sugar at 144. The RN obtained a telephone order from an advanced practice provider (APP) to initiate metformin 500 mg, per os (PO, aka orally), bis in die (BID, aka twice a day), obtain BID blood sugars, and to notify an APP if any blood sugar reading was over 400. Mr. REYES-Clemente's chest x-ray was negative.
- **On February 28, 2019**, an APP completed Mr. REYES-Clemente's physical exam. The exam was normal, except for pterygium (a non-cancerous growth of the eye). The APP diagnosed Type 2 diabetes mellitus, restless leg syndrome (RLS), and tinea unguium (toenail fungal infection). The APP ordered baseline laboratory tests; prescribed metformin 500 mg, PO, BID, to keep on person (KOP), and gabapentin 200 mg, PO, daily, KOP to treat RLS; and noted treatment of the tinea unguium would be considered after reviewing the laboratory results. The APP provided education to Mr. REYES-Clemente and scheduled him for a one-week follow-up.



- **On March 7, 2019**, an APP evaluated Mr. REYES-Clemente, who voiced that the gabapentin was not relieving his RLS. The physical exam was normal. The results of the baseline laboratory tests were reviewed with the following abnormalities noted: creatinine was low at 0.59 (normal range of 0.76 – 1.27), potassium was low at 3.4 (normal range of 3.5 – 5.2), alkaline phosphatase was high at 153 (normal range of 39 – 117), red blood cell count was low at 4.11 (normal range of 4.14 – 5.80), hematocrit was low at 37.4 (normal range of 37.5 – 51.0), and hemoglobin A1c was high at 6.1 (normal range of 4.8 – 5.6). The APP increased the gabapentin dosage to 400 mg, PO, daily; prescribed a daily aspirin, KOP; and scheduled Mr. REYES-Clemente for a four-week follow-up.
- **On March 17, 2019**, an RN advised an APP that Mr. REYES-Clemente refused his blood sugar finger stick.
- **On March 20, 2019**, ERO transferred Mr. REYES-Clemente to LPCC. At LPCC, an RN completed Mr. REYES-Clemente's intake screening. All findings were consistent with those noted at FSPC and his medications were continued. The RN cleared Mr. REYES-Clemente to work in food services and made a routine referral to mental health and dental services. The next day, ERO transferred Mr. REYES-Clemente back to FSPC.
- **On March 25, 2019**, an APP completed Mr. REYES-Clemente's physical exam visit. The APP did not perform a physical exam, noting one had been completed within the last 90 days. All medications and treatments were continued, and annual follow-up appointments were scheduled. No other treatment was provided.
- **On March 29, 2019**, the order to measure Mr. REYES-Clemente's blood sugar BID expired and was not renewed.
- **On March 30, 2019**, a housing unit officer escorted Mr. REYES-Clemente to the medical department, because he was in possession of a bottle of expired metformin. The officer was concerned he may not have been taking his medication as prescribed. Mr. REYES-Clemente was also in possession of a current prescription of metformin. An RN interviewed Mr. REYES-Clemente and determined he was taking his medication as prescribed.
- **On April 1, 2019**, an APP evaluated Mr. REYES-Clemente for complaints of fever, chills, sore throat, and mild cough that began two nights prior. The APP noted a temperature of 100.1, a heartrate of 114, and a pulse oximetry reading (level of oxygen in arterial blood) of 96% (normal range of 95 – 100). The APP noted Mr. REYES-Clemente appeared ill and had the symptoms described. The remainder of the physical exam was normal. The APP diagnosed influenza (flu) and prescribed oseltamivir (antiviral) 75 mg, PO, BID, for the flu, and acetaminophen 650 mg, PO, four times daily, as needed for pain and fever. The APP provided education and planned to see Mr. REYES-Clemente again for his scheduled appointment on April 4, 2019. Later that same day, at 5:23 p.m., the APP ordered that Mr. REYES-Clemente be housed in medical segregation with daily nursing checks.
- **On April 2, 2019**, an RN noted Mr. REYES-Clemente needed assistance to sit up in bed, took his medicines as prescribed, and was encouraged to hydrate and eat throughout the day. His temperature was 100.0. A physical exam was not documented.
 - At 12:15 p.m., an RN completed nursing rounds on Mr. REYES-Clemente, noting a normal physical exam, except a heartrate of 103 and a pulse oximetry reading of 83%. A security officer informed the RN that Mr. REYES-Clemente had been lying in bed all day. The RN encouraged Mr. REYES-Clemente to be more active and educated him on hydration.



- At 2:56 p.m., the RN advised an APP that Mr. REYES-Clemente's pulse oximetry readings ranged from 79–83%, and his heartrate ranged from 103–110. The RN noted Mr. REYES-Clemente was ambulatory in his cell and had no complaints other than knee pain after ambulating. The RN documented a concern that Mr. REYES-Clemente may not have been taking his medications as prescribed, because he was in possession of expired prescriptions for metformin and aspirin.

Synopsis of Death

- **On April 3, 2019, at 4:36 a.m.,** an RN completed nursing rounds on Mr. REYES-Clemente, noting he sat up for the assessment, his heart rate was 100, temperature was 98.6, and pulse oximetry reading was 94%. The RN also noted he refused to take his morning medications.
 - At 6:12 a.m., the segregation housing officer called the medical department for someone to respond, because Mr. REYES-Clemente was having difficulty breathing. While medical staff were en route, a medical emergency was announced, and security staff initiated cardiopulmonary resuscitation (CPR) on Mr. REYES-Clemente as he laid in bed. When the medical staff arrived, Mr. REYES-Clemente was transferred from his bed to the floor. Emergency medical services (EMS) were called. An RN noted Mr. REYES-Clemente was unconscious, unresponsive to any stimuli, had a weak, thready pulse, and that the pulse oximeter could not detect a reading. CPR was continued. Automatic external defibrillator (AED) electrodes were applied to Mr. REYES-Clemente, but the AED advised no shock. CPR was continued. Additional medical personnel and equipment arrived. A RN used suction equipment to remove secretions from Mr. REYES-Clemente's oral airway.
 - At 6:24 a.m., EMS personnel arrived, assumed care of Mr. REYES-Clemente, and continued CPR. The EMT noted Mr. REYES-Clemente was pulseless, had no spontaneous respiration, the back of his right leg and the back of his chest were discolored and appeared to have lividity (the settling of blood into the lowest blood vessels, after death, resulting in the skin being discolored). The electrocardiogram indicated Mr. REYES-Clemente did not have a heartbeat. The EMT reported his findings to a medical doctor (MD) overseeing EMS actions.
 - At 6:33 a.m., the MD pronounced Mr. REYES-Clemente dead.
- On April 29, 2019, the Pinal County Forensic Chief Medical Examiner documented the cause of death as complications of liver cirrhosis, diabetes mellitus, and hypertensive cardiovascular disease, and the manner of death was natural.



**U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: RODRIGUEZ-Espinoza, Roberto**

General Demographic/Background Information

- **Date of Birth:** January 3, 1982
- **Date of Death:** September 10, 2019
- **Age:** 37
- **Gender:** Male
- **Country of Citizenship:** Mexico
- **Marital Status:** Single
- **Children:** NA

Immigration History

- On September 3, 2019, ICE Homeland Security Investigations (HSI) encountered Mr. RODRIGUEZ in Chicago, Illinois (IL), while conducting investigations for violations of the Immigration Nationality Act and transferred Mr. RODRIGUEZ to the custody of ICE Enforcement and Removal Operations (ERO) Chicago at McHenry County Adult Correctional Facility (MCACF) for overnight housing.
- On September 4, 2019, ERO processed Mr. RODRIGUEZ at the Broadview Service Staging Area in Broadview, IL before transferring Mr. RODRIGUEZ back to MCACF.

Criminal History

- On May 29, 2008, Mr. RODRIGUEZ was convicted in Cook County, IL of a class A misdemeanor larceny charge and sentenced to six months' supervision.
- On September 21, 2016, Mr. RODRIGUEZ was convicted of both a class 2 felony burglary charge and a class 1 felony residential burglary charge. Mr. Rodriguez was sentenced to 2 years' probation with 324 days credit time served.

Medical History

- **On September 3, 2019**, an MCACF custody officer completed Mr. RODRIGUEZ's medical intake screening and documented Mr. RODRIGUEZ's appearance as "ok." Mr. RODRIGUEZ did not report any medical or mental health issues, and denied taking any medications, but he reported a history of drinking "a six pack every day." A licensed practical nurse (LPN) reviewed the intake screening and no further actions were noted.
- **On September 7, 2019:**
 - At approximately 3:30 p.m., an MCACF custody officer observed Mr. RODRIGUEZ acting confused and unfamiliar with his surroundings and reported this behavior to an LPN. The LPN observed Mr. RODRIGUEZ's behavior as consistent with possible alcohol withdrawal. The LPN initiated alcohol detoxification protocols and advised the officer to transfer Mr. RODRIGUEZ to medical for observation.
 - At approximately 4:19 p.m., an LPN administered Mr. RODRIGUEZ an immediate dose of chlordiazepoxide (Librium; a tranquilizer used to treat anxiety and alcoholism) 25 mg, by mouth.
 - At approximately 9:45 p.m., the LPN contacted the facility's medical doctor (MD) and reported Mr. RODRIGUEZ's history of alcohol abuse and ongoing altered mental status.



The MD ordered Mr. RODRIGUEZ transferred to the local emergency department (ED) for a neurological evaluation and to rule out delirium tremens.

- At approximately 10:45 p.m., Mr. RODRIGUEZ arrived at Northwestern Medicine Woodstock Hospital (NMWH) ED.
- **On September 8, 2019:**
 - At approximately 2:30 a.m., an MCACF LPN spoke to a NMWH ED medical representative who reported Mr. RODRIGUEZ required a transfer to Northwestern Medicine Huntley Hospital (NMHH) for a higher level of care, due to his severely altered mental status.
 - At approximately 3:10 a.m., Mr. RODRIGUEZ arrived at NMHH, where he received a computed tomography (CT) scan, which showed a bleed in his brain requiring intubation and a neurosurgery evaluation. Since NMHH did not have a neurosurgeon at their facility, NMHH transferred Mr. RODRIGUEZ to Northwestern Medicine Central DuPage Hospital (NMCDH) for a higher level of care.
 - At approximately 7:43 p.m., Mr. RODRIGUEZ arrived at NMCDH and received a neurological examination, to which he failed to respond. NMCDH's neurosurgeon evaluated Mr. RODRIGUEZ and advised against surgery to treat his chronic acute brain bleed because Mr. RODRIGUEZ had irreversible loss of all brain function and a poor chance of survival. The neurosurgeon admitted Mr. RODRIGUEZ into the intensive care unit and placed him on life support.
- **On September 9, 2019,** Mr. RODRIGUEZ remained in critical condition and dependent on life support. ERO continued to seek familial contact in order to determine next steps due to his poor prognosis.

Synopsis of Death

- **On September 10, 2019:**
 - At approximately 8:00 p.m., NMCDH performed imaging studies to identify Mr. RODRIGUEZ's blood flow in his brain. The results showed no blood flow.
 - At approximately 9:35 p.m., NMCDH MDs disconnected Mr. RODRIGUEZ from life support and pronounced him dead.
- Preliminary cause of death: subdural hematoma (a collection of blood outside of the brain).



U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: ROMERO, Ronal Francisco (aka CRUZ, Ronald)

General Demographic/Background Information

- **Date of Birth:** January 24, 1979
- **Date of Death:** May 16, 2018
- **Age:** 39
- **Sex:** Male
- **Country of Citizenship:** Honduras
- **Marital Status:** Single
- **Children:** None reported.

Immigration History

- On May 15, 2002, Mr. ROMERO was encountered and apprehended near Carricitos, Texas (not a Port of Entry) by U.S. Border Patrol (USBP). He was placed under arrest, transported to the Harlingen, Texas USBP station for processing, and ultimately released with a DHS form I-862 – Notice to Appear.
- On September 25, 2002, Mr. Romero was ordered removed in absentia by an Immigration Judge in Houston, Texas.
- On January 20, 2016, U.S. Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) took custody of Mr. ROMERO upon his release from Jackson County Jail in Kansas City, MO for driving while intoxicated.
- On January 21, 2016, ERO received travel documents for Mr. ROMERO, and on January 29, 2016, he was removed from the country via ICE Air Operations.
- On May 9, 2018, USBP apprehended Mr. ROMERO and transported him to the McAllen, TX USBP station for processing.
- On May 12, 2018, Mr. ROMERO had his Final Order of Removal reinstated and ERO requested travel documents.

Criminal History

- On January 14, 2016, Mr. ROMERO was convicted of Driving Under the Influence, and was sentenced to two (2) days in jail.

Medical History

- **On May 14, 2018**, Mr. ROMERO arrived at Port Isabel Detention Center (PIDC) and underwent intake screening conducted by a licensed vocational nurse (LVN). Mr. ROMERO had no medical or mental health complaints, his vital signs were within normal limits, and the LVN labeled Mr. ROMERO's intake screening as "normal."
- **On May 15, 2018**, an advanced practice provider (APP) evaluated Mr. ROMERO as a referral from nurse sick call. Mr. ROMERO complained of fever, headache, left ear pain, sore throat, and body aches. Based on the examination, the APP diagnosed Mr. ROMERO with fever, streptococcal pharyngitis (aka "strep throat"), and unspecified abnormal findings in urine. The APP ordered amoxicillin for 10 days and ordered baseline laboratory tests. The APP admitted Mr. ROMERO to the medical housing unit (MHU) for treatment and intravenous fluid (IV) management. A physician reviewed and co-signed the APP's treatment plan. Later, an APP evaluated Mr. ROMERO for altered mental status and noted:



“mental status: stupor, slow responsiveness; eyes: pupils sluggish, round, hyporeactive to light, and accommodation; neurology: cooperative with exam, lethargic, follows commands (albeit to a limited extent); assessment: altered mental status.” The APP ordered and referred Mr. ROMERO to a local emergency department by emergency medical services’ (EMS) transport for further evaluation.

Synopsis of Death

- **On May 16, 2018**, Mr. ROMERO was admitted to the medical intensive care unit at the Valley Baptist Medical Center (VBMC) with a diagnosis of diabetic ketoacidosis (a life-threatening complication of diabetes mellitus) and sepsis (infection). VBMC reported Mr. ROMERO had coded (emergency resuscitative efforts for cardiopulmonary arrest), was successfully resuscitated at 12:55 a.m. and 1:09 a.m., and started him on medications for circulatory support. Mr. ROMERO coded at approximately 8:30 a.m. with a heart rhythm of asystole (no heart activity), but was successfully resuscitated after approximately 10 minutes (however, he remained unresponsive). At 4:30 p.m., the attending physician pronounced Mr. ROMERO brain dead, and ordered to keep Mr. ROMERO on his current medications and ventilatory support. At 6:48 p.m., Mr. ROMERO again coded, and despite 20 minutes of advanced cardiac life support measures, he was pronounced dead.
- On June 15, 2018, the State of Texas issued a Certificate of Death documenting Mr. ROMERO’s cause of death as meningitis, clinical history of diabetic ketoacidosis, clinical history of sepsis, and no evidence of trauma.



**U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: SINGH, Simratpal**

General Demographic/Background Information

- **Date of Birth:** January 29, 1998
- **Date of Death:** May 3, 2019
- **Age:** 21
- **Gender:** Male
- **Country of Citizenship:** India
- **Marital Status:** Single
- **Children:** NA

Immigration History

- On February 5, 2019, U.S. Border Patrol (USBP) arrested Mr. SINGH near Otay Mesa, CA, for illegal entry into the United States.
- On February 9, 2019, USBP transferred Mr. SINGH to the custody of ICE Enforcement and Removal Operations (ERO) Phoenix at the San Luis Regional Detention Center (SLRDC), in San Luis, AZ for 11 days before ultimately transferring him to La Palma Correctional Center (LPCC), in Eloy, AZ.
- On April 29, 2019, ERO Phoenix released Mr. SINGH on bond.
- On May 1, 2019, La Paz County Jail (LPCJ) notified ERO Phoenix of Mr. SINGH's arrest and ERO Phoenix lodged an immigration detainer.
- On May 2, 2019, Mr. SINGH posted bond in his criminal case and was transferred to the legal custody of ERO Phoenix while remaining detained at LPCJ.

Criminal History

- On April 30, 2019, the La Paz County Sheriff's Office arrested Mr. SINGH for "assault and sexual assault" and booked him into LPCJ.

Medical History

- During Mr. SINGH's detention period at SLRDC from February 12 to 20, 2019, there were no reported medical or mental health concerns.
- During Mr. SINGH's detention period at LPCC from February 20 to April 29, 2019, Mr. SINGH denied any history of medical or mental health concerns. His mental health examination was normal. He accessed sick call on three occasions for treatment of minor ailments. No further complaints were noted.
- During Mr. SINGH's detention period at LPCJ from April 30 to May 2, 2019, ICE records contain no reports of medical or mental health concerns.
- **On May 2, 2019**, between 9:30 and 11:30 a.m., an LPCJ custody officer interviewed Mr. SINGH to conduct his classification assessment. The custody officer completed a formal classification assessment and assigned him to protective segregation housing. The custody officer returned SINGH to his holding cell pending the housing transfer.
- At 5:56 p.m., LPCJ custody staff called a medical emergency after discovering Mr. SINGH hanging in his cell. Mr. SINGH was unresponsive, not breathing, and did not have a pulse. LPCJ custody and medical staff administered cardiopulmonary resuscitation (CPR).



U.S. Immigration and Customs Enforcement
Enforcement and Removal Operations

- At 5:59 p.m., LPCJ contacted the Parker, AZ Fire Department (PFD) and River Medical Emergency Medical Services (EMS).
- At 6:15 p.m., EMS and PFD arrived on scene and determined that Mr. SINGH did not have a pulse or a heart rhythm. EMS and PFD took over CPR efforts.
- At 6:20 p.m., EMS transported Mr. SINGH to the local emergency department at the La Paz Regional Hospital (LPRH), in Parker, AZ. Upon arrival to LPRH's emergency department, Mr. SINGH required critical care services.
- At 6:58 p.m., LPRH medical staff regained Mr. SINGH's pulse and heart rhythm.
- At 9:53 p.m., LPRH transferred Mr. SINGH by air EMS to Abrazo West Campus Hospital (AWCH) in Goodyear, AZ, for a higher level of care.
- At 10:43 p.m., Mr. SINGH arrived at AWCH in a deep comatose state with a pulse and heartbeat. Mr. SINGH experienced sudden cardiac arrest, and despite life-saving measures, medical staff were unable to resuscitate him.
- **On May 3, 2019** at 1:58 a.m., Mr. SINGH died. Mr. SINGH's preliminary cause of death was anoxic (absence of oxygen) brain injury and respiratory failure.

Synopsis of Death

- On July 31, 2019, the Maricopa County Office of the Medical Examiner documented Mr. SINGH's cause of death as hanging and the manner of death as suicide.



**U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: TRAN, Huy Chi**

General Demographic/Background Information

- **Date of Birth:** August 7, 1970
- **Date of Death:** June 12, 2018
- **Age:** 47
- **Sex:** Male
- **Country of Citizenship:** Vietnam
- **Marital Status:** Single
- **Children:** None reported

Immigration History

- Mr. TRAN was admitted as a Lawful Permanent Resident (P53) at San Francisco, California on June 25, 1984.
- On November 9, 2000, Mr. TRAN was encountered and interviewed at the Arizona Department of Corrections (ADOC) Alhambra Intake and Reception Facility (Alhambra). Mr. TRAN claimed there are no applications or petitions pending on his/her behalf with U.S. Immigration and Customs Enforcement (ICE).
- Mr. TRAN was apprehended on March 25, 2003, and booked into the Eloy Detention Center (EDC) on March 31, 2003.
- Mr. TRAN was issued a Final Order of Removal on September 21, 2004.
- On January 5, 2005, Mr. TRAN was released from EDC on an Order of Supervision (Zadvydas Release). ICE was unable to obtain travel documents for Mr. TRAN.
- On August 14, 2013, Mr. TRAN was booked into the Phoenix Hold Room, and then released on an Order of Recognizance
- On July 12, 2017, an ICE 287(g) officer encountered and interviewed Mr. TRAN at the ADOC Alhambra facility.
- On May 25, 2018, ADOC released Mr. TRAN to ICE ERO, and he was processed and booked into the Florence Service Processing Center (SPC).
- On May 28, 2018, ICE ERO transferred Mr. TRAN to the EDC.

Criminal History

- On May 8, 1994, Mr. TRAN was convicted of Disorderly Conduct and sentenced to 12 months of probation.
- On September 12, 1996, Mr. TRAN was convicted of Shoplifting and fined \$320.
- On November 3, 1996, Mr. TRAN was convicted of Disorderly Conduct and sentenced to three (3) years of probation.
- On November 22, 1996, Mr. TRAN was convicted of Shoplifting and fined \$300.
- On October 25, 2000, Mr. TRAN was convicted of two counts of Aggravated Assault (Non-family-Strongarm and Non-family-Weapon) and sentenced to 3.5 years imprisonment in the ADOC.
- On April 8, 2009, Mr. TRAN was convicted of Aggravated Assault (Family-Weapon). And was sentenced to five (5) years imprisonment in the ADOC.



- On August 14, 2015, Mr. TRAN was convicted of Damaging Property and sentenced to 120 days in jail and three (3) years of probation.
- On July 10, 2017, Mr. TRAN was convicted of Disorderly Conduct and sentenced to one year and six months (1.5 years) imprisonment in the ADOC.

Medical History

- **On May 25, 2018**, a licensed vocational nurse (LVN) completed Mr. TRAN's prescreening. Mr. TRAN denied any medical issues, current or chronic, but stated he was taking medications to treat schizophrenia and major depressive disorder. The LVN labeled Mr. TRAN's prescreening as priority level – 1 (PRI-1).
- **On May 26, 2018**, a registered nurse (RN) completed the Mr. TRAN's intake screening, noting he verbalized a history of and taking medication for depression for the past 20 years. Mr. TRAN denied any suicidal or homicidal thoughts, hallucinations, or history of substance abuse or mental health hospitalizations. The RN completed the abnormal involuntary movement scale (AIMS) assessment on Mr. TRAN and documented a score of zero. The RN consulted with an advanced practice provider (APP) and received verbal orders to continue Mr. TRAN's medications and to schedule him for a physical examination and a mental health appointment on May 29, 2018. A licensed clinical social worker (LCSW) completed Mr. TRAN's mental health intake. The LCSW assessed Mr. TRAN with schizophrenia, scheduled a follow-up appointment on June 2, 2018, and encouraged him to continue to take his prescribed medications.
- **On May 28, 2018**, Mr. TRAN was transferred to EDC. An RN completed Mr. TRAN's prescreening and reviewed Mr. TRAN's Florence transfer summary. Mr. TRAN denied suicidal/homicidal ideations; however, he appeared anxious. The RN labeled Mr. TRAN's prescreening as "PRI-1." A RN conducted Mr. TRAN's intake screening, where he denied a history of current medical, dental, or mental health conditions but stated he took medication for depression. Mr. TRAN again denied any suicidal or homicidal ideations. Mr. TRAN's vital signs were within normal limits. The RN labeled Mr. TRAN's intake screening as "abnormal" and submitted a referral to medical and mental health for further evaluation. A physician (MD) reviewed the RN's telephone encounter and scheduled Mr. TRAN's evaluation on June 4, 2018. An APP completed Mr. TRAN's physical examination, noting Mr. TRAN was missing all his lower and upper teeth without a prosthesis. Mr. TRAN denied a history of head injury or surgery. The APP noted an existing mental health referral. Mr. TRAN verbalized a history of schizophrenia and "moderate" anxiety disorder for 17 years, and denied any side effects from the medication. Mr. TRAN's vital signs were within normal limits, and his AIMS score was zero. The APP's assessment included schizophrenia, unspecified, and anxiety disorder, unspecified, with orders for medication. The APP ordered Mr. TRAN's blood work for May 31, 2018.
- **On May 31, 2018**, a RN drew Mr. TRAN's blood work.
- **On June 1, 2018**, the APP received and reviewed Mr. TRAN's laboratory results.
- **On June 04, 2018**, the MD completed the initial mental health evaluation on Mr. TRAN. The MD documented an AIMS score of 3, indicating evidence of tardive dyskinesia (TD). The MD documented that Mr. TRAN does not pose as an imminent risk of danger to others/danger to self (DTO/DTS). Despite of his current mental health, he is able to cope in the general population, which is the least restrictive alternative for him. The MD adjusted when Mr. TRAN takes his medications.



- **On June 5, 2018**, the MD requested Mr. TRAN's complete health record from Corizon Health – ADOC Arizona State Prison Complex (ASPC) Tucson-Manzanita as well as his Southwest Network – San Tan Clinic, Chandler, AZ, medical records. The psychologist (PsyD) evaluated Mr. TRAN and documented that Mr. TRAN "presented as depressed and apathetic." Initially, Mr. TRAN 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." Mr. TRAN acknowledged that he had been moving more slowly overall, which "began in the last few weeks." Mr. TRAN denied issues with sleep or appetite. He said that he has been consistently taking his psychotropic medication, and denied any thoughts of self-harm, plan, and intent. The PsyD ordered Mr. TRAN's placement in medical housing observation (MHO) with mental health nursing checks twice-a-day, CoreCivic checks every 15 minutes, and for the mental health provider to follow up with Mr. TRAN in two days.

