

**DETAINEE DEATH REVIEW – Jose Manuel AZURDIA-Hernandez  
JICMS #201602241**

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**SYNOPSIS**

On December 24, 2015, Jose Manuel AZURDIA-Hernandez (AZURDIA), a fifty-four-year-old citizen and national of Guatemala, died while in the custody of U.S. Immigration and Customs Enforcement (ICE) at St. Mary Medical Center (SMMC) San Bernardino, California (CA). The State of California Certificate of Death documented the cause of AZURDIA's death as Cardiogenic Shock, Massive Right Ventricular Infarction, and Severe Ischemic Heart Disease.

AZURDIA was detained at the Adelanto Detention Facility (ADF), Adelanto, CA, at the time of his death. ADF is owned and operated by the GEO Group, Inc. (GEO), under an Inter-Governmental Service Agreement (IGSA), which requires the facility to comply with the ICE Performance-Based National Detention Standards (PBNDS) 2011. At the time of AZURDIA's death, ADF housed 1,473 detainees for periods in excess of 72 hours. Medical care at ADF is provided by GEO, supported by contractor Correctional Care Solutions (CCS). An IHSC Field Medical Coordinator (FMC) based in Los Angeles, CA, is assigned to the facility.

**DETAILS OF REVIEW**

From January 19 to 21, 2016, ICE Office of Professional Responsibility, Office of Detention Oversight (ODO) staff visited ADF and, with the assistance of contract subject matter experts (SME) in both correctional healthcare and correctional security, reviewed the circumstances surrounding AZURDIA's death. The contract SMEs are employed by Creative Corrections, a national management and consulting firm contracted by ICE to provide subject matter expertise in detention management and compliance with detention standards, including in the areas of health care and security. As part of its review, ODO reviewed immigration, medical, and detention records pertaining to AZURDIA, in addition to conducting in-person interviews of individuals employed by ADF, as well as ICE Enforcement and Removal Operations (ERO) staff.

During the review, the ODO review team took note of any deficiencies observed in the detention standards as they relate to the care and custody of the deceased detainee and documented those deficiencies herein for informational purposes only. Their inclusion in the report should not be construed in any way as indicating the deficiency contributed to the death of the detainee. ODO determined the following timeline of events, from the time of AZURDIA's apprehension by ICE, through his detention at ADF, and eventual death at SMMC.

**IMMIGRATION AND DETENTION HISTORY**

On October 24, 1980, AZURDIA was admitted to the United States under Section 203(a)(2) of the Immigration and Nationality Act (INA), as the unmarried son of a lawful permanent resident alien.<sup>1</sup> On

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<sup>1</sup> See Form I-130, Petition to Classify Status of Alien Relative for Issuance of Immigration Visa, dated September 26, 1979.

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October 16, 1989, AZURDIA was ordered to appear in anticipation of deportation under Section 241 (a)(ii) of the INA.<sup>2</sup> On May 2, 1990, AZURDIA was granted a waiver under Section 212 (c) of the INA.<sup>3</sup>

On June 20, 2015, AZURDIA was encountered by ERO Los Angeles at the Wasco State Prison, Wasco, CA, where he was serving a 16 month sentence for attempted first degree robbery and served with an immigration detainer.<sup>4</sup>

On June 22, 2015, upon his release from the Wasco State Prison, AZURDIA was placed in the custody of ERO Los Angeles,<sup>5</sup> and served with a Notice to Appear, Form I-862, charging him with being a removable alien pursuant to Section 237(a)(2)(A)(iii) of the Immigration and Nationality Act (INA).<sup>6</sup>

### CRIMINAL HISTORY

On November 10, 2014, AZURDIA was convicted by the California Superior Court, Los Angeles County Southeast District, for attempted first degree robbery.<sup>7</sup> AZURDIA also had prior convictions for being under the influence of a controlled substance (1987); petty theft (1989); ordinance violation (trespass, 1994); and inflicting corporal injury to a spouse or cohabitant (1995).<sup>8</sup>

### NARRATIVE SUMMARY OF EVENTS

**On June 22, 2015,** AZURDIA was transferred from Wasco State Prison to the ADF. Upon arrival at the ADF, an initial classification and Prison Rape Elimination Act Risk Assessment was completed by ADF personnel using the ICE Custody Classification Worksheet. AZURDIA was classified as “high” based on the severity of his charges, the most serious conviction and prior convictions. On June 23, 2015, this rating was approved by a supervisor.<sup>9</sup> ODO notes AZURDIA’s detention records did not contain documentation of a reclassification review, although a review was due on September 22, 2015, 90 days after his initial classification.

At 7:15 p.m., AZURDIA completed his medical intake screening with Registered Nurse (RN) [REDACTED]. [REDACTED] ODO confirmed the form used to document the screening addressed all elements required in PBNDS 2011. RN [REDACTED] documented AZURDIA spoke English with no barriers to communication. She took his vital signs which were all within normal limits, and she documented his weight as 188 pounds. At the time of arrival, AZURDIA denied having pain, any significant medical problems, or any family history of significant medical problems. He reported having a past positive purified protein derivative skin test for tuberculosis (TB), and receiving 12 weeks of treatment for TB while at Wasco

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<sup>2</sup> See Form I-221S, Order to Show Cause, Notice of Hearing, and Warrant or Arrest of Alien, dated October 16, 1989.

<sup>3</sup> See Department of Justice (DOJ), Executive Office of Immigration Review Court Order, dated May, 2, 1990.

<sup>4</sup> See Form I-247, Immigration Detainer – Notice of Action, dated June 20, 2015.

<sup>5</sup> See Form I-213, Record of Deportable/Inadmissible Alien, dated March 16, 2015.

<sup>6</sup> See Form I-862, Notice to Appear (and associated Form I-831 continuation page dated March 13, 2015).

<sup>7</sup> *Id.*

<sup>8</sup> See Form I-213, Record of Deportable/Inadmissible Alien, dated June 22, 2015.

<sup>9</sup> See ICE Custody Classification Worksheet 2.2.A, and Adelanto Detention Facility PREA Risk Assessment, both dated June, 22, 2015.

<sup>10</sup> See Exhibit 1: Medical intake screening by RN [REDACTED] (and associated Medical Notes), dated June 22, 2015.

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State Prison.<sup>11</sup> Documentation of a February 18, 2015 chest x-ray conducted by the Wasco State Prison accompanied AZURDIA to ADF and contained a notation that the results were “essentially within normal limits.” During her interview with ODO, RN [redacted] stated that because AZURDIA was negative for signs and symptoms of TB, and the negative chest x-ray was completed approximately four months prior to his admission to ADF, she did not schedule him for expedited examination by a provider and did not initiate a request for records from Wasco State Prison.<sup>12</sup> AZURDIA signed his consent for medical, dental, and mental health services, in which he also acknowledged receipt of information on how to access health care.<sup>13</sup> The related intake screening form was reviewed and signed on June 23, 2015, by Physician Assistant (PA) [redacted].<sup>4</sup>

