

DETAINEE DEATH REVIEW – Saul Enrique BANEGAS-Guzman JICMS #201602890

SYNOPSIS

On January 22, 2016, Saul Enrique BANEGAS-Guzman, a forty-five year-old citizen and national of Honduras, died while in the custody of U.S. Immigration and Customs Enforcement (ICE) at the Rapides Regional Medical Center (RRMC), in Alexandria, Louisiana (LA). The State of Louisiana Certificate of Death, issued May 19, 2016, does not provide the cause or manner of death because, as a matter of practice, the State of Louisiana does not provide that information.

BANEGAS was detained at the LaSalle Detention Facility (LDF), Jena, LA, at the time of his death. LDF is owned and operated by the GEO Group, Inc. (GEO) under a Dedicated-Intergovernmental Service Agreement (D-IGSA), which requires the facility to comply with the ICE Performance Based National Detention Standards (PBNDS) 2011. At the time of BANEGAS' death, LDF housed 863 male and 213 female detainees of all classification levels for periods in excess of 72 hours. Medical care at LDF is provided by the ICE Health Service Corps (IHSC) and supported by contractor InGenesis. InGenesis supplements their medical staffing at LDF through a subcontract with STG International, Inc (STG).

DETAILS OF REVIEW

From January 26 to 28, 2016, ICE Office of Professional Responsibility, Office of Detention Oversight (ODO) staff visited LDF and, with the assistance of contract subject matter experts (SME) in both correctional healthcare and security, reviewed the circumstances surrounding BANEGAS' 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 BANEGAS, in addition to conducting in-person interviews of individuals employed by LDF, as well as local 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 BANEGAS' apprehension by ICE, through his detention at LDF, and eventual death at RRMC.

IMMIGRATION AND DETENTION HISTORY

Saul Enrique BANEGAS-Guzman unlawfully entered the United States using an alias in 1996. The exact date and location of his entry are unknown.¹

¹ Form I-877, Record of Sworn Statement, December 10, 2015.

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On May 30, 2014, BANEGAS was encountered by ERO at the Arkansas Department of Corrections (ADOC) in Pine Bluff, Arkansas (AR), where he was serving a sentence for the manufacturing, delivering and possession of a controlled substance and was served with an immigration detainer.²

On November 30, 2015, BANEGAS was paroled out of ADOC and administratively arrested by ICE ERO. He was served a Notice of Intent to Issue a Final Administrative Removal Order charging him as deportable pursuant to §101(a)(43)(B) of the INA.³

On December 1, 2015, ERO transferred BANEGAS to LDF.

CRIMINAL HISTORY

BANEGAS was convicted on three occasions by the Sebastian County Circuit Court, Fort Smith, AR. On November 27, 2000, BANEGAS was sentenced to 45 days in jail for driving under the influence; on June 2, 2005, he was sentenced to one year in jail for larceny; and, on August 30, 2005, he was sentenced to 20 years in confinement at the ADOC in Pine Bluff for manufacturing, delivering, and possession of a controlled substance.⁴

NARRATIVE SUMMARY OF EVENTS

On December 1, 2015, at 8:34 a.m., BANEGAS was admitted into LDF by Officer [REDACTED] and received an initial classification assessment by Officer [REDACTED]. Officer [REDACTED] used the ICE Custody Classification Worksheet and appropriately rated BANEGAS as a high custody level detainee based on his criminal history and prior convictions. The classification rating was not approved by a first-line supervisor or classification supervisor.⁶ BANEGAS was assigned to Owl Dorm B, a high custody housing unit, where he remained throughout his detention at LDF.⁷

At 6:50 p.m., BANEGAS received a medical pre-screening⁸ by InGenesis RN [REDACTED]. RN [REDACTED] documented BANEGAS did not take any medications and denied having any current illnesses or health problems.

² See Form I-247, Immigration Detainer – Notice of Action, May 30, 2015.

³ See Form I-213, Record of Deportable/Inadmissible Alien, November 30, 2015.

⁴ *Id.*

⁵ See Alien Booking Record, December 1, 2015.

⁶ See Exhibit 1: ICE Custody Classification Worksheet, December 1, 2015.

⁷ See GEO Track Subject Profile, December 1, 2015.

⁸ See Medical Pre-Screening, December 1, 2015.

⁹ LDF uses the electronic medical records software, E-Clinical Works. The software allows for multiple encounters on the same progress note, even though the encounters occurred at different times. Occasionally, progress notes related to BANEGAS were not entered by the medical staff member who conducted the encounter. Progress notes were also not consistently electronically signed at the time of the encounter. The time stamps on the electronic medical records are automatically generated in Mountain Standard Time even though LDF is located in the central time zone. All times in this report have been adjusted to reflect central time.

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At 11:37 p.m., STG RN [redacted] completed the medical intake screening and documented BANEGAS spoke fluent English.¹⁰ RN [redacted] also documented his vital signs were all within normal limits, his chest x-ray was negative for tuberculosis, and he weighed 171 pounds. RN [redacted] documented that BANEGAS arrived with no medication and denied any recent medical treatment. During the intake screening, BANEGAS reported having a prior chicken pox infection and admitted to prior substance abuse. BANEGAS signed the English version of the Medical Consent Form.¹¹

On December 11, 2015, at 11:35 a.m., STG RN [redacted] conducted BANEGAS' initial physical examination.¹² His vital signs were all normal with the exception of a slow pulse rate of 60 beats per minute.¹³ RN [redacted] documented BANEGAS denied any medical or mental health history and also denied a history of chicken pox¹⁴. IHSC physician [redacted] acting Clinical Director, documented he reviewed the physical examination on December 12, 2015, at 3:13 p.m. BANEGAS had no other contact with medical staff until January 5, 2016, the day of his medical emergency.