Synopsis of Death

- **On June 5, 2018**, the APP documented a medical emergency was called and medical responded to find Core Civic officers performing cardiopulmonary resuscitation (CPR) on Mr. TRAN. Medical assisted with CPR and initiated a call for emergency medical services (EMS). When EMS arrived on the scene, they took over CPR and prepared Mr. TRAN for transport to Banner Casa Grande Medical Center's emergency department.
- During Mr. TRAN's eight-day hospitalization, he remained unresponsive with no reflexes, including gag and pupils; on mechanical ventilation; receiving hypothermia therapy; and medication management.
- **On June 12, 2018**, the doctor performed an electroencephalography (EEG) that showed no brain activity. These findings were confirmed with apneic, resulting in Mr. TRAN pronounced brain dead.
- On July 17, 2018, the Chief Medical Examiner signed the completed forensic examination report, stating the cause of death was coronary artery disease.



**U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: VOLKOV, Guerman**

General Demographic/Background Information

- **Date of Birth:** February 16, 1962
- **Date of Death:** November 30, 2018
- **Age:** 56
- **Sex:** Male
- **Country of Citizenship:** Russia
- **Marital Status:** Single
- **Children:** None

Immigration History

- Mr. VOLKOV entered the United States through Miami, Florida on November 4, 1998 as a nonimmigrant Temporary Visitor for Pleasure/B-2 with authorization to remain in the United States for a temporary period not to exceed May 3, 1999. Mr. VOLKOV remained in the United States beyond May 3, 1999 without authorization.
- On June 26, 2017, Mr. VOLKOV was encountered at the Pasco County Jail (PCJ) in Land O' Lakes, Florida. Mr. VOLKOV readily admitted he did not have any valid documents to lawfully be or remain in the United States. Mr. VOLKOV was taken into custody without incident and transported to the Tampa ERO resident office for processing and issuance of a Notice to Appear.
- On June 26, 2017, Mr. VOLKOV was booked into the Baker County Detention Center.
- On December 15, 2017, Mr. VOLKOV was issued a Final Order of Removal.
- On January 29, 2018, ERO requested travel documents for Mr. VOLKOV.

Criminal History

- 05/13/1999 – DISORDERLY CONDUCT (NCIC 5311) – Convicted (09/08/1999) and had to pay court costs
- 12/25/1999 – DRIVING UNDER INFLUENCE LIQUOR (NCIC 5404) – Convicted (02/02/2000) sentenced to nine (9) months' probation, fined, and had to pay court costs
- 02/10/2016 – FELONY ASSAULT (NCIC 1399) – Convicted (03/18/2016) sentenced to time served (38 days), one-year probation, and had to pay court costs

Medical History

- **On June 27, 2017**, a licensed practical nurse (LPN) completed Mr. VOLKOV's intake screening and reviewed his accompanying PCJ and Pinellas County Sheriff's Office transfer summaries. The transfer summaries noted Mr. VOLKOV had a medical history of hypertension and conversion disorder (a mental condition in which a person has blindness, paralysis, or other neurologic symptoms that cannot be explained by medical evaluation) and was on the following medications: lisinopril and metoprolol (anti-hypertensive medications) and levetiracetam and carbamazepine (anti-seizure medications for conversion disorder). Mr. VOLKOV reported a history of seizure disorder (last seizure two months ago), hypertension, a heart condition, broken/missing teeth, and denied a history of mental health conditions. His vital signs (VS) were within normal limits (WNL), except an elevated blood pressure (BP) of 136/90 (normal 120/80). The LPN consulted with Baker County Detention



Center's (BCDC) medical director (MD) regarding Mr. VOLKOV's medical conditions and scheduled Mr. VOLKOV for a chronic care clinic evaluation. The MD continued Mr. VOLKOV's medications.

- **On June 29, 2017**, an MD completed Mr. VOLKOV's chronic care evaluation. Mr. VOLKOV did not report any symptoms and his examination was unremarkable, except for an elevated BP of 155/102. The MD ordered an EKG for that day and laboratory studies to be drawn on July 3, 2017: complete blood count (CBC) with differential, comprehensive metabolic panel (CMP), lipid profile, carbamazepine level, and a urinalysis (UA).
- **On July 3, 2017**, the laboratory studies were drawn as ordered on June 29, 2017. Mr. VOLKOV's abnormal laboratory studies results showed mild anemia and mildly elevated cholesterol (very low-density lipoprotein (VLDL) and low-density lipoprotein (LDL).
- **On September 12, 2017**, an MD evaluated Mr. VOLKOV for his chronic care conditions and a painful left inguinal hernia. Mr. VOLKOV denied any past hospitalizations and his VS were WNL. The MD documented a good degree of control of Mr. VOLKOV's hypertension and seizure disorder with his current medications.
- **On September 12, 2017**, BCDC's security staff notified an LPN that Mr. VOLKOV stated, "If I can't go home, then I just want to kill myself." The LPN notified a licensed mental health counselor (LMHC) and initiated suicide watch protocols.
- **On September 13, 2017**, a Licensed Mental Health Clinician (LMHC) discontinued suicide precautionary measures and cleared Mr. VOLKOV for general population.
- **On September 20, 2017**, a LMHC evaluated Mr. VOLKOV during a mental health encounter. Mr. VOLKOV presented with rapid speech, anxiety, possible delusional speech, and reported he felt unsafe, because there was a "hit" ordered on his life by President Trump and the sheriff. He also voiced that he was afraid he would be raped during the night. Mr. VOLKOV felt reassured after a custody officer informed him of the 15-minute safety checks. He denied suicidal or homicidal ideations.
- **On October 11, 2017**, Mr. VOLKOV reported to the LMHC complaining of irritability and dysphoria (a profound state of unease or dissatisfaction). He denied suicidal and homicidal ideations.
- **On October 23, 2017**, a RN documented Mr. VOLKOV's VS were stable, except for a low BP of 79/56 right arm and 82/62 left arm. The RN gave Mr. VOLKOV some Gatorade and encouraged him to increase his fluid intake. Later that day, Mr. VOLKOV's BP was 90/56 and he was asymptomatic.
- **On December 6, 2017**, a LMHC reported to an LPN that Mr. VOLKOV was not feeling well. Mr. VOLKOV provided mumbled responses to questions pertaining to his BP of 75/58. The MD was notified and ordered continued monitoring and to hydrate with Gatorade. Later that day, a psychiatrist evaluated Mr. VOLKOV for previous reports of "racing thoughts." During the assessment, Mr. VOLKOV presented calm, cooperative, and reported having a good appetite and no seizures. Mr. VOLKOV reported difficulty sleeping and requested medication for insomnia. The psychiatrist diagnosed Mr. VOLKOV with acute stress disorder, with anxiety, insomnia, and hallucinations. The psychiatrist continued chlorpromazine and initiated hydroxyzine pamoate (antihistamine and sleep aid).
- **On December 26, 2017**, a BCDC's custody officer notified medical staff that Mr. VOLKOV was found "lying in bed and not acting right." An LPN saw Mr. VOLKOV lying on his back, with his right leg elevated and bent, due to muscle spasms. The LPN notified



the MD, who ordered a one-time dose of cyclobenzaprine (muscle relaxant). The LPN administered the medication to Mr. VOLKOV and scheduled him for an MD follow-up.

- **On February 13, 2018**, a RN consulted with the MD after Mr. VOLKOV allegedly reported he fell (unwitnessed). The MD ordered Mr. VOLKOV to be admitted to the MHU for oral rehydration, pending evaluation. Mr. VOLKOV reported he hit his forehead during the fall. The RN identified a quarter size abrasion to his left forehead and on exam, his pupils were equal, reactive to light, and accommodation. Mr. VOLKOV denied having any nausea, sweating, or pain, and his VS were WNL, except for a low BP of 85/65. The RN provided Mr. VOLKOV with Gatorade and an ice pack for his forehead.
- **On February 14, 2018**, Mr. VOLKOV refused all morning medications, Gatorade, and his BP was 70/52. A RN received a verbal order from the MD to continue encouraging oral hydration and to obtain the following laboratory studies: complete blood count, comprehensive metabolic panel, and carbamazepine and levetiracetam levels. Mr. VOLKOV's VS were WNL and he denied any further complaints.
- **On February 18, 2018**, Mr. VOLKOV's BP was 63/50. The LPN contacted the MD. The following verbal orders were given: hold Mr. VOLKOV's BP medications, discontinue metoprolol, encourage fluid hydration with Gatorade, and continue BP checks every shift, for five days.
- **On February 20, 2018**, the MD discharged Mr. VOLKOV from MHU to general population and ordered the following: discontinuation of metoprolol, increase oral fluids and exercise, and continue BP monitoring for five days.
- **On August 8 and 9, 2018**, Mr. VOLKOV refused his annual health assessments.
- **On October 3, 2018**, a LMHC identified Mr. VOLKOV's medications were expired and he refused psychiatric treatment. The LMHC educated Mr. VOLKOV on the importance of medication compliance and adherence to scheduled medical appointments.
- **On November 26, 2018**, at 7:05 a.m., a LPN responded to an urgent call to evaluate Mr. VOLKOV in the dorm for "unresponsiveness." Mr. VOLKOV's vital signs were abnormal with an elevated pulse (P) rate of 114 and a respiratory (R) rate of 22, and a low oxygen saturation (SaO₂) of 86%. Mr. VOLKOV also had an elevated random blood sugar level of 187 mg/dl. Mr. VOLKOV appeared pale, diaphoretic (sweating), confused, with periods of apnea (cessation of breathing), difficult arousing, and abrasions to his skin. The LPN notified the medical director, who ordered to initiate oxygen via non-breather mask and transport to local emergency department (ED) via emergency medical services (EMS).
 - At approximately 7:15 a.m., EMS transported Mr. VOLKOV from BCDC to Ed Fraser Memorial Hospital (EFMH) ED.
 - At 9:45 a.m., EFMH's staff provided an update to BCDC's LPN: stable condition, and that Mr. VOLKOV would be transferred to Memorial Hospital of Jacksonville (MHJ) for continued evaluation and treatment.
- **On November 28, 2018**, at 8:30 p.m., an MD gave a verbal order to a RN to admit Mr. VOLKOV to the MHU for observation when discharged from MHJ, to include the implementation of suicide watch protocols because Mr. VOLKOV had verbally expressed a desire to die in the hospital.
 - At 8:15 p.m., a BCDC RN contacted MHJ for a status update. MHJ staff reported Mr. VOLKOV was diagnosed with a small bowel obstruction, had a hemoglobin (Hgb) result of 8.4 g/dl, and nutritional support was provided using a nasogastric tube (catheter inserted through the nose, past the throat, and down into the stomach).



- The RN also reported that Mr. VOLKOV was verbally abusive to MHJ's staff and reported that he would rather die than to get better and he wished to die.
- At 9:00 p.m., Mr. VOLKOV returned to BCDC from MHJ "against medical advice." He was admitted to the MHU on suicide watch and referred to a mental health provider. Mr. VOLKOV refused vital signs assessment.
 - • At 10:10 p.m., Mr. VOLKOV refused to have a physical exam performed.
 - **On November 29, 2018**, during morning rounds, an RN administered Mr. VOLKOV's medications and scheduled him a same day psychiatric appointment. His VS were WNL and he denied any complaints.
 - At 7:55 a.m., Mr. VOLKOV reported, "I don't want to kill myself, not today, not tomorrow, not next month." The LMHC discontinued the suicide watch protocols and initiated mental health observation, with clothing and utensil restrictions, for every thirty minutes.
 - At 9:00 a.m., an MD evaluated Mr. VOLKOV for unstable VS and altered mental status. The MD evaluated Mr. VOLKOV in a wheelchair and reported he was in stable condition.
 - At 12:15 p.m., the LMHC initiated a special needs form to discontinue all suicide watch protocols and cleared Mr. VOLKOV for general population without restrictions. Mr. VOLKOV did not exhibit any signs or symptoms of suicidal/homicidal ideations.
 - At approximately 7:10 p.m., a psychiatrist evaluated Mr. VOLKOV and found him experiencing shortness of breath while talking and unable to verbalize if his abdomen was hurting. "Nurses advised to consult with primary care for [chest x-ray] and possible aspiration pneumonia." Mental status exam (MSE): disheveled appearance, oriented with good eye contact, anxious with congruent affect, intact memory, unremarkable behavior, cooperative, coherent speech, and unremarkable thought content. Mr. VOLKOV denied any suicidal or homicidal ideations, or distorted perception. Mr. VOLKOV presented with anxiety and complained of a poor appetite. The psychiatrist diagnosed Mr. VOLKOV with unspecified psychosis. All psychotropic medications were ordered to be held at this time due to a possible small bowel obstruction, and a follow-up visit was scheduled in 30 days.

Synopsis of Death

- **On November 30, 2018**, an RN evaluated Mr. VOLKOV in MHU. He did not report or appear to be in acute distress. His vital signs were: BP 143/94, P 112, R 23 (even and unlabored), and SaO2 was 96% on room air. Examination: lung sounds clear in all four quadrants.
- At approximately 11:30 a.m., the MD examined Mr. VOLKOV and noted the following: alert and oriented, visibly in distress, difficulty breathing, distended abdomen, severe abdominal pain on palpation, negative bowel sounds, and pale skin. His vital signs were: BP 94/61, P 120, R 16, and SaO2 of 76%.
- At approximately 11:48 a.m., the MD ordered Mr. VOLKOV to be transported to the local hospital and informed him of his assessment findings, his pending hospital referral, and the importance of remaining in the hospital.
- At approximately 12:05 p.m. Mr. VOLKOV was transported to MHJ's ED via EMS.



- At approximately 12:59 p.m., Mr. VOLKOV arrived at MHJ's ED. The admitting diagnosis was ascites (excess fluid in the abdomen), unstable vital signs, dyspnea (shortness of breath), and generalized weakness. Mr. VOLKOV complained of mid to umbilical abdominal pain. Examination: alert, oriented, but displayed symptoms of respiratory distress. Mr. VOLKOV's vital signs were: T 97.1, R 26, P 120, BP 91/64, and SaO2 of 86%, on room air. Fifteen liters of oxygen were initiated via non-rebreather mask and his SaO2 increased to 96%. Abdomen: bowel sounds sluggish in upper right and left quadrants and absent in right and left lower quadrant.
- At approximately 1:11 p.m., Mr. VOLKOV "vomited feces" and experienced cardiac arrest. Advanced cardiac life support (ACLS) measures were initiated. After forty-eight minutes of an unsuccessful resuscitation, an MHJ physician pronounced Mr. VOLKOV dead at 1:59 p.m.



**U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: ABIENWI, Nebane**

General Demographic/Background Information

- **Date of Birth:** October 28, 1981
- **Date of Death:** October 1, 2019
- **Age:** 37
- **Gender:** Male
- **Country of Citizenship:** Cameroon
- **Marital Status:** Married
- **Children:** 3

Immigration History

- On September 5, 2019, Mr. ABIENWI presented to the San Ysidro Port of Entry in San Ysidro, California (CA). U.S. Customs and Border Protection (CBP) officers detained Mr. ABIENWI at the San Ysidro Admissibility Enforcement Unit.
- On September 19, 2019, ICE booked Mr. ABIENWI into custody and placed him at the Otay Mesa Detention Center (OMDC).

Criminal History

- N/A

Medical History

- **On September 11, 2019**, while Mr. ABIENWI was in CBP custody, an advanced practice provider (APP) evaluated him for constipation and a skin rash. The APP documented normal vital signs and a normal physical examination and cleared him for transport.
- **On September 18, 2019**, a registered nurse (RN) completed Mr. ABIENWI's pre-screening evaluation. Mr. ABIENWI asserted a history of past/current illness and taking medications. The RN assigned Mr. ABIENWI "priority 1" status for an expedited intake screening.
- **On September 19, 2019**, an RN completed Mr. ABIENWI's ICE intake screening. Mr. ABIENWI reported the following history: a three-day hospitalization in Mexico for elevated blood pressure readings; a hypertension diagnosis on August 23, 2019, also in Mexico; taking antihypertensive medications for two weeks (discontinued by a doctor because his blood pressure was "already normal"); sexual abuse in December 2017; and rarely drinking four cans of beer, the last instance of which was on September 4, 2019. The RN documented normal vital signs and a lower abdominal rash. As the intake screening was normal, a routine physical examination was scheduled for September 29, 2019.
 - Mr. ABIENWI's OMDC medical records included a certificate dated August 30, 2019, for medical care provided in Mexico, at the Centro De Salud Tijuana. This record outlined Mr. ABIENWI's medical history of hypertension and medication orders for captopril 25 mg (antihypertensive) and ranitidine 150 mg (antacid).
- **On September 26, 2019:**
 - At approximately 3:24 a.m., an OMDC custody officer called a medical emergency for Mr. ABIENWI after he fell off his top bunk, landed on blankets on a chair, and sat on the floor.



- At approximately 3:28 a.m., an RN responded to the medical emergency and observed Mr. ABIENWI confused, sweating, not responding to commands, unable to move the extremities on his left side, experiencing “jerky movements” in all extremities, and complaining of thirst.
- At approximately 3:43 a.m., the RN documented Mr. ABIENWI’s ability to speak and respond to questions; however, he was only alert and oriented to his name. The RN documented normal vital signs except for an elevated blood pressure reading of 180/100 (normal range is between 90/60 and 120/80 mmHg).
- At 3:50 a.m., OMDC staff contacted emergency medical services (EMS).
- At approximately 4:12 a.m., EMS arrived at OMDC.
- At approximately 4:34 a.m., EMS departed OMDC with Mr. ABIENWI.
- At Sharp Chula Vista Medical Center (SCVMC), an emergency department physician (MD) completed Mr. ABIENWI’s physical examination, documented his inability to follow commands, nonverbal responses, and inability to open his eyes. The MD intubated (insertion of a tube into the trachea for ventilation) Mr. ABIENWI, initiated ventilator-assisted breathing, and consulted a neurosurgeon who admitted him to the intensive care unit (ICU). Mr. ABIENWI was diagnosed with acute severe right intraparenchymal hemorrhage (bleeding within the brain).
- **From September 27 to 30, 2019**, Mr. ABIENWI remained in the ICU with multi-system organ involvement, declining neurological examinations, and a high risk for morbidity and mortality.

Synopsis of Death

- **On October 1, 2019**, at approximately 12:05 p.m., two SCVMC MDs confirmed Mr. ABIENWI’s clinical examination results were consistent with brain death and pronounced him dead.
 - At approximately 12:38 p.m., Mr. ABIENWI’s wife was notified of Mr. ABIENWI’s death.
 - At approximately 2:37 p.m., SCVMC discontinued Mr. ABIENWI’s ventilator support.
- Preliminary cause of death: brain death secondary to herniation secondary to basal ganglia hemorrhage.



**U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: AHN, Choung Woong**

General Demographic/Background Information

- **Date of Birth:** June 2, 1945
- **Date of Death:** May 17, 2020
- **Age:** 74
- **Gender:** Male
- **Country of Citizenship:** South Korea
- **Marital Status:** Married
- **Children:** N/A

Immigration History

- On November 3, 1988, Mr. AHN was admitted into the United States (U.S.) in San Francisco, California (CA) as a lawful permanent resident.
- On February 21, 2020, Enforcement and Removal Operations (ERO) San Francisco took custody of Mr. AHN upon his release from Solano State Prison in Vacaville, CA. ERO San Francisco issued and served a Notice to Appear (Form I-862), charging AHN as being a removable alien under § 237 (a)(2)(A)(iii) of the Immigration and Nationality Act (convicted of an aggravated felony after admission). Mr. AHN was transferred to Mesa Verde ICE Processing Facility (MVIPF) for detention.
- On April 28, 2020, ERO conducted a case review for COVID-19 pandemic risk factors, and continued detention due to high flight risk/or risk to public safety.
- On May 13, 2020, a district court denied bail.

Criminal History

- On June 25, 2013, the Superior Court of California convicted Mr. AHN for the offense of attempted murder in violation of California Penal Code (CPC) Section 187(a) with an enhancement for using a firearm in violation of CPC Section 12022.5. The court imposed a sentence of seven years in prison for the offense of attempted murder with an additional three years for the firearms enhancement.

Medical History

MVIPF Medical Records

- **On February 22, 2020**, a licensed vocational nurse (LVN) completed Mr. AHN's medical intake screening and noted a history of hypertension (HTN), type 2 diabetes mellitus (T2DM), angina (chest pain), and hyperlipidemia (HLD). Mr. AHN denied a history of mental health conditions and suicide attempts/ideations. He also denied allergies, recent hospitalizations, and tobacco, alcohol, or drug use. The LVN's observations and Mr. AHN's vital signs (VS) were normal. The LVN continued Mr. AHN's medications, referred him to an advanced practice provider (APP), and cleared him for general population (GP).
- **On February 24, 2020**, Mr. AHN's chest x-ray result revealed unfolding and tortuosity of the thoracic aorta, 5.0 x 5.0 cm size mass-like infiltrate peripheral to right lower hilum. "Malignancy must be suspected, negative for active pulmonary tuberculosis (TB)." An APP reviewed and signed the results on February 25, 2020.



- **On February 25, 2020**, an APP completed Mr. AHN's health appraisal and initial chronic condition evaluation.
 - Mr. AHN reported a history of T2DM since 1995, HLD since 2015, angina since 2019, HTN since 2017, and latent tuberculosis infection (LTBI), since February 2020.
 - Mr. AHN denied a history of surgeries, hospitalizations, mental health disorders, suicide attempt(s)/ideation(s), TB disease, and recent use of tobacco, alcohol, or illicit drugs.
 - Mr. AHN's VS and exam were normal, but he complained of chronic low back pain. The APP diagnosed the following conditions: HTN, chronic pain, HLD, angina, and LTBI. The APP ordered acetaminophen for pain and added a gas reliever (simethicone) and aspirin to his medication list.
 - The APP ordered baseline laboratory tests and procedures, a cardiac diet, blood glucose monitoring every morning for thirty days, continue medications as noted, and scheduled a three-month follow-up visit.
- **On March 6, 2020**, the medical doctor (MD) evaluated Mr. AHN for follow-up of abnormal chest x-ray results. Mr. AHN's VS and exam were normal.
 - Mr. AHN stated, in the past, he was told his chest x-ray was abnormal, admitted to positive LTBI and tobacco use (one pack per day for thirty years), and denied TB prophylaxis, BCG vaccine (TB vaccine), or current symptoms. Mr. AHN refused LTBI treatment, was informed of the benefits of treatment and the risks in refusing treatment, signed a refusal, and requested to stop the daily blood sugar monitoring.
 - The MD diagnosed Mr. AHN with a hilar mass – patient with history of smoking and rule out malignancy, and ordered the following: chest CT scan – to be completed within two weeks, discontinue daily blood sugar monitoring, and add coccidioides titer [*result: negative*] to the previously ordered laboratory tests.
- **On March 12, 2020**, during sick call, a registered nurse (RN) evaluated Mr. AHN for complaint of a worsening non-productive cough and sore throat for three days. The RN noted history of right hilar mass and CT scan scheduled for next week. His VS and exam were normal, except diminished right upper and lower lung sounds and throat redness.
 - The RN referred Mr. AHN to the APP, and an order was obtained to transfer him to the hospital emergency department (ED). Mr. AHN was admitted to Mercy Truxtun Hospital (MTH) for cough with a history of right hilar mass, LTBI, T2DM, HTN, and HLD. His VS and examination were normal.
- **On March 13 and 14, 2020**, a pulmonologist evaluated Mr. AHN. His chest CT scan results revealed a 6.7 cm x 5.2 cm size mass-like lesion on his right lower lobe attenuating differential consideration mass versus lesion, and total collapse of right middle lobe. The pulmonologist ordered a CT-guided lung biopsy. No discharge was planned.
- **On March 17, 2020**, Mr. AHN's lung CT-guided lung biopsy [*result: negative for malignancy*] and post biopsy chest x-ray were completed [*results: no evidence for pneumothorax, re-demonstration of right middle lobe mass and volume loss, corresponds to prior CT finding.*]
- **On March 18, 2020**, an APP evaluated Mr. AHN for status post (s/p) hospital discharge, and a CT-guided right lung mass biopsy. Mr. AHN denied any complaints. His VS and exam were normal, except a slightly elevated blood pressure (BP) of 139/89 mmHg (normal 90/60 – 120/80 mmHg). The APP diagnosed Mr. AHN with right pulmonary mass s/p mass biopsy, scheduled an MD appointment in one week for biopsy results, continued current treatment plan and medications, and cleared for GP.