**On July 28, 2015**, AZURDIA completed a medical history and physical examination with PA [redacted].<sup>5</sup> ODO notes this physical examination occurred 22 days outside the timeframe of 14 days required by the ICE PBNDS 2011. During his interview with ODO, PA [redacted] stated that staffing and patient caseload at the time the physical examination was due, necessitated triaging scheduled appointments based on medical priority. PA [redacted] could not recall whether AZURDIA’s medical record was reviewed before the decision was made to postpone his examination.<sup>16</sup> AZURDIA’s vital signs at the time of the physical were within normal limits, with the exception of a mild, unremarkable elevation in body temperature. AZURDIA’s weight was 184 pounds. Abnormal assessment findings included allergic rhinitis,<sup>17</sup> intermittent headaches of four months duration, arcus senilis,<sup>18</sup> and Latent Tuberculosis Infection (LTBI). AZURDIA had no symptoms suggestive of active TB. AZURDIA declined HIV screening,<sup>19</sup> and signed a refusal form which was present in the medical record. PA [redacted] documented AZURDIA received Motrin and Tylenol for pain and medication for allergy symptoms.<sup>20</sup>

PA [redacted] completed the physical examination and signed the intake screening which documented that AZURDIA reported receiving LTBI treatment the previous 12 weeks.<sup>21</sup> ODO notes PA [redacted] did not document any effort to verify AZURDIA’s receipt of LTBI treatment. During their interviews, both PA [redacted] and Susan Lawrence, Medical Doctor (MD), stated that the appropriate duration of LTBI treatment is nine to 12 months, versus the 12 weeks AZURDIA stated he underwent at Wasco State Prison.<sup>22</sup> PA [redacted] and Doctor Lawrence both stated that absent the actual chest x-ray and record of treatment at the prison, a repeat x-ray and a follow-up assessment with a provider should have been completed to rule out active disease. While it is noted PA [redacted] ordered AZURDIA to be

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<sup>11</sup> *Id.*

<sup>12</sup> ODO interview with RN [redacted], January 19, 2016.

<sup>13</sup> See GEO Health Services Notice & Consent To Medical, Dental, and Mental Health Services, dated June 22, 2015.

<sup>14</sup> See Exhibit 1: Medical intake screening by RN [redacted] and associated Medical Notes), dated June 22, 2015.

<sup>15</sup> See Exhibit 2: GEO History and Physical Assessment by PA [redacted] dated July 28, 2015.

<sup>16</sup> ODO interview with PA [redacted] January 19, 2016.

<sup>17</sup> Inflammation of the mucus membranes of the nose.

<sup>18</sup> A commonly occurring benign eye condition in older adults, characterized by a white or gray circle around the outer part of the cornea, caused by fat deposits.

<sup>19</sup> See GEO Refusal of Health Services Form by RN [redacted] dated July 28, 2015.

<sup>20</sup> Chlor-Trimeton Chlorpheniramine Maleate (CTM) and nasal spray.

<sup>21</sup> See Exhibit 2: GEO History and Physical Assessment by PA [redacted] dated July 28, 2015.

<sup>22</sup> ODO interviews with PA [redacted] and Doctor [redacted] January 19 & 21, 2016.

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scheduled for a follow-up with Doctor [redacted] for an assessment of LTBI within one to two weeks,<sup>23</sup> the medical record contains no evidence the assessment was ever conducted.

Doctor [redacted] stated that Adelanto experienced a serious nursing shortage at the time of AZURDIA's detention, necessitating prioritization of patient encounters based on clinical need. She indicated that as a result, patients were not consistently seen within referral timeframes, and appointments were not always rescheduled when canceled. Doctor [redacted] stated that there have been significant improvements in scheduling since that time.<sup>24</sup>

ODO notes that a prostate examination was not completed during the physical examination conducted by PA [redacted].<sup>25</sup> Per the GEO policy and Center for Disease Control guidelines, prostate examinations are to be conducted on male detainees over 50 years of age. During his interview, PA [redacted] reported that the prostate examination was offered, but was refused by AZURDIA. AZURDIA's medical record did not contain a refusal form. Additionally, although the "master problem list" contained in AZURDIA's medical record documented his varicella immunity, none of the initial assessment diagnoses were included on the list.<sup>26</sup>

Between July 28, 2015, when the physical examination was completed, and December 19, 2015, when AZURDIA experienced symptoms which resulted in his hospitalization, he was seen by medical staff on four occasions. Three of those encounters were for complaints of pain in various locations; the fourth was for a complaint of eye irritation and a rash.

- **On September 3, 2015**, RN [redacted] triaged AZURDIA's request for a refill of Ibuprofen and acetaminophen for pain, and referred him for an evaluation.<sup>27</sup> AZURDIA was subsequently evaluated by RN [redacted] on September 5, 2015, who documented the detainee complained of a headache and hip pain, which he described as a level eight on a scale of one to ten, with ten being worst. AZURDIA's vital signs were all within normal limits. The nursing diagnosis was alteration in comfort related to bilateral hip discomfort. AZURDIA was provided Ibuprofen and muscle rub,<sup>28</sup> instructed to do light range of motion exercises in the mornings, and return to the clinic should the symptoms persist or worsen.<sup>29</sup>
- **On September 30, 2015**, RN [redacted] completed a nursing assessment protocol form addressing AZURDIA's complaint of back pain which he rated at level eight on the pain scale.<sup>30</sup> AZURDIA's vital signs were normal with the exception of his blood pressure which was 90/58 sitting and 92/60 standing.<sup>31</sup> The pulse rate was described as strong. With the exception of the

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<sup>23</sup> During his interview, PA [redacted] indicated RNs are responsible for transcribing and executing orders, including referrals for follow-up appointments.

<sup>24</sup> ODO interview with Doctor [redacted], January 21, 2016.

<sup>25</sup> See Exhibit 2: GEO History and Physical Assessment by PA [redacted] dated July 28, 2015.

<sup>26</sup> See GEO Master Problem List, dated July 31, 2015.

<sup>27</sup> See GEO Request for Health Services, dated September 3, 2015.

<sup>28</sup> See GEO Keep On Person Medication Sign Out Sheet, dated September 5, 2015.

<sup>29</sup> See GEO Medical Provider Progress Notes, dated September 5, 2015.

<sup>30</sup> See Exhibit 3: GEO Musculoskeletal Pain/Trauma Protocol & Progress Note by RN [redacted] dated September 30, 2015.

<sup>31</sup> Blood pressure of 90/58 is considered high or "hypotensive."

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low blood pressure, all vital signs were within normal limits. The nursing diagnosis was alteration in comfort related to a previous back injury, for which AZURDIA was provided a three-day supply of Ibuprofen and analgesic balm for pain<sup>32</sup> and was instructed to return to the clinic if symptoms persisted or worsened.

During his interview, RN [ ] stated that because there is no nursing protocol for hypotension, he did not make a referral to a provider or otherwise develop a plan of action.<sup>33</sup> PA [ ] advised ODO that a blood pressure at that level should always be referred to a provider to determine a possible underlying cause. PA [ ] also indicated he likely would place a hypotensive patient in medical observation for follow-up.<sup>34</sup> Alternatively, Doctor [ ] stated that absent other symptoms, the need for follow-up by a provider may not have been indicated.<sup>35</sup>

- **On October 26, 2015**, RN [ ] completed a nursing assessment protocol form and progress note addressing AZURDIA's complaint of ongoing back pain.<sup>36</sup> His vital signs were all within normal limits, and his weight was 187 pounds. RN [ ] found AZURDIA had decreased range of motion related to back pain. Per the nursing protocol for musculoskeletal pain/trauma, AZURDIA was provided Ibuprofen for three days and instructed to return to medical if symptoms persisted or worsened. RN [ ] did not document a pain level and did not complete the section of the protocol form requiring a description of the pulse.