On January 5, 2016, at 12:45 p.m., BANEGAS and 57 other detainees exited Owl Dorm and made their way to LDF's recreation yard for recreation.¹⁵ The facility shift roster¹⁶ shows Officers [redacted] were assigned to the recreation yard, and Officer [redacted] was assigned to perimeter patrol.¹⁷

As seen in video surveillance footage of the recreation yard,¹⁸ at 1:16 p.m.,¹⁹ BANEGAS, who was standing on the edge of the soccer field, fell face first onto the concrete sidewalk bordering the field. Officer [redacted] stated during his interview that he was conducting his rounds on the recreation yard at this time when he heard yelling and saw detainees near the soccer field waving for his assistance.²⁰ He responded to the area where he saw a detainee on the ground and several detainees fanning him with their shirts. Officer [redacted] stated he called for medical assistance via radio, and that within a minute of his call, he heard Officer [redacted] call a code black²¹ over the radio. Officer [redacted] stated during his interview that as he passed by the recreation yard during his patrol, he observed several detainees gathering and taking their shirts off; he called a

¹⁰ See Exhibit 1: Medical Intake Screening, December 1, 2015

¹¹ See Medical Consent Form, December 1, 2015.

¹² See Exhibit 2: Initial Physical Examination, December 11, 2015.

¹³ A normal pulse rate is defined as 60 to 100 beats per minute.

¹⁴ ODO notes the discrepancy in the detainee's answers concerning chicken pox was never addressed.

¹⁵ See Owl B Dorm Logbook, January 5, 2016.

¹⁶ See GEO 1st Shift Turn-Out Roster, January 5, 2016.

[redacted]

¹⁸ LDF has [redacted] video surveillance cameras mounted [redacted]. All video surveillance cameras have a time and date stamp. ODO was provided with footage from [redacted] camera angles. [redacted]

[redacted]

¹⁹ The times used for this report were taken from the referenced video footage.

²⁰ ODO interview with Officer [redacted] February 24, 2016.

²¹ At LDF, a code black signifies an aggressive incident (i.e. fight, assault).

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code black because he thought the detainees were engaged in a fight.²² ODO notes Officer [redacted] did not complete an incident statement regarding his code black call, and neither the Perimeter Patrol Shift Log nor the Daily Inspection Log mention the code black call.²³ Shift Lieutenant (Lt.) [redacted] stated during her interview that Officer [redacted] should have completed an incident statement; however, she also acknowledged that supervisors are responsible for requesting an incident statement from an officer.²⁴

At the time of BANEGAS' fall, Officer [redacted] who was assigned to the recreation yard with Officer [redacted] was in Eagle dorm assisting an officer on an unrelated issue.²⁵ According to Officer [redacted] only one officer is required to be on the yard when there are less than 100 detainees on the yard. According to both Chief of Security (COS), Major [redacted] and Assistant Warden (AW) [redacted], because Owl dorm houses high custody detainees,²⁷ both officers assigned to the recreation yard must remain on the yard for the full recreation period, regardless of the number of detainees on the yard. Additionally, supervisory approval must be obtained any time an officer is reassigned or leaves the recreation yard to perform alternate duties. Both Lt [redacted] and Sergeant (Sgt.) [redacted] stated during their interviews that they were unaware Officer [redacted] was not on the recreation yard at the time of BANEGAS' fall and stated they did not authorize his absence.²⁸

At 1:18 p.m., the first officers arrived to the recreation yard in response to the code black call.²⁹ Although he was away from his post at the time, Officer [redacted] was one of those first officers to arrive, accompanied by Lt. [redacted] and Sgt [redacted]. Sgt [redacted] informed ODO he was equipped with a handheld video camera when he responded but did not film the scene.³¹ During Major [redacted] interview with ODO, he stated all shift supervisors and sergeants carry video cameras, but handheld video footage was not taken during the BANEGAS response because the officers were preoccupied rendering assistance to the detainee.³²

Lt [redacted] and Sgt [redacted] stated that when they arrived to the recreation yard, BANEGAS was in a seated position and was propped up by other detainees who were lifting the detainee's arms trying to revive him. The officers stated BANEGAS was moving and breathing, but that his eyes were closed, and he had blood on his forehead. Lt. [redacted] stated she checked for and found a pulse.³³ The officers stated they quickly recognized the incident was a medical emergency,

²² ODO interview with Officer [redacted], February 23, 2016.

²³ The Perimeter Patrol Officer must complete the Daily Inspection Log when roving the perimeter to ensure all areas are clean, hazard free, and secure.

²⁴ ODO interview with Lt. [redacted] February 24, 2016.

²⁵ ODO interview with Officer [redacted] February 23, 2016.

²⁶ ODO interview with Major [redacted] February 24, 2016.

²⁷ ODO interview with Assistant Warden [redacted] February 23, 2016.

²⁸ ODO interview with Sergeant [redacted] February 25, 2016.

²⁹ See Video Surveillance Footage, January 5, 2016.

³⁰ ODO interview with Lieutenant [redacted] February 24, 2016.