- **On March 26 and April 3, 2020**, an APP evaluated Mr. AHN for constant right shoulder pain for eight days and worsening bilateral ankle/pedal edema (observable swelling from accumulation of fluid to the area) for ten days, respectively. The APP treated Mr. AHN with ibuprofen for pain, ordered a right shoulder x-ray [*results: negative*], and a diuretic (furosemide) for his lower extremity edema. The APP then scheduled Mr. AHN for a follow-up on April 7, 2020.
- **On April 7, 2020**, an APP evaluated Mr. AHN for re-evaluation of bilateral pedal edema after completing a three-day regimen of furosemide. Mr. AHN denied any complaints and his edema was resolved. The APP ordered hydrochlorothiazide [(HCTZ); diuretic to treat edema] 12.5 mg, one tablet, daily, repeat laboratory tests, and scheduled a chronic care visit, when laboratory results returned.
- **On April 24, 2020**, a psychologist evaluated Mr. AHN due to a third-party referral. Mr. AHN reported a history of one suicide attempt by overdose in 2012, when he was placed in county jail and received mental health counseling for two years, while at state prison.
 - Mr. AHN also admitted to taking medications for depression and reported feeling sad, experiencing insomnia, low energy, and loss of desire for socialization. He denied suicidal/homicidal ideations and his mental status exam was essentially normal.
 - The psychologist diagnosed Mr. AHN with unspecified depressive disorder and referred him to a psychiatrist for medication assessment (advised self-referral, as needed), and scheduled a follow-up on May 15, 2020.
- **On April 30, 2020**, a psychiatrist evaluated Mr. AHN for unspecified depressive disorder and medication assessment. Mr. AHN reported a different history of suicide attempts by overdose stating there were three occurring in 2014, 2015, and 2019 respectively, but stated that no one knew about the latter two attempts. Mr. AHN reported a history of mental health treatment in 2014 or 2015, for approximately two years, and was prescribed medications for insomnia and depression. Mr. AHN admitted to self-discontinuing the medications due to feelings of over sedation.
 - Mr. AHN stated he does not think he needs medications again, because his current depression is due to his situation. The psychiatrist noted, “patient declines medications,” ordered to follow-up with the psychologist for therapy, and advised Mr. AHN to inform staff in case of suicidal/homicidal ideations. Due to Mr. AHN’s history of overdose, the doctor ordered that Mr. AHN receive his keep-on-person (KOP) medications on a weekly, not monthly, basis, and scheduled a follow-up in two to three weeks.
- **On May 12, 2020**, an APP evaluated Mr. AHN for acute chest pain lasting for one hour and unrelieved with nitroglycerine. The APP referred Mr. AHN to Bakersfield Memorial Hospital (BMH), and he was admitted on the same day with chest pain, T2DM, HTN, HLD, and LTBI. The attending MD ordered laboratory testing, electrocardiogram [*results: normal sinus rhythm with right bundle branch block*], echocardiogram [*results: aortic sclerosis with mild aortic regurgitation, mild concentric left ventricular hypertrophy and diastolic dysfunction*], and a cardiac stress test. Mr. AHN’s COVID-19/SARS-CoV-2 results were negative, and he was stable and in no acute distress.
- **On May 13, 2020**, Mr. AHN’s chest x-ray revealed slight atelectasis (collapsed lung). Mr. AHN was scheduled for a Lexi scan (stress agent given to increase blood flow to the heart in preparation for radiologic procedures), and no discharge was planned at this time.
- **On May 14, 2020**, Mr. AHN’s Lexi scan was completed [*results: negative*], and his discharge was pending.



- **On May 15, 2020**, an APP evaluated Mr. AHN for post-hospitalization discharge with diagnoses of non-specific chest pain and cardiac evaluation negative for acute myocardial infarction. Mr. AHN denied current complaints and his VS were normal. The APP deferred Mr. AHN's exam due to the COVID-19 precautions, continued his previous medications, and assigned Mr. AHN to medical housing for 14-day observation/quarantine per COVID-19 guidelines.
- **On May 16, 2020**, during isolation rounds, a psychologist evaluated Mr. AHN for unspecified depressive disorder. Mr. AHN admitted to a history of three suicide attempts by overdose, as well as a history of taking antidepressants and receiving mental health treatment for two years (2014 - 2015) while incarcerated at state prison. Mr. AHN reported feeling sad, insomnia, low energy, and bored being alone in his room. Mr. AHN denied current suicidal ideations and auditory/visual hallucinations. The psychologist ordered close monitoring and weekly follow-up.
- **On May 17, 2020**, a licensed clinical social worker (LCSW) evaluated Mr. AHN and completed the Clinical Segregation Data Checklist noting that Mr. AHN was participating in recreation activities outside his cell and watching television. The LCSW noted that Mr. AHN received daily medical and mental health encounters and offered weekly "talk" therapy sessions.

Synopsis of Death

- **On May 17, 2020** at 9:07 p.m., a medical (custody) officer called for a code for a detainee [Mr. AHN] hanging from the shower in a medical observation room. A nurse entered the cell, advised the officer to call 911 and get the cut down tool. MVIPC staff removed Mr. AHN from the hanging position, checked for a pulse, and initiated cardio-pulmonary resuscitation (CPR) until emergency medical services (EMS) personnel arrived and assumed care.
 - Despite continued life saving measures, the EMS personnel efforts were unsuccessful, and the EMS personnel pronounced Mr. AHN dead at 9:52 p.m.
 - An autopsy is pending.



**U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: AKINYEMI, Anthony Oluseye**

General Demographic/Background Information

- **Date of Birth:** March 6, 1963
- **Date of Death:** December 21, 2019
- **Age:** 56
- **Gender:** Male
- **Country of Citizenship:** Nigeria
- **Marital Status:** Married
- **Children:** 3

Immigration History

- On December 13, 2017, U.S. Customs and Border Protection admitted AKINYEMI into the United States (U.S.) at New York City, New York, as a B2 non-immigrant with authorization to remain in the U.S. for a temporary period not to exceed June 12, 2018. However, he remained beyond that date without authorization.
- On July 23, 2019, Enforcement and Removal Operations (ERO) Baltimore served an Immigration Detainer-Notice of Action, Form I-247, on Mr. AKINYEMI after his arrest on charges for sexual abuse of a minor.
- On December 20, 2019, Baltimore City Jail in Baltimore, Maryland (MD) released Mr. AKINYEMI to ERO Baltimore pursuant to the immigration detainer. ERO transferred Mr. AKINYEMI to Worcester County Jail (WCJ) for housing.

Criminal History

- On July 2, 2019, Mr. AKINYEMI was charged with felony assault (1399) as well as a misdemeanor sex offense (3699). He was convicted of both crimes on December 19, 2019 and sentenced to eight (8) years' incarceration and was released with a suspended sentence and three years' probation.

Medical History

- **On December 20, 2019**, at approximately 10:21 p.m., a licensed practical nurse (LPN) completed Mr. AKINYEMI's medical intake screening. Mr. AKINYEMI reported a history of hypertension and taking antihypertensive medications. Mr. AKINYEMI denied pain, discomfort, mental health or suicide attempt history. Mr. AKINYEMI stated that he did something he should not have done. He stated that he assaulted his daughter, had concerns about losing his family, and expressed an inability to cope emotionally or manage stress. The LPN informed Mr. AKINYEMI where to locate information on coping exercises, scheduled a mental health appointment for December 23, 2019, medically cleared him for general population, and provided a verbal order to continue his anti-hypertensive medications.

Synopsis of Death

- **On December 21, 2019**, at approximately 4:43 a.m., a WCJ correctional officer conducted his unit rounds where Mr. AKINYEMI was temporarily housed and confirmed that Mr. AKINYEMI was in bed.



- At approximately 5:03 a.m., a WCJ correctional officer conducted unit rounds and discovered Mr. AKINYEMI hanging with a sheet wrapped around his neck. The correctional officer immediately radioed the WCJ shift supervisor.
- At approximately 5:04 a.m., a WCJ supervisor arrived with the WCJ nurse, immediately cut down Mr. AKINYEMI, initiated cardiopulmonary resuscitation (CPR), activated emergency medical services (EMS), and applied the automatic external defibrillator, but no shock was advised.
- At approximately 5:05 a.m., Snow Hill, MD, voluntary fire department and advanced life support EMS arrived at the scene, assumed care, observed Mr. AKINYEMI as unresponsive, not breathing, no palpable pulse, and cold to touch. The EMS personnel transferred Mr. AKINYEMI to their cardiac monitor, which revealed asystole (also known as flatline, a condition of cardiac arrest where there is no discernible electrical activity in the heart).
- At approximately 5:23 a.m., the EMS personnel contacted the on-call physician at Peninsula Regional Medical Center in Salisbury, MD, and requested orders to terminate CPR efforts. The on-call physician advised them to cease CPR efforts and pronounced Mr. AKINYEMI deceased.
- At approximately 5:50 a.m., an LPN notified the on-call provider of Mr. AKINYEMI's death.



**U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: ARRIAGO-Santoya, Pedro**

General Demographic/Background Information

- **Date of Birth:** July 15, 1975
- **Date of Death:** July 24, 2019
- **Age:** 44
- **Gender:** Male
- **Country of Citizenship:** Mexico
- **Marital Status:** Single
- **Children:** NA

Immigration History

- On March 30, 2019, ICE Enforcement and Removal Operations (ERO) placed a detainer on Mr. ARRIAGO-Santoya after he was arrested by Appling County Sheriff's Office, in Baxley, Georgia (GA).
- On April 24, 2019, ICE ERO took custody of Mr. ARRIAGO-Santoya and housed him at Folkston ICE Processing Center (FIPC), in Folkston, GA, until his transfer to Stewart Detention Center (SDC), in Lumpkin, GA, on July 10, 2019.
- On June 6, 2019, an immigration judge issued Mr. ARRIAGO-Santoya a final order of removal.

Criminal History

- On May 7, 2015, Mr. ARRIAGO-Santoya was convicted of Disorderly Conduct.
- On March 3, 2019, Mr. ARRIAGO-Santoya was arrested by the Appling County Sheriff's Office for violation of his probation and being drunk in public (Public Order Crimes).

Medical History

- **On April 25, 2019**, Mr. ARRIAGO-Santoya received an intake screening. He denied a history of medical/mental health issues, surgeries or hospitalizations, or current medications.
- **On May 7, 2019**, Mr. ARRIAGO-Santoya received a comprehensive health assessment. He again denied a history of medical or mental health issues, surgeries or hospitalizations, or current complaints. His vital signs (VS) and exam findings were within normal limits.
- **On July 10, 2019**, Mr. ARRIAGO-Santoya was transferred to SDC. At intake, he again denied a history of medical/mental health issues, surgeries or hospitalizations. His VS were within normal limits.
- **On July 16, 2019**, Mr. ARRIAGO-Santoya received a second health assessment. He again denied a history of medical/mental health issues, surgeries, hospitalizations, or current complaints. His VS and exam findings were unremarkable except for abnormal heart sounds. An electrocardiogram, laboratory tests, and a follow-up were ordered for July 31, 2019.
- **On July 20, 2019:**
 - At 12:57 p.m., Mr. ARRIAGO-Santoya received an evaluation for complaints of intermittent right lower quadrant (RLQ) pain and was referred to the Southwest Georgia Regional Medical Center (SGRMC) emergency department (ED) in Cuthbert, GA, via emergency medical services (EMS) for further evaluation.



- At 2:05 p.m., EMS arrived at SDC and transported Mr. ARRIAGO-Santoya, in stable condition, to SGRMC.
- At 2:33 p.m., Mr. ARRIAGO-Santoya was admitted to SGRMC with a diagnosis of RLQ abdominal pain, nausea/vomiting, cholecystitis (inflammation of the gallbladder), cardiomegaly (a condition in which the heart is enlarged), hepatomegaly (a condition in which the liver is enlarged), colitis (inflammation of the inner lining of the colon), and elevated liver enzymes (this may indicate inflammation or damage to the cells of the liver). The medical doctor (MD) ordered intravenous (IV) fluids and IV antibiotics and referred Mr. ARRIAGO-Santoya to Piedmont Columbus Regional Midtown Hospital (Piedmont Hospital) for suspected gallbladder disease.
- **On July 21, 2019:**
 - At approximately 1:30 p.m., Mr. ARRIAGO-Santoya was transferred to Piedmont Hospital in Columbus, GA, via EMS.
 - At approximately 6:00 p.m., an MD evaluated Mr. ARRIAGO-Santoya for progressive right sided abdominal pain. The MD diagnosed Mr. ARRIAGO-Santoya with acute cholecystitis, systemic inflammatory response syndrome (inflammatory state affecting the entire body), respiratory distress and hyponatremia (low sodium levels in the blood). Mr. ARRIAGO-Santoya was admitted and referred to general surgery and gastroenterology (GI) specialists.
 - At approximately 9:30 p.m., the general surgeon evaluated Mr. ARRIAGO-Santoya for treatment of cholecystitis.

Synopsis of Death

- **On July 22, 2019**, at approximately 3:57 a.m., Mr. ARRIAGO-Santoya experienced cardiac arrest. Despite advanced cardiac life support, a normal sinus rhythm was regained but he remained unresponsive. Mr. ARRIAGO-Santoya was transferred to the intensive care unit.
- **On July 24, 2019**, the attending MD diagnosed Mr. ARRIAGO-Santoya with disseminated intravascular coagulation (a condition in which blood clots are excessively formed in the body's blood vessels) with multi-organ system failure, dilated cardiomyopathy and endocarditis (infection of the heart valve). The MD consulted with vascular surgery, infectious disease, and cardiology. Mr. ARRIAGO-Santoya's prognosis remained grave, and he experienced another cardiac arrest. Lifesaving measures were unsuccessful, and he was pronounced dead at 3:10 p.m.
- On January 28, 2020, the Georgia Department of Public Health issued Mr. ARRIAGO's death certificate and documented his cause of death as valvular heart disease with cardiomegaly and hepatic cirrhosis.



U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: BALDERRAMOS-Torres, Yimi Alexis

General Demographic/Background Information

- **Date of Birth:** May 2, 1989
- **Date of Death:** June 30, 2019
- **Age:** 30
- **Gender:** Male
- **Country of Citizenship:** Honduras
- **Marital Status:** Single
- **Children:** One (1) son of Honduran citizenship

Immigration History

- On August 5, 2013, a U.S. Border Patrol (USBP) agent apprehended Mr. BALDERRAMOS in the Rio Grande Valley, Texas Border Patrol Sector. Mr. BALDERRAMOS was processed for Expedited Removal and removed from the United States on August 14, 2013.
- On May 17, 2019, Mr. BALDERRAMOS entered the U.S. in El Paso, TX. On this same date, the USBP arrested Mr. BALDERRAMOS and issued a Notice to Appear (NTA). The USBP returned Mr. BALDERRAMOS to Mexico under the Migrant Protection Protocols to await a hearing before an immigration judge that was scheduled for September 30, 2019.
- On or about May 27, 2019, Mr. BALDERRAMOS entered the U.S. near Hidalgo, TX, without an immigration officer admitting him or placing him on parole.
- On June 6, 2019, Montgomery County Sheriff's Office in Conroe, TX, encountered Mr. BALDERRAMOS during a traffic stop for suspected smuggling activities and reported him to U.S. Immigration and Customs Enforcement (ICE) Homeland Security Investigations (HSI). HSI responded and arrested Mr. BALDERRAMOS.
- On June 7, 2019, HSI transferred Mr. BALDERRAMOS to ICE Enforcement and Removal Operations (ERO) Houston at the Montgomery Processing Center (MPC) in Conroe, TX, for booking.
- On June 18, 2019, ERO Houston transferred Mr. BALDERRAMOS to the Houston Contract Detention Facility (HCDF).

Criminal History

- N/A

Medical History

- **On June 6, 2019**, a registered nurse (RN) completed Mr. BALDERRAMOS' intake screening. Mr. BALDERRAMOS reported having a rash to his arms and abdomen due to mosquito bites he acquired during his travel to the U.S. The RN documented normal vital signs (VS) and a negative chest x-ray, medically cleared him, and scheduled him for a complex physical examination.
- **On June 7, 2019**, an advanced practice provider (APP) completed Mr. BALDERRAMOS' complex physical examination and reviewed his intake screening. Mr. BALDERRAMOS denied any chronic or acute medical complaints. The APP evaluated Mr. BALDERRAMOS and documented generalized, scattered redness/rashes on his trunk, arms, and legs with healing



nail scratch marks, but no signs of infection. The APP prescribed anti-itch cream and skin moisturizer to apply to his body and extremities.

- **On June 18, 2019**, a licensed vocational nurse (LVN) at HCDF reviewed Mr. BALDERRAMOS' transfer summary and completed his intake screening. Mr. BALDERRAMOS denied any medical history. The LVN documented normal VS and medically cleared him for custody.
- **On June 29, 2019**, an RN completed Mr. BALDERRAMOS' initial physical exam and reviewed his intake screening. Mr. BALDERRAMOS again denied any medical history. The RN did not document any abnormal findings.

Synopsis of Death

- **On June 30, 2019** at 5:39 a.m., custody staff called a medical emergency.
 - At 5:40 a.m., two RNs responded to the medical emergency and found Mr. BALDERRAMOS lying in bed, pulseless, without spontaneous respirations, cyanotic (bluish discoloration of skin), with his mouth slightly open without drainage. The RN documented, "no bruises, or bleeding noted to visible areas."
 - At 5:41 a.m., the RNs initiated cardiopulmonary resuscitation (CPR) and instructed custody staff to call emergency medical services (EMS).
 - At 5:43 a.m., medical personnel utilized emergency equipment (bag valve mask, oxygen, and automated external defibrillator (AED)) to try to resuscitate Mr. BALDERRAMOS. Medical initiated 15 rounds of CPR and observed bloody drainage from the side of Mr. BALDERRAMOS' mouth and nose, but no pooling of blood to the back of his mouth. Medical staff cleared his airway and repositioned his head.
 - At 5:55 a.m., EMS personnel arrived, continued CPR, applied their AED, oxygen, and electrocardiogram (EKG); intubated Mr. BALDERRAMOS, assessed his blood sugar (36 mg/dl), and administered intravenous fluids with fifty percent dextrose solution (to treat his low blood sugar) and epinephrine (adrenaline) two times.
 - At 6:10 a.m., the EMS personnel reassessed Mr. BALDERRAMOS' blood sugar, which increased to 78 mg/dl.
 - At 6:15 a.m., the EMS personnel transported Mr. BALDERRAMOS to Memorial Hermann Northeast Hospital (MHNH), where he remained unresponsive.
 - At 6:45 a.m., a MHNH's medical doctor (MD) pronounced Mr. BALDERRAMOS dead.
- On September 4, 2019, the Assistant Medical Examiner from the Harris County Institute of Forensic Sciences stated the cause of death was sudden cardiac death associated with biventricular cardiac dilation, and the manner of death was natural. Findings of the accompanying Toxicology Report, dated September 4, 2019, were determined to be non-contributory to the death.



**U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: BATEN-Oxlaj, Santiago**

General Demographic/Background Information

- **Date of Birth:** July 13, 1985
- **Date of Death:** May 24, 2020
- **Age:** 34
- **Gender:** Male
- **Country of Citizenship:** Guatemala
- **Marital Status:** Married
- **Children:** Three (3)

Immigration History

- In 2005, Mr. BATEN entered the United States (U.S.) without inspection via the Arizona-Mexico border.
- On March 2, 2020, ICE Enforcement and Removal Operations (ERO) Atlanta arrested Mr. BATEN at the Marietta Municipal Probation Office in Marietta, Georgia (GA), pursuant to his driving under the influence (DUI) conviction. ERO Atlanta served Mr. BATEN with a Notice to Appear (Form I-862), charging inadmissibility pursuant to Section 212(a)(6)(A)(i) of the Immigration and Nationality Act, as an alien present in the U.S. without admission or parole by an immigration officer.
- On March 5, 2020, ERO transferred Mr. BATEN from the Irwin County Detention Center (ICDC) in Ocilla, GA, and housed him at the Stewart Detention Center (SDC).
- On March 18, 2020, an immigration judge (IJ) denied Mr. BATEN's request for release on an immigration bond.
- On March 26, 2020, an IJ granted Mr. BATEN voluntary departure under safeguards to Guatemala on or before April 27, 2020.

Criminal History

- On June 18, 2019, the Kennesaw Municipal Court convicted Mr. BATEN of driving without a valid license and sentenced him to 48 hours of confinement.
- On February 19, 2020, the Marietta Municipal Court convicted Mr. BATEN of DUI and sentenced him to one (1) day of confinement and 11 months and 28 days of probation.

Medical History

SDC Medical Records

- **On March 5, 2020**, a registered nurse (RN) completed Mr. BATEN's intake medical screening. Mr. BATEN's ICDC transfer summary outlined Mr. BATEN's history of diabetes mellitus - Type II and taking metformin and regular insulin (sliding scale) to treat his diabetes. The RN documented Mr. BATEN's blood sugar level of 341 mg/dL (normal range: 80 - 130 mg/dL), gave Mr. BATEN his evening medication, and cleared him for general population. The RN scheduled him for a follow-up appointment with an advanced practice provider (APP).
- **On March 6, 2020**, an APP completed Mr. BATEN's health exam. Mr. BATEN reported a history of diabetes mellitus - Type II and taking metformin. He denied any medical concerns, past surgeries, or hospitalizations. The APP documented normal examination findings, ordered



baseline laboratory studies, cleared Mr. BATEN for regular housing placement, and ordered a chronic care follow-up appointment.

- **On April 8, 2020**, an APP completed Mr. BATEN's chronic care evaluation, documented his history and poor control of diabetes (since 2016), new hyperlipidemia (an abnormally high concentration of fats or lipids in the blood) diagnosis, normal vital signs (VS), and an elevated hemoglobin A1C level of 10.2% (normal range: 4 - 5.6%). The APP continued Mr. BATEN's gemfibrozil (lipid-lowering medication), metformin HCL, regular insulin (sliding scale), and increased his Lantus Insulin to 31 units, daily.
- **Between April 13-15, 2020**, SDC housed Mr. BATEN in the medical observation unit (MOU) for fever and flu-like symptoms. The medical staff evaluated and monitored Mr. BATEN daily, documented his initial symptom of fever, with subsequent headaches, dry cough, and sore throat. Mr. BATEN did not present in any acute distress and his VS remained relatively normal, except for elevated temperature readings. Mr. BATEN received intravenous fluid resuscitation, fever reducing medication, and an antibiotic. The medical doctor (MD) documented Mr. BATEN's cohort status, due to exposure to a person with possible COVID-19. Mr. BATEN remained cohorted from April 13-17, 2020.
- **On April 16, 2020**, an RN evaluated Mr. BATEN and documented his reports of continued headache, sore throat, and dry cough, calm and cooperative state, and even and non-labored breathing pattern. His VS were: blood pressure (BP) – 100/60 (normal: 115-120/75-80 mmHg), pulse (P) – 96 (normal 60-100 beats per minute), respiratory rate (RR) – 18 (normal 12-20 breaths per minute), temperature (T) – 100.9 (normal 97.6-99.6 degrees in Fahrenheit (F), and oxygen saturation (SpO2) level – 93% (normal 96-100%), on room air.
 - At approximately 5:36 p.m., an RN evaluated Mr. BATEN and documented his inability to breath and decreased oxygen saturation of 88%. The RN initiated supplemental oxygen and contacted the on-call APP, who gave a verbal order to contact emergency medical services (EMS) for transport to the local emergency department (ED). SDC's MD called the RN and requested a repeat check of Mr. BATEN's oxygen saturation, with use of another monitor. Mr. BATEN's oxygen saturation increased to 91 - 92%, on room air. The MD gave a verbal order to cancel Mr. BATEN's transfer to the ED, continued monitoring of Mr. BATEN's oxygen saturation levels, continued supplemental oxygen, via nasal canula, and to contact EMS if Mr. BATEN's symptoms worsened.
 - At approximately 11:30 p.m., during an RN evaluation, Mr. BATEN became restless, experienced shortness of breath, while on supplemental oxygen, which impaired his ability to verbally communicate without pausing to catch his breath. Mr. BATEN remained in SDC's MOU with continued monitoring.
- **On April 17, 2020**, an RN documented Mr. BATEN's oxygen desaturation in the mid 80's with ambulation and tachypnea (rapid breathing).
 - During an MD evaluation, Mr. BATEN's SpO2 level continued low at 91%, despite supplemental oxygen via nasal cannula. Mr. BATEN's VS were BP - 102/63, P – 102, RR – 22, and T – 101.4. As a result, the MD ordered Mr. BATEN's transfer to Piedmont Columbus Regional Hospital (PCRH) ED in Columbus, GA, via EMS, and he was admitted.
- **Between April 18 - May 23, 2020**, a PCRH provider diagnosed Mr. BATEN with COVID-19. Mr. BATEN remained in a hospital cohort unit until his symptoms worsened, requiring his



transfer to the intensive care unit. Mr. BATEN required intubation, pressure control ventilation, and became critically ill.

Synopsis of Death

- **On May 24, 2020**, at approximately 4:45 a.m., Mr. BATEN went into cardiopulmonary arrest and the PCRH medical staff initiated advance life support.
 - At 5:03 a.m., PCRH pronounced Mr. BATEN deceased. The preliminary cause of death was complications related to COVID-19.



U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: CARCAMO-Navarro, Orlan Ariel

General Demographic/Background Information

- **Date of Birth:** June 16, 1992
- **Date of Death:** March 18, 2020
- **Age:** 27
- **Gender:** Male
- **Country of Citizenship:** Honduras
- **Marital Status:** Married
- **Children:** 2

Immigration History

- On February 19, 2020, Mr. CARCAMO, along with his son, were encountered at the Presidio Texas Port of Entry in Presidio, Texas (TX), without entry documents. Mr. CARCAMO and his son were screened and processed by U.S. Customs and Border Protection (CBP) before being transported to Border Patrol Station 1 in El Paso, TX to arrange housing placement.
- On February 21, 2020, CBP transferred Mr. CARCAMO and his son to the Karnes County Residential Center (KCRC).

Criminal History

- N/A

Medical History

KCRC Medical Records

- **On February 21, 2020**, a registered nurse (RN) completed Mr. CARCAMO's intake screening. Mr. CARCAMO denied having any pain, mental health issues, hospitalizations, taking psychotropic medications, previous suicide attempts, or suicidal ideations. The RN referred Mr. CARCAMO for further evaluation to a physician, dentist, and mental health provider.
- **On February 22, 2020**, an advanced practice provider (APP) completed Mr. CARCAMO's physical assessment, documented normal findings, and instructed Mr. CARCAMO to follow up, as needed.
- **On February 24, March 2 and 9, 2020**, a licensed master social worker (LMSW) completed Mr. CARCAMO's weekly parent audit check and documented normal and negative findings for social, emotional, and/or behavioral problems.
- **On March 5, 2020**, a mental health caseworker (MHCW) observed Mr. CARCAMO during a trauma group session. The MHCW completed Mr. CARCAMO's group assessment and documented his active participation, neatly groomed appearance, calm mood, appropriate affect, and moderate attentiveness; however, Mr. CARCAMO started crying and left the session early. Mr. CARCAMO informed the MHCW he became upset after discussing his experiences and the negative news he received about his case, approximately a week ago. KCRC's chaplain spoke to Mr. CARCAMO and provided additional support. Mr. CARCAMO refused psychiatric services, signed a refusal form, and denied having suicidal ideations.
- **On March 10, 2020**, Mr. CARCAMO attended a stress management group session. An MHCW documented Mr. CARCAMO's minimal participation, neatly groomed appearance,



moderate alertness and appropriate affect. The MHCW documented Mr. CARCAMO did not require any additional referrals.