At 10:20 a.m. RN [ ] obtained a verbal order from a provider prescribing Motrin 800 mg twice daily, as needed, for 30 days.<sup>37</sup> In documenting the verbal order, RN [ ] failed to include the name of the provider who prescribed the medication. Doctor [ ] Medical Doctor (MD),<sup>38</sup> signed the verbal order on October 28, 2015.<sup>39</sup>

- **On November 17, 2015**, RN [ ] completed a nursing assessment protocol and progress note addressing AZURDIA's complaints of irritated eyes and under arm rash. His vital signs were all within normal limits, and his weight was 186 pounds.<sup>40</sup> RN [ ] nursing diagnosis was alteration in comfort related to dry eyes and rash, for which AZURDIA was provided artificial tears and hydrocortisone cream.<sup>41</sup> Ten days later, on November 27, 2015, PA [ ]

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<sup>32</sup> See GEO Keep On Person Medication Sign Out Sheet, dated September 30, 2015.

<sup>33</sup> ODO interview with RN [ ] January 19, 2016.

<sup>34</sup> ODO interview with PA [ ] January 19, 2016.

<sup>35</sup> ODO interview with Doctor [ ] January 21, 2016.

<sup>36</sup> See Exhibit 4: GEO Musculoskeletal Pain/Trauma Protocol & Progress Note by RN [ ] dated October 26, 2015.

<sup>37</sup> See GEO Keep On Person Medication Sign Out Sheet, dated October 26, 2015.

<sup>38</sup> Dr. Katan Patel was ADF's Medical Director at the time of AZURDIA's detention. He was no longer employed at ADF at the facility at the time of ODO's visit.

<sup>39</sup> See Exhibit 4: GEO Medical Provider Progress Note by RN [ ] dated October 26, 2015.

<sup>40</sup> See GEO Rash Protocol & Progress Note by RN [ ], dated November 17, 2015.

<sup>41</sup> See GEO Keep On Person Medication Sign Out Sheet, dated November 17, 2015.

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[redacted] renewed an order for over-the-counter allergy medication for a period of two weeks.<sup>42</sup>

**December 19, 2015**

At 8:11 a.m., Officer [redacted] who was assigned to Unit 3C where AZURDIA was housed throughout his time at ADF, documented in the post log that she conducted a security check.<sup>43</sup> Video surveillance footage of the 3C dayroom shows that Officer [redacted] did not make a complete round of the housing unit during the security check; she did not check three cells, including cell 201 where AZURDIA was housed.<sup>44</sup> At 8:48 a.m., Officer [redacted] was relieved for her lunch break by Officer [redacted]. Officer [redacted] made almost continuous rounds of the unit, including making visual checks into cell 201 on four occasions between 8:50 a.m. and 9:21 a.m.<sup>45</sup>

During his interview, Officer [redacted] stated that approximately ten minutes after he relieved Officer [redacted] detainee [redacted] reported to him that AZURDIA was sick.<sup>46</sup> Officer [redacted] stated he went to cell 201, observed that AZURDIA appeared to be normal, and left the detainee in the cell. Officer [redacted] stated he later heard vomiting, but he did not go back to cell 201 to check on AZURDIA. Officer [redacted] stated he remembered [redacted] stating that AZURDIA wanted to see medical before a scheduled visit with his wife later that day; however, Officer [redacted] did not initiate a visit to medical for AZURDIA.

ODO notes discrepant information was reported by Officer [redacted] in two separate incident reports, and during his interview with ODO, regarding his involvement with AZURDIA on December 19, 2015. In the first incident report, dated December 22, 2015, Officer [redacted] documented that after being informed AZURDIA was ill, he checked on the detainee, asked if he was ok, and AZURDIA waved and said he was alright. He further noted that when he heard vomiting sounds from AZURDIA's cell, he returned to the cell to check on the detainee.<sup>47</sup> In the second incident report, dated January 13, 2016, Officer [redacted] documented that he conducted a security check when he learned a detainee was sick but did not find anything abnormal or urgent.<sup>48</sup> During his interview, Officer [redacted] stated that he did not recall speaking to AZURDIA and that he did not return to the cell when he heard vomiting.<sup>49</sup>

Licensed Vocational Nurse (LVN) [redacted] entered Unit 3C at 9:30 a.m. to conduct medication distribution.<sup>50</sup> During his interview, Officer [redacted] stated he informed LVN [redacted] that AZURDIA was sick and vomiting, to which LVN [redacted] responded by saying she did not want to see AZURDIA because

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<sup>42</sup> See GEO Medical Provider Progress Note by PA [redacted] dated November 27, 2015.

<sup>43</sup> See Exhibit 5: GEO Unit 3C Post Log, dated December 19, 2015.

<sup>44</sup> ADF Video Surveillance Footage, December 19, 2015.

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

<sup>46</sup> During the onsite review, ODO learned detainee [redacted] was assigned to the bunk above AZURDIA. [redacted] was no longer detained at ADF at the time of ODO's onsite review and was not available for interview.

<sup>47</sup> See GEO Incident Report, by Officer [redacted] dated December 22, 2015.

<sup>48</sup> See GEO Incident Report, by Officer [redacted] dated January 13, 2015.

<sup>49</sup> ODO interview with Officer [redacted] January 19, 2016.

<sup>50</sup> ADF Video Surveillance Footage, December 19, 2015.

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she did not want to get sick.<sup>51</sup> LVN [ ] was still in the housing unit when Officer [ ] returned at 9:32 a.m.<sup>52</sup> Officer [ ] stated he did not make an entry in the log book concerning AZURDIA, or inform Officer [ ] the detainee was ill, because he assumed LVN [ ] would see the detainee while in the unit.<sup>53</sup> LVN [ ] distributed medications until she left at 9:44 a.m.<sup>54</sup>

AZURDIA's medical record includes a progress note by LVN [ ] which she documented she wrote at 9:35 a.m. In the note, LVN [ ] wrote that during "pill pass" she was approached by a detainee who informed her AZURDIA was throwing up and not feeling well. She noted the detainee asked her to see AZURDIA, but she declined stating "if he is throwing up from being sick like the flu that the best thing for him to do is rest and make sure he was hydrated." She noted she advised the detainee to make sure AZURDIA was brought to medical if he continued to throw up and to make sure he rested and stayed hydrated.<sup>55</sup>

It is noted that at the time of ODO's review, LVN [ ] was on administrative leave and was not available for interview. Acting Health Services Administrator ((A) HSA [ ]<sup>56</sup> stated during his interview that LVN [ ] progress note was improper because it was not clinical in nature. He also expressed concern that the note was not documented as a late entry even though it was clearly prepared at some point after the recorded time.<sup>57</sup>

At 9:45 a.m., Officer [ ] made a complete security check of the housing unit. She did not conduct another security check until 10:29 a.m., although one was due within 30 minutes.<sup>58</sup> Both Officer [ ] incomplete round conducted at 8:11 a.m., and her failure to conduct a round every 30 minutes, violate ADF Housing Unit Post Orders.

During her interview, Officer [ ] stated that she first learned AZURDIA was sick when she returned from her lunch break and was approached by a detainee who reported AZURDIA was throwing up.<sup>59</sup> ODO notes that Officer [ ] documented discrepant information in two written reports. In the first, an incident report dated December 21, 2015, Officer [ ] wrote that she recalled a detainee stating he told both Officer [ ] and a nurse that AZURDIA was ill, and that neither seemed interested.<sup>60</sup> In the second, a memorandum to a supervisor dated January 13, 2016, Officer [ ] wrote that a detainee reported AZURDIA's illness only to the nurse.<sup>61</sup>

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<sup>51</sup> During her interview, Officer [ ] stated that when she returned to Unit 3C, she asked LVN [ ] how her day was going. LVN [ ] replied that she felt very ill from consuming too much alcohol the night before.