³¹ ODO interview with Lt. [redacted] February 24, 2016.

³² ODO interview with Major [redacted] February 24, 2016.

³³ ODO interview with Lt. [redacted] February 24, 2016. See also Incident Statement by Sgt. [redacted] dated January 5, 2016.

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rather than a fight, and placed a code blue (medical emergency) call via radio. The officers did not recall who placed the code blue call.

Within a minute of Officer [redacted] Lt. [redacted] and Sgt. [redacted] arriving to the recreation yard, additional officers responded including Major [redacted] AW [redacted] Lt. [redacted] and Officers [redacted].³⁴ During their interviews, only three of the officers who responded to the scene recalled hearing a code blue call; the others responded to the code black call.³⁵ Although Officer [redacted] stated during his interview his initial radio call was for medical assistance, not a code blue, neither call was logged by Central Control.³⁶ ODO was unable to determine if a code blue was called.

During interviews with security staff, ODO learned there are [redacted] officers assigned to the clinic: [redacted] Medical Front Desk Officer, [redacted] Short Stay Unit Officer, and [redacted] Medical Rovers. On January 5, 2016, Officer [redacted] was assigned to the Medical Front Desk and Officer [redacted] was assigned to the Short Stay Unit.³⁷ Officer [redacted] stated during her interview she left her post to escort a detainee to his dorm when she heard the call for medical assistance over her radio.³⁸ Because she was just outside the clinic when she heard the call, Officer [redacted] returned to the clinic to inform Officer [redacted] of the call.³⁹ Officer [redacted] stated she immediately informed nurses in the clinic that medical assistance and a stretcher were needed on the Owl recreation yard. She also began logging events on a sheet of paper⁴⁰ which Officer [redacted] later transferred to the medical logbook.⁴¹ ODO notes the medical logbook did not document Officer [redacted] departure from the post or that she was relieved by another officer. ODO observed that Officer [redacted] noted “DE” in the logbook to indicate “delayed entry” for several entries regarding the BANEGAS response, but did not make this notation consistently. As a result, the medical logbook does not provide clear documentation of the chronological order of events.

STG RNs [redacted] and STG Licensed Practical Nurse (LPN) [redacted] responded to the call for medical assistance on the Owl recreation yard.⁴² During their interviews, the nurses stated they gathered emergency medical equipment,

³⁴ See Video Surveillance Footage, January 5, 2016.

³⁵ At LDF a code blue signifies an incident requiring immediate medical assistance.

³⁶ It should be noted LDF General Post Orders do not explain the difference between a code blue and a medical assistance call. During interviews with staff, ODO was informed a medical assistance call is for incidents that involve minor injuries, such as, a detainee with a sprained ankle.

³⁷ See First Shift Roster, dated January 5, 2016.

³⁸ ODO interview with Officer [redacted] February 24, 2016.

³⁹ Radios are not available to medical staff in the clinic or in the medical administration area; therefore, medical personnel rely on officers to communicate calls for medical assistance. According to Lieutenant [redacted] Officers are expected to sign out a radio from Central Control at the start of their shift. On January 5, 2016, Officer [redacted] did not have a radio, and the Central Control log indicates she did not sign one out.

⁴⁰ ODO interview with Officer [redacted] February 25, 2016.

⁴¹ During interviews of security staff, ODO learned that the Medical Front Desk Officer sits at the front desk of the clinic and is responsible for answering the phone and logging all activities in a post log book. ODO notes that LDF did not have a post log addressing the duties of the Medical Front Desk Officer at the time of the review.

⁴² See Exhibit 4: Medical Progress Note by RN [redacted] January 5, 2016.

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including the automated external defibrillator (AED),⁴³ ambu-bag,⁴⁴ oxygen tank, trauma bag, and a stretcher, and left for the Owl recreation yard. The nurses reported that security staff had gates and doors open for them, enabling them to reach the Owl recreation yard quickly. Video surveillance shows medical staff entering the recreation yard at 1:20 p.m., within four minutes of BANEGAS' collapse.⁴⁵ ODO notes all four nurses stated that while en route to the recreation yard, they were told by security staff that a code black was called and assumed they were responding to detainees who were injured in a fight.

RN [] stated during her interview that as the nurses entered the recreation yard she heard someone yell "code blue" and that Lt. [] took the stretcher from her.⁴⁶ RN [] further stated she observed several detainees in red uniforms huddled around BANEGAS and asked security staff to move the detainees to the other side of the recreation yard.⁴⁷ RN [] stated nothing was done by security staff to immediately clear the area, and all nurses reported feeling unsafe while on the recreation yard. Lt. [] and Sgt. [] both stated they immediately directed detainees to clear the area surrounding BANEGAS when they arrived at the recreation yard; however, video surveillance footage shows detainees were cleared from the area by security staff at 1:22 p.m., two minutes after medical staff arrived on scene.⁴⁸

RN [] documented that when the nurses reached BANEGAS, he was lying on the ground on his left side.⁴⁹ She also documented the detainee was unresponsive and had a weak carotid pulse⁵⁰ with slow labored breathing. During their interviews, the nurses stated that due to the number of detainees in the area, they decided to immediately transport BANEGAS to the clinic on the stretcher instead of conducting an initial assessment on the yard. Sgt. [] and Officer [] lifted the detainee onto the stretcher and assisted medical staff in carrying the stretcher off the recreation yard at 1:23 p.m.⁵¹ At 1:24 p.m., BANEGAS was carried into the clinic.⁵²

ODO interviewed all medical personnel who participated in or observed the emergency response inside the clinic. Because there are no cameras located in the clinic and no staff member was designated as a recorder for the incident, the following accounting of events is gleaned from staff interviews and available written documentation, including incident reports. ODO notes that many of the actions described took place simultaneously rather than sequentially.