- **On March 15, 2020**, an APP evaluated Mr. CARCAMO for pain due to a right thigh abscess. The APP ordered an antibiotic and pain-relieving medication.
- **On March 16, 2020**, an LMSW completed Mr. CARCAMO's weekly parent audit check, documented his reports of having anxiety, insomnia (difficulty sleeping), nightmares, and referred Mr. CARCAMO for an individual psychiatric evaluation. The LMSW noted Mr. CARCAMO was alert/attentive, calm, cheerful, but with adjustment problems.

Synopsis of Death

- **On March 17, 2020**, at approximately 11:35 p.m., a KCRC resident advisor (RA) looked into Mr. CARCAMO's room window on security rounds but did not observe him. At approximately 11:54 p.m. a nurse entered the room and conducted a wellness check on the child but did not observe Mr. CARCAMO.
- **On March 18, 2020**, at approximately 12:30 a.m., during a security check, an RA noted Mr. CARCAMO was not in his bed and the room lights were off. The RA turned the lights on, opened Mr. CARCAMO's room door, observed Mr. CARCAMO hanging, and announced a medical emergency over the radio.
 - At approximately 12:32 a.m., security and nursing staff entered Mr. CARCAMO's room, observed him hanging from a shower rod with a bed sheet, requested a cut down tool, and activated emergency medical services (EMS) via 911. The nursing staff cut the bed sheet from around Mr. CARCAMO's neck, lowered his body to the floor, initiated cardiopulmonary resuscitation (CPR), and attached an automated external defibrillator. CPR continued until EMS arrived.
 - At approximately 12:42 a.m., EMS arrived on scene, noted Mr. CARCAMO's body was cold to touch, his mouth was difficult to open, and he was in cardiac arrest. EMS intubated Mr. CARCAMO, started intraosseous fluids (a process used to inject medication and fluids directly into the bone marrow), and advanced life-support measures.
 - At approximately 12:55 a.m., EMS pronounced Mr. CARCAMO deceased, after failed resuscitation attempts.



**U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: DE LA ROSA, Efrain Romero**

General Demographic/Background Information

- **Date of Birth:** September 17, 1977
- **Date of Death:** July 10, 2018
- **Age:** 40
- **Sex:** Male
- **Country of Citizenship:** Mexico
- **Marital Status:** Single
- **Children:** None reported

Immigration History

- Mr. DE LA ROSA entered the United States without inspection near Arizona in 2000.
- On April 05, 2017, U.S. Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) encountered Mr. DE LA ROSA at the Marion Correctional Treatment Center, in Marion, VA after a referral from the Virginia Department of Corrections. Alienage and removability were confirmed via personal interview.
- On March 11, 2018, Mr. DE LA ROSA was booked into Wake County Sheriff's Department in Raleigh, North Carolina (NC).
- On March 13, 2018, ICE transferred Mr. DE LA ROSA to their Raleigh, NC, hold room where he was later transferred and booked into the Steward Detention Center (SDC).
- On May 4, 2018, ICE transferred Mr. DE LA ROSA to the Columbia Regional Care Center (CRCC) in Atlanta, GA.
- On June 12, 2018, Mr. DE LA ROSA returned to SDC.
- On June 18, 2018, ICE housed Mr. DE LA ROSA in segregation for a code 207 violation (for sexual proposals). On June 21, 2018, the SDC institutional panel sentenced Mr. DE LA ROSA to 30 days in disciplinary segregation.
- On June 27, 2018, the SDC confinement review committee reviewed Mr. DE LA ROSA's case and recommended that he remain in segregation until July 18, 2018.
- On July 3, 2018, Mr. DE LA ROSA appeared for a court hearing and an immigration judge ordered Mr. DE LA ROSA to be removed.

Criminal History

- On April 12, 2004, the Alexandria Police Department, in Alexandria, VA, arrested Mr. DE LA ROSA for Felony: Assault. On May 17, 2004, the charge was dismissed.
- On June 09, 2004, the Alexandria Police Department arrested Mr. DE LA ROSA for Felony: Robbery and Felony: Felonious Assault. On October 28, 2004, the robbery charge was nolle prossed. No disposition is available for the felonious assault charge.
- On July 08, 2004, the Fairfax County Circuit Court, in Fairfax, VA, convicted Mr. DE LA ROSA for Misdemeanor: Driving Under the Influence. A sentence of six months incarceration was imposed.
- On September 30, 2004, the Alexandria Circuit Court convicted Mr. DE LA ROSA for Felony: Possession of Burglary Tools. A sentence of thirty days, with all thirty being suspended was imposed.



- On October 28, 2004, the Alexandria Circuit Court convicted Mr. DE LA ROSA for Felony: Carjacking and Felony: Receiving Stolen Goods. Mr. DE LA ROSA was sentenced to 20 years incarceration (all but eight years being suspended) for the carjacking conviction and six (6) months incarceration for receiving stolen goods.
- On December 06, 2004, the Fairfax County Circuit Court convicted Mr. DE LA ROSA for Misdemeanor: Escape without Force by Misdemeanant. A sentence of 30 days incarceration, with all 30 being suspended was imposed.
- On January 07, 2005, the Fairfax County Circuit Court convicted Mr. DE LA ROSA for Felony: Carjacking. No sentencing disposition is available.
- On March 9, 2018, Mr. DE LA ROSA was convicted of two counts of Unsafe Movement and sentenced to 28 days incarceration at the Wake County Detention Center.

Medical History

- **On March 13, 2018**, ICE booked Mr. DE LA ROSA into SDC. A registered nurse (RN) completed Mr. DE LA ROSA's intake screening, and he reported a history of: schizophrenia, taking eight (8) different medications for schizophrenia, smoking 10-12 cigarettes daily, use of illicit drugs, and alcohol consumption. Mr. DE LA ROSA reported feeling "good," denied pain, past suicide attempts, or active suicidal/homicidal ideations. However, he reported auditory hallucinations.
- **On March 15, 2018**, an advanced practice provider (APP) completed Mr. DE LA ROSA's physical exam. Mr. DE LA ROSA's vital signs were within normal limits. During the evaluation, Mr. DE LA ROSA reported a history of schizophrenia with hospitalizations in 2004 and 2010. Mr. DE LA ROSA reported that a physician discontinued his psychiatric medications while enrolled at an NC outreach program, due to trouble sleeping. Mr. DE LA ROSA denied having any suicidal/homicidal ideations, or active hallucinations. However, he reported having auditory hallucinations in the past.
- **On March 16, 2018**, a psychologist completed Mr. DE LA ROSA's mental health evaluation. Mr. DE LA ROSA denied having anxiety or visual hallucinations. He reported that God is talking to him and telling him what will happen in the future, but adamantly denied command hallucinations. He also denied feeling depressed, having loss of appetite, or inability to concentrate. Mr. DE LA ROSA reported having stressors relating to his legal case. The psychologist found Mr. DE LA ROSA psychiatrically stable, released him to general population, scheduled a follow-up with a psychiatrist, and a four-week follow-up with a mental health provider.
- **On April 3, 2018**, an RN cleared Mr. DE LA ROSA for segregation. Mr. DE LA ROSA remained in segregation until April 18, 2018. He received daily nursing evaluations and weekly mental health evaluations, while in segregation.
- **On April 4, 2018**, a licensed correctional social worker (LCSW) evaluated Mr. DE LA ROSA during mental health segregation rounds. Mr. DE LA ROSA reported that he was adjusting well in segregation and the LCSW found Mr. DE LA ROSA alert to person, place, and situation. Mr. DE LA ROSA did not present with a delusional thought process, psychosis, suicidal/homicidal ideations, intent, or plan.
- **On April 11, 2018**, an LCSW evaluated Mr. DE LA ROSA during weekly mental health rounds and found no deterioration in Mr. DE LA ROSA's condition while in segregation.



- **On April 16, 2018**, an LCSW evaluated Mr. DE LA ROSA for a routine mental health evaluation and found no deterioration in his condition. The LCSW inquired about his willingness to start medications, but he refused.
- **On April 18, 2018**, an LCSW evaluated Mr. DE LA ROSA during segregation rounds and found no deterioration in his condition.
- **On April 24, 2018**, a mental health APP evaluated Mr. DE LA ROSA for auditory hallucinations. Mr. DE LA ROSA reported having auditory hallucinations, stating he was the “Anti-Christ,” and would be dead in three days. The mental health APP observed Mr. DE LA ROSA responding to internal stimuli, with limited insight and judgement, but without suicidal or homicidal ideations. Mr. DE LA ROSA reported there was a potential danger to himself or others in the dorm. As a result, the mental health APP placed Mr. DE LA ROSA on 1:1 suicide watch, with direct observation in the medical housing unit (MHU). The APP offered Mr. DE LA ROSA anti-psychotic medications, but he refused.
- **On April 25, 2018**, a physician (MD) evaluated Mr. DE LA ROSA. Mr. DE LA ROSA reported that God was trying to kill him. He denied having any suicidal or homicidal ideations, but admitted to auditory and visual hallucinations. The MD ordered continued monitoring in the MHU.
- **On April 30, 2018**, a LCSW evaluated Mr. DE LA ROSA and he continued to present with fixed delusions and refused psychotropic medication administration. The LCSW found Mr. DE LA ROSA at risk for danger to himself and/or others, with the inability to progress in his current environment. As a result, the LCSW escalated a detainee transfer request to CRCC for continued monitoring while on suicide watch.
- **On May 1, 2018**, a LCSW evaluated Mr. DE LA ROSA for a wellness check. Mr. DE LA ROSA presented with fixed delusions and a fixation on the concepts of death.
- **On May 2-3, 2018**, during a mental health evaluation, the LCSW witnessed Mr. DE LA ROSA laughing inappropriately during the exam and found him to be at risk of acting impulsively and inflicting self-harm. Mr. DE LA ROSA reported to the LCSW that he will die three terrible deaths soon, feeling hopeless/helpless, with delusions, but non-suicidal. Mr. DE LA ROSA denied the need for treatment.
- **On May 4, 2018**, ICE transferred Mr. DE LA ROSA to CRCC.
- **On June 12, 2018**, Mr. DE LA ROSA transferred back to SDC from CRCC. A RN completed Mr. DE LA ROSA’s intake screening. Mr. DE LA ROSA reported he was taking medication. He denied any previous suicide attempts, or suicidal ideations. A LCSW also evaluated Mr. DE LA ROSA, who reported that his life was the same, his medication was ineffective, and that he would suffer three terrible deaths in the future, but would never kill himself. He reported that he did not want to continue medications because he did not need it.
- **On June 13, 2018**, an APP completed Mr. DE LA ROSA’s 90-day physical examination review. Mr. DE LA ROSA denied having any suicidal or homicidal ideations. The APP scheduled Mr. DE LA ROSA for a two-week follow-up and cleared him medically for deportation.
- **On June 15 and 17, 2018**, Mr. DE LA ROSA refused his morning medication. A LCSW scheduled a follow-up appointment with Mr. DE LA ROSA for June 19, 2018.
- **On June 19, 2018**, a LCSW evaluated Mr. DE LA ROSA for his medication refusals and documented that Mr. DE LA ROSA’s diagnosis met the criteria for a serious mental illness (SMI), and completed a Form IHSC-883 (ICE Health Service Corps Mental Health Review). The LCSW educated Mr. DE LA ROSA on medication education and compliance, but Mr.



DE LA ROSA stated, "I do not need them." A RN cleared Mr. DE LA ROSA for segregation placement.

- **On June 20, 2018**, a LCSW evaluated Mr. DE LA ROSA, and documented Mr. DE LA ROSA's limitation in mental functioning, his refusal of medication administration, and the potential of his behavior worsening. Mr. DE LA ROSA denied having any thoughts of self-harm, or signs of ineffective coping, or acute emotional distress.
- **On June 27, 2018**, a mental health APP evaluated Mr. DE LA ROSA during segregation rounds. Mr. DE LA ROSA presented pleasant, well groomed, with good attention, cooperative, happy, and with a logical thought process. The mental health APP documented compliance to medication administration.
- **On July 4, 2018**, a mental health APP evaluated Mr. DE LA ROSA during segregation rounds. Mr. DE LA ROSA presented with a happy mood, appropriate affect, insightful judgement, and without paranoia or suicidal ideations.
- **On July 10, 2018**, an RN evaluated Mr. DE LA ROSA during segregation rounds. Mr. DE LA ROSA answered questions appropriately, denied any suicidal/homicidal ideations, and had no acute distress. During a mental health follow-up evaluation, a LCSW documented that Mr. DE LA ROSA would benefit from a referral to a higher level of care mental health facility. He denied hearing voices, having suicidal thoughts/ideations, or presenting as a danger to self or others. Mr. DE LA ROSA reported he was going to die and reiterated his desire of not taking medications, because he did not need them.

Synopsis of Death

- **On July 10, 2018**, at approximately 10:34 p.m., custody officers called a medical emergency for a possible hanging. A custody officer found Mr. DE LA ROSA unresponsive and not breathing, hanging from an upper bunk railing. The custody officer cut down the noose and began cardiac pulmonary resuscitation (CPR). Upon arrival, SDC medical staff continued CPR and applied an automated external defibrillator (AED). At approximately 10:48 p.m., emergency medical services (EMS) arrived and began advanced cardiac life support measures. At approximately 11:03 p.m., EMS departed SDC and transported Mr. DE LA ROSA to Southwest Georgia Regional Medical Center (SWGRMC), while continuing CPR. At 11:39 p.m., SWGRMC pronounced Mr. DE LA ROSA deceased.

ICE Health Service Corps

Event Review, Root Cause Analysis/Action Plan

Facility:	Date & Time Event Discovered:	Location of Event:	Type of Event:
Choose a facility. Houston	6/30/2019	Dorm	Unanticipated Death

Brief Summary of Event (Use page 3 of this document to provide the Sequence of Events):

Balderamo-Torres, Yimi A# 206179679

"At 0538, RNs were on site for sick call rounds. Core civic called an emergency at 0539. At 0540, both RNs were in the dorm and found detainee lying in bed, unresponsive to stimuli." Vital signs: "During routine assessment, detainee was pulseless and without spontaneous respirations. EMS assessed blood sugars: 36 mg/dl and 78 mg/dl."

"At 0538, RNs were on site for sick call rounds. Core civic called an emergency at 0539. At 0540, both RNs were in the dorm and found detainee lying in bed, unresponsive to stimuli and cyanotic. RNs immediately moved detainee to the floor for initiation of CPR; right radial and left carotid were found to be pulseless. CPR initiated at 0541 and instruction was given to Core Civic to call 911. 911 called at 0542. Emergency equipment arrived to dorm and AED placed on detainee at 0543, as well as, ambu-bag with oxygen. After approximately 15 rounds of CPR, some bloody drainage noted from side of mouth and nose. During compressions, detainee's head was turned to right side to clear airway; no pooling of blood noted to back of mouth; head repositioned for oxygenation. First responders arrive at 0555. CPR was maintained continuously until first responders took over at 0556. At that time, responders continued CPR and applied their own AED device, intubated detainee and used oxygen. Responders applied EKG; blood sugar was assessed and found to be 36 mg/dl. Responders administered D50 fluids and epinephrine twice. Blood sugar reassessed by responders at 0610 and found to be 78 mg/dl. Responding teams continue CPR attempts on detainee while leaving the dorm at 0615. "

Severity Score	Probability Score	Risk score
☒ Negligible (1) ☐ Minor (2) ☐ Moderate (3) ☐ Major (4) ☐ Catastrophic (5)	☒ Rare (1) ☐ Unlikely (2) ☐ Possible (3) ☐ Likely (4) ☐ Almost certain (5)	☒ Low (1-3) ☐ Moderate (4-6) ☐ High (8-12) ☐ Extreme (15-25)
Severity score multiplied by probability score equals risk score		

☒ Event Review Only	☐ Full RCA
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Outcome of Event:

☒ Death	☐ Permanent Harm	☐ Severe Temporary Harm	☐ No Significant Harm with Additional Monitoring	☐ No Harm
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**ICE Health Service Corps
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HEADQUARTERS USE ONLY

Assigned HQ Risk Manager

Assigned FHPM

Assigned RCS

Assigned HSA/AHSA

Date RCA Initiated

[Click here to enter a date.](#)

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

**ICE Health Service Corps
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Sequence of Events Log

Date	Time	Provider	Sequence of Events
6/6/2019	23:00	RN	Intake screening performed at MONTGOMERY Processing Center. Pain assessment and all screenings were negative/within normal limits [WNL] (to include: medical screening, trauma screening, substance abuse screening, oral and mental health screening). He denied a past medical history Pt complained of "rash on b/l arms and on the abdomen said he had mosquito bites when he was coming through the desert." Review of systems negative except "<u>SKIN</u>: Rash admits, on the extremities b/l arms and abdomen. , that is moderate." Vitals 98.6 Temp (T), 61 Heartrate (HR), 104/64 Blood pressure (BP), 17 respirations (R), 119.2 lbs and 98% O2 sat. Patient was noted to be oriented to person, place, time and situation. The intake exam was WNL. Assessment was documented as "risk for impaired skin integrity." RN documented, "Disposition: Medically cleared, f/u visit scheduled, pending cxr." (Incidental finding: RN documented "No" to the templated response "skin broken out in bumps/rash observed")
6/6/2019	23:00	RN	Prescreening normal. Disposition: Not documented
6/7/2019	07:43	APP	Physical exam performed by APP. APP documented that the pt had, "significant health history, but was bitten by mosquitoes on his way into the country and is requesting for a cream for it, especially on his arms and his body." The detainee denied a medical and surgical history. Review of symptoms indicated, "Itching admits, that is moderate to arms and body. Rash admits, on the trunk, on the extremities, that is moderate." Vital signs: 98.2T, 53 HR, 127/75 HR, 120.8 lbs, and 98% O2 sat Patient's physical exam was normal except: "SKIN: Generalized scattered erythematous rashes on trunk, BUE and legs with healing nail scratch marks, no infections noted."

ICE Health Service Corps Event Review, Root Cause Analysis/Action Plan

			Diagnosis: Bitten or stung by nonvenomous insect and other nonvenomous arthropods, initial encounter. Treatment: Hydrocortisone Cream 1%, (trunk, arms, legs) BID 14 days and ammonium lactate cream 12% (trunk, arms, and legs) BID 90 days Pt was "educated on assessment; Tx plan; prescribed MEDS and their side effects; patient verbalized understanding." Follow up scheduled for 1 year. Pt was medically cleared for custody.
6/18/2019	10:58	RN	Transfer summary completed by RN
6/18/2019	19:02	LVN	Pre-screening completed. Pre-screening was normal. Disposition: Pre-Screening: No Priority (incidental finding-LVN did not update the medication question to "yes")
6/18/2019	21:54	LVN	Intake screening performed at HOUSTON Contract Detention Facility. Pain assessment and all screenings were negative/within normal limits (to include: medical screening, trauma screening, substance abuse screening, oral and mental health screening) Review of systems negative. Vitals 98.9T, 72 min, 130/77 HR, 16 respirations, 125.8 lbs, and 99% O2 sat The intake exam was WNL. LVN documented, "Disposition: Medically cleared for custody." RN co-signature noted at 06:09 on 6/20/19.
6/29/2019	10:00	RN	Physical exam (simple) performed by RN. The detainee denied a medical and surgical history. Review of symptoms was negative (WNL) Vital signs: 98.1T, 84 HR, 136/83 HR, 18 respirations, 126.6 lbs, and 100% O2 sat Patient's physical exam was normal. Skin exam was documented as, "SKIN: normal, no rash or evidence of infection." Assessment: "Encounter for general adult medical examination without abnormal findings - Z00.00 (Primary)" Follow up 1 year MD signed off on exam 7/1/19: "07/01/2019 08:00 > No obvious conditions, Detainees encounters reviewed from arrival at MPC to passing on 06/30/2019, denied past medical history. Only reported complaint of rash on body and arms"
6/30/2019	06:02	RN	ER referral note. Patient was unresponsive. Treatment documented as "Referral to-Ambulance Land; Reason: Unresponsive" Disposition: Referral to appropriate health care service for emergency treatment

ICE Health Service Corps Event Review, Root Cause Analysis/Action Plan

			Notes: Transferred to ER via EMS 07/01/2019 04:36 AM "the note was locked by the health service administrator but completed by the RN"
6/30/2019	Time	RN	Documentation as follows: "At 0538, RNs were on site for sick call rounds. Core civic called an emergency at 0539. At 0540, both RNs were in the dorm and found detainee lying in bed, unresponsive to stimuli." Vital signs: "During routine assessment, detainee was pulseless and without spontaneous respirations. EMS assessed blood sugars: 36 mg/dl and 78 mg/dl." "At 0538, RNs were on site for sick call rounds. Core civic called an emergency at 0539. At 0540, both RNs were in the dorm and found detainee lying in bed, unresponsive to stimuli and cyanotic. RNs immediately moved detainee to the floor for initiation of CPR; right radial and left carotid were found to be pulseless. CPR initiated at 0541 and instruction was given to Core Civic to call 911. 911 called at 0542. Emergency equipment arrived to dorm and AED placed on detainee at 0543, as well as, ambu-bag with oxygen. After approximately 15 rounds of CPR, some bloody drainage noted from side of mouth and nose. During compressions, detainee's head was turned to right side to clear airway; no pooling of blood noted to back of mouth; head repositioned for oxygenation. First responders arrive at 0555. CPR was maintained continuously until first responders took over at 0556. At that time, responders continued CPR and applied their own AED device, intubated detainee and used oxygen. Responders applied EKG; blood sugar was assessed and found to be 36 mg/dl. Responders administered D50 fluids and epinephrine twice. Blood sugar reassessed by responders at 0610 and found to be 78 mg/dl. Responding teams continue CPR attempts on detainee while leaving the dorm at 0615."
Select date.	Time	Click here to enter text.	Click here to enter text.

Process Review

<u>Process</u>	<u>Steps</u> (Document each step in the process)	<u>Process Vulnerabilities</u> (Behavioral Choices-reckless behavior, at risk behavior, human error, staffing, equipment, staff performance, communication,)	<u>Incidental/Contributing Factor/Root Cause</u>
Pre-screening	Step One: Nurse triage of patient and prioritize the patient	RN documented the pre-screening but did not update the eCW template to reflect that the detainee was prescribed 2 medications (template question not updated: "Are you taking any medications? No")	Incidental
	Step Two: Nurses document in eCW after seeing the patient (no computer		

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	available in area used for pre-screening)		
	Step Three: RN documents pre-screening within 2 hours and updates eCW pre-screen template as needed		
	Step four: Nurse selection disposition of patient		
Intake	Step One: Nurse sees patient (one by one) and updates eCW template via computer	If patient was transferred from another facility, did a medical transfer summary accompany the patient? No	Incidental
	Step Two: Determine disposition of patient (normal exams pending CXRs are for RN follow)		
	Step Three: Medically clear patient		
	Step Four: LVNs assign eCW note to RN for review		
	Step Five: eCW automatically generates PE-S for normal findings for 10 days (PE-C for abnormal findings)		
	RN co-signs the LVN note within 24 hours	RN signed note 2 days after LVN completion in eCW	
PE-Simple	Step One: RNs performs a review of the chart to verify if a previous PE-S was completed	The RN performed the PE-S review	Incidental
	Step Two: If it was not completed, then the RN performs full physical exam (site RNs notified of 90 review, but full physical is more thorough)		
	Step Three: RN assigns PE-S to physician for review	Per IIU findings, RN performed PE-S and was not aware of the 90 day review documentation that could have been completed	
	Step four: Physician will review RN and sign off within 14 days		
Emergency Reponse	Step One: If pt is found unresponsive by custody, CPR is to be initiated	Custody did not immediate start CPR, but medical was nearby and initiated response efforts. Add language from AHA	Incidental
	Step Two: Medical is informed of pt status and need for backup		

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	Step Three: EMS called		
	Step Four: CPR continues until EMS arrives and assumes		

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Root Cause Analysis

Root Cause Analysis Committee Composition

#	Discipline	Title
1	Click here to enter text.	Click here to enter text.
2	Click here to enter text.	Click here to enter text.
3	Click here to enter text.	Click here to enter text.
4	Click here to enter text.	Click here to enter text.
5	Click here to enter text.	Click here to enter text.
6	Click here to enter text.	Click here to enter text.
7	Click here to enter text.	Click here to enter text.
8	Click here to enter text.	Click here to enter text.

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Action Plan

Contributing Factors or Root Cause	Risk Reduction Strategies (Action Plan)	Implementation Due Date	Classification of Action Plan	Responsible Party	Measurement Strategy and Expected Outcome	Action Plan Follow Up Date	Compliance Level Achieved	Complete
Incidental	Action Item #1: - Training on Medication Reconciliation at intake for nursing staff - In-service with talking points - Staff Roster to track those trained	October 2019	Training	Nurse Manager	Measurement: Attendance to training Expected Outcome: Trained nursing staff	November QI Check-in	10/31/2019	Yes
Incidental	Action Item #2: Training on PE-S policy with nursing staff to be held concurrently with Action Item #1 training	October 2019	Training	Nurse Manager	Measurement: Attendance to training Expected outcome: Trained nursing staff	November QI Check-in	10/31/2019	Yes
Incidental	Action Item #3: Custody staff CPR response was consistent with American Heart Association training for providing CPR to adults	N/A	N/A	N/A	Measurement: N/A Expected Outcome: N/A	N/A	Click here to enter a date.	Yes

If compliance levels were not met, what actions were taken?