<sup>52</sup> ADF Video Surveillance Footage, December 19, 2015.

<sup>53</sup> ODO interview with Officer [ ] January 19, 2016.

<sup>54</sup> ADF Video Surveillance Footage, December 19, 2015.

<sup>55</sup> See Exhibit 6: GEO Medical Provider Progress Note by LVN [ ] dated December 19, 2015.

<sup>56</sup> (A) IISA [ ] is also an Assistant Warden at Adelanto.

<sup>57</sup> ODO interview with (A) IISA [ ] dated January 20, 2016.

<sup>58</sup> ADF Video Surveillance Footage, December 19, 2015.

<sup>59</sup> ODO interview with Officer [ ] January 19, 2016.

<sup>60</sup> See GEO Memorandum from Officer [ ] to Chief [ ] (first name unknown), dated December 21, 2015.

<sup>61</sup> See GEO Memorandum from Officer [ ] to Captain [ ] (first name unknown), dated January 13, 2016.

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Officer [redacted] told ODO that upon hearing AZURDIA was ill, she asked the Pod Control Officer,<sup>62</sup> Officer [redacted] to call the medical unit via telephone but did not go to AZURDIA's cell to check on his welfare.<sup>63</sup> During her interview, Officer [redacted] stated she called the medical officer per Officer [redacted] request but received no answer. She stated she informed Officer [redacted] via intercom that the medical officer did not answer the phone.<sup>64</sup> ODO notes that Officer [redacted] stated she was not informed Officer [redacted] did not make contact with the medical officer.<sup>65</sup>

At 10:14 a.m., AZURDIA was assisted down the staircase by detainee [redacted] AZURDIA had his left arm over the shoulder of [redacted] and leaned on him for support. At 10:16 a.m., AZURDIA took a seat at a table immediately in front of the officer's podium and placed his head in his arms on the table. Thereafter [redacted] is seen on the video surveillance footage speaking to Officer [redacted] and pointing to his chest area.<sup>66</sup>

ODO interviewed [redacted] who stated that he and three other detainees reported to an officer after breakfast that AZURDIA was vomiting. Because AZURDIA was still sick later that morning [redacted] advised AZURDIA to go downstairs into the dayroom to get help from an officer [redacted] assisted AZURDIA down the stairs, and once in they were in the dayroom, he told the officer on duty that AZURDIA had chest pain, was vomiting, and needed help.<sup>67</sup>

At 10:19 a.m., Officer [redacted] arrived on the unit to escort AZURDIA to visitation for his scheduled visit with his wife.<sup>68</sup> Officer [redacted] stated during her interview, that when she approached AZURDIA, it was obvious he was too ill to go to visitation, and that he needed to go to medical instead. Officer [redacted] stated Officer [redacted] informed her that she had been trying to reach medical.<sup>69</sup> Both Officer [redacted] and Officer [redacted] stated they made continued attempts to contact medical by radio but got no response.<sup>70</sup> During the onsite review, ODO learned a detainee fight occurred in the segregation unit during the time the officers attempted to contact the medical unit. A "Code Yellow" was called for the fight, which required medical staff and all available officers to respond.<sup>71</sup>

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<sup>62</sup> ADF practices direct supervision in general population housing units. [redacted] officer is stationed within the unit at all times, and [redacted] officer is assigned to the pod control area. Each pod is designed so that a central pod control area is surrounded by four housing units within the pod (A, B, C, and D). Each housing unit has windows facing the pod control area so that the pod control officer has visibility into each unit. Responsibilities of the officer assigned to pod control include controlling doors to the four units and monitoring radio traffic. Because there are no telephones within the housing units, the pod control officer handles telephone communications for the entire pod. [redacted]

<sup>63</sup> ODO interview with Officer [redacted] January 19, 2016.

<sup>64</sup> ODO interview with Officer [redacted] January 20, 2016.

<sup>65</sup> ODO interview with Officer [redacted] January 19, 2016.

<sup>66</sup> ADF Video Surveillance Footage, December 19, 2015.

<sup>67</sup> ODO interview with Detained [redacted] January 20, 2016.

<sup>68</sup> ADF Video Surveillance Footage, December 19, 2015.

<sup>69</sup> ODO interview with Officer [redacted] January 19, 2016.

<sup>70</sup> ODO interview with Officer [redacted] & Officer [redacted] January 19, 2016.

<sup>71</sup> See Exhibit 5: Unit 3C Post Log, dated December 19, 2015.



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Officer [ ] stated that she did not call a “Code Blue” (medical emergency) for AZURDIA because she feared getting in trouble.<sup>72</sup> During interviews with multiple security staff, ODO learned officers lack clarity with respect to situations in which a Code Blue is warranted. Specifically, officers have the understanding that a detainee must be unconscious or severely injured before a Code Blue can be called, whereas Assistant Warden (AW) for Security, [ ] stated officers may use discretion when assessing whether a Code Blue is warranted.<sup>73</sup> During his interview, (A) HISA [ ] stated he reviewed ADF’s training plan for responding to medical emergencies and determined the plan does not provide adequate instruction for identifying medical emergencies and calling Code Blue.<sup>74</sup>

Officer [ ] stated when she could not reach anyone in the medical unit by radio, she left the unit and attempted to enter the Pod Control area to call medical by telephone. She was unable to enter Pod Control because Officer [ ] the assigned Pod Control Officer, had left the post and locked the gate behind her.

ODO notes Officer [ ] left the Pod Control area five times on December 19, 2015, without being relieved by another officer.<sup>75</sup> ADF Pod Control Officer Post Orders require the post to be staffed 24 hours a day, and specify that if the pod control officer is authorized to leave, the shift supervisor will send a relief person to take over.<sup>76</sup> The first time Officer [ ] left her post, she was gone for 50 minutes for her meal break, instead of the allotted 30 minutes. The second and third time, she left her post to give housing unit officers bathroom breaks. The fourth time, she left to take an inventory form to the shift supervisor’s office. The fifth and final time, she left to relieve another officer for lunch.<sup>77</sup> Officer [ ] stated that each time she left the post she was instructed to do so by Lieutenant [ ] her shift supervisor, and that she would not leave the post without first gaining his permission.<sup>78</sup> It is noted that on four of the five occasions she left her post, Officer [ ] failed to make entries to the logbook documenting the time she returned.<sup>79</sup>

During his interview, Lieutenant [ ] the assigned Watch Command Officer and Officer [ ] shift supervisor on December 19, 2015, denied giving permission to Officer [ ] to leave the Pod Control area on any of the five occasions on December 19, 2015. However, he acknowledged granting permission in the past for bathroom and meal breaks and to bring inventory sheets to the watch office. Officer [ ] who was assigned to Central Control on December 19, 2015, stated during her interview that she allows exit from Pod Control areas only after she has verified with the shift supervisor that departure from the post has been authorized.<sup>80</sup> ODO reviewed selected Pod Control logbook entries from December 14-19, 2015 and found that during that period, posts were regularly left unmanned.<sup>81</sup>

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<sup>72</sup> ODO interview with Officer [ ] January 19, 2016.

<sup>73</sup> ODO interview with AW [ ] January 20, 2016.

<sup>74</sup> ODO interview with (A) HISA [ ] dated January 20, 2016.

<sup>75</sup> ADF Video Surveillance Footage, December 19, 2015.

<sup>76</sup> See ADF Pod Control Officer Post Orders.

