

DETAINEE DEATH REVIEW – Raquel CALDERON De-Hildago JICMS #201701893

SYNOPSIS

On November 27, 2016, Raquel CALDERON De-Hildago (CALDERON), a thirty-six year old citizen and national of Guatemala, died while in the custody of U.S. Immigration and Customs Enforcement (ICE) at the Banner Casa Grande Medical Center (BCGMC) in Casa Grande, Arizona (AZ). The State of Arizona Certificate of Death, issued December 1, 2016, documented the cause of CALDERON's death as pulmonary embolism¹ due to deep vein thromboses,² and her manner of death as accidental.

CALDERON was detained at Eloy Detention Center (EDC),³ Eloy, AZ from November 23, 2016, until her death. EDC is owned and operated by Core Civic under a Dedicated Intergovernmental Service Agreement (DIGSA), which requires the facility to comply with the ICE Performance Based National Detention Standards (PBNDS) 2011. At the time of CALDERON's death, EDC housed 934 male and 526 female detainees of all classification levels for periods in excess of 72 hours. Medical care at EDC is provided by ICE Health Service Corps (IHSC) and supported by InGenesis Medical Staffing (InGenesis).

DETAILS OF REVIEW

From January 31 to February 2, 2017, ICE Office of Professional Responsibility, External Reviews and Analysis Unit (ERAU) staff visited EDC to review the circumstances surrounding CALDERON's death. ERAU was assisted in its review by contract subject matter experts (SME) in correctional healthcare and security. ERAU's contract SMEs are employed by Creative Corrections, a national management and consulting firm.⁴ As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to CALDERON, in addition to conducting in-person interviews of individuals employed by EDC, IHSC, InGenesis, and local Enforcement and Removal Operations (ERO) staff.

During the review, the ERAU 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. ERAU determined the following timeline of events, from the time of CALDERON's apprehension by ICE, through her detention at EDC, and eventual death at BCGMC.

¹ Pulmonary embolism is a condition caused by blood clots.

² Deep vein thrombosis is a condition that occurs when a blood clot forms in one or more of the deep veins of the body, usually in the legs.

³ EDC is also referred to as Eloy Federal Contract Facility (EFCF). For the purposes of this report, ERAU will refer to the facility as EDC.

⁴ See Exhibit I: Creative Corrections Medical and Security Compliance Review.

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IMMIGRATION AND DETENTION HISTORY

On November 8, 2016, CALDERON unlawfully entered the United States near Sasabe, AZ.⁵

On November 17, 2016, an United States Border Patrol (USBP) agent encountered and arrested CALDERON near Robles Junction, AZ.⁶ On November 18, 2016, USBP processed CALDERON for expedited removal pursuant to Section 235(b)(A)(iii) of the Immigration and Nationality Act, for entering the United States without admission or parole.

CRIMINAL HISTORY

CALDERON had no known criminal history.

NARRATIVE SUMMARY OF EVENTS

On November 20, 2016, USBP sent her to the Banner University Medical Center (BUMC) in Tucson, Arizona for her complaints of right ankle pain and swelling, right leg pain, and a headache. An emergency room physician diagnosed her with an ankle sprain, soft tissue injury of the right knee and ankle, and a headache due to trauma. While in the hospital, CALDERON received ibuprofen⁷ for pain and acetaminophen⁸ for her headache.⁹ Upon her discharge to the USBP later that day, the physician advised CALDERON to rest, apply compression to her ankle using an elastic compression wrap, and keep her ankle elevated as much as possible for two weeks. The physician also gave CALDERON a prescription for ibuprofen, and instructed her to follow-up with a primary care provider.¹⁰

On November 23, 2016, USBP transferred CALDERON to ICE custody and she was booked into EDC at approximately 11:00 a.m. The intake officer appropriately classified CALDERON as medium-low based on her ICE Risk Classification Assessment completed by ERO.¹¹ CALDERON's property inventory form documents the detainee arrived at EDC with personal items including clothing, a key chain, religious items, a cell phone, jewelry, and "four foreign bills." Both CALDERON and an officer signed a receipt for her non-valuable items. However, CALDERON did not sign the receipt for her valuable items; the receipt was only signed by two officers.¹²

At 1:52 p.m., IHSC Registered Nurse (RN) Lieutenant [REDACTED] conducted both a medical pre-screening¹³ and a medical and mental health intake screening¹⁴ on CALDERON.¹⁵

⁵ See Form I-213, Record of Deportable/Inadmissible Alien, dated November 18, 2016.