Click here to enter text.	Comments: Click here to enter text.
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What immediate improvement measures have already been implemented?

Click here to enter text.	Comments:
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	Click here to enter text.
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Headquarters Recommendations for National Implementation

Click here to enter text.

Signatures	
(b)(6); (b)(7)(C)	DAD of HCC
	Unit Chief
	Regional Compliance Specialist
	Risk Manager
	AD (as needed)

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

Digitally signed by (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C)
Date: 2020.06.09 13:24:27 -04'00'

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

Digitally signed by (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C)
Date: 2020.06.18 15:33:15 -04'00'

**ICE Health Service Corps
Root Cause Analysis and Action Plan**

ROOT CAUSE ANALYSIS AND ACTION PLAN FRAMEWORK TEMPLATE

The IHSC Root Cause Analysis and Action Plan has nine analysis questions. The following framework is intended to provide a template for answering the analysis questions and aid in organizing the steps in a root cause analysis. All possibilities and questions should be fully considered in seeking “root cause(s)” and opportunities for risk reduction. Not all questions will apply in every case and there may be findings that emerge during the course of the analysis. Be sure however to enter a response in the “Root Cause Analysis Findings” field for each question. For each finding continue to ask “why?” and drill down further to uncover why parts of the process occurred or didn’t occur when they should have. Significant findings that are not identified as root causes themselves have “roots.

As an aid to avoid “loose ends,” the two columns on the right are provided to be checked off for later reference:

- “Root cause” should be answered with “Yes” or “No” for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding is relevant to the event is not a root cause, be sure that it is addressed later in the analysis with a “why?” questions such as “why did it contribute to the likelihood of the event?” or “why did it contribute to the severity to f the event?” Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.
- “Plan of action” should be answered with “Yes” for any finding that can be reasonably considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan.

INSTRUCTIONS

1. Complete the form with as much detail as possible.
2. Click on grey default text to add your own text.
3. Fields will automatically expand to fit the content. Do not attempt to resize the boxes manually.

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Facility:	Date & Time Event Discovered:	Location of Event:	Type of Event:
Port Isabel	5/16/2018	PIDC Clinic	Unanticipated Death

Date of Arrival:	Diagnosis:
5/14/2018	Meningitis, Diabetic Ketoacidosis, and Sepsis

Brief Summary of Event (Use page 3 of this document to provide the Sequence of Events):

39 year old male detainee with a normal pre-screen and intake encounter upon arriving to the facility; however just prior to being transferred from the processing area to general population he reported that he was not feeling well. He informed the security officer who then notified medical. The detainee was evaluated by a Licensed Vocational Nurse (LVN) in the staging area who then refers the detainee to the clinic. Upon arrival to the clinic the detainee was evaluated by an Advanced Practice Provider (APP) who diagnosed him with fever, influenza like symptoms, dehydration and clinical strep throat. It was noted that the detainee had a random blood sugar of 266 mg/dl and a temperature of 102.4 F. A urine dipstick was completed during the encounter showing orange clear urine, glucose of 500 mg/dl, ketones $\geq$ 160 mg/dl, specific gravity $\geq$ 1.030, small blood and protein 100 mg/dl. The APP ordered amoxicillin 500 mg 1 tab twice daily, acetaminophen and ibuprofen as needed, and admitted the detainee to the medical housing unit (MHU) for closer observation. Within five hours of admission to the MHU, a registered nurse (RN) evaluated and observed a change in the detainee's health status; he presented with altered mental status and elevated blood pressure. The RN consulted with the APP, and received orders to call emergency medical services (EMS). The detainee was transported to Valley Baptist Medical Center (VBMC). On May 16, 2018 the detained passed away at VBMC.

Event Type: Select one below

Near Miss	Adverse Event	Sentinel Event
☐ Medication Error Caught Prior to Administration ☐ Wrong Patient ☐ Wrong Procedure ☐ Other (Brief Description): Click here to enter text.	☐ Medication Error That Reached Patient ☐ Injury Due to Medical Equipment Failure ☐ Fall With Injury ☐ Suicide Attempt ☐ Other (Brief Description): Click here to enter text.	☐ Suicide ☒ Unanticipated Death

☐ Event Requires Full RCA	☐ Event Does Not require Full RCA
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Outcome of Event:

☒ Death	☐ Permanent Harm	☐ Severe Temporary Harm	☐ No Significant Harm with Additional Monitoring	☐ None
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HEADQUARTERS USE ONLY

Assigned HQ Risk Manager	Date RCA Initiated:	Date RCA Received at HQ:	Date RCA Reviewed by RM:	Date of Six Month Follow-Up:
(b)(6); (b)(7)(C)	12/6/2018	(b)(6); (b)(7)(C)	10/1/2019	Click here to enter a date.

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Root Cause Analysis and Action Plan**

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Sequence of Events Log

Date	Time	Provider	Sequence of Events
			Fact Finder notes: Prior to arriving to PIDC detainee spent five days at a U.S. Customs and Boarder Protection (CBP) station where he received treatment (oral and otic antibiotics) for an ear infection; he was transferred to PIDC without a transfer summary or medical documentation; Medications were discovered in his property (Ciproflaxin/dexamethasone ear drops and Azithromycin 250 mg with three tablets remaining in the bottle)
5/14/2018	1849	Licensed Practical Nurse (LPN)	Pre-Screen encounter is noted by a Licensed Practical Nurse (LPN). A normal prescreen was documented. Per the note a no was documented in response to the following questions: 1) If the detainee transferred from another facility, 2) Is he taking any medication and 3) Does he have any current illness or health problems. Pre-Screening Priority: No Priority
5/14/2018	2119	Licensed Practical Nurse (LPN)	Intake encounter is noted by a LPN. Unremarkable intake encounter is documented, except for BMI of 28.6 all other vitals are within normal limits.
			Fact Finder notes: per video surveillance footage, during the pre-screen encounter the detainee was one of four detainees who raised his hand when the RN was speaking to the group inside the holding cell. RN spoke to each detainee and then wrote something down on the I-216 (ICE Record of Persons and Property Transferred form) she was holding. The RN documented on that piece of paper the encounter where the detainee verbalized a history of an acute medical condition by raising his hand when the RN asked questions in the video ased question. This document was destroyed (i.e. shredded by the LVN) and the information was not documented in the detainee's electronic medical record. The RN completed the Pre-screen encounter, however the LVN documented the encounter.
		Interview with the Licensed Vocational Nurse (LVN)	Fact Finder Interview notes: the LVN stated that a security officer from processing came to the medical staging area to informed him of a detainee who was reporting that he did not feel well. He told the officer to bring the detainee over for an evaluation. He reported that the detainee appeared weak and lethargic; he complained of feeling really tired and reported a 10 out of 10 on the pain scale for his headache; he took the detainee's vitals and all vitals were normal except for his temperature. He consulted with the Clinical Coordinator (CC) about the case and was instructed to bring the detainee to the urgent care room. Once he got to the urgent care room in the clinic the clinical coordinator and one of the Advanced Practice Provider (APP) left for an emergency code in the dorm. He waited in the hallway for a little bit with the detainee seated in a wheelchair. He eventually brought the detainee in the urgent care room

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			once a female detainee who was in the occupying the room was moved. He told the patient care coordinator to inform the CC and APP that the detainee was in the urgent care room prior to leaving the clinic. After a while he came back to the clinic and noticed that the CC and the APP were still tending to the other medical emergency. The CC asked him to start an IV on the detainee, administer a bolus and then he will take care of him. He stated after initiating the IV, checked the detainee blood sugar and he went back to the medical staging area and did not return to the clinic.
		Memorandum for Record by Clinic Coordinator (CC)	Memorandum for Record by the Registered Nurse (RN) stated that the Licensed Vocational Nurse (LVN) who was assigned to the staging medical area informed him that there was a detainee in processing reporting that he had a fever and was not feeling well. The security officer requested that medical evaluate the detainee.
		Interview with the Clinical Coordinator (CC)	Fact Finder Interview notes: I instructed the LVN to bring the detainee from processing to the clinic to be seen by an APP. At that time, they called a "chest pain" medical emergency for a female detainee in the court area. I assisted with that emergency to coordinate having that female detainee sent to the ER. Simultaneously I triaged other clinic walk-in (b)(6); (b)(7)(C) was placed in the urgent care room and I assigned him to one of the APPs. I did not assess the detainee, too much going on in the clinic. The detainee appeared tired and weak and had to use wheelchair to move him to the urgent care. He would open his eyes, answer questions, and follow instructions, however he appeared sleepy and I wasn't with him long enough to obtain an accurate assessment. Detainee was seen by the APP and from there I called the MHU to coordinate getting him a room and admitted to the MHU. I ordered the LVN to start the IV and hang NS; I believe I gave him the 1 gram of acetaminophen, but I did not sign the MAR for the Acetaminophen or document the IV bolus either. I don't recall who performed the urine dip, I did not know it was ordered and I did not know it was an order in the APP's note. I wheeled him from the urgent care to the MHU common area and gave a brief report to the MHU RN. The report was not detailed just that the detainee had a fever and ILI. If I could do something differently I would advocate for correct staffing; sick call should be allotted 4 – 5 nurses, being with only 2. Short staffing takes away from details about delivery of care. We don't have enough staff to work all the cases to include emergencies which is crucial with all patient care. Being short staff causes things to be overlooked. I could have obtained an assessment of the detainee and provided a better report to the MHU RN. Also, with the census in the MHU having additional staff there maybe detainee's condition could have been caught earlier. RNs are aware of their role being short staff has affected RN accountability. Recommend looking into staffing model. We are at 60% RN staffing and the shortage puts a big burden on RN; they are tired; Recommend more hands on training instead of online in-services regarding true emergencies, use of C-collars, IVs, PICC lines; more training to respond to patient care needs; This operation is too big and not being able to staff

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			it appropriately. At least 40 hours of hands on nursing training to recognize signs and symptoms of certain conditions. Mission is missed due to quota's that must be met by 1500; things are missed and things that should have been caught were not.
5/15/2018	1011	Advanced Practic Provider (APP)	Detainee was referred from sick call with complaints of fever, headache, left ear pain, sore throat and body ache. Detainee reported that he was being treated with ear drops and once a day oral antibiotic for the left ear infection at his pervious facility. Detainee appeared sleepy and stated he did not sleep well due to the fever and pain the previous night. Detainee was alert and oriented x 3 and denied history of any chronic medical conditions. A Urine dipstick was completed during the encounter showing orange clear urine, glucose of 500 mg/dl, ketones $\geq$ 160 mg/dl, specific gravity $\geq$ 1.030, small blood and protein 100 mg/dl. Vital signs were: Pain 10 on 0 – 10 pain scale. T: 102.4 F, HR: 100/min, BP: 143/78, RR: 18, Finger stick: 266 mg/dl, O2 Sat: 96% room air. Exam findings: no acute distress is noted, well developed, well-nourished but ill appearing. Ears: bilateral ears with mild erythema, no bulging or perforations to the TMs, good visible cone of light, no drainage noted. Throat: tonsils enlarged 1+, and erythematous oropharynx with some peritonsillar exudates to left tonsil. Positive left cervical lymphadenopathy was noted, remainder of exam was unremarkable. Assessment: Fever, Strep pharyngitis and unspecified abnormal findings in urine. Plan: admit to MHU, treat empirically for strep throat, urine dipstick results suspect likely from fever and poor water intake, start: acetaminophen 325 mg 3 tabs QID/PRN, Ibuprofen 600 mg 1 tab PO TID/PRN, Amoxicillin 500 mg 1 cap PO BID and sodium chloride 0.5% 1 litter bolus IV then keep vein open. Repeat urine dipstick after normal saline bolus if given later today and notify provider. Labs were ordered for 5/16/18: complete urinalysis, CMP 1, CBC, urine culture, HgA1C, TSH, Lipid panel, and creatinine kinase.
5/15/2018	1046	Advanced Practic Provider (APP)	MHU admission encounter by an APP is noted utilizing MHU admission template.
		Interview with the APP	Fact Finder Interview notes: Due to the number of patients who arrive with fever, dehydration and improve after treatment (bolus/medication), they usually bounce back. Thought that with IV fluids, rest and acetaminophen, detainee would improve but if not better would send him out to ED; My differential diagnosis included otitis media resolving, fever, strep throat; I thought of meningitis without LOC, rare HIV disease or bug. I did not consider DKA and did not assess nuchal rigidity; I thought of sepsis but his vital signs were normal and he was not diaphoretic; the rapid strep test was not completed since we did not have the supplies for the test on site at that time, however the detainee met all 4 criteria for pharyngitis, strep throat and flu so I decided to treat. I verbally consulted with the CD about the case but did not document the consultation; per the discussion the plan was if no improvement we would send him to the ED. I admitted him to the MHU and ordered vitals every eight hours because I knew that the vitals would

ICE Health Service Corps Root Cause Analysis and Action Plan

			be completed, and I would be notified. I thought he would improve like many others did. The Clinical Coordinator assumed care of the detainee to implement the orders; I communicated verbally orders for IV Normal Saline and Tylenol to be given now, afterwards to repeat urine dipstick and I would determine if he needed to go to the hospital. I assumed it was done while the detainee was in the urgent care room by either the LVN or Clinical Coordinator. There were lots of admission to the MHU, so it took a while to get the detainee moved back to the MHU, however while he was in the urgent care room I continued to check on patient. I did not give a verbal report to the APP scheduled in the MHU regarding this detainee. I don't know a lot about DKA; I learned about it during ER rotation during PA program and a couple case discussions; meningitis – just read about it.
		Interview with the CD	Fact Finder Interview notes: I did not see the detainee; however, the APP verbally reviewed the case with me after assessing the detainee with considerations for influenza like illness and MHU admission for fever and other symptoms. We see lots of dehydration and flu like illness, we were focusing on treating the dehydration and then repeating the UA dip to determine the next step. We reviewed the UA dipstick results and although ketones in the urine could mean rhabdomyolysis, diabetes and dehydration, DKA should have been included in the differential diagnosis but it was not at that time; Our plan was to give him fluids and repeat urine dip and monitor for further ketones, glucose and adjust care as needed; If truly DKA would need to be hospitalized and managed with insulin drip; Although I have talked about undiagnosed diabetes with the APPs, more training on DKA is needed and I plan to provide it. Would have terms of orders and vigilance to making sure orders were carried through in timely manner are the things I would have done differently.
5/15/2018	1340	Registered Nurse (RN)	MHU Registered Nurse (RN) admission encounter is noted. Per that encounter vitals: 7 on 0-10 pain scale, Temperature: 100 F, HR: 102, BP: 147/84, RR: 18, weight: 172 lbs., O2 sat: 99% room air. Exam: alert, ill-appearing, uncomfortable due to pain, cooperative, mild distress, well nourished, well hydrated, in no acute distress. Throat: tonsil red, swollen, and white exudates on tonsils. Remainder of exam otherwise WNL.
5/15/2018	1620	Advanced Practic Provider (APP)	Urgent encounter noted with an APP. Per the encounter a nursing referral was made to the APP secondary to detainee with alerted mental status. Per the review of systems (ROS) detainee unable to give a clear ROS. Vitals: temperature: 99.5, HR: 106, BP: 170/104, RR: 16, O2 Sat: 96% room air. Exam: in bed recumbent position, stupor, slow responses, pupils sluggish but round; hyporeactive to light and accommodation; cooperative with exam, lethargic, follow commands albeit to a limited extent. Assessment: alerted mental status. Plan: primary nurse instructed to activate EMS, detainee to be transported to ER

ICE Health Service Corps Root Cause Analysis and Action Plan

5/15/2018	1635	Registered Nurse (RN)	MHU encounter with a RN. Per the encounter. Detainee housed in MHU isolation room for influenza like illness, strep and fever. Detainee was lying on the bunk with eyes closed, hard to arouse, oriented to person only, he did not know where he was or what day it was. His vitals: BP 170/104 and 180/107, temp: 99.5 and O2 sat: 96% on room air. Detainee was asked to provide a urine sample, he went to the ante room near the toilet, he stood at the toilet, "went" then flushed and returned with an empty specimen cup. The provider was notified of the detainee's status and received an order to send the detainee to the ER via EMS. Detainee was removed from his room and brought to the common area in the MHU for observation until EMS arrived. EMS arrived at 1700 and the detainee was placed on a stretcher and left the MHU without incident. Exam: ill-appearing, pale, confused, somnolent, lethargic, needs assistance with ambulation, pupils equal, non-reactive, tachycardic, clear to lungs are auscultation bilaterally, no wheezes, rales, rhonchi, strength decreased, decreased strength left upper extremity and right upper extremity. Assessment and plan: acute confusion, activated EMS system and detainee to be in route to HMC for diagnosis of altered mental status.
5/16/2018	0235	Registered Nurse (RN)	Telephone encounter of hospital update by a RN. Per the note: transport reports that detainee coded and was resuscitated. They also stated that he was placed on a ventilator in the ICE. After multiple attempts of trying to reach the nurse taking care of the detainee for the past hours she/he is unable to answer the phone. Only information obtained was that the detainee is in fact in the ICU.
5/16/2018	0441	Registered Nurse (RN)	Telephone encounter of hospital update by a RN. Per the note: update obtained from the HSA in hospital. Detainee admitted to Valley Baptist Medical Center MICU 207 with diagnosis of DKA and sepsis. Detainee was resuscitated twice 0055 and 0109. Vitals: HR 161 sinus tachy (HR max 187 this morning), BP: 93/56, T: 100.2, BS: 236. Detainee is on a vent AC TV: 500 PEEP: 5 O2 sat 100% Drips: epinephrine, Levophed, and dopamine. Sedation turned off at 0100 and was on Propofol and fentanyl. Plan: wean epinephrine drip and go to vasopressin. Start insulin drip. Neuro: unresponsive and pupils fixed at 5+ and non-reactive.
5/16/2018	0800	Registered Nurse (RN)	Telephone encounter of hospital update by a RN. Per the note hospital updates at 0800 and 0845. Relevant Medical History: Housed in MHU for ILI symptoms, Diagnosed at PIDC with Fever, Streptococcal pharyngitis; Date of Admission: 5/16/18; Current Diagnosis: DKA and Sepsis; Reason sent to ER: Altered mental status; Admitting Physician ICU Intensivist: Dr. Dube Current Status: at 0800: Report received from Carry RN. Patient is pending to be seen today by physician around 0900. Neuro status: patient is unresponsive, pupils fixed at 5+ and no gag reflex present. Current plan of care is to titrate patient off drips if possible. Current vital signs: B/P 108/81, HR 140, Temp 98.9, RR 24, O2 Sat 99%. Patient is currently on the following drips: Levophed 30 mcg/ min, Dopamine 4 mcg/kg/min, Vasopressin 0.04 units/ min, Sodium Bicarbonate 100 ml/ HR and insulin 8 units/ hr. Urine output in the last 12 hours was 1.7 liters. Patient remains on a ventilator, which the currently setting: Vent on Assist Control, Rate 24, Tidal

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			Volume 500, Peep 5 % and FIO2 100%. At 0845: report received from (b)(6); (b)(7)(C) At around 0830, patient coded, heart rhythm asystole. Code ran for about 10 minutes. Patient was resuscitated, remains unresponsive. Current vital signs: B/P 108/80, HR 173, O2 Sat 85% while on ventilator setting for FIO2 is at 100%. Lab drawn post code, pending lab result.
5/16/2018	1243	Registered Nurse (RN)	telephone encounter of hospital update by a RN. Per the note at 1200: Report received from (b)(6); (b)(7)(C) RN. Patient was seen this morning by (b)(6); (b)(7)(C) the ICU Intensivist. (b)(6); (b)(7)(C) consulted (b)(6); (b)(7)(C) the palliative care physician (b)(6); (b)(7)(C) as taken over as the primary care physician. Neuro status: patient is still unresponsive, glaucoma score is a 3, pupils fixed at 5+, still no gag reflex present and not responding to stimuli. Current plan of care is to continue to provide full measure of care, and possible attempt to titrate patient off drips. Current vital signs: B/P 125/81, HR 145, Temp 99.7, RR 24, O2 Sat 78%. Patient is currently on the following drips: started on Phenylephrine 80 mg/ml, Levophed decreased to 20 mcg/min, Dopamine increase to 10 mcg/kg/min, Vasopressin 0.04 units/min, Sodium Bicarbonate increased to 150 ml/ hr and insulin drip increased to 16 units/ hr. Patient started on Vancomycin 1250 mg IV every 12 hours, and Cefepime 2 grams IV every 12 hours. Patient remains on a ventilator, which the currently setting: Ventilator on Assist Control, Rate 24, Tidal Volume increased to 550, Peep 5 % and FIO2 100%.
5/16/2018	1637	Registered Nurse (RN)	telephone encounter of hospital update by a RN. Per the note at 1630 the client was pronounced brain dead by (b)(6); (b)(7)(C) official time, case will be updated to (b)(6); (b)(7)(C). Plan of action is to keep client on current medications: Phenylephrine 80 mg/ml, Levophed 20 mcg/min, Dopamine 10 mcg/kg/min, Vasopressin 0.04 units/min, Sodium Bicarbonate 150 ml/ HR and insulin 16 units/ hr. Ventilator Rate: 24. Tidal Volume: 550. Peep: 5 % and FIO2 100%. -client will have all drips and ventilator discontinued in the AM, unless otherwise. Report received from Lerma, RN.
5/16/18	1922	Registered Nurse (RN)	telephone encounter of hospital update by a RN. Per the note at 1848 pm the client coded, code blue team worked on client for 20mins and was pronounced dead, unknown time at this moment. Hospital staff still working on documentation and changing shifts. Report received from jessie charge nurse RN.
Select date.	Time	Scanned Medication Administration Record (MAR)	Per the MAR: Amoxicillin 500 mg 1 cap twice daily x 10 days (RN initial is noted for the 0800 administration on 5/15/18); Ibuprofen 600 mg 1 tab PO three times daily x 10 days, acetaminophen 325 mg 3 tabs PO four times daily as needed x 10 days (RN initial is noted for the 1200 administration on 5/15/18), sodium chloride flush 0.9% flush saline lock with 5 ml NS IV every shift (every eight hours) for 3 days to maintain patient IV access; sodium chloride 0.9% infuse 1 liter IV bolus now 5/15/18 (in the morning) (RN initial is noted for the 1200 administration on 5/15/18).
Select date.	Time	Scanned Hospital Records	Valley Baptist Medical Center Updated hospital records dated 5/16/18 is noted (30 pages):

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			a. CT Scan head without contrast on 5/15/18 (18:48): Findings: the ventricular system is normal, no shift of the midline or mass effect. No extra-axial fluid collections are demonstrated and the posterior fossa structures are intact. Normal brain parenchymal attenuation. No evidence for acute hemorrhage or territorial infraction. The calvarium is normal. The imaged paranasal sinuses are predominately clear. Impression: Brain within normal limits. b. CXR on 5/15/18 (18:07) Impression: No acute disease. c. CXR on 5/15/18 (23:25): Impression: no acute cardiopulmonary disease detected. d. CXR on 5/16/18 (09:18): Impression: there is left lung opacification suggestive of left lung atelectasis. Endotracheal tube is seen with its distal tip at the level of the carina. The endotracheal tube needs to be pulled back. Critical results was given to the floor. e. Admission H&P EMR dated 5/15/18: Patient was found to have elevated temperature of 103.3 HR: 112, BP: 179/92, white count: 24.6 and lactic acid 2.4 and sepsis protocol was initiated. Patient placed on IV vancomycin and Zosyn. Patient found to be in DKA. During the evaluation patient stood lifted his gown and proceeded to urinate on the floor. Patient remained severely alerted and was placed on 1:1 sitter and will be admitted to the medical ICU under the critical care team. Assessment/Plan: 1) DKA, DKA protocol, 2) Sepsis, IV fluids, continue with IV antibiotics and follow lab and culture results 3) Alerted mental status, pending drug screen, liver enzymes and ammonia level, follow neuro and mental status closely. f. Procedure note dated 5/15/18 (2325) Right internal jugular central venous catheter with limited vascular access as the indication for the procedure. Procedure completed with no complications.
	Time	Scanned Hospital Records	Valley Baptist Medical Center hospital records dated 5/15/18 is noted (37 pages)
Select date.	Time	Scanned Ambulance Service Records	Los Fresnos Ambulance Service Patient Care Records dated 5/15/18 is noted (7 pages); Primary impression: alerted mental status, secondary impression: fever; protocol used: suspected stroke; positive for left sided facial droop; transport delayed while waiting for escort. Upon the findings they upgraded to code 3 and transported patient to appropriate stroke facility for further evaluation. Patient transported without incident and left in nurses' care.
Select date.	Time	Scanned County Forensic Pathology Report	Cameron County Forensic Pathology Report dated 5/21/18 is noted (3 pages); Sufficient natural disease was found at autopsy to allow certification of death as noted: Cause of death Meningitis. Other significant conditions contributing to death: clinical history of diabetic ketoacidosis and clinical history of sepsis. Pending further studies.
Select date.	Time	Scanned Hospital Records	Valley Baptist Medical Center Patient Expiration Records dated 5/16/18 is noted (2 pages)
Select date.	Time	Click here to enter text.	Click here to enter text.
Select date.	Time	Click here to enter text.	Click here to enter text.