<sup>77</sup> See Exhibit 7: Unit 3 Pod Control Log, dated December 19, 2015.

<sup>78</sup> ODO interview with Officer [ ] January 20, 2016.

<sup>79</sup> See Exhibit 7: Unit 3 Control Log, dated December 19, 2015.

<sup>80</sup> ODO interview with Officer [ ] January 21, 2016.

<sup>81</sup> See GEO Pod Control Post Log, December 14-19, 2015.

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Specifically, Pod Control officers left the post without relief on at least ten occasions. Several shift supervisors, including Lieutenant [redacted] logged their approval of those posts being left vacant.<sup>82</sup>

Although ODO cannot conclusively determine whether Lieutenant [redacted] permitted Officer [redacted] to leave her post on December 19, 2015, it is clear that her absence from the post contributed to the delay in providing medical care to AZURDIA. During her interview, Officer [redacted] stated that about a week before ODO's visit, AW [redacted] communicated to officers that pod control areas are not to be left unattended at any time.<sup>83</sup>

At 10:23 a.m., Officer [redacted] encountered Officer [redacted] when she returned to her post, the two officers entered pod control, and Officer [redacted] called medical. Officer [redacted] spoke with Officer [redacted] a medical escort officer, and stated that a detainee in Unit 3C needed to be seen because he was having chest pains and had been vomiting. During his interview, Officer [redacted] stated he informed RN [redacted] that a detainee in Unit 3C needed medical attention.<sup>85</sup> Officer [redacted] stated he told RN [redacted] that AZURDIA was reported to be experiencing chest pains; however, during her interview, RN [redacted] stated she was only informed the detainee was vomiting.<sup>86</sup>

RN [redacted] asked that AZURDIA be brought to the medical unit in a wheelchair, and Officer [redacted] who was in the medical unit at the time, left to retrieve the detainee.<sup>87</sup> At 10:28 a.m., Officer [redacted] arrived at Unit 3C with a wheelchair, and several detainees helped lift AZURDIA into the wheelchair.<sup>88</sup> At 10:29 a.m., 13 minutes after AZURDIA entered the dayroom area of Unit 3C, he was taken off the unit in the wheelchair by Officer [redacted].<sup>89</sup>

During his interview, Officer [redacted] stated AZURDIA told him when they left the unit that his chest was heavy, and it felt like someone was sitting on top of him. Officer [redacted] also stated that AZURDIA said he had thrown up numerous times, his left arm was numb, he was having trouble breathing, and he had pain in his shoulder and neck.<sup>90</sup> Officer [redacted] described AZURDIA's speech as slurred.<sup>91</sup>

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<sup>82</sup> ODO also noted Lieutenant [redacted] did not complete any log entries for his watch office post on December 19, 2015, including the fight in segregation discussed earlier on the report. Lieutenant [redacted] stated during his interview that he was too busy to complete logs on that day, and forgot to complete a late entry for the fight or any other event.

<sup>83</sup> ODO interview with Officer [redacted] January 20, 2015.

<sup>84</sup> ODO interview with Officer [redacted] January 19, 2016.

<sup>85</sup> ODO interview with Officer [redacted] January 21, 2016.

<sup>86</sup> ODO interview with RN [redacted] January 20, 2016.

<sup>87</sup> *Id.*

<sup>88</sup> ADF Video Surveillance Footage, December 19, 2015.

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

<sup>90</sup> In a written statement prepared on January 15, 2016, Officer [redacted] only documented that AZURDIA told him he had numbness and pain, and was tired, weak and nauseous. Officer [redacted] stated during his interview that he was called into work on January 15, 2016, his day off, to prepare a statement regarding AZURDIA, and that he may have abbreviated the description of his interaction with AZURDIA because he wanted to finish the statement quickly.

<sup>91</sup> ODO interview with Officer [redacted] January 19, 2016. ODO notes that none of the other witnesses interviewed described AZURDIA's speech as slurred.

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At 10:32 a.m., Officer [redacted] wheeled AZURDIA into the clinic and took the detainee to the nurses' station, where RN [redacted] and RN [redacted] were present.<sup>92</sup> RN [redacted] stated during her interview that she immediately asked AZURDIA several questions, including whether he had any pain. AZURDIA stated he had pain in his chest and down his left arm and that he had not been feeling well since breakfast.<sup>93</sup>

At 10:33 a.m., RN [redacted] used an electronic vital signs monitor to check AZURDIA's vital signs.<sup>94</sup> RN [redacted] stated during interview that she could not get a blood pressure reading, so she switched arms. When she still could not get a blood pressure reading, she tried using a different machine, but no reading could be obtained. No attempt was made to take AZURDIA's vital signs manually. RN [redacted] assisted during the attempted vital signs checks, as did LVN [redacted].<sup>95</sup> LVN [redacted] stated during his interview that he was present because he had been asked to stand by to perform an EKG.<sup>96</sup> At 10:36 a.m., LVN [redacted] retrieved an oxygen tank, and an oxygen mask was then placed on AZURDIA.<sup>97</sup>

ODO notes ADF's nursing assessment protocol addressing chest pain instructs that the patient be placed in the supine position with the head slightly elevated.<sup>98</sup> It includes direction to give one aspirin if the patient is awake and alert; deliver oxygen via nasal cannula<sup>99</sup> and monitor oxygen saturation; obtain an electrocardiogram (EKG);<sup>100</sup> and to start an intravenous (IV) line. Although oxygen was provided per the protocol, the nurses failed to transfer AZURDIA to a gurney, initiate IV fluids, or provide the detainee aspirin.<sup>101</sup> During her interview, RN [redacted] explained she believed it was safer for AZURDIA to leave him in the wheelchair rather than move him to a gurney; that IV fluids are not administered at ADF, as a matter of practice; and, that an EKG was not done because she was focused on getting AZURDIA to the hospital as quickly as possible and did not want to take the time to complete one. RN [redacted] stated because Doctor [redacted] Medical Doctor, was in the clinic at the time and came to assist with AZURDIA, she decided to defer to Doctor [redacted] on whether to administer aspirin.<sup>102</sup> RN [redacted] stated that as attempts were made to get AZURDIA's vital signs, she instructed the medical officer to find and bring Doctor [redacted] to AZURDIA immediately.<sup>103</sup>

Doctor [redacted] stated during her interview that she was performing rounds in the infirmary and was seeing a patient when the medical officer approached her, so she did not immediately follow him.<sup>104</sup> RN [redacted] stated that when the officer returned without Doctor [redacted] she went to get the doctor herself.<sup>105</sup> RN [redacted] returned with Doctor [redacted] at 10:41 a.m., nine minutes after AZURDIA was

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<sup>92</sup> ADF Video Surveillance Footage, December 19, 2015.

<sup>93</sup> ODO interview with RN [redacted] January 20, 2016.

<sup>94</sup> ADF Video Surveillance Footage, December 19, 2015.

<sup>95</sup> *Id.*

<sup>96</sup> ODO interview with LVN [redacted], January 20, 2016.

<sup>97</sup> ADF Video Surveillance Footage, December 19, 2015.

<sup>98</sup> See ADF Nursing Assessment Protocol: Chest Pain.

<sup>99</sup> A thin tube inserted into the nostril to deliver oxygen.

<sup>100</sup> A test that checks for problems with electrical activity of the heart.

<sup>101</sup> See GEO Medical Provider Progress Note by Doctor Jackson dated December 19, 2015.

<sup>102</sup> ODO interview with RN [redacted] January 20, 2016.