⁶ See Id.

⁷ Ibuprofen is a nonsteroidal anti-inflammatory drug used to treat pain, fever, and inflammation.

⁸ Acetaminophen is a pain reliever and fever reducer.

⁹ See BUMC Medical Records, dated November 28, 2016.

¹⁰ CALDERON's intake records from EDC contain no documentation showing she arrived at the facility with either ibuprofen or a compression wrap.

¹¹ See Initial Custody Classification Worksheet, dated November 23, 2016.

¹² See Exhibit 2: Disposition of Non-Allowable Property, dated November 23, 2016.

¹³ See Exhibit 3: Medical Pre-Screening Form by RN [REDACTED] dated November 23, 2016.

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Because CALDERON spoke no English, InGenesis Licensed Practical Nurse (LPN) [REDACTED] provided Spanish interpretation assistance during both screenings.¹⁶

- **Pre-screening:** During her pre-screening, CALDERON reported general pain and RN [REDACTED] designated the detainee as “priority one (PRI-1),” indicating the detainee be seen by a provider prior to departing the intake area for housing.¹⁷ RN [REDACTED] stated she made the priority determination based on her review of CALDERON’s emergency room paperwork from BUMC which CALDERON provided to her.
- **Medical and mental health intake screening:** Following the pre-screening, RN [REDACTED] conducted CALDERON’s medical and mental health intake screening and noted the following:¹⁸
 - CALDERON’s vital signs were all within normal limits.¹⁹
 - RN [REDACTED] gave CALDERON a pregnancy test, which was negative, and also screened the detainee for tuberculosis via chest x-ray, which was also negative.
 - CALDERON complained of a headache and pain in her right ankle which she rated at level seven out of ten.²⁰ CALDERON reported she twisted her ankle while walking through the desert and that the pain worsened when she walked on it. RN [REDACTED] noted CALDERON had mild swelling in her right ankle and walked slowly. ERAU notes RN [REDACTED] did not issue a special needs form requiring assignment to a low tier, bottom bunk, and/or crutches, a wheelchair, or walker. RN [REDACTED] stated she did not feel ambulatory assistance was needed prior to a provider evaluation, which she assumed would occur the same day.²¹
 - CALDERON reported childhood-onset asthma.²²
 - RN [REDACTED] gave CALDERON ten ibuprofen tablets and instructed the detainee to take one tablet every six hours for two days, as needed.

¹⁴ See Exhibit 4: Medical Intake Assessment by RN [REDACTED] dated November 23, 2016.

¹⁵ ERAU notes the pre-screening and intake screening documentation in the electronic medical record (EMR) are date stamped November 24, 2016. EDC staff indicated that due to the high volume of detainees on November 23, 2016, paper forms were used to document pre-screenings and intake screenings at the time they were done, and the EMR was updated with the information the following morning. Additional documentation in CALDERON’s medical record (i.e. chest X-ray, pregnancy test, varicella test, and consent forms) supports the assertion that the screenings were conducted within the 12-hour timeframe required by the PBNDS 2011.

¹⁶ ERAU interview with NP [REDACTED] January 31, 2017.

¹⁷ See Exhibit 3. PRI-1 is a designation for the priority/triage system that EDC uses to designate those detainees who need a provider evaluation for urgent medical needs prior to leaving intake.

¹⁸ See Medical Progress Note by RN [REDACTED] dated November 23, 2016.

¹⁹ Normal temperature is 98.6; normal range for pulse is 60 to 100 beats per minute; normal range for respirations is 12 to 20 breaths per minute; and, normal blood pressure is 120/80, with 90/60 to 139/89 considered within normal range.

²⁰ A numerical rating pain scale measures a patient’s pain intensity, typically 1-10 from least to most painful.

²¹ ERAU interview with RN [REDACTED] January 31, 2017.

²² Asthma is a respiratory condition marked by spasms in the bronchial airways of the lungs, causing difficulty in breathing.

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- RN [] designated CALDERON as “Physical Examination – Complex” which designated the detainee as requiring a physical examination by a provider within 24 hours.