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Process Review (Process vulnerabilities Identified):

- 1) Facility to facility transfer communication: Lack of communication of patient's health condition during the facility to facility transfer resulting in a lack of continuity of care: no transfer summary or medical documentation accompanied detainee from CBP to PIDC. Detainee's medications were discovered in his property and not brought to medical's attention in a timely manner.**
 - a. Why did a transfer summary not accompany the detainee during the facility to facility transfer? Is there a delay in receiving transfer summaries?**
 - b. What is the current process for security staff to notify medical when a detainee transfers with medications? Medications were checked into Mr. Romero's property upon arrival however, custody staff did not alert medical staff. Is detainee's property checked for medications or is it up to the detainee to report he has medications with him? Is there a policy and/or LOP explaining this process; if so cite below?**
- 2) Documentation:**
 - a. RN completed the pre-screen; however, the LVN documented the encounter. Please reference any pertinent policy and/or LOP describing/supporting this process and if this was just a breach in the intended process. Incidental finding; breach in policy, this is not a contributing factor or root cause therefore this is not actionable/trackable; just recommend having the NM remind nursing staff.**
 - b. Clinical Coordinator (CC) and LVN failed to document their medical interventions in the detainee's medical record. → Incidental Finding**
 - c. MHU RN documented medication/IV administration which was a task performed by the LVN and CC.**
 - d. The APP failed to document the consultation with the CD in his note or in a telephone encounter.**

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- 3) Transitions of Care (communication/coordination): Lack of continuity and coordination of care by CC and APP → Contributing Factor**
- a. CC: failed to assess the detainee, document his encounter with the detainee, fully assume care of the detainee while in the urgent care room, or review the APP's note/orders resulting in an ineffective verbal report off to the MHU RN.**
 - b. APP: failed to provide report of the case/care plan to the assigned MHU APP or follow up in a timely manner with his care plan that after the IV bolus was administered he would determine if the detainee should be sent to the ER. Transition of care did not take place from APP to APP (from ambulatory care to MHU). At the change of shift, the clinic APP went to the MHU to verify if the repeat urine was completed which reminded the off-going MHU RN to notify the on-coming MHU RN that a repeat urine was needed.**
- 4) Decreased RN staffing affecting patient safety: PIDC medical department experienced a shortage of RN staffing. It's current RN vacancy rate is 40% (12 filled/20 positions). Two RNs scheduled for sick call duties versus the required four to five RNs. Only one RN (CC) was in the clinic responsible for responding to normal clinic activities and emergent events. At the time Mr. Romero arrived at the clinic, the CC was not available. As a result, the staging LVN was required to remain with the detainee until an APP arrived and assumed care. Also, upon his arrival to the clinic, another female detainee was in the urgent care room and a medical emergency simultaneously occurred which impacted the CC's availability to assume medical care for Mr. Romero. The second RN assigned to the clinic performed sick call in medical staging area leaving the CC as the only RN in the clinic. Facility did not have a sufficient number of RN to provide adequate and timely evaluation and treatment consistent with contemporary standard of care. Healthcare services were not provided by a sufficient number of appropriately trained and qualified personnel. IHSC Sick Call Process Guidelines, facilities with greater than 1001 detainee population, there should be four to five RNs performing sick call, there were only two.**

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- 5) Delay in completing diagnostic order: clinician orders were not implemented in a timely manner (repeat urine dipstick was not obtained in a timely manner). APP verbalized wanting the repeat urine dip after the normal saline (NS) bolus was completed but it was never obtained resulting in a delay in the treatment plan. → Contributory
- 6) Training on DKA and Meningitis: consider initiating training on DKA and meningitis and/or other clinical topics of interest (clinical presentation and management) to staff, could be periodic (Q6 months or annually) to help staff identify when to add it as part of their differential diagnosis.

Root Cause Analysis

#	Analysis Question	Prompts	Root Cause Analysis Findings (Explain/identify the areas that were not followed)	Root Cause/Contributing Factor/Incidental	Ask "Why"	Plan of Action
1	Was there a breakdown in the intended process? Yes	List the relevant process steps as defined by the policy, procedure, protocol, or guidelines in effect at the time of the event. You may need to include multiple processes. Select the appropriate policy of process that should have been followed: ☒ Medical Care ☐ Mental Health ☒ Nursing Guidelines	Documentation: 2a. RN completed pre-screen, however, that encounter was documented by an LVN - ISHC Medical Records Documentation powerpoint: (Annual Training): pg 15 don't document for someone else; 2b. Medical assessment were not documented by nursing staff. - IHSC Sick Call Process: 2e: If the complaint is not within the RN's scope of practice, the RN documents the sick call and encounter and refers the detainee/resident to the MLP or to	Incidental Finding	2a. Typical pre-screen process involves an RN or LVN who goes to a bus of incoming detainees and pre-screens the patients. The pre-screen encounters are then documented by nursing staff in staging. 2b. Direct referral to provider, due to LVN assessment and fever, which are outside of nursing scope of practice and require APP evaluation	No

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#	Analysis Question	Prompts	Root Cause Analysis Findings (Explain/identify the areas that were not followed)	Root Cause/Contributing Factor/Incidental	Ask "Why"	Plan of Action
			another healthcare professional to be seen at a minimum the next business day or as appropriate. • ISHC Medical Records Documentation powerpoint: (Annual Training): pg 11, Do's of Documentation: Do document as soon as possible after encounter or note "late entry" 2c. LVN & CC carried out specific interventions, however, MHU RN documented these events • ISHC Medical Records Documentation powerpoint: (Annual Training): pg 15 don't document for someone else. • Unable to find any other applicable standards(NCCHC, ACA, PBNDS, ISHC Directive/Guide of documentation standard) 2d. After consultation with CD, APP did not document the specific details of the consultation • ISHC Medical Records Documentation powerpoint (Annual Training): pg 6 If it's not documented, it didn't happen.		2c. Due to increased workloads (simutanoues medical emergencies, high volumes of walk-in patients to the clinic) and decreased nursing staff, ordered interventions were carried out by nursing staff but were not documented at the time due to time constraints 2d. Upon APP chart review, a note was entered for communication with the CD, however, details of the note and tele-phone encounter	

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#	Analysis Question	Prompts	Root Cause Analysis Findings (Explain/identify the areas that were not followed)	Root Cause/Contributing Factor/Incidental	Ask "Why"	Plan of Action
					with the CD were not documented.	
2	What human factors were relevant to the outcome?	Discuss staff-related human performance factors that contributed to the event. Examples may include, but are not limited to: Choose an item.	N/A	N/A	N/A	N/A
3	How did the equipment performance affect the outcome?	Consider all medical equipment and devices used in the course of patient care, including AED devices, crash carts, suction, oxygen, instruments, monitors, infusion equipment, etc. In your discussion, provide information on the following as applicable: Choose an item.	N/A	N/A	N/A	N/A
4	Were there any other factors that directly influenced this outcome?	List any other factors not yet discussed: Choose an item.	<u>Training on DKA:</u> consider initiating training to staff on DKA, meningitis to staff periodic (Q6 months or annually) to help staff identify when to add it as part of their differential diagnosis. 6a. DKA: contributing cause of death on autopsy Providers have access to review guidelines on DKA, however no formalize annual training is available.	Contributing Factor	6a. Need continuation education and reinforcement of the presentation and management of DKA	Yes

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#	Analysis Question	Prompts	Root Cause Analysis Findings (Explain/identify the areas that were not followed)	Root Cause/Contributing Factor/Incidental	Ask "Why"	Plan of Action
			6b. Meningitis: cause of death on autopsy report was meningitis Providers have access to review guidelines on meningitis, however no formalize annual training is available		among nursing staff and APPs 6b. Need APP continuing education of the history of present illness, presentation, and when to include meningitis as a differential diagnosis	
5	Was the staff properly qualified and currently competent for their responsibilities at the time of the event?	Include information on the following for all staff and providers involved in the event. Comment on the processes in place to ensure staff is competent and qualified. Examples may include but are not limited to: Choose an item.	N/A	N/A	N/A	N/A
6	Did the staffing mix on the day of the event directly contribute to event?	Were the proper disciplines available to provide necessary care? Were more staff needed to provide necessary care?	<u>Decreased RN staffing affecting patient safety at PIDC:</u> 4. IHSC Directive 17-002, Clinic Scheduling Guidelines; 4-1.5; 4-1.6, Schedule Administration, October 10, 2017 According to PBNDS Standard 4.3. Medical Care 3. Priority: All facilities shall provide a medical staff and sufficient support personnel to meet these Standards. A staffing plan,	Incidental Finding	4. High nursing turnover rates, staff vacations, staff resignations and terminations, and long hiring process has contributed to decreased nursing	No

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#	Analysis Question	Prompts	Root Cause Analysis Findings (Explain/identify the areas that were not followed)	Root Cause/Contributing Factor/Incidental	Ask "Why"	Plan of Action
			which is review at annually, identifies the position needed to perform the required services. • NCCHC standard, J-C-07, Staffing • According to IHSC Sick Call Process Guidelines II-A, facilities with greater than 1001 detainee population should have four to five RNs performing sick call.		staff. At the time of this incident PIDC experienced a shortage of RN staffing. Its current RN vacancy rate is 40% (12 filled/20 positions). According to Port Isabel Staffing Plan FY 18: Total RN Position 21. Only two RNs were scheduled for sick call duties versus the required four to five RNs, and one of the sick call RNs was also the CC for the shift. This left only one RN (CC) to respond to normal clinic activities and emergent events. At the time Mr. Romero arrived at the clinic, the CC was not immediately available due to a simultaneous medical emergency which required the CC to respond. As a result, the staging LVN was required to remain with the detainee until	

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#	Analysis Question	Prompts	Root Cause Analysis Findings (Explain/identify the areas that were not followed)	Root Cause/Contributing Factor/Incidental	Ask "Why"	Plan of Action
					an APP arrived and assumed care. The facility did not have a sufficient number of RNs to provide adequate and timely evaluation and treatment consistent with contemporary standard of care. During this event, there were only two RNs performing sick call, which was inappropriate staffing to detainee ratio and failed to ensure continuity of operations and optimal utilization of human capital.	
7	Did staff performance during the event meet expectations?	Describe whether staff performed as expected within or outside of the processes. To what extent was leadership aware of any performance deviations at the time? What proactive surveillance processes are in place for leadership to identify deviations from expected processes?	Delay in timing of completing diagnostic order: 5. APP ordered a repeat urine dipstick after NS bolus administration, however, was not carried out by nursing staff. According to NCCHC J-E-09 Continuity, Coordination, and Quality of Care During Incarceration; Prescriber orders should be implemented in a timely manner; Diagnostic test are reviewed by the provider in a timely manner.	Contributing Factor	5. Due to decreased nursing staff available, a simultaneous patient emergency, and high volumes of sick call traffic at the time, the urine dipstick was not collected.	Yes

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#	Analysis Question	Prompts	Root Cause Analysis Findings (Explain/identify the areas that were not followed)	Root Cause/Contributing Factor/Incidental	Ask "Why"	Plan of Action
		Include omissions in critical thinking and/or performance variance from defined policy, procedure, protocol and guidelines in effect at the time.				
8	Was all the necessary information available when needed? Accurate? Complete? Unambiguous? Yes	Discuss where patient assessments were completed, share, and accessed by members of the treatment team, to include providers, according to the organizational processes. Identify the information systems used during patient care. Discuss to what extent the available patient information (e.g. radiology studies, lab results, or medical record) was clear and sufficient to provide an adequate summary of the patient's condition, treatment, and response to treatment. Describe staff utilization and adequacy of policy, procedure, protocol, and guidelines specific to the patient care provided.	<u>Facility to facility transfer communication:</u> 1. Inadequate communication of patient's health condition during the facility to facility transfer resulting in inadequate continuity of care: 1a. No transfer summary or medical documentation accompanied detainee from CBP to PIDC - Prior to the incident, no process was in place for CBC to provide transfer summaries or medical records to PIDC from CBP - LOP: 8.1.1 (Jan 2018) Medical Intake Screening 3-5 states that "prior to conducting the Medical Intake Screening, the health care provider will review the Pre-Screening, medical transfer information, and any health	Incidental Finding	1a. Prior to this incident, CBP was not providing transfer summaries and medical records did not accompany detainees prior to this incident, during facility to facility transfer 1b. The detention staff who checked in the medication to the patient's property has not been able to be identified.	No

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#	Analysis Question	Prompts	Root Cause Analysis Findings (Explain/identify the areas that were not followed)	Root Cause/Contributing Factor/Incidental	Ask "Why"	Plan of Action
			information and medication traveling with the detainee." 1b. Detainee's medications were discovered in his property during the mortality site visit and were not brought to medical's attention in a timely manner. Detention staff did not notify medical staff of medications, which lead to a delay in care. - PIDC 4.5.3 Medical Services Medical Staff must approve medication brought into the facility before being given to the detainee or placing them in the detainee's property. - PIDC Policy 3.1.17: Procedure for handling Contraband (evidence) Medicine the detainee brings into the facility upon arrival will be forward to the facility medical staff for disposition. Duly approved medicine will be returned to the detainee. - LOP: 8.1.1 (Jan 2018) Medical Intake Screening 3-25-1 states that "each medication that the detainee has in possession will be listed on the intake screening, which includes name of medication, dosage, route, frequency, and start and stop dates.			
9	Was the communication among participants	Analysis of factors related to communication should include evaluation of verbal, written, electronic communication or the lack thereof.	(Transitions of Care (communication/coordination): 3a.Full assessment and documentation was not rendered by the CC during sick call visit; CC was	Contributing Factor	3a. Due to increased workloads	Yes

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#	Analysis Question	Prompts	Root Cause Analysis Findings (Explain/identify the areas that were not followed)	Root Cause/Contributing Factor/Incidental	Ask "Why"	Plan of Action
	adequate for this situation?	Consider the following in your response, as appropriate: - The timing of communication of key information. - Misunderstandings related to language/cultural barriers, abbreviations, terminology, etc. - Proper completion of internal and external hand-off communication.	not aware of APP's notes and orders so standing orders were not communicated to receiving MHU RN upon admission to the MHU - IHSC Sick Call Process: 2e: If the complaint is not within the RN's scope of practice, the RN documents the sick call and encounter and refers the detainee/resident to the MLP or to another healthcare professional to be seen at a minimum the next business day or as appropriate. - ISHC Medical Records Documentation powerpoint: (Annual Training): pg 11, Do's of Documentation: Do document as soon as possible after encounter or note "late entry" 3b. APP failed to provide report of the case/care plan to the assigned MHU APP or follow up in a timely manner with his care plan that after the IV bolus was administered he would determine if the detainee should be sent to the ER. Transition of care did not take place from ambulatory APP to MHU APP. - Unable to find any applicable standards(NCCHC, ACA, PBNDS, ISHC Directive/Guide of documentation standard) 5. <u>Inadequate timing of completing diagnostic order</u> APP ordered a repeat urine dipstick after NS bolus administration, however, was not carried		(simutanoues medical emergencies and walk-in patients to the clinic) and decreased nursing staff (RN vacancy 40%; 12 RN filled/20 RN positions), the CC was unable to fully assume care of the patient as he was required to respond to a medical emergency 3b. Usually report of patient admission to the MHU is provided to the MHU RN by the CC. More often than not, a report from clinic APP is not given to the MHU APP. 5. Nursing staff (RN vacancy 40%) 12 RN filled/20 RN position), decreased nursing staffing, nursing staff	

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#	Analysis Question	Prompts	Root Cause Analysis Findings (Explain/identify the areas that were not followed)	Root Cause/Contributing Factor/Incidental	Ask "Why"	Plan of Action
			out by nursing staff; At the change of shift, the clinic APP went to the MHU to verify if the repeat urine was completed which reminded the off-going MHU RN to notify the on-coming MHU RN that a repeat urine was needed. According to NCCHC J-E-09 Continuity, Coordination, and Quality of Care During Incarceration; Prescriber orders should be implemented in a timely manner; Diagnostic test are reviewed by the provider in a timely manner.		not available to complete diagnostic order. CC was attending another emergency and urgent walk in to the clinic.	

Root Cause Analysis Committee Composition

#	Discipline	Title
1	APP	Risk Manager
2	APP	Regional Compliance
3	RN	Health Service Administrator
4	LCSW	Assistant Health Service Administrator
5	MD	Clinical Director
6	RN	Compliance Officer
7	RN	Infection Control Officer
8	RN	Nurse Manager

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Action Plan

Date Implemented	Organization Plan of Action Risk Reduction Strategies	Method: Policy, Education, Audit, Observation & Implementation	Classification of Corrective Action	Responsible Party	Measurement Strategy	Expected Outcome	Due Date	Complete
4/1/2019	Action Item #1: Transition of care; Ineffective APP to APP communication	1. Education	Communication	Clinical Director	1. Clinic APPs will directly give patient report to the MHU APP during all MHU admissions at the time of admission. All staff will be notified of this expectation verbally and via email communication.	100% staff roster signatures (APPs only)	6/3/2019	1) Yes 3/26/2019
				Facility Health Care Program Manager	2. 10 monthly chart audits will be conducted by FHPM to ensure APPs are giving appropriate report during MHU admissions	100% APP documentation of APP to APP report given on MHU admissions		2) 12/1/19

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4/1/2019	Action Item #2: Untimely completion of APP orders and ineffective APP to RN communication	Education: Written education will be provided to APPs and Nursing	Training	Clinical Director Nursing Manager	1. APPs will specify timeframes when writing orders; Example: STAT (now), in 30 minutes, at hour of sleep, tomorrow at 0500, etc.	100% APP roster signatures	6/3/2019	8/23/19
		Written & verbal education will be provided to nursing staff regarding carrying out APP orders in the designated timeframe		Clinical Director Nursing Manager	2. APPs will issue a telephone encounter with new orders to a daily assigned RN who can carry out requested orders during the timeframe specified	100% RN/LVN roster signatures	5/11/20	5/11/20
		Verbal reinforcement for APPs and nursing staff at monthly staff meetings		Facility Health Care Program Manager	3. 10 monthly random chart audits conducted by FHCPM	100% of audited charts contain telephone encounter of APP orders with specified timeframe carried out by RN within specified timeframe	5/11/20	5/11/20
4/1/2019	Action Item #3: Diabetic Ketoacidosis (DKA) Training	Education: DKA powerpoint provided to APPs	Training	Clinical Director	5 multiple choice question pre- and post-test for written education	100% scores on post-test feedback	6/3/2019	9/13/19

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		at the discretion of the CD			5 open-ended case study questions for APPs	100% on case study feedback		
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If compliance levels were not met, what actions were taken?

2. 10 monthly chart audits will be conducted by FHPM to ensure APPs are giving appropriate report during MHU admissions

Comments: Chart review completed, however PIDC did not meet compliance level. Will be discussed in the next provider meeting

What immediate improvement measures have already been implemented?

3/26/2019: CD (b)(6); notified all APPs during APP meeting of new expectations (APPs will send designated RN telephone encounter w/ orders clinic APPs will give direct report to MHU APPs during admission process)
Staff roster to follow

4/2/2019: CD (b)(6); will reinforce teaching with APPs during weekly APP meeting to ensure compliance
Staff roster to follow

Comments:

1. Changes made to intake process:
 - a. The LVN or RN who performs the prescreen must document the prescreen
 - b. If a detainee declares a medical condition during group prescreen, the LVN/RN must provide a secured, private area for detailed patient prescreen apart from other detainees
2. Staffing module:
 - a. 100% nursing staffing is required to provide high quality patient care and to minimize risk for human error
 - b. Revisit staffing module to provide PIDC with the nursing positions to adequately serve the needs of PIDC and RGV staging
3. Direct oversight of medical staff in RGV staging, possible administrative position to provide supervision, direction, and support of staff

Headquarters Recommendations for National Implementation

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Root Cause Analysis and Action Plan**

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

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**ICE Health Service Corps
Root Cause Analysis and Action Plan**

ROOT CAUSE ANALYSIS AND ACTION PLAN FRAMEWORK TEMPLATE

The IHSC Root Cause Analysis and Action Plan has nine analysis questions. The following framework is intended to provide a template for answering the analysis questions and aid in organizing the steps in a root cause analysis. All possibilities and questions should be fully considered in seeking “root cause(s)” and opportunities for risk reduction. Not all questions will apply in every case and there may be findings that emerge during the course of the analysis. Be sure however to enter a response in the “Root Cause Analysis Findings” field for each question. For each finding continue to ask “why?” and drill down further to uncover why parts of the process occurred or didn’t occur when they should have. Significant findings that are not identified as root causes themselves have “roots.”

As an aid to avoid “loose ends,” the two columns on the right are provided to be checked off for later reference:

- “Root cause” should be answered with “Yes” or “No” for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding is relevant to the event is not a root cause, be sure that it is addressed later in the analysis with a “why?” questions such as “why did it contribute to the likelihood of the event?” or “why did it contribute to the severity of the event?” Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.
- “Plan of action” should be answered with “Yes” for any finding that can be reasonably considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan.

INSTRUCTIONS

1. Complete the form with as much detail as possible.
2. Click on grey default text to add your own text.
3. Fields will automatically expand to fit the content. Do not attempt to resize the boxes manually.

ICE Health Service Corps Root Cause Analysis and Action Plan

Facility:	Date & Time Event Discovered:	Location of Event:	Type of Event:
Choose a facility.	Click here to enter a date.	Click here to enter the location.	Choose an event type.

Date of Arrival:	Diagnosis:
5/28/2018	Cardiac Arrest

Brief Summary of Event (Use page 3 of this document to provide the Sequence of Events):

A medical emergency was called and medical responded and to found Core Civic officers performing cardiopulmonary resuscitation (CPR) on the detainee. Medical assisted with CPR and initiated a call for emergency medical services (EMS). When EMS arrived on the scene, they took over CPR and prepared the detainee for transport to Banner Casa Grande Medical Center's emergency department. EMS departed EDC. During his eight-day hospitalization, the detainee remained unresponsive with no reflexes, including gag and pupils (eye movement); on mechanical ventilation (breathing machine); receiving hypothermia therapy (maintain body temperature); and medication management [suxamethonium chloride (skeletal muscle relaxant)], propofol (used to induce or maintain anesthesia), norepinephrine (vasoconstrictor), and piperacillin/tazabactam (antibiotic). On June 12, 2018, the doctor performed an electroencephalography (EEG – a tool used to measure electrical activity of the brain) that showed no brain activity. These findings were confirmed with apneic testing (mandatory examination for determining brain death, because it provides an essential sign of definitive loss of brainstem function), resulting in the detainee being pronounced brain dead.