<sup>103</sup> ODO interview with RN [redacted] January 20, 2016.

<sup>104</sup> ODO interview with Doctor [redacted] January 21, 2016.

<sup>105</sup> ODO interview with RN [redacted] January 20, 2016.

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brought to the medical unit.<sup>106</sup> Doctor [ ] stated that when she arrived on scene, AZURDIA reported nausea, vomiting, and chest discomfort, but could not elaborate about the nature or intensity of the discomfort. She noted AZURDIA was visibly chilled and had rigors.<sup>107</sup> Doctor [ ] described AZURDIA as coherent but lethargic.<sup>108</sup>

Both Doctor [ ] and RN [ ] stated AZURDIA never lost consciousness; RN [ ] described the detainee as alert and oriented.<sup>109</sup> Doctor [ ] stated AZURDIA did not complain of shortness of breath; however, his pulse was weak, and the medical team could not get a blood pressure reading, or a second oxygen saturation<sup>110</sup> reading. Doctor [ ] stated she was concerned about sepsis.<sup>111</sup> She also stated that because AZURDIA's condition was declining, she decided it best to leave him where he was rather than moving him to the urgent care room for placement on a gurney and completion of an EKG. Doctor [ ] stated she gave a verbal order for a nurse to administer aspirin to the detainee, but she did not know whether the aspirin was ever administered.<sup>112</sup> The nurses who were present did not report the order for aspirin, nor did Doctor [ ] document it in her progress note.<sup>113</sup>

In her progress note, Doctor [ ] wrote she was called to evaluate AZURDIA for complaints of chest pain, nausea and vomiting, lethargy, chills and rigors. The detainee's vital signs were documented as unobtainable, with the exception of an initial oxygen saturation reading of 82 percent, and his ventilations were described as slow. An EKG was not done.<sup>114</sup> Doctor [ ] confirmed that AZURDIA's medical record was reviewed during this encounter, and that she made an entry to the medical record describing the event.<sup>115</sup> ODO notes that although RN [ ] assumed the lead role when AZURDIA was brought to the clinic, she did not write a progress note.

Doctor [ ] gave a verbal order to call 911 within five minutes of her arrival, at 10:46 a.m., RN [ ] called Lieutenant [ ] in the Watch Command office.<sup>116</sup> Lieutenant [ ] stated that he immediately directed Central Control to call 911.<sup>117</sup> Central Control documented that 911 was called at 10:46 a.m., 14 minutes after AZURDIA arrived in medical, and 30 minutes after he was brought to the officer in Unit 3C with complaints of chest pain.<sup>118</sup>

Doctor [ ] completed a consultation/emergency room referral form at 10:52 a.m., documenting AZURDIA exhibited acute illness with chest pain, nausea and vomiting, rigors, slow mental activity, but

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<sup>106</sup> ADF Video Surveillance Footage, December 19, 2015.

<sup>107</sup> Shivering accompanied by rise in temperature, often with copious sweating.

<sup>108</sup> ODO interview with Doctor [ ] January 21, 2016.

<sup>109</sup> ODO interview with RN [ ] & Doctor Jackson, January 20 & 21, 2016.

<sup>110</sup> Oxygen saturation refers to the amount of oxygen in the blood. Normal oxygen saturation levels in humans is 95-100 percent.

<sup>111</sup> Infection spread through body tissues.

<sup>112</sup> ODO interview with Doctor [ ] January 21, 2016.

<sup>113</sup> See Exhibit 8: GEO Medical Provider Progress Note by Doctor [ ] dated December 19, 2015.

<sup>114</sup> *Id.*

<sup>115</sup> ODO interview with Doctor [ ] January 21, 2016.

<sup>116</sup> ODO interview with RN [ ] January 20, 2016.

<sup>117</sup> ODO interview with Lieutenant [ ] January 21, 2016.

<sup>118</sup> ADF Video Surveillance Footage, December 19, 2015.

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that he was oriented to person, place, and time.<sup>119</sup> She documented the inability to obtain a blood pressure or temperature for AZURDIA, that he had chills and rigors, and that he was generally pale and lethargic. Doctor [ ] documented provisional diagnosis included acute gastroenteritis,<sup>120</sup> suspected hypotension, and hypothermia,<sup>121</sup> and that sepsis should be ruled out. Doctor [ ] stated she completed the form before the paramedics arrived and performed an EKG which determined AZURDIA was having a heart attack.<sup>122</sup>

An Adelanto Fire Department vehicle arrived at the ADF East building intake gate at 10:54 a.m., eight minutes after the 911 call was logged by Central Control. No ADF officer was present to facilitate the vehicle's entry through the gate. At 10:55 a.m., an officer appeared and spoke into the intercom near the gate. At 10:56, the gate was opened and the fire department vehicle entered the vehicle sally port. It is noted the perimeter officer arrived to open the gate nine minutes after 911 was called.<sup>123</sup>

At 10:59 a.m., an American Medical Rescue (AMR) ambulance arrived at the sally port gate immediately preceded by an ADF chase vehicle. At 11:01 a.m., both vehicles entered the vehicle sally port. Also at 11:01 a.m., fire department staff arrived at the nurses' station and began checking AZURDIA. At 11:05 a.m. AMR staff arrived at the nurses' station with a stretcher.<sup>124</sup>

Doctor [ ] documented in her progress note that the AMR staff placed chest leads for an EKG on AZURDIA. The EKG provided a preliminary diagnosis of massive heart attack. She described that AZURDIA was still awake, lethargic but arousable, and cold with positive rigors.<sup>125</sup> At 11:11 a.m., AZURDIA was able to stand up from his wheelchair and sit down on the AMR stretcher.<sup>126</sup> Two minutes later, he was wheeled out of the clinic. The fire department, AMR, and ADF chase vehicles all left the vehicle sally port and exited the facility at 11:19 a.m., and AZURDIA was transferred to SMMC.<sup>127</sup>

AZURDIA arrived at the hospital at 11:32 a.m. and was immediately taken to the emergency room where intravenous fluids were initiated, X-Rays were done, and AZURDIA was intubated.<sup>128</sup> At 12:50 p.m., AZURDIA was taken to the cath lab<sup>129</sup> for a coronary angiogram,<sup>130</sup> and he was placed in the Intensive Care Unit at 2:10 p.m.<sup>131</sup>

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<sup>119</sup> See Exhibit 9: Consultation/emergency room referral from completed by Doctor [ ] December 19, 2015.

<sup>120</sup> Inflammation of the lining of the intestines cause by a virus, bacteria, or parasite.

<sup>121</sup> A potential dangerous drop in body temperature that occurs when the body loses heat faster than it can produce heat.

<sup>122</sup> Until that time, Doctor [ ] had not diagnosed heart attack.

<sup>123</sup> ADF Video Surveillance Footage, December 19, 2015.

<sup>124</sup> *Id.*

<sup>125</sup> See Exhibit 8: GEO Medical Provider Progress Note by Doctor [ ] dated December 19, 2015.

<sup>126</sup> ADF Video Surveillance Footage, December 19, 2015.

<sup>127</sup> ADF Video Surveillance Footage, December 19, 2015.

<sup>128</sup> SMMC Medical Record, dated December 19, 2015.

<sup>129</sup> An examination room with diagnostic imaging equipment to visualize the arteries and chambers of the heart and to treat any abnormalities, such as placing a stent to keep a blocked artery open.

<sup>130</sup> A procedure that uses X-ray imaging to see the heart's blood vessels, generally done to see if there is a restriction in blood flow going to the heart.