⁴³ A portable device that checks the heart rhythm and can send an electric shock to the heart to try to restore normal rhythm.

⁴⁴ A respiration device used to provide manual ventilation.

⁴⁵ See Video Surveillance Footage, January 5, 2016.

⁴⁶ ODO interview with RN [] February 24, 2016. See also Exhibit 3.

⁴⁷ Red is the uniform color worn by high custody detainees.

⁴⁸ See Video Surveillance Footage, January 5, 2016.

⁴⁹ See Exhibit 4.

⁵⁰ The pulse taken from either side of the front of the neck, just below the angle of the jaw.

⁵¹ See Video Surveillance Footage, January 5, 2016.

⁵² *Id.*

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STG NP [redacted] who assumed the role of team leader during the medical emergency,⁵³ stated BANEGAS was obviously non-responsive when he was carried into the clinic and had blood around his nose and mouth.⁵⁴ RN [redacted] reported that she observed BANEGAS was no longer breathing when he was brought inside the clinic.⁵⁵ Once inside the clinic, BANEGAS was placed in the urgent care room, where NP [redacted] and RN [redacted] immediately initiated cardiopulmonary resuscitation (CPR).⁵⁶

As BANEGAS was brought into the urgent care room, InGenesis RN [redacted] called 911 from the nurse's station and then reported to the urgent care room to provide assistance.⁵⁷ ODO notes both Lt. [redacted] and Lt. [redacted] stated they believed 911 was called while medical staff were with BANEGAS on the recreation yard.⁵⁸ LPN [redacted] stated she also called 911 after BANEGAS entered the clinic and was informed by the dispatch operator that dispatch was already notified.⁵⁹ ODO notes the Central Control logbook does not document when 911 was called.

STG NP [redacted] who was seeing detainees in the clinic when BANEGAS was brought in, reported to the urgent care room to assist RN [redacted] with chest compressions.⁶⁰ STG Family Nurse Practitioner (FNP) [redacted] who was in Hawk dorm when BANEGAS was brought to the clinic, was informed of the emergency by an officer and also promptly reported to the clinic.⁶¹

Upon arriving to the clinic, FNP [redacted] observed NP [redacted] and RN [redacted] performing CPR and noted others present were trying to locate the ambu-bag and AED.⁶² As previously mentioned, the equipment was taken to the recreation yard when nurses responded to the medical assistance call; upon returning to the clinic, medical staff left the equipment in the clinic's hallway. RN [redacted] located the equipment, retrieved the ambu-bag and handed the device to NP [redacted].⁶³ STG RN [redacted] activated suction equipment for NP [redacted] to suction the detainee's mouth; RN [redacted] started an intravenous line (IV); and, AED leads were placed on BANEGAS' chest.⁶⁴

⁵³ All medical staff interviewed reported that although NP [redacted] was the designated lead, there was a lack of clarity concerning who was responsible for performing specific tasks during the response. Staff described the scene as chaotic and disorganized, largely due to a large number of staff in the urgent care room, and to staff yelling over one another. All staff stated the atmosphere of confusion did not impede on the emergency care rendered to the detainee.

⁵⁴ ODO interview with NP [redacted] February 25, 2016.

⁵⁵ ODO interview with RN [redacted] February 24, 2016.

⁵⁶ See Exhibit 5: Medical Progress Note by NP [redacted] January 5, 2016.

⁵⁷ ODO interview with RN [redacted] February 25, 2016.

⁵⁸ ODO interviews with Lt. [redacted] and Lt. [redacted] February 24, 2016.

⁵⁹ ODO interview with LPN [redacted] February 24, 2016.

⁶⁰ ODO interview with NP [redacted] February 23, 2016.

⁶¹ ODO interview with FN [redacted] February 23, 2016.

⁶² *Id.*

⁶³ ODO interview with RN [redacted] February 25, 2016.

⁶⁴ See Exhibit 5.

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At approximately 1:32 p.m., the AED analyzed a shockable rhythm and a shock was delivered. After the shock was delivered, mucus was suctioned from BANEGAS' mouth, and CPR was continued by FNI [] and RN []. The AED analyzed a second shockable rhythm at approximately 1:34 p.m., and a shock was delivered. Following the second shock, NP [] reported the detainee attempted to breathe with weak respiratory effort. The AED detected an unstable cardiac rhythm but did not detect a pulse, so a third shock was not advised. CPR continued with staff rotating chest compressions to prevent fatigue.⁶⁵

The LaSalle Public Ambulance Service (LPAS) arrived to LDF's sally port at 1:32 p.m.⁶⁶ and entered the clinic at 1:36 p.m.⁶⁷ The LPAS responders consisted of one paramedic and one basic emergency medical technician (EMT).⁶⁸ During her interview, NI [] stated while she and other LDF medical staff were attempting to resuscitate BANEGAS, she repeatedly asked where paramedics were until one of the LDF medical staff noticed they were standing outside of the urgent care room with a stretcher and emergency bag. NP [] stated she yelled for the LPAS responders to enter the room, and when they did, she informed them BANEGAS needed epinephrine.⁶⁹ ODO was informed epinephrine cannot be administered by LDF medical staff because they are certified in basic life support, but not in advanced life support, which is the certification level required to administer epinephrine.