Event Type: Select one below

Near Miss	Adverse Event	Sentinel Event
☐ Medication Error Caught Prior to Administration ☐ Wrong Patient ☐ Wrong Procedure ☐ Other (Brief Description): Click here to enter text.	☐ Medication Error That Reached Patient ☐ Injury Due to Medical Equipment Failure ☐ Fall With Injury ☐ Suicide Attempt ☐ Other (Brief Description): Click here to enter text.	☐ Suicide ☒ Unanticipated Death

☐ Event Requires Full RCA	☐ Event Does Not require Full RCA
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Outcome of Event:

☒ Death	☐ Permanent Harm	☐ Severe Temporary Harm	☐ No Significant Harm with Additional Monitoring	☐ None
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HEADQUARTERS USE ONLY

Assigned HQ Risk Manager	Date RCA Initiated:	Date RCA Received at HQ:	Date RCA Reviewed by RM:	Date of Six Month Follow-Up:
(b)(6); (b)(7)(C)	12/7/2018	12/14/2018	12/17/2018	8/5/2019

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Sequence of Events Log

Date	Time	Provider	Sequence of Events
5/28/2018	07:37	RN	Prescreening completed in English. Detainee was reported to have transferred from Florence Detention Facility. He denied pain, SI/HI. Reported taking medications and having a current illness for which he took medications. Prescreening priority was designated as PRI-1
5/28/2018	09:54	RN	Registered nurse (RN) completed the intake screening. Detainee verbalized a history of depression for the past 20 years and taking haloperidol and fluoxetine daily. He also reported a hx of mental health treatment at the Southwest clinic in Phoenix, AZ. Mr. TRAN denied any suicidal or homicidal thoughts, hallucinations, or history of substance abuse or mental health hospitalizations. The RN consulted with an advanced practice provider (APP) and received verbal orders to continue Mr. TRAN's medications (haloperidol and fluoxetine) and to schedule him for a physical examination (complex) and a mental health appointment on May 29, 2018. Telephone encounters were sent to the APP and mental health provider. Patient arrived with medications: Haloperidol 5 mg, tab; 1 tab PO morning; Fluoxetine 20 mg, caps; 1 cap PO morning. He reported taking the medication x 5 years and the last dose of the medication was the prior afternoon. Vitals within normal limits.
5/28/2018	10:44	RN	TE send to APP: "Patient arrived with medications: Haloperidol 5 mg, tab; 1 tab PO morning; Fluoxetine 20 mg, caps; 1 cap PO morning. Patient denies SI/HI. Patient denies hallucination, hearing voices; anxiety; depression. Patient reports taking medications for about 5 years. Patient reports last time took medications yesterday afternoon."
5/28/2018	10:45	RN	TE sent to MD: "Patient arrived with medications: Haloperidol 5 mg, tab; 1 tab PO morning; Fluoxetine 20 mg, caps; 1 cap PO morning. Patient denies SI/HI. Patient denies hallucination, hearing voices; anxiety; depression. Patient reports taking medications for about 5 years. Patient reports last time took medications yesterday afternoon."
5/28/2018	00:30	APP	Physical examination completed. The APP noted an existing mental health referral (b)(6); (b)(7)(C) verbalized a history of schizophrenia and anxiety disorder (described as moderate) for 17 years, he denied any side effects from the medication. (b)(6); stated he spent one year in DOC, and prior to his imprisonment, he lived with his parents in Phoenix, AZ. The physical assessment was unremarkable. (b)(6); VS were WNL, and his AIMS score was zero. The APP's assessment included schizophrenia, unspecified, and anxiety disorder, unspecified, with orders for medication: haloperidol tablet, 5 mg, one tablet orally, daily for 14 days; fluoxetine 20 mg capsules, one capsule orally, daily for 14 days. The APP documented a telephone consultation with a psychiatrist. [Note: There was no telephone encounter submitted to the psychiatrist.] An MD documented a

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			confirmatory signature on May 31, 2018, at 2:34 p.m. Labs ordered: TSH, Lipid panel, CMP, CBC, HgbA1C
6/4/2018	14:57	MD (Psych)	Mental health evaluation completed by psychiatrist. MD documented that the patient reported hearing voices since the age of 20. He started receiving treatment for mental health symptoms 2 years prior. He denied commanded hallucinations, but he believed that others could control his mind. He reported taking fluoxetine for anxiety and described the anxiety as restlessness and not feeling comfortable around others. He denied depressed mood, hopelessness, helplessness, SI, suicidal intent or plan. The detainee reported hearing voices "once in a few months." He experienced VH and stated that he would see a person of medium stature. The detainee reported receiving outpatient treatment at Southwest Network from 2013-2017. His AIMS score was 3. He was noted to be well nourished and not in distress. He was cooperative with the examination and showed mild psychomotor retardation. The detainee's speech was slow and he had latent responses with a low volume and slow rate with normal rate, rhythm and prosody. His mood was euthymic, affect blunt, thought process was slow with impoverished thought stream. MD wrote: "He exhibits EPS which will be addressed with Cogentin." The MD ordered a 30 day supply of Haloperidol 5mg QHS and Fluoxetine 20 mg daily at noon. Cogentin was not ordered. Follow up scheduled for 4 weeks.
6/5/2018	00:35	PsyD	Patient referred to medical to be seen. He was evaluated by the staff psychologist who documented the following: "Pt was seen for a MH f/u assessment, as referred by Civic Core staff. Pt presented as depressed and apathetic. He exhibited flat affect with alogia. Additionally, he presented as extremely slow moving, lethargic, and exhibited rigid movements with occasional hand tremors. Pt 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. Pt 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 towards the end of the session. Initially Pt denied sx 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. Pt acknowledged that he has been moving more slowly overall, which began in the last few weeks. Pt denied issues with sleep or appetite. Pt denied past and current AVH. It should be noted that during his initial intake on 5/26/18 at Florence, he reported experiencing AVH prior to taking his psychotropic medication. Pt said that he has been consistently taking his psychotropic medication. Pt exhibited longer pauses between responses towards the end of the session. He appeared somewhat distracted. At one point, Pt asked why he was being asked these questions. Pt was cooperative overall, though he ultimately said that he didn't want to talk anymore. In terms of coping mechanisms, Pt reported that he attends recreation, but said that he

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			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. Pt denied thoughts of self-harm, plan, and intent." The PsyD ordered Mr. TRAN's placement in medical housing observation (MHO) with mental health nursing checks twice-a-day, Core Civic checks every 15 minutes, and for the mental health provider to follow up with Mr. TRAN in two days.
6/5/2018	16:15	RN	Medical Emergency was called at 16:15 in B600. First Medical Team members arrived at 16:18. Core Civic officers had started CPR. Pt was laying on the bed unresponsive and not breathing. Sternal Rub administered without reaction. Pulse Ox read SPO2 48% faint irregular pulse was felt on the right wrist. oxygen was applied upon arrival and an Ambu bag applied to give rescue breaths during CPR. A provider arrived at 16:20 and took over the lead during CPR. The shirt was cut open and AED Pads placed on the patient. Nursing staff attempted Blood Pressure check with negative results. Blood glucose was checked with a Glucometer reading of 208. Peripheral intravenous catheter insertion attempted X2 without success. Oxygen saturation reading was between 48% to 93 % with peripheral pulse ranging from 50-115 during CPR. CPR lasted 17 minutes before the ambulance arrived. There was no shock advise throughout the duration of CPR by medical team. AED analyzed the patient several times without shockable rhythm. CPR Continued until EMS arrival and assumed patient care at Approx 16:33.
6/5/2018	16:155	APP	Upon arrival to Bravo 600, Pt was in his room face up on his bed, t(b)(7)(E) were alternating administering chest compressions with a third officer was helping with counting the compressions. Provider (b)(6); (b)(7)(C) and RN (b)(6); (b)(7)(C) were managing the air way and giving two breaths every 30 compressions. Pt had two AED leads on his chest that were adhered partially. Three times the AED called for rhythm check, and no shock was advised. Twice while pt was assisted with breathing, this provider listened for heart sounds or breath sounds; both times breath sound were noted, but no heart sounds. This provider noted a black PulseOx device on pt's right finger. The pulse was noted in the 115's and the oxygen saturation was noted to change from 39 to 85%. When compressions were stopped, the PulseOx device had no reading. An IV was attempted in the left antecubital area and was successful for a short time, but not long enough to administer fluids; This provider attempted an IV site in the right antecubital area and was unsuccessful. EMS arrived on scene and took over on the compressions, obtained IV access on the anterior tibial area of left leg. Narcan and Epinephrin were administered. They placed their own AED lead on

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			pt and were able to obtain a weak pulse. Pt was supported by a back board and transported to EMS gurney and removed from facility. The only time that this provider was aware of was when EMS removed pt from facility 14:45.
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Root Cause Analysis

#	Analysis Question	Prompts	Root Cause Analysis Findings (Explain/identify the areas that were not followed)	Root Cause/Contributing Factor/Incidental	Ask "Why"	Plan of Action
1	Was there a breakdown in the intended process?	List the relevant process steps as defined by the policy, procedure, protocol, or guidelines in effect at the time of the event. You may need to include multiple processes. Select the appropriate policy of process that should have been followed: ☒ Medical Care ☐ Mental Health ☐ Nursing Guidelines	1. Medication Administration Process a. Missed medication doses	Incidental Finding	Medication Administration Process Missed medication doses-Per pill line RN, if medications come after morning pill line, it is assumed medication will start the next day. Nursing staff complete the morning (AM) pill line on nightshift (0400-0700); therefore, when new orders are received after 0700, the medication is not started until the next day, unless otherwise specified. Additionally, pharmacy does not verbally tell nursing staff that administration times have changed. As a result, the detainee	Yes

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					missed medications on three occasions. Additionally, a medication (Fluoxetine) time was changed. As a result, the medication was given twice in one day. The Psychiatrist changed the scheduled time for the medication, the administration record (MAR) was updated when the new stickers were provided. WHY DOUBLE DOSE WAS GIVEN????? Order on the MAR was verified correctly by the nurse. The nurse who administered the noon dose stated that she gave the medication to the patient under the direction of the psychiatrist while the patient was still in the psychiatrist's office. Will question	
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					the psychiatrist when he returns from vacation. Dose may have not been given in error. May have been given appropriately as directed by M.D. Process is to perform a thorough verification of the MAR. The psychiatrist does not recall giving the LVN verbal instructions to administer the noon dose of Prozac. The psychiatrist was not aware that the patient received the morning dose of the Prozac. The medication administration time was changed to noon in order to improve medication adherence. The second dose of Prozac ordered and the medication	
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					order was written for the patient to receive the medication on 06/6/2018.	
2	What human factors were relevant to the outcome?	Discuss staff-related human performance factors that contributed to the event. Examples may include, but are not limited to: Choose an item.	N/A	N/A	N/A	Choose an item.
3	How did the equipment performance affect the outcome?	Consider all medical equipment and devices used in the course of patient care, including AED devices, crash carts, suction, oxygen, instruments, monitors, infusion equipment, etc. In your discussion, provide information on the following as applicable: Choose an item.	1. AED pads did not adhere to the patient's skin during the CPR, but the pads were not changed and continued to be used	Incidental Finding	Site unsure why the pads did not stick, but during the emergency response, they did not have a second set of pads available for use. Additionally, medical staff did not request a second set of AED pads for use.	Yes

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4	Were there any other factors that directly influenced this outcome?	List any other factors not yet discussed: Choose an item.	1. Cogentin documented by staff psychologist as being needed, but was not ordered 2. The psychiatrist documented changes in Mr. TRAN's AIMS scores; however, he did not make a referral to medical or change the frequency of AIMS monitoring.	Incidental Finding	The physician reported that he intended to write the prescription for Cogentin and he thought that it was ordered. He does not routinely utilize the eCW feature "eprescription logs" to verify if medications have been ordered and sent via the eprescription process. The staff pharmacist does not routinely review provider notes associated with the orders. If there is "a red flag we (pharmacist) will go into the providers notes (to review the note) or (if the) diagnosis does not match the order received." The pharmacist was "not aware of Cogentin order until after he was hospitalized."	No
5	Was the staff properly qualified and currently competent for their	Include information on the following for all staff and providers involved in the event. Comment on the processes in place to ensure staff is competent and qualified.	1. Psychologist qualified to identify signs and symptoms of EPS. Documentation noted EPS symptoms, but an official diagnosis was not noted	Incidental Finding	Staff psychologist reported not having much experience with EPS symptoms. She stated that she worked with patients in the	Yes

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	responsibilities at the time of the event?	Examples may include but are not limited to: Choose an item.			past that had medication side effects, but had no experience with patients who had severe/life threatening side effects. Additionally, the psychologist did not have any interactions with the detainee prior to June 5, 2018. She was not aware that he missed medications.	
6	Did the staffing mix on the day of the event directly contribute to event?	Were the proper disciplines available to provide necessary care? Were more staff needed to provide necessary care?	1. Mental Health evaluation did not occur until seven days after his arrival to EDC. Site has a staff psychiatrist that works 36 hours per week. Site covered by tele-psych when the staff psychiatrist is not available 2. There was one CO assigned to cover two SHUs: 1) segregation/protective custody housing and 2) medical SHU.	Incidental Finding	Staff psychiatrist works 3 days a week, 12 hour shifts. He also covers some weekends occasionally. The site utilizes telepsychiatry weekly on Tuesdays. The psychiatrist reviews all medications refills, emails, and referrals. The MD sees patients after performing his administrative duties. He reported that it takes 2-3 hours to complete the administrative duties. The psychiatrist also reported that his schedule was busy and he often has to	Yes

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					prioritize his schedule due to these factors. Additionally, the site mental health providers were notified by the Regional Behavioral Mental Provider that local providers could review the chart and triage according to the symptoms documented. Guidance was given that MH referrals could be completed within 14 days.	
7a	Did staff performance during the event meet expectations?	Describe whether staff performed as expected within or outside of the processes. To what extent was leadership aware of any performance deviations at the time? What proactive surveillance processes are in place for leadership to identify deviations from expected processes? Include omissions in critical thinking and/or performance variance from defined policy, procedure, protocol and guidelines in effect at the time.	1. CPR was administered on a mattress, no back boards or removal of mattress utilized.	Incidental Finding	CPR was being performed when medical staff arrived. Compressions were noted to be adequate and recoil was noted. A backboard was available for use however, interruption of CPR to place a backboard was not necessary.	No

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7b	Did staff performance during the event meet expectations?	Describe whether staff performed as expected within or outside of the processes. To what extent was leadership aware of any performance deviations at the time? What proactive surveillance processes are in place for leadership to identify deviations from expected processes? Include omissions in critical thinking and/or performance variance from defined policy, procedure, protocol and guidelines in effect at the time.	2. Staff unable to secure a seal when administering oxygen via ambubag	Contributing Factor	The frequency in which the staff performs the action is low. Therefore, expertise in using the device is challenging.	Yes
7c	Did staff performance during the event meet expectations?	Describe whether staff performed as expected within or outside of the processes. To what extent was leadership aware of any performance deviations at the time? What proactive surveillance processes are in place for leadership to identify deviations from expected processes? Include omissions in critical thinking and/or performance variance from defined policy, procedure, protocol and guidelines in effect at the time.	3. Placement of the AED pads was not per the manufacture's instruction and the pads did not adhere to the detainee's chest wall well. 4. Staff did not request a second set of AED pads when the initial set did not adhere to the patient's skin	Contributing Factor	See analysis question #???	

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8	Was all the necessary information available when needed? Accurate? Complete? Unambiguous?	Discuss where patient assessments were completed, share, and accessed by members of the treatment team, to include providers, according to the organizational processes. Identify the information systems used during patient care. Discuss to what extent the available patient information (e.g. radiology studies, lab results, or medical record) was clear and sufficient to provide an adequate summary of the patient's condition, treatment, and response to treatment. Describe staff utilization and adequacy of policy, procedure, protocol, and guidelines specific to the patient care provided.	Yes, eCW was functional and available. Medical records from previous MH treatment center was requested.	N/A	N/A	N/A

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9	Was the communication among participants adequate for this situation?	Analysis of factors related to communication should include evaluation of verbal, written, electronic communication or the lack thereof. Consider the following in your response, as appropriate: - The timing of communication of key information. - Misunderstandings related to language/cultural barriers, abbreviations, terminology, etc. Proper completion of internal and external hand-off communication.	- Psychiatrist did not communicate to pill line nursing staff that there was a change in the time of the medication (Fluoxetine). - The EDC pill line nurse's documentation did not include changes in behavior when Mr. TRAN reported to pill line twice a day. The psychologist placed Mr. TRAN in SHU for increased monitoring but did not ask for a medical evaluation prior to his placement.	Incidental Finding Contributory	The psychiatrist entered the medication order in eCW. The electronic prescription was processed and submitted to the pharmacy and the medication was dispensed by the pharmacy. This is the normal process during business hours. 3. The EDC pill line nurse's documentation did not include changes in behavior when Mr. TRAN reported to pill line twice a day- noted to be investigator's finding. MAR does not support this documentation	Yes
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Root Cause Analysis Committee Composition

**ICE Health Service Corps
Root Cause Analysis and Action Plan**

#	Discipline	Title
1	RN	Risk Manager
2	RN	Regional Compliance Specialist
3	PA	Health Services Administrator
4	LCSW	Assistant Health Services Administrator
5	RN	Nurse Manager
6	Click here to enter text.	Click here to enter text.
7	Click here to enter text.	Click here to enter text.
8	Click here to enter text.	Click here to enter text.

ICE Health Service Corps Root Cause Analysis and Action Plan

Action Plan

Date Implemented	Organization Plan of Action Risk Reduction Strategies	Method: Policy, Education, Audit, Observation & Implementation	Classification of Corrective Action	Responsible Party	Measurement Strategy	Expected Outcome	Due Date	Complete
1/7/2019	Action Item #1: Missed medication doses: Pill line nurse will perform a two person verification of medications with the clinic coordinator RN.	LOP As of April 2019 SMART medication administration system implemented in facility; therefore, two person verification process null and void. LOP method will be replaced with the implementation of the SMART system.	Equipment	HSA or designee	The site will track medication errors going forward and compare future occurrence rate with current occurrence rate. The two nurses verifying the medication will sign the MAR after checking the order to ensure that the medication dosage, time, and frequency are accurate. The site will track the errors x 3 months. Any medication changes will be communicated by the provider to nursing staff. Nursing staff will verify the change with the provider when the MAR review is completed. A LOP	Expected Outcome is that the site will have zero occurrences related to the lack of verification of medications. 100% of medical staff will receive the LOP and sign the roster upon receipt of the information. The LOP will be reviewed upon orientation of new staff members. April 25, 2019- LOP process will be removed from this action plan due to SMART	7/30/2019	Choose an item.

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					will be, reviewed and emailed to all staff. Staff will sign a roster verifying that the information has been received and understood. April 25, 2019- Tracking will be conducted to determine if new SMART system verification process has eliminated medication errors due to verification.	system replacement.		
1/7/2019	Action Item #2: Medical emergency response (AED pads) Emergency response drills will incorporate varied scenarios to include equipment issues to ensure that training includes issues with AED pads. Drills include a debriefing	Education	Training	Medical training officer	Site will conduct man-down drills as per policy and will include scenarios such as: detainee sweating/AED not sticking, AED cord broken, and if any other equipment is needed. Scenarios will also include response to CPR when a seal is not secured when using the ambubag.	100% of medical response drills will incorporate varied scenarios. The site will continue to debrief on medical responses that occur. The medical staff will attend or review the training and debrief. A	4/30/2019	Choose an item.

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						signature roster will be utilized		
1/31/2019	Action Item #3: Mental health training on EPS	Updated needed by end of Jan. 2019 from RCD regarding MH training on life threatening side effects. Powerpoint Presentation/Training provided to all staff	Training	HSA/FHPM	Pre/Post test completed by all staff; signature roster included to verify completion	100% attendance of training and 100% completion with 80% pass rate on post test.	5/30/2019	Choose an item.
2/1/2019	Action Item #4: Staffing and triage Site will reinforce the ability to refer other mental health providers if the staff psychiatrist is not available. Site will assign a duty provider to review the medication renewal orders on the day that the staff psychiatrist is not onsite. Site will continue to update HQ on the physician need and staffing plan	Implementation	Staffing/Training	HSA and Lead APP	The site will perform an audit of 10 mental health referrals to confirm compliance with the 72 hour timeframe per month x 3 months.	100% compliance with IHSC standards regarding mental health referrals	5/30/2019	Choose an item.
Click here to enter a date.	Action Item #5: There was one CO assigned to cover two SHUs: 1) segregation/protective custody housing and 2) medical SHU.	Custody referral	SOP/Policy	HSA	HSA will follow up with custody leadership to determine if female custody staff can enter male cell or if male	Clear understanding of Custody policy and or staffing via memo from custody staff.	5/30/2019	Choose an item.

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	A review of the video footage and interviews revealed, two female COs (first responders) hesitated prior to entering Mr. TRAN's cell. It was not until a male CO entered the cell before they entered, causing a delay in starting cardiopulmonary resuscitation (CPR). [Investigator's note: Core Civic policy states, "All personnel responding to an incident				custody staff must be present for female staff to enter. If female staff cannot enter alone then new policy/procedure recommended regarding staffing; ensuring females are not staff alone. If gender is not the reason for delay, then HSA will get information from custody staff regarding how they decided to address concern of staff delaying emergency care.			
Click here to enter a date.	Action Item #6: Communication on patient's health needs and continuity of care. Click here to enter text.	Education staff to sharing "need to know" information with custody when been monitored/observed.	Training	FHPM	All staff will attend education session/meeting. Attendance roster will be obtained to include signatures; those unable to attend will read meeting minutes/training and sign acknowledgement	100% participation in educational training.	5/30/2019	Choose an item.
Click here to enter a date.	Action Item #7: Click here to enter text.	Click here to enter text.	Choose a classification.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter a date.	Choose an item.

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Click here to enter a date.	Action Item #8: Click here to enter text.	Click here to enter text.	Choose a classification.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter a date.	Choose an item.
Click here to enter a date.	Action Item #9: Click here to enter text.	Click here to enter text.	Choose a classification.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter a date.	Choose an item.

What immediate improvement measures have already been implemented?

Click here to enter text.	Comments: Click here to enter text.
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Headquarters Recommendations for National Implementation

Consider national review of BHPs knowledge of EPS symptoms withing IHSC??????

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ICE Health Service Corps **Event Review, Root Cause Analysis/Action Plan**

Facility:	Date & Time Event Discovered:	Location of Event:	Type of Event:
Florence	4/3/2019	Segregation	Unanticipated death

Brief Summary of Event (Use page 3 of this document to provide the Sequence of Events):

(215-881-614) Medical officer received a call from segregation at approximately 06:12 that medical needed to report to segregation. Information regarding the specific patient was not disclosed at that time. Two registered nurses (RN-1 and RN-2) went to the segregation area after verifying the patient and reason for the referral. The segregation officer reported that the patient was having difficulty breathing. As a result, a third RN (RN-3) and LVN (LVN-1) obtained the oxygen tank and exited the clinic. A 10-10 (medical emergency) was then called on the radio with no additional information given. Upon arrival to the segregation building, officers notified medical staff that compressions had been started. RN-1 and RN-2 went to segregation to assist and advised (sic) the custody lieutenant to call 911. Upon arrival of the cell, RN's noted that CPR was in progress by two segregation officers. The patient was on the bed. RN-3 instructed the officers to place the patient on the floor and requested for an AED. While the patient was being transferred to the floor, RN-3 assessed for a radial pulse and felt a weak, thready pulse. The pulse oximetry was applied to the left finger and no reading was detected. The patient was unconscious with his eye open. He did not respond to name, touch, or pain. Compressions were continued while the patient started to have brown secretions coming out of the left side of his mouth. RN-3 asked for a towel and cleaned up the fluid from the patient's mouth, then he took began administering compressions, while the segregation officers can rescue breaths via an ambu bag. RN-2 took over compression while the AED pads were placed on by RN-3. The AED did not advise shock and compressions were continued. After RN-2, LVN-1 took over compressions and the AED instructions continued to be followed. RN-4 and RN-5 arrived on the scene with additional medical equipment and the patient's mouth was suctioned. The fire/rescue department arrived to the site at 06:23 and AMR (American Medical Response-ambulance) arrived at 06:24 and assumed care. CPR efforts were in progress throughout the encounter without pause.

Severity Score	Probability Score	Risk score
☐ Negligible (1) ☐ Minor (2) ☐ Moderate (3) ☐ Major (4) ☒ Catastrophic (5)	☐ Rare (1) ☐ Unlikely (2) ☐ Possible (3) ☒ Likely (4) ☐ Almost certain (5)	☐ Low (1-3) ☐ Moderate (4-6) ☐ High (8-12) ☒ Extreme (15-25)
Severity score multiplied by probability score equals risk score		

ICE Health Service Corps Event Review, Root Cause Analysis/Action Plan

☐ Event Review Only ☐ Full RCA

Outcome of Event:

☒ Death ☐ Permanent Harm ☐ Severe Temporary Harm ☐ No Significant Harm with Additional Monitoring ☐ No Harm

HEADQUARTERS USE ONLY

Assigned HO Risk Manager

Assigned FHPM

Assigned RCS

Assigned HSA/AHSA

Date RCA Initiated

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

5/14/2019

Sequence of Events Log

Date	Time	Provider	Sequence of Events
2/28/19 through 3/19/19			Patient (pt) seen for pre-screening, intake, and PE. No significant findings or events related to the outcome noted. Pt was also seen for chronic care visits, sick call, and medication review. Vital signs and oxygen saturation were within normal limits for all visits during this period. The pt was transferred to La Palma Correctional Facility on 3/19/19.
3/21/19	23:46	RN	Pt seen for pre-screening, Pre-screening priority was PRI-LB (Priority-Language Barrier). Pt was noted to be taking ASA 81 mg daily, Gabapentin 400 mg daily, and Metformin 500 mg twice a day; however, he did not arrive with the medications. RN did not use an interpreter and documented, "No interpreter available during visit." The RN documented that a chart review was completed and the pt had a history of being diagnosed with "DM AND RESTLESS LEG SYNDROME."
3/22/19	03:41	RN	Telephone encounter sent to APP by RN who documented, "DT ARRIVED WITH ASA 81MG DAILY, GABAPENTIN 400MG DAILY IN THE EVENING AND METFORMIN 500MG TWICE A DAY. T/E TO PROVIDER NIENHUIS, PA-C AND PE-C SCHEDULED FOR 3/22/19."
3/22/19	03:35	RN	Intake completed. Per RN documentation, the detainee did not arrive with a medical transfer summary. When asked, "How do you feel today," he responded "Ok." RN documented a history of "DM, NEUROPATHY." Medications listed were ASA, Gabapentin, and Metformin. He denied all other significant history. Vital signs were 98.1 T, 96 HR, 126/80 BP, 16 R, 149 lbs, 98% O2 Sat on room air. Pt was "oriented to person, place, time and situation." He had no other significant findings on intake. The RN documented, "Abnormal intake screening, referred to medical provider ; T/E sent to provider (PA-C) and PE was scheduled for 3/22/19).
3/25/19	09:26	APP	PE-Initial 90 day review. Pt denied pain, vital signs: 98.3 oral/100.5 tympanic T, 105 HR, 115/71 BP, 16 RR, 306 glucose, 97% O2 sat on RA. Pt started on ASA 81, Gabpentin 400 mg, and Metformin

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**ICE Health Service Corps
Event Review, Root Cause Analysis/Action Plan**

			500 mg. Was advised to return in 11 months and educated on access to medical care. Chart was reviewed by MD on 03/28/2019 at 2:42 PM
3/26/19	08:15	RN	Pt seen for sick call. RN documented, "While triage for RN visit, detainee asked why he was here. I told him that his name was on SICK CALL list. He stated he is fine and did not request this visit. Has no complaints. I checked yesterdays vitals and he has no fever." Vital signs were: 99.1 T, 89 HR, 107/62 BP, 20 RR, 97% O2 on room air. Pt returned to dorm.
3/28/19	03:30	RN	Pt was seen by RN for 6/10, mild-moderate bilateral foot pain x 1-2 days. Pt reported having the foot pain x 5 months. He reported severe foot pain overnight. Pt stated that he had foot pain for 5 months and severe foot pain overnight. He stated that he "needed additional medications to control the pain," which he rated as 8/10. Pt reported daily pain as 6-7 and reported informing the provider of this. The pt stated that he wanted to go home to get medication that works for him. He was unable to recall the name of the medication. Pt had mild erythema with no inflammation to his bilateral feet. He had dry skin to his lower legs. Pt's exam was otherwise unremarkable. Vital signs were: 97.6 T, 98 HR, 118/80 BP, 18 RR, 98% O2 on room air. RN consulted with PA-C for a medical history review. Per APP, pt to follow up on 4/9/19. RN educated the pt on the increase in the gabapentin. RN advised pt to return to clinic (RTC) for sick call if needed.
3/30/19	08:23	RN	Pt seen by RN. RN wrote, "pt did not request to come to medical clinic." Security brought an expired bottle of medications to the clinic. The pt denied that the pills were extra and stated that he was taking his medication as ordered. Pt had metformin and ASA as KOP. Vital signs: Temp 97.6 T, 100 HR, 106/69 BP, 17 RR, 95% O2 Sat on room air. Pt was not in distress and his general exam was unremarkable. RN documented that the note was assigned to the medical provider for chart review and that pt was scheduled for follow up on 4/4/19. Pt was educated on medication administration and informed that his foot pain was related to diabetes. The pt stated that he was taking his medications as ordered. Pt was returned to his housing area with all of his medications and educated on the sick call process. APP co-signed the note on 04/01/2019 at 08:09 AM
4/1/19	10:30	APP	APP saw pt for "flu like symptoms." APP wrote, "Patient c/o flu like symptoms beginning Saturday night. Has fever, chills, sore throat and mild cough when lying flat." Vital signs: 100.1 Temp, 114 HR, 105/65 BP, 96% O2 sat on room air. Pt appeared ill, had mucoid discharge from his nose, throat was mildly erythematous-pt's physical exam was otherwise unremarkable. APP ordered Oseltamivir 75 BID x 5 days and Acetaminophen 325 mg, 2 tabs PRN QID x 5 days. Pt was advised to increase fluid intake, increase rest, and to return to sick call sooner as needed. Pt was scheduled for a f/u appt on 4/4/19
4/1/19	17:23	RN	Telephone encounter by RN was sent to APP. RN documented, "Received order from PA-C to move pt to SEG due to his limited mobility and strength. Nursing check daily. VORBV." APP locked TE on 4/2/19 at 08:13 AM. No assessment or vital signs were documented.