<sup>131</sup> See Exhibit 10: GEO Hospital Security Log, December 19, 2015.

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ADF officers assigned to the hospital made entries to a log book from the time of AZURDIA's arrival at the hospital until his death. This log was maintained in accordance with all policies and procedures and contained a thorough reporting of all events.

**On December 20, 2015**, AZURDIA received approximately 11 IV lines to maintain blood pressure, which was documented at 99/62. During the physician's attempt to do a stent<sup>132</sup> placement, it was determined the heart was too weak to continue, and hospital staff awaited the cardiothoracic surgeon's assessment to determine the next plan of action. AZURDIA's preliminary diagnosis was hypotension post heart attack with severe full thickness tissue damage of the heart. His prognosis was deemed poor. At 10:15 a.m., AZURDIA's blood pressure was improved at 112/59, but his prognosis remained poor. A report completed at 8:00 p.m. on December 20, 2015, documented the decision by the cardiothoracic surgeon to not perform surgery because AZURDIA was too unstable. His blood pressure was recorded as 78/46, and his prognosis remained poor. There were no subsequent hospital reports in the medical record.<sup>133</sup>

**On December 23, 2015, at 11:01 p.m.**, AZURDIA was pronounced dead by Doctor [redacted]  
[redacted] An autopsy was not conducted.

**On December 24, 2015, at 1:30 a.m.**, hospital security staff transported AZURDIA's body to the morgue.<sup>135</sup> At 2:01 a.m., ADF officers left SMMC and returned to ADF. Both officers completed incident reports stating AZURDIA's time of death was 11:00 p.m.<sup>136</sup> The time of death was later corrected to 11:01 p.m., based on the Certificate of Death. The death certificate listed AZURDIA's cause of death as Cardiogenic Shock, Massive Right Ventricular Infarction and Severe Ischemic Heart Disease.<sup>137</sup>

After AZURDIA's hospitalization but prior to his death, (A) HSA [redacted] reviewed the medical record and surveillance video. He stated he immediately recognized the actions of LVN [redacted] on December 19, 2016, were concerning, and a formal internal inquiry into those actions was subsequently initiated by the Deputy Warden [redacted] who was unavailable for interview during ODO's visit. Both LVN [redacted] and staff having personal knowledge of LVN [redacted] actions on December 19, 2015, were required to submit statements. As noted, LVN [redacted] was placed on administrative leave prior to ODO's visit.<sup>138</sup>

On December 24, 2015, (A) HSA Devasa completed a written Death Report Summary documenting AZURDIA's medical history and medications.<sup>139</sup> In reference to the December 19, 2015 event, (A) HSA [redacted] documented AZURDIA was transferred to the hospital by ambulance "due to loss of consciousness, chest pain and hypotension." ODO notes no staff involved with the event reported that AZURDIA ever lost consciousness.

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<sup>132</sup> A tubular support placed inside a blood vessel to relieve and obstruction.

<sup>133</sup> See Exhibit 11: GEO Hospital Admission and Follow Up by RN [redacted] December 20, 2015.

<sup>134</sup> See Exhibit 12: State of California Certificate of Death, December 23, 2015.

<sup>135</sup> See Exhibit 13: GEO Hospital Security Log, December 24, 2015.

<sup>136</sup> See GEO General Incident Reports by Officer [redacted] (first name unknown), and Officer [redacted] (first name unknown), dated December 23, 2015.

<sup>137</sup> See Exhibit 12: State of California Certificate of Death, December 23, 2015.

<sup>138</sup> ODO interview with (A) HSA [redacted] dated January 20, 2016.

<sup>139</sup> See Exhibit 14: GEO Death Report Summary by (A) HSA [redacted] dated December 24, 2015.

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**After Action Review (AAR)**

AW [ ] was responsible for conducting an AAR of AZURDIA's death. Her AAR report was provided to ODO at the outset of the onsite review.<sup>140</sup> As evidenced in the report, AW [ ] interviewed only four officers during the AAR: Officer [ ] Officer [ ] Officer [ ] (who had no direct involvement with AZURDIA), and Officer [ ] (a laundry officer who was present in Unit 3C on December 19, 2015). AW [ ] did not interview Officer [ ] or Lieutenant [ ]. ODO also noted the lack of incident reports included in the AAR, and AW [ ] indicated that only those officers who were at the hospital when AZURDIA died were required to complete an incident report. AW [ ] stated that it was not until an internal review of LVN [ ] actions was initiated, that facility administrators became aware of potential issues regarding the handling of AZURDIA's medical condition in the housing unit on December 19, 2015. At that time, January 13-15, 2016, approximately three weeks after AZURDIA's death, and one week prior to ODO's visit, written statements were collected from officers involved in the events on December 19, 2015.

According to the AAR report, the scope and objective of the review was to examine medical conditions, staffing, security procedures, emergency response protocols, investigative procedures, security threat group affiliation, and classification information. In light of this stated scope and objective, ODO identified numerous concerns with the AAR report, discussed below.

- AW [ ] wrote that she "utilized interviews with staff and a comprehensive review of all applicable documents and procedures pertinent to the incident" during her review; however, it was not until her interview with ODO, 27 days after AZURDIA's death, that AW [ ] became aware that Officer [ ] left her post a total of five times on December 19, 2015. AW [ ] was only aware Officer [ ] was absent from her post when attempts were made to contact medical.
- Although AW [ ] concluded in her report that staff must be at their assigned posts at all times, she did not investigate whether Officer [ ] left her post with or without supervisory approval, or whether leaving a post unattended was an isolated occurrence or common practice.
- Although AW [ ] was aware that the Watch Command log for December 19, 2015, was blank, she did not initiate an investigation into why Lieutenant [ ] made no entries for this date.
- AW [ ] did not address any concerns with the untimely and less than thorough security rounds conducted by Officer [ ] on December 19, 2015.
- The AAR report lists a cause of death that is inconsistent with the Death Certificate. Specifically, the report states AZURDIA's cause of death was cardiopulmonary arrest secondary to multi-organ failure. The Death Certificate, however, records his cause of death as Cardiogenic Shock, Massive Right Ventricular Infarction, and Severe Ischemic Heart Disease.

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<sup>140</sup> See Exhibit 15: GEO After Action Review, December 23, 2015. Although the report is undated, AW [ ] advised ODO that it was completed the morning of January 19, 2016, prior to ODO's arrival.

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- The AAR report does not address AZURDIA’s missing reclassification review. As determined during her interview, AW [redacted] was unaware a reclassification review was never completed for AZURDIA.<sup>141</sup>

### MEDICAL CARE AND SECURITY REVIEW

Creative Corrections, a national management and consultant firm contracted by ICE to provide subject matter expertise in detention management including medical care and security, reviewed the medical care AZURDIA was provided by GEO, as well as his safety and security while detained at the facility. Creative Corrections found deficiencies in ADF’s compliance with the following Standards in ICE PBNDS 2011: Medical Care, Custody Classification System, and Facility Security and Control.<sup>142</sup>

### CONCLUSIONS

#### Findings

ODO found ADF deficient in the following areas of the ICE PBNDS 2011, Medical Care:

1. ICE PBNDS 2011, Medical Care, Section (V)(A)(2, 3, 4, 6), *Expected Practices*, states, “every facility directly or contractually provide its detainee population with the following: medically necessary and appropriate medical, dental and mental health care and pharmaceutical services; comprehensive, routine and preventive health care, as medically indicated; emergency care; and timely responses to medical complaints.” As described in the narrative:
  - On July 28, 2015, PA [redacted] referred AZURDIA to the staff physician within one to two weeks for assessment of latent tuberculosis infection. His medical record contains no documentation the appointment was ever completed.
  - On July 28, 2015, PA [redacted] failed to provide a prostate examination as required by National Commission on Correctional Health Care (NCCHC) for detainees over the age of 50.
  - On December 19, 2015, LPN [redacted] failed to triage AZURDIA following reports of his being ill.
  - On December 19, 2015, delays were noted in initial contact with medical personnel, transport to the medical department, and EMS notification.
2. ICE PBNDS 2011, Medical Care, Section (V)(B), *Designation of Authority*, states, “all facilities provide medical staff and sufficient support personnel to meet the standard.”
  - ADF’s staffing plan at the time of ODO’s review showed an ongoing nurse shortage, with five RN vacancies. As significant as the number of vacancies at the time of the site visit or on any given day, is the high turnover rate among nursing staff, which impacts delivery and quality of care. Additional leadership vacancies included the director of nurses and the assistant HSA. ADF has had two HSAs since October 2014, the first of whom moved to the assistant HSA position and was on administrative leave at the time of the site visit.

<sup>141</sup> ODO interview with AW [redacted] January 20, 2016.

<sup>142</sup> See Exhibit 16: Creative Corrections Security and Medical Compliance Analysis.



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3. ICE PBNDS 2011, Medical Care, Section (V)(I), *Medical Personnel*, states, “all health care staff must be verifiably licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements. Copies of the documents must be maintained on site and readily available for review.”
  - Credentials for Doctor [ ] including granted privileges, qualifications and training, primary-sourced education and licensure, and DEA registration were unavailable on site at the time of ODO’s review.
4. ICE PBNDS 2011, Medical Care, Section (V)(L), *Comprehensive Health Assessment*, states, “a comprehensive health assessment, including a physical examination and mental health screening, on each detainee within 14 days of arrival unless more immediate attention is required due to an acute or identifiable chronic condition.”
  - AZURDIA’s initial physical assessment conducted by PA [ ] was delayed by 22 days beyond the 14-day requirement.
5. ICE PBNDS 2011, Medical Care, Section (V)(Y)(1), *Medical Records*, states, “the HSA shall maintain a complete health record on each detainee that is organized uniformly in accordance with appropriate accrediting body standards; available to all practitioners and used by them for health care documentation; and properly maintained and safeguarded in a securely locked area within the medical unit.”
  - All healthcare staff interviewed reported that at least 20 percent of the time, detainee medical records cannot be reviewed prior to medical encounters because the medical files are not located in time.

ODO found ADF deficient in the following areas of the ICE PBNDS 2011, related to safety and security:

1. ICE PBNDS 2011, Custody Classification System, Section (V)(H)(1), states “the first reclassification assessment be completed 60 to 90 days after the date of the initial classification.”
  - AZURDIA’s initial classification was completed on June 22, 2015, and no reclassification assessment was completed for the detainee, although one was due by September 22, 2015.
2. ICE PBNDS 2011, Facility Security and Control, Section (H)(4), states, “information about routine procedures, emergency situations and unusual incidents be continuously recorded in permanent logs and shift reports.”
  - The watch commander, Lieutenant [ ] did not complete any log entries for his entire shift on December 19, 2015.

**AREAS OF NOTE**

- Upon AZURDIA’s admission, ADF medical staff received documentation from the Wasco State Prison, from which he was transferred, that he underwent a chest x-ray on February 18, 2015, that was “essentially within normal limits.” Because AZURDIA had been in continuous custody and the TB symptom check upon arrival was negative, this was accepted as documentation of TB clearance within the past six months, as allowed by the standard. However, given the detainee’s

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report of LTBI treatment for 12 weeks while incarcerated at the Wasco State Prison, and the fact the radiology report itself was not received, his complete medical record from the prison should have been pursued.

- The only entry on the master problem list contained in AZURDIA’s medical record is varicella immunity. None of the problems identified during his physical examination were listed, including LTBI, allergic rhinitis, headache, and arcus senilis.
- On October 26, 2015, RN [ ] did not document the name of the provider who gave a verbal order for medication. Verbal and telephone orders must document the full prescription, read-back verification, and the name of the provider/registered nurse.
- On October 26, 2015, the nurse failed to obtain AZURDIA’s pain level during a sick call encounter to address back pain.
- AZURDIA’s medical record did not contain documentation of any updates on his status from SMMC for December 21, or December 22, 2015.
- ICE PBNDS 2011, Medical Care, Section (II)(1), Expected Outcomes, states, “medical facilities within the detention facility shall achieve and maintain current accreditation with the standards of the National Commission on Correctional Health Care (NCCHC), and shall maintain compliance with those standards.” ADF is not accredited by NCCHC.
- ADF Housing Unit Post Orders, section (V)(B)(6), requires that the welfare of detainees be checked through visual inspections of each cell and bunk area every 30 minutes at irregular intervals. Officer [ ] did not check all cells when she made a round in unit 3C, and she did not make rounds every 30 minutes on December 19, 2015.
- ADF Pod Control Officer Post Orders, section (III), requires that Pod Control be staffed 24 hours each day; also, that the officer stay in Pod Control unless specifically authorized by the on duty Shift Supervisor. The Shift Supervisor must designate a relief if the Pod Control Officer is authorized to leave Pod Control. During the 6:00 a.m. to 2:30 p.m. shift on December 19, 2015, Officer [ ] left the 3C West Pod Control post five times.
- ADF Pod Control Officer Post Orders section (VI)(D)(6), states that the Pod Control Officer is responsible for making entries and maintaining a Pod Control logbook in accordance with the Policy and Procedure on Permanent Logs and Reports. Log entries must include, but are not limited to, relief from and assumption of the post. On December 19, 2015, Officer [ ] did not log the time she returned to her post on four separate occasions.
- ADF Policy 7.1.3.A, General Incident Reports, states that emergency situations and unusual incidents will be documented on a General Incident Report (GIR) Form. The same policy requires that immediately following any incident, staff members will submit an incident report, and that all incident reports and any supporting documentation must be completed before the end of the shift on which the incident occurred. Written reports were not collected from all involved staff until three weeks after the incident.

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**EXHIBITS:**

1. Medical intake screening by RN [redacted] and associated Medical Notes), dated June 22, 2015.
2. GEO History and Physical Assessment by PA [redacted] dated July 28, 2015.
3. GEO Musculoskeletal Pain/Trauma Protocol & Progress Note by RN [redacted] dated September 30, 2015.
4. GEO Musculoskeletal Pain/Trauma Protocol & Progress Note by RN [redacted] dated October 26, 2015.
5. GEO Unit 3C Post Log, dated December 19, 2015.
6. GEO Medical Provider Progress Note by LVN [redacted] dated December 19, 2015.
7. GEO Unit 3 Control Log, December 19, 2015.
8. GEO Medical Provider Progress Note by Doctor [redacted] dated December 19, 2015.
9. Consultation/Emergency Room Referral by Doctor [redacted] dated December 19, 2015.
10. GEO Hospital Security Log, December 19, 2015.
11. GEO Hospital Admission and Follow Up by RN [redacted] December 20, 2015.
12. State of California Certificate of Death, December 23, 2015.
13. GEO Hospital Security Log, December 24, 2015.
14. GEO Death Report Summary by (A) HSA [redacted], dated December 24, 2015.
15. GEO After Action Review by AW [redacted]
16. Creative Corrections Security and Medical Compliance Analysis.