NP [] documented the LPAS responders administered epinephrine and attached their AED leads to the detainee's chest at approximately 1:38 p.m.⁷⁰ The AED analyzed an unstable rhythm and a third shock was administered to BANEGAS. LDF medical staff continued CPR, pausing briefly when the EMT attempted to intubate⁷¹ the detainee. When the attempt was unsuccessful, the paramedic injected BANEGAS with another dose of epinephrine. CPR continued until the EMT made a second attempt to intubate the detainee, which was also unsuccessful. In the LPAS Patient Care Record, the paramedic documented the EMT was unable to intubate due to swelling and a bloody airway.⁷² During interviews, medical staff expressed concerns regarding the competency level of the EMT and noted the paramedic did not assist with the attempts to intubate BANEGAS.

According to NP [] and FNP [] after the second intubation attempt, NP [] pulled the LPAS stretcher into the urgent care room,⁷³ and at approximately 1:41 p.m., BANEGAS was moved by LDF staff to the LPAS stretcher.⁷⁴ RN [] stated she provided the paramedic a brief report summarizing the events of the emergency and the detainee's medical history.⁷⁵ NP [] documented that after BANEGAS was transferred to the LPAS stretcher,

⁶⁵ *Id.*

⁶⁶ See LDF Central Control log book, January 5, 2016.

⁶⁷ See LDF Medical log book, January 5, 2016.

⁶⁸ See LPAS Patient Care Record, January 5, 2016.

⁶⁹ Epinephrine is an antiarrhythmic drug used to stabilize the heartbeat.

⁷⁰ See Exhibit 5.

⁷¹ Intubation is the placement of a flexible plastic tube into the trachea to maintain an open airway.

⁷² See LPAS Patient Care Record, January 5, 2016.

⁷³ ODO interviews with NI [] February 25, 2016, and FNP [] February 23, 2016.

⁷⁴ See Exhibit 5.

⁷⁵ ODO interview with RN [] February 24, 2016.

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rescue breathing with the ambu-bag and oxygen was continued by the EMT.⁷⁶ During her interview, FNP [redacted] stated that she observed the LPAS responders were not performing chest compressions on BANEGAS as they left the clinic.⁷⁷ She stated that out of concern for the patient, she got on top of the stretcher and started chest compressions.

All medical staff interviewed stated they were anxious for EMTs to arrive and questioned why they didn't immediately enter the urgent care room and take charge. Staff consistently observed that the LPAS responders appeared reluctant to assume care of BANEGAS and did not assume control of the situation as emergency medical services are trained to do. Although the statements made by LDF medical staff during the interviews concerning the inadequate response by the LPAS responders were consistent, the LPAS Patient Care Record provides a different account. A notation by the paramedic in the LPAS Patient Care Record documents, among other things, that LDF staff did not relinquish care to the LPAS responders, and that the scene in the LDF urgent care room was chaotic. Because no LDF medical staff completed an incident statement recounting the events or the challenges encountered with the LPAS responders, and because interviews of the LPAS responders is outside the scope of ODO's review, inconsistencies between the two accounts are difficult to resolve. However, ODO notes discrepancies in the accounting of events exist within the LPAS report itself.⁷⁸

At 1:41 p.m., the LPAS responders exited the clinic with BANEGAS on the stretcher and with FNP [redacted] performing chest compressions.⁷⁹ The group was accompanied by RN [redacted] who walked beside the stretcher to stabilize FNP [redacted] ensuring she did not fall, and RN [redacted] who carried the oxygen tank. The group arrived to the ambulance at 1:42 p.m., and at 1:43 p.m., 19 minutes after BANEGAS first arrived in the clinic, the stretcher was loaded into the ambulance with FNP [redacted] still performing CPR.⁸⁰ RN [redacted] stated during his interview that because he believed the LPAS responders were not going to take over chest compressions, he boarded the ambulance to assist FNP [redacted].⁸¹ At 1:46 p.m. the doors to the ambulance were closed and the ambulance exited the facility.⁸² ODO notes the ambulance doors remained open for three minutes after BANEGAS was loaded into the ambulance. Officer [redacted] who was assigned by Sgt. [redacted] to accompany BANEGAS to the hospital in the ambulance, stated during his interview that the delay was due to the LPAS responders.⁸³ Officer [redacted] followed the ambulance in a chase vehicle.

FNP [redacted] and RN [redacted] stated that at no time before or after the ambulance departed LDF did the LPAS responders offer to take over chest compressions.⁸⁴ Instead, for the duration of the trip, FNP [redacted] and RN [redacted] alternated performing chest compressions and checking

⁷⁶ See Exhibit 5.

⁷⁷ ODO interview with FNP [redacted] February 23, 2016.

⁷⁸ Additional detail regarding the discrepant reporting by the LPAS responders can be found in the Creative Corrections Security and Medical Compliance Review, pages 12-14.

⁷⁹ See Video Surveillance Footage, January 5, 2016.

⁸⁰ Id.

⁸¹ ODO interview with RN [redacted], February 25, 2016.

⁸² See Video Surveillance Footage, January 5, 2016.

⁸³ ODO interview with Officer [redacted] February 25, 2016.

⁸⁴ ODO interviews with RN [redacted] February 25, 2016, and FNP Mitchell, February 23, 2016.