**ICE Health Service Corps
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4/2/2019	05:30	RN	RN rounds for vital signs. Pt seen in SEG for medication administration. RN documented that the pt was "AXOX3," felt weak, and needed help sitting up in bed. The RN and custody officer assisted the patient to sit up and open his food tray. Pt was encouraged to eat breakfast and eat water. He was encouraged to take KOP acetaminophen for elevated body temperature and was advised to remove his jacket. He was observed eating and drinking. Pt advised that medical would return later and was advised to inform staff if he felt worse throughout the day. Pt understood and denied having any questions. He was reported to have tolerated meds well. Temperature was 100.
4/2/2019	06:00	RN	Telephone encounter by RN to APP. RN wrote, "FYI- pt c/o of generalized weakness and difficulty sitting up in bed x1 day. He is able to sit up with medical and CO help. He is AOX3 and complied with taking AM meds without any issues- denies CP, SOB, Transient vision changes, facial weakness, or severe HA- pt is encouraged to hydrate and eat throughout the day" TE Locked by APP at 08:14 AM
4/2/2019	12:15PM	RN	RN seg rounds. Per documentation, pt denied medical complaints or concerns. RN documented "No" to the template question, "Was referral made to clinical services (MD/MLP, Dental, MH, Sick Call?" Vital signs were documented at 2:53PM at follows: 97.3 T, 103 HR, 98/62 BP, 14 Respirations, 143 lbs, 83% O2 sat. RN documented, see TE to APP". General examination findings were documented as unremarkable. Per RN documentation, the pt was not in acute distress, had normal lung sounds, normal heart rhythm, and appeared to be within normal limits of behavior.
4/2/2019	14:56	RN	Telephone encounter by RN to APP. RN documented: APP "was notified of findings of V/S O:2 79-83%, HR 103-110, regular, non-compliance with meds regimen since several bottle of old Metformin and Aspirin was recovered from SEG and still have some left in them. Pt is however is ambulatory, able to respond in spanish/english, and denies any pain except his knees after walking." TE was locked by APP on 4/3/19 at 07:35 AM.
4/3/2019	04:30	RN	Patient seen by RN on seg round for temp, heartrate, and O2 check. Pt was sitting upright for heartrate check and oxygen check. Seen with segregation officers at 0436 per jail control. Jail segregation logs indicated visit at 0441. No complaints, pt reported that he still felt tired. Vitals as follows and recorded at 0706: 98.6 T, 100 HR, 94% O2 sat.
4/3/19	07:48	RN	Medical officer received a call from segregation at approximately 06:12 that medical needed to report to segregation. Information regarding the specific patient was not disclosed at that time. Two registered nurses (RN-1 and RN-2) went to the segregation area after verifying the patient and reason for the referral. The segregation officer reported that the patient was having difficulty breathing. As a result, a third RN (RN-3) and LVN (LVN-1) obtained the oxygen tank and exited the clinic. A 1010 (medical emergency) was then called on the radio with no additional information given. Upon arrival to the segregation building, officers notified medical staff that compressions had been started. RN-1 and RN-2 went to segregation to assist and advised the custody lieutenant to call 911. Upon arrival of the cell, RN's noted that CPR was in progress by two segregation officers.

**ICE Health Service Corps
Event Review, Root Cause Analysis/Action Plan**

			The patient was on the bed. RN-3 instructed the officers to place the patient on the floor and requested for an AED. While the patient was being transferred to the floor, RN-3 assessed for a radial pulse and felt a weak, thread pulse. The pulse oximetry was applied to the left finger and no reading was detected. The patient was unconscious with his eye open. He did not respond to name, touch, or pain. Compressions were continued while the patient started to have brown secretions coming out of the left side of his mouth. RN-3 asked for a towel and cleaned up the fluid from the patient's mouth, then he took began administering compressions, while the segregation officers can rescue breaths via an ambu bag. RN-2 took over compression while the AED pads were placed on by RN-3. The AED did not advise shock and compressions were continued. After RN-2, LVN-1 took over compressions and the AED instructions continued to be followed. RN-4 and RN-5 arrived on the scene with additional medical equipment and the patient's mouth was suctioned. The fire/rescue department arrived to the site at 06:23 and AMR (American Medical Response-ambulance) arrived at 06:24 and assumed care. CPR efforts were in progress throughout the encounter without pause.
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**ICE Health Service Corps
Event Review, Root Cause Analysis/Action Plan**

Process Review			
<u>Process</u>	<u>Steps</u> (Document each step in the process)	<u>Process Vulnerabilities</u> (Behavioral Choices-reckless behavior, at risk behavior, human error, staffing, equipment, staff performance, communication,)	<u>Incidental/Contributing Factor/Root Cause</u>
Use of interpreter	Step One: Patient (pt) prioritized	Pre-screening completed and pt was noted to have a language barrier	Incidental Finding
	Step Two: If language barrier is identified, then pt is upgraded for intake screening to be completed prior to English speaking patients. Note: The site does have telephones available tele-rooms areas	Patient was not taken into the tele-room area for use of phone during pre-screen; There are only two phones available in the tele-trailer. Intake and pre-screening were done within the 12-hour timeframe per policy	
	Step Three: Pre-screening disposition is assigned as PRI-LB	RN documented PRI-LB	
Use of interpreter in SEG setting	Step one: RN to use interpreter in SEG setting for follow up	No telephone access in SEG; RNs who assess patient's in the facility do not have telephone access	Contributory Factor
Medication reconciliation process	Step One: RN calls provider to obtain a continuation order for medications	RN documented the medications in a TE and sent the TE to the provider	Incidental
	Step Two: RN receives an order for the continuation of medication	Do not see documentation to support that the RN called the Provider	
	Step Three: RN places TE with the providers order (reading back and verifying)	Do not see read back/verification process by RN as the provider was not called per eCW documentation (site was not able to verify in esMART that the pt received meds)	
	Step four: Per pharmacy OM, the provider should co-sign the order within 72 hours or on the provider's next scheduled workday.	Provider signed TE on March 25, 2019 (pt arrived on 3/22/19)	
	Step five: Patient to receive medications as ordered by provider	Site unable to verify that pt was given medications on 3/23 and 3/24	
Addressing Abnormal vital signs on PE-C and influenza	Step One: If a provider notices abnormal vital signs, then they are to address the issue	There is no documentation in eCW that supports a follow up on abnormal vital signs (T 100.5, HR 105, Glucose 306)	Incidental

**ICE Health Service Corps
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	Step two: Flu vaccine is to be offered to patients during flu season, documented, and ordered by the provider	Flu vaccine was not noted to have been offered or given	
	Step three: Flu vaccine is administered by pharmacy and documents administration	Flu vaccine was not ordered or administered	
Physical exam-use of interpreter	Step one: Provider performs physical exam 90 day review and utilizes interpreter for PE-C exam	Provider did not utilize an interpreter during the PE exam and documented that he spoke the detainee's native language. Per Florence admin staff, the provider speaks limited Spanish.	Incidental
Sick Call RN Process	Step one: RN performs sick call visit, if symptoms were within the RN scope then the RN would continue the note. If not, then the RN would continue to see the patient, complete the note, and then refer to the provider	RN did not document a sick call visit; visit was updated to an acute note and the pt was seen by the provider	Incidental
Management of patient with IU	Step One: Pt's with IU are isolated from other detainees; Per policy, "when influenza or IU is diagnosed in a detainee/resident, health staff must institute standard and droplet precautions and separate the ill detainee/resident from detainees/residents without influenza or IU."	Pt was not isolated and was sent back to the dorm (site to verify why pt was not isolated and sent to dorm); pt's temp was T 100.1, HR 114)	Incidental
	Step two: Provider should place the detainee in SEG with orders for admission (MHU policy to be followed)	Pt was not isolated. As a result, no segregation admission or orders were done	
	Step three: Per policy, a detainee may be housed in the Special Management Unit (SMU) to undergo medical/mental health	Pt was not isolated. As a result, no segregation admission or orders were done	

**ICE Health Service Corps
Event Review, Root Cause Analysis/Action Plan**

	observation or treatment, if an MHU is unavailable. The admission and discharge processes that apply to the MHU are utilized when use of SMU is required for medical reasons.		
Documentation/Telephone Encounter for urgent needs	Step one: SOAP note documentation for urgent medical issues	No assessment was documented when patient was sent to SEG	Contributory Factor
	Step two: Notification to provider should be completed verbally	Provider was not called	
	Step three: TE sent to provider for verification of orders	TE sent to provider	
	Step four: If pt is going into SEG for medical reasons, MHU policy and nursing rounds apply	Nursing rounds ordered daily and not every 8 hours	
SEG medications (KOP vs PL)	Step one: Patients placed in SEG have meds placed on pill line	Per RN documentation, pt had KOP meds. Per site, Pt did have KOP (April 1) upon arrival to SEG, but the medications were changed to pill line on April 2	Incidental
Communication of patient's status to APP	Step one: During off shifts, RNs are to notify providers of a change in the patient's status via a telephone call	RN sent a TE and the APP signed off on the TE 2 hours later	Contributory
Notification of patient status change	Step one: When notified of an acute care issue via call, provider should follow up with the patient	No appointment (appt) noted in eCW	Contributory
	Step two: The patient is scheduled for a f/u with the provider	No follow up appt noted in eCW	
RN follow up and referral	Step one: If abnormal vitals assessed, RN is to notify the provider of the abnormal vital sign(s)	Pt had critical vital signs that the RN documented in eCW note and via a TE.	Contributory
	Step two: Attempt to take oxygen sat with a second device when	Medical equipment is maintained in a SEG bag for SEG patients. A second supply of medical equipment is available, but is housed in another part of the facility that is further away from segregation.	

**ICE Health Service Corps
Event Review, Root Cause Analysis/Action Plan**

	pulse ox reading is low and document the repeat in the chart		
	Step three: RNs should document all provider orders		
APP follow up on abnormal vital signs	Step one: Provider to assess the patient	Patient was not seen by provider	Contributory
	Step two: Re-evaluate and obtain repeat vitals	Patient was not seen by provider; thus, no repeat vital were completed	
	Step three: Triage as necessary	Pt not brought to clinic for evaluation. SEG housing is away from the clinic and logistically it is difficult to have patient brought to the clinic. Facility complex is large and causes difficulty in getting patient to the clinic, especially if pt is in SEG housing.	
1500 Huddle does not occur at the site	Step one: Best practice-Staff huddle at beginning and end of provider shift to communicate patient needs and follow up	Site does not perform 1500 huddles. RHSA highly recommends having the 1500 huddle for communication and pass information from shift to shift. This is considered a best practice and is not currently in policy. Per site, nursing works 12 hours shifts.	Incidental/ Contributory
Communication of critical vital signs	Step One: RN to call and notify provider immediately of findings (provider to be notified in a timely manner)	RN sent telephone encounter to the provider	Contributory
	Step two: Provider should take action and give definitive orders to RN	Provider did not see the patient and answered the TE the next day (4/3/19)	
	Step three: Provider to document actions taken and orders in eCW	No provider notification noted in eCW	
Late entry RN documentation	Step one: RN charting to occur 1 hour after the encounter	Pt was in SEG. RN did not chart until ~2.5 hrs after pt was seen. Nightshift RN performs SEG round, accu checks, and pill pass in SEG. On the day of the event housing and staffing were as follows: 4 in TIFF, 4 in SEG, 2 in SHU, 9 on co-hort, 61 screened, 100+ seen in intake-4 RNs/LVNs	Incidental
	Step two: RN to document encounters as "late entry" if not completed within an hour	eCW documentation was not documented as late entry. Documentation was completed at 0708AM, which was after the medical emergency. RN who performed the documentation was a part of the medical emergency response.	
RN documentation of rounds	Step one: RN rounds to be documented as MHU rounds would be	RN did not use SOAP format and did not document a translator. The site stated that a phone is not available in SEG	Incidental

**ICE Health Service Corps
Event Review, Root Cause Analysis/Action Plan**

Root Cause Analysis Committee Composition

#	Discipline	Title
1	RN	AHSA
2	RN	FHPM (acting)
3	RN	RN NM (acting)
4	RN	RN Nurse Coordinator
5	MD	Regional CD
6	MD	Staff CD (acting)
7	RN	Regional Compliance Specialist
8	RN	Risk Manager

**ICE Health Service Corps
Event Review, Root Cause Analysis/Action Plan**

Action Plan Development

Contributing Factors or Root Cause	Risk Reduction Strategies (Action Plan)	Classification of Action Plan	Responsible Party	Measurement Strategy and Expected Outcome (i.e. What will be measured? How long it will be measured? What is the expected level of compliance?)	Implementation Due Date	Action Plan Follow Up Date	Compliance Level Achieved	Complete
	Action Item #1: Use of interpreters for primary languages other than English. a) Check with HSA/Health Ops to determine if there is availability to get 2 or more phones for interpreter use in Seg and other areas where phones don't exist. b) Use Custody staff in emergency situations and check on options to use staff during other times that are not urgent but a phone is not available.	Equipment	Team Florence	Measurement a: Response from Leadership regarding request for additional phones Measurement b: Response from custody staff's leadership	7/1/2019	9/30/2019 updated date 10/31/2019		Choose an item.

**ICE Health Service Corps
Event Review, Root Cause Analysis/Action Plan**

	c) Education staff on current options including use of custody staff. Training added to orientation			Measurement c: Attendance roster and acknowledgment of understanding from those who physically attended and those who read minutes Expected Outcome c: 100% of all staff will receive education/training				
	Action Item #2: a) Documentation of assessments/urgent care notes Development of LOP regarding use of verbal orders only for urgent situations b) Ensuring appropriate coverage (recent hire of APP since incident). Site will inform leadership of minimal staffing coverage as a contributing factor	SOP/Policy	Team Florence	Measurement a: LOP – Signed by Regional HSA Expected Outcome a: LOP created and implemented by due date Measurement b: Local tracking of staffing coverage Expected Outcome b: Current staffing coverage meets agency requirement. Goal is to sustain coverage and/or notify leadership of additional needs	7/1/2019	10/31/2019		Choose an item.

**ICE Health Service Corps
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	at the time of the incident c) Seg Clearance Sheet: RN must review eCW to ensure note entered prior to clearing detainee for Seg d) Urgent care outside of Seg: Review of eCW for urgent care cases and have CC check to ensure notes are completed. e) Training provided to staff regarding change in processes			Measurement c: File folder will be created to hold a copy of all clearance sheets to cross check that notes were completed Daily audits of sheets with eCW documentation will be conducted for three months for all shifts Expected Outcome c: Audits will show 100% compliance with cross check process. Measurement d: Weekly audit for three months on all shifts of eCW for urgent cases and adjoining documentation Expected outcome d: 100% of audits will have appropriate documentation for urgent cases Measurement e:				
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**ICE Health Service Corps
Event Review, Root Cause Analysis/Action Plan**

	Information/training will be added to orientation program			Expected 100% education/training and 100% on new processes				
	Action Item #3: Communication between provider and RN (for urgent care cases telephone call must occur) Modification of current urgent care LOP language to ensure it's clear on the requirement to call the provider for urgent cases in addition to TE	SOP/Policy	Team Florence	Measurement: Audit urgent care cases weekly using the daily report to review chart to ensure verbal notification was made if needed via confirmation of date and time of call in TE Expected Outcome: 100% compliance with verbal notification when needed for urgent care cases.	7/1/2019	10/31/2019		Choose an item.
	Action Item #4: Follow-up regarding notification of status change between RN and Provider:	Choose a classification.		Addressed in Meeting minutes	7/1/2019	10/31/2019		Choose an item.

**ICE Health Service Corps
Event Review, Root Cause Analysis/Action Plan**

	Add action buckets to RN and add action note within TE and then select addressed or noted.							
	Action Item #5: Change of shift report: Add huddles at 1500 which include other change of shift reports that are already occurring. Reimplement 1500 huddle 6/4/19	Communication		Measurement: Memo stating action was implemented and continues; Process Study Expected Outcome: 100% compliance with daily 1500 Huddles	6/4/2019	10/31/2019		Choose an item.

If compliance levels were not met, what actions were taken?

	Comments:
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**ICE Health Service Corps
Event Review, Root Cause Analysis/Action Plan**

What immediate improvement measures have already been implemented?

	Comments:
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Headquarters Recommendations for National Implementation

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	(b)(6); (b)(7)(C)	atures
		DAD of HCC
		Unit Chief
		Regional Compliance Specialist
		Risk Manager
		AD (as needed)

From: (b)(6); (b)(7)(C)
To:
Subject: FW: Afternoon report
Date: Tuesday, August 27, 2019 2:08:38 PM

From: (b)(6); (b)(7)(C)
Sent: Tuesday, June 04, 2019 11:20 AM
To: #IHSC_Florence (b)(7)(E)@ice.dhs.gov>
Cc: (b)(6); (b)(7)(C)@ice.dhs.gov>
Subject: Afternoon report

Good afternoon,

Effective today, we will be resuming the afternoon report (@1500) in an effort to improve overall staff communication.

Thank you.

Very Respectfully,

(b)(6); (b)(7)(C)
RN, BSN, CCHP
LCDR, USPHS
Assistant HSA
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Florence Detention Center
3250 N Pinal Parkway
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To: Florence Staff

Subject: Staff Meeting June 27, 2019

Attendance:

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

This Meeting was called to order at 1400 hrs.

A. Policies and Procedures: (b)(6); (b)(7)(C)

1. Policies and Procedures:

- i. Med Psych alerts need to be added to chronic identified patients at intake
- ii. Make sure count has been completed prior to your shift ending.
- iii. If you are doing a transfer sheet on a patient that has been exposed to mumps, you need to do the following:
 - Document the beginning, and the expected end date of the cohort, the date the MMR was given and the date the second dose is due.
 - Make sure the appointment is already made
 - If the appointment is not made the second dose is due 28 days after the first dose given.
 - If a Patient has been exposed to mumps is transferring they do not need to wear a mask. Please make sure the patient is asymptomatic prior to completing the transfer. You can do this by either calling the person to the clinic or ask the nurse that did rounds that day. Don't forget to document in the transfer sheet the patient is asymptomatic.
 - If the patient is transferring to another facility, notify the facility and document it in the chart.
- iv. If you are not fluent in the patient's native language you need to use the interpreting services available and document, it.
- v. The only time you should use security staff as an interpreter is in emergency situations and if you need to communicate with a patient in segregation.
- vi. If you need to use a security officer as your interpreter in segregation, document the reason why. Such as there is no outside phone line available at the patients current housing location.

vii. Also make sure the guard understands that all information exchanged during the encounter is to remain confidential and protected by HIPPA. Document that the security guard understands that HIPPA applies to your encounter and patient.

viii. Segregation Clearances-

- All patients placed in segregation or in TIF need to have a segregation clearance charted in eCW. Any KOP meds they have on them need to be confiscated and placed on pill line. The provider also needs to change the order in eSMART.

ix. Starting July 1st providers will need to add a note to the TEs sent by nurses. For example, a TE sent concerning an elevated BP reading. The provider can type their response in the TE in the action taken tab section by writing "noted" prior to clicking status addressed in the TE.

x. Email Notifications-(b)(6); (b)(7)(C) would like to clarify a few points regarding ER send out/admission, and hospital update e-mails.

- These e-mails are important because it allows the n (b)(6); (b)(7)(C) to communicate with local ICE leadership. In addition, (b)(6); (b)(7)(C) CDR (b)(6); (b)(7)(C) forward these e-mails to IHSC leadership (Deputy Medical Director, Regional HSAs, Regional Clinical Directors, etc.) so it is important they are filled out completely and give a clear clinical picture.
- (b)(6); (b)(7)(C) sends out a general e-mail that notifies transportation about a pending send-out. Medical providers and nurses however, should utilize the templates sent out on June 19th. These templates are more complete and provide pertinent medical information. Please be sure to include vital signs in the information.
- Please send to these notifications to #IHSC Florence AND FLO Management. There are still inconsistencies with FLO Management not being notified.
- It is not necessary to send an e-mail notification for scheduled appointments (x-rays, labs, etc.)

2. Miscellaneous: Nothing to report.

B. STGi: (b)(6); (b)(7)(C)

- i. There have been a lot of errors on the e-timesheets. Please remember that your e-timesheet is an actual government invoice. It needs to be correct. (b)(6); (b)(7)(C) made up a packet on how to complete your e-timesheet correctly, it will be outside her office in the wall cubie. Please read, sign and return.
- ii. She will be changing out your e-timesheet excel spreadsheets over the next few days please do not add any hours for June 29th or June 30th to the June e-timesheet. The last two days of June will be added to your July – e-timesheet.
- iii. The STG contract ends June 28th, so we need to close out all invoices on that day and start fresh June 29th.
- iv. This will not affect when or how you get paid, but there will be a new code to add to your Deltek this pay period also. Once (b)(6); (b)(7)(C) gets further instructions and gets the new

codes added, she will reach out to everyone with further directions. Please keep watch for a text from her over the weekend or very early Monday Morning. There is very little wiggle room and many changes need to be made in a short time to assure that everyone will get paid on time.

C. Nursing: (b)(6); (b)(7)(C) Nothing to report

D. Safety, Infection Control (SIPC): LT Selling-Nothing to report.

E. Education Programs: CDE (b)(6); (b)(7)(C)

- i. Please make sure to complete your Regulated Medical Waste Training.
- ii. Make sure your Preventing and Addressing Workplace Harassment Mandatory PALMS training is complete by July 12.

F. Performance Improvement: Nothing to report.

G. Mental Health:

- i. Everyone is doing a good job designating mental health referrals to (b)(6); (b)(7)(C)

H. Chronic Care:

- i. The providers thanked the nurses for doing the PE simples. This helps them out Tremendously.

I. Dental:

- i. Dental Equipment is now up and running.

J. Pharmacy:

- i. Make sure the detainee is gone in enforce before you take them off pill line.
- ii. The immediate-release and non-enteric coated formulations of the medications listed below are to be crushed before administering to patients. A copy will be posted in the pill line room. Please make sure you follow this policy.....**NO exceptions.** Providers, please type in the word **crush** in the instructions when ordering the following medications. The only exceptions are **delayed/extended** release formulations.

GENERIC NAME	BRAND NAME
Acetaminophen/Codeine	Tylenol #3
Acetaminophen/Hydrocodone	Vicodine
Acetaminophen/Oxycodone	Percocet
Amitriptyline	Elavil
Bupropion	Wellbutrin/Zyban
Doxepin	Sinequan
Imipramine	Tofranil
Morphine Sulfate	Duramorph
Tramadol	Ultram

Open forum:

- i. Even though eCW is not allowing the providers to send medication orders, we are still not allowed to do paper MARs. If sSMART is working you need to manually put the information in. The only time its acceptable to make a paper MAR is if sSMART is down.
- ii. Please OPEN and READ your emails.

Meeting adjourned at 1425 hrs.

From: (b)(6); (b)(7)(C)
To:
Subject: FW: Florence issues
Date: Tuesday, September 3, 2019 8:22:56 AM

From: (b)(6); (b)(7)(C) <[redacted]@ice.dhs.gov>
Sent: Tuesday, September 03, 2019 7:30 AM
To: (b)(6); (b)(7)(C) <[redacted]@ice.dhs.gov>
Cc: [redacted] <[redacted]@ice.dhs.gov>
Subject: Florence issues

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

Two things from Florence:

1. Laptop – we asked for one for (b)(6); (b)(7)(C) already, I think?
2. They need telephone access in SMU to be able to have a translator. It's been a finding on prior audits. HOU side has been trying to get this accomplished. Perhaps CSU side could bring it up and see if HOU is still pursuing and/or if we can help accomplish this in some way?

V/R,

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

**Commander, USPHS
MSN, MBA, CCHP-RN, NEA-BC
Western Regional Nurse Manager**

ICE Health Service Corps (IHSC)
Enforcement and Removal Operations (ERO)
U.S. Immigration and Customs Enforcement (ICE)

ICE iPhone: 202-321 (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C) @ice.dhs.gov

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