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BANEGAS' pulse between rounds. RN [] stated he asked LPAS responders if another dose of epinephrine would be administered, to which the paramedic replied the medication would not be "wasted" on "this kind of patient."⁸⁵ The LPAS Patient Care Record shows epinephrine was not given to the detainee, and no further attempts were made to intubate BANEGAS, but amiodarone⁸⁶ was administered by the paramedic intravenously.⁸⁷ Both FNP [] and RN [] stated another AED shock was delivered to the detainee in the ambulance.⁸⁸

LaSalle General Hospital

LGH records show the ambulance carrying BANEGAS arrived at LGH at 1:57 p.m.⁸⁹ FNP [] and RN [] stated that upon entering the emergency room (ER), LGH staff stood to the side and made no attempt to assume care for detainee.⁹⁰ FNP [] and RN [] continued to perform chest compressions. IHSC Commander (CDR) [] RN, Nurse Manager, who followed the ambulance to LGH for the purpose of bringing FNP [] and RN [] back to the facility, stated during his interview that because he observed hospital staff just standing around when he entered the ER, and FNP [] and RN [] still performing chest compressions on BANEGAS, he stepped in to assist.⁹¹ FNP [] RN [] and CDR [] all stated that while they continued doing chest compressions, the hospital respiratory therapist intubated BANEGAS, the AED advised and delivered one shock, and the detainee was hooked up to a cardiac monitor. Additionally, a central venous line⁹² was started in the detainee's femoral vein⁹³ by the ER physician and a new IV was started in the detainee's right arm.⁹⁴ CDR [] FNP [] and RN [] stated they ceased chest compressions per the physician's instructions when a pulse was found.⁹⁵ FNP [] documented the pulse was weak and irregular. Once a pulse was detected, LDF medical staff departed the hospital and Officer [] remained with the detainee.⁹⁶

After LDF medical staff returned to LDF, BANEGAS began spontaneously breathing and had a palpable pulse and blood pressure.⁹⁷ At 3:22 p.m., BANEGAS was placed on a ventilator and the ER physician determined the detainee required greater comprehensive care and should be

⁸⁵ ODO interview with RN [] February 25, 2016.

⁸⁶ Amiodarone is an antiarrhythmic agent that is given to patients who are unresponsive to defibrillation, CPR, and epinephrine.

⁸⁷ See LPAS Patient Care Record, January 5, 2016.

⁸⁸ Based on NF [] documentation this was the fourth shock delivered to the detainee, with the first three delivered in the urgent care room.

⁸⁹ See LGH Emergency Room Record, January 5, 2016. ODO notes the LPAS Patient Care Report documents the arrival time as 2:02 p.m.

⁹⁰ ODO interviews with RN [] February 25, 2016, and FNP [] February 23, 2016.

⁹¹ ODO interview with CDR [] February 24, 2016.

⁹² A central venous line is a tube used to give medicines, fluids, nutrients, or blood products over a long period of time.

⁹³ The femoral vein runs alongside the femoral artery which is located in the upper area of the thigh.

⁹⁴ See LGH Emergency Room Record, January 5, 2016.

⁹⁵ See Medical Progress Note by FNP [] January 5, 2016. The timing of BANEGAS regaining a detectable pulse was not documented.

⁹⁶ *Id.*

⁹⁷ See LGH Emergency Room Record, January 5, 2016.

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transferred to RRMC. At 3:55 p.m. the detainee was transported via ambulance to RRMC.⁹⁸ Officer [] accompanied the detainee in the ambulance, and Officer [] followed the ambulance in the chase vehicle. ODO notes the ambulance was staffed by different personnel than the paramedic and EMT who responded to LDF.

Rapides Regional Medical Center

At 4:35 p.m., the ambulance carrying BANEGAS arrived at RRMC and the detainee was placed in a trauma room.⁹⁹ At 6:20 p.m., Officers [] were relieved by officers from the Alexandria Staging Facility (ASF).¹⁰⁰

BANEGAS was admitted to the Intensive Care Unit (ICU) of RRMC at approximately 6:43 p.m. and was placed on a ventilator.¹⁰¹ The RRMC medical record documents BANEGAS was unresponsive upon his admission to the ICU.

From January 6 to 22, 2016, LDF received and documented daily updates from RRMC on BANEGAS' condition. Notable updates include:

- On January 6, 2016, BANEGAS was diagnosed with multi-vessel cardiac disease but was not deemed to be a surgical candidate at that time.¹⁰²
- On January 7, 2016, BANEGAS was reported to be in acute renal failure,¹⁰³ and a nephrologist¹⁰⁴ was consulted.¹⁰⁵
- On January 11, 2016, dialysis¹⁰⁶ was initiated.¹⁰⁷
- On January 12, 2016, the physician treating BANEGAS decided to wean the detainee off the ventilator to determine if he could breathe on his own.¹⁰⁸
- On January 14, 2016, BANEGAS was placed back on the ventilator due to increasingly frequent and labored breathing.¹⁰⁹ A computerized tomography (CT) scan¹¹⁰ of the brain was conducted and revealed acute cerebral ischemia.¹¹¹

⁹⁸ See LGH General Medical Records, January 5, 2016. Officer [] logged the departure time from LGH as 4:00 p.m. See Hospital log book, January 5, 2016.

⁹⁹ See Hospital log book, January 5, 2016.

¹⁰⁰ *Id.*

¹⁰¹ See RRMC Medical Record, January 5, 2016.

¹⁰² See Medical Progress Note by [] RN, dated January 6, 2016.

¹⁰³ Acute renal failure occurs when the kidneys suddenly become unable to filter waste products from the blood.

¹⁰⁴ Medical doctor specializing in kidney disease.

¹⁰⁵ See Medical Progress Note by RN [] dated January 7, 2016.

¹⁰⁶ A treatment that filters and purifies the blood using a machine.

¹⁰⁷ See Medical Progress Note by [], RN, January 10, 2016.

¹⁰⁸ See Medical Progress Note by RN [] January 12, 2016.

¹⁰⁹ See Medical Progress Note by RN [] January 14, 2016.

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- From January 16 to 19, 2016, BANEGAS' medical condition remained substantially unchanged.¹¹² On January 16, 2016, BANEGAS' family was permitted to visit him, and on January 17, 2016, he was visited by both his family and a priest who baptized him.¹¹³
- On January 20, 2016, at 8:33 a.m., BANEGAS experienced ventricular fibrillation¹¹⁴ during a dialysis session, a code was called, and he was revived. At 4:10 p.m., he coded again and was revived.¹¹⁵
- On January 21, 2016, BANEGAS was reported to be stable, but his condition was unchanged.¹¹⁶

January 22, 2016, Day of Death

On January 22, 2016, the RRMC physician met with BANEGAS' family to discuss whether to continue with care or to place the detainee on do not resuscitate (DNR) status.¹¹⁷ Following the discussion, BANEGAS' mother signed a consent form authorizing both a DNR order and the withdrawal of life support.¹¹⁸ At 6:29 p.m., RRMC medical staff removed BANEGAS from the ventilator, and at 8:25 p.m. he was pronounced dead by Dr. [redacted] (first name unknown).¹¹⁹ ASF Office [redacted] who was assigned to BANEGAS at the hospital, documented that ASF Lt. [redacted] was immediately notified of the death, and he in turn notified Warden [redacted] of LDF who notified ICE.¹²⁰ Officer [redacted] and ASF Officer [redacted] who was also assigned to BANEGAS at the hospital, noted BANEGAS' family was given access to detainee's body until 10:14 p.m., and that at 10:56 p.m. the officers assisted medical staff with the movement his body to the morgue.¹²¹

On January 25, 2016, ICE ERO notified the Consulate of Honduras of BANEGAS' death.¹²²

¹¹⁰ A CT scan combines a series of X-ray images taken from different angles, and uses computer processing to create cross-sectional images of the bones, blood vessels and soft tissues inside the body.

¹¹¹ Cerebral ischemia is a condition in which there is insufficient blood flow to the brain which leads to poor oxygen supply and death of brain tissue.

¹¹² See Medical Progress Notes, various providers, January 16-19, 2016.

¹¹³ See ASF log book, January 16, 2016.

¹¹⁴ Ventricular fibrillation is a heart rhythm problem that occurs when the heart beats with rapid, erratic electrical impulses, which causes ventricles to quiver uselessly, instead of pumping blood.

¹¹⁵ See Medical Progress Notes by RN [redacted], January 2016.

¹¹⁶ See Medical Progress Note by RN [redacted], January 21, 2016.

¹¹⁷ See Medical Progress Note by AIISA [redacted], January 22, 2016.

¹¹⁸ See ASF log book, January 22, 2016.

¹¹⁹ See Exhibit 6: Medical Progress Note by AIISA [redacted], January 22, 2016, documenting the detainee's time of death, and that IHSC Headquarters was notified of the death.

¹²⁰ See Officer [redacted] Incident Statement, January 22, 2016.

¹²¹ See ASF log book, January 22, 2016.

¹²² See Notification to Consulate of Honduras, January 25, 2016.

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An autopsy was not performed on BANEGAS. A Certificate of Death was issued for BANEGAS on May 19, 2016, which does not list a cause of death, as that is not the practice of the State of Louisiana.¹²³

Post-Death

All LDF security staff interviewed by ODO stated no formal debriefing was held following BANEGAS' medical emergency at the facility, or upon his death. Similarly, medical staff interviewed stated they were not provided information regarding the availability of an employee assistance program (EAP) following the medical emergency or death. ODO notes that during the onsite review, AHSA [redacted] sent all IHSC medical staff information regarding the ICE EAP.

AHSA [redacted] reported that following the medical emergency, procedures have been implemented by IHSC since BANEGAS' death to improve coordination among medical staff responding to emergencies.¹²⁴ Specifically, daily nursing assignments were enhanced to identify specific staff for the emergency response team, including designation of the team leader, and of the staff responsible for the AED, chest compressions, rescue breathing, and recording events.

Following BANEGAS' medical emergency, GEO did not prepare a written after-action report analyzing the events based on incident reports and available video documentation. During his interview with ODO, Major [redacted] stated that he collected incident statements from involved staff following BANEGAS' emergency on the recreation yard;¹²⁵ however, during the course of the review, ODO learned that not all staff with pertinent knowledge were asked to complete statements. Major [redacted] stated that all incident materials (i.e. incident statements and relevant video documentation) were provided to the Warden, but no written analysis of the security response to identify policy violations or issues was prepared.

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 BANEGAS was provided by IHSC, InGenesis and STG, as well as his safety and security while detained at the facility. Creative Corrections found deficiencies in LDF's compliance with the following standards in the ICE PBNDS 2011: Custody Classification System, Post Orders, and Emergency Plans.¹²⁶

CONCLUSIONS

¹²³ See Exhibit 7: Certificate of Death.

¹²⁴ ODO interview with AHSA [redacted] February 23, 2016.

¹²⁵ ODO interview with Major [redacted] February 25, 2016.

¹²⁶ See Exhibit 8: Creative Correction Security and Medical Compliance Review.

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Medical Findings

ODO did not find any deficiencies in LDF's compliance with the ICE PBNDS 2011, Medical Care standard.

Safety and Security Findings

ODO found LDF failed to comply with the following ICE PBNDS 2011.

1. ICE PBNDS 2011, Custody Classification System, Section (V)(A)(4), states "Each detainee's classification shall be reviewed and approved by a first-line supervisor or classification supervisor."
 - A supervisor did not approve the classification rating completed for BANEGAS on December 1, 2015.
2. ICE PBNDS 2011, Post Orders, section (V)(A)(1), states "The facility administrator shall ensure that there are written post orders for each security post."
 - At the time of ODO's onsite review, no written post orders existed for the medical front desk post.
3. ICE PBNDS 2011, Emergency Plans, section (V)(D)(18)(f), states "The post-emergency part of the plan shall include the following action items: collecting written reports."
 - Written reports related to BANEGAS' medical emergency on the recreation yard were not collected from all involved staff. An incident statement was not completed by Officer [redacted] Office [redacted] or Officer [redacted] ODO notes this finding also violates LDF Policy Number Eighteen, "Medical Emergency Response, section (A)(15), which states, "Injury reports, witness statements, and information reports will be completed as soon as possible."

AREAS OF NOTE

1. ICE PBNDS 2011, Facility Security and Control, section (II)(4), Expected Outcomes, states "Information about routine procedures, emergency situations, and unusual incidents will be continuously recorded in permanent logs and shift reports."

The recreation officer, Officer [redacted] did not complete any log entries for January 5, 2016; the perimeter patrol officer, Officer [redacted] who called code black to the recreation yard on January 5, 2016, did not enter that information into his log; and, the medical log book entries for January 5, 2016, concerning BANEGAS's medical situation were not clear and were not entered into the log by Officer [redacted] who was officer onsite at the time of each incidence. ODO notes Office [redacted] failure to log his code black call also violates LDF Mobile Patrol Post Orders, which state, "Officers must

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be constantly alert, articulate in the logging of events...” and “...will complete a daily report to include: Activities.”

2. Office [] left his assigned post on the recreation yard on January 5, 2016, without being properly relieved. Although Officer [] stated during his interview that only one officer is required to be present when there are fewer than 100 detainees on the recreation yard, supervisory staff stated no such threshold exists.
3. LDF Policy Number Eighteen, Medical Emergency Response, section (A)(2), requires that in the event of a medical emergency, a code blue is called via radio. ODO noted there was not a consensus among staff that a code blue was ever called on January 5, 2016, even after it was determined the incident was a medical emergency and not a fight. While staff interviewed by ODO recalled hearing “medical assistance” called via radio, they did not consistently report that a code blue was called. Further, the Central Control log book does not document a code blue was called.
4. LDF Policy Number Eighteen, Medical Emergency Response, section (A)(11), states “Security staff will secure the area to keep onlookers from crowding around, and hampering rescue efforts.” Staff interviews and video surveillance footage demonstrated that detainees in the recreation yard on January 5, 2016, were not effectively cleared from the scene prior to medical staff’s arrival. As discussed in the narrative summary, nursing staff stated they felt unsafe and, as a result, decided to transport BANEGAS to the clinic for treatment instead of assessing him on the yard. ODO notes the decision to transport the detainee to the clinic did not cause his death; however, security staff should ensure the area is secure to avoid delay of medical treatment.
5. As noted in the narrative, documentation of events following the arrival of LPAS personnel to the facility are discrepant. Resolution of the discrepancies was not within the scope of ODO’s review; however, it is noted that at the time of ODO’s visit to LDF, no action had been taken to address discrepancies between the LPAS responders’ reports and those of LDF medical staff, or to ensure the apparent rift between the LPAS responders and LDF does not cause problematic emergency responses in the future.
6. Although NI [] assumed the lead on treating BANEGAS once he was brought to the urgent care room on January 5, 2016, the roles and responsibilities of the other medical staff present were unclear, resulting in a degree of confusion. Of note, a recorder was not designated to document the time and type of care administered to BANEGAS, resulting in inconsistent documentation. As noted in the narrative, all staff stated the confusion did not impede delivery of care, and no delay in care was identified by ODO.
7. ODO was informed by medical staff that LDF has one AED to service the entire facility. ODO notes a single AED is insufficient to ensure availability in the event of multiple emergencies occurring at the same time.

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8. ODO notes that although handheld video cameras were available at the scene of the emergency on January 5, 2016, they were not used to record the security response.

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EXHIBITS

1. ICE Custody Classification Worksheet, December 1, 2015.
2. Medical Intake Screening, December 1, 2015
3. Initial Physical Examination, December 11, 2015.
4. Medical Progress Note by RN [redacted] January 5, 2016.
5. Medical Progress Note by NP [redacted] January 5, 2016.
6. Medical Progress Note by AHSA [redacted] January 22, 2016.
7. Certificate of Death
8. Creative Correction Security and Medical Compliance Analysis