At 2:50 p.m., upon completion of CALDERON’s intake screening, RN [] documented a telephone encounter with Nurse Practitioner (NP []) the provider on duty, in which she informed the NP of CALDERON’s ankle sprain, soft tissue knee injury, and headache due to trauma, and noted she gave the detainee ibuprofen.

At 3:13 p.m., RN [] documented a second telephone encounter with NP [] in which she notified the NP of CALDERON’s history of asthma, which she neglected to address in the prior telephone encounter, and also that the detainee’s vital signs, including respirations, were normal during her intake screening. ERAU notes RN [] did not inform NP [] that CALDERON rated her pain at a level seven in either telephone encounter.

Although not documented, NP [] stated after receiving both of RN [] telephone encounters, she went to the intake area and called CALDERON’s name. When she received no response from CALDERON, she moved on to the next detainee.²³ NP [] stated that based on the information in the telephone encounter, she was not overly concerned CALDERON’s ankle sprain needed immediate attention, and because the detainee experienced asthma symptoms during childhood with no current symptoms, she determined the detainee did not need immediate provider assessment.²⁴ After deeming CALDERON’s physical examination as non-urgent, and because the following day was the Thanksgiving holiday, NP [] scheduled CALDERON for a provider appointment on Friday, November 25, 2016, with NP []

EDC learned that CALDERON and nine other detainees with whom she arrived were potentially exposed to the varicella virus²⁵ prior to their transfer to the facility. All ten detainees were tested for varicella during their respective intake screenings, placed in a cohort together, and assigned to the Echo 600 Unit, pending medical clearance for housing in general population.²⁶

Accordingly, at 3:48 p.m., CALDERON was moved to Echo 600 where she was assigned to a lower bunk.²⁷ The Echo 600 housing unit officer, Officer [] stated CALDERON limped when she arrived at the housing unit that afternoon and told Office [] she injured her ankle crossing the border.

In a telephone encounter timed at 7:24 p.m., NP [] acknowledged RN [] notation that CALDERON reported an ankle sprain and asthma as a child during intake, and ordered the detainee 800 mg of ibuprofen, to take three times daily for 14 days as a Keep-On-

²³ ERAU was unable to confirm whether NP [] attempted to see Calderon as reported, or whether Calderon failed to respond to [] when called.

²⁴ ERAU interview with NP [], January 31, 2017.

²⁵ The varicella virus (also called chickenpox) is a highly contagious viral infection causing an itchy, blister-like rash on the skin.

²⁶ ERAU interview with Health Services Administrator (HSA []) January 31, 2017.

²⁷ See Housing History Record, November 23, 2016.

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Person (KOP) medication, and 500 mg of acetaminophen, to take three times daily for 14 days, also as KOP.²⁸ Because EDC's pharmacy was closed at the time NP [] entered the order, the order was not processed.²⁹ According to HSA [], nursing staff have access to these medications from the overnight stock cabinet but did not retrieve them for CALDERON.

On Thursday, November 24, 2016 at 1:13 p.m., RN [] who is fluent in Spanish,³⁰ conducted a nursing round in Echo 600.³¹ RN [] documented CALDERON's vital signs were all within normal limits and noted the detainee complained of ankle pain, which she rated at a level nine and described as severe, aching, constant and aggravated by physical activity. Although the pharmacy remained closed at the time of RN [] evaluation, RN [] obtained a one day supply of both 800 mg of ibuprofen and 500 mg of acetaminophen from the overnight stock cabinet,³² pursuant to NP [] November 23, 2016 order, and provided the medications to CALDERON.³³ RN [] also instructed CALDERON to apply cold compresses to her ankle for the first 24 hours, 20 to 30 minutes at a time, and then apply heat for 24 hours, 20 to 30 minutes at a time, four times a day, in accordance with RN Guidelines for sprains, strains, and contusions.³⁴

The morning of Friday, November 25, 2016, CALDERON was scheduled to receive a physical examination with NP [] however, due to a heavy patient load, NP [] could not leave the medical unit to conduct Calderon's examination in Echo 600, where she was still quarantined. HSA [] explained that moving CALDERON to the clinic for her physical examination would have necessitated clearing the clinic in order to avoid potentially exposing other detainees to varicella. Due to clinic's the heavy patient load that day, doing so was logistically difficult.³⁵

Later that morning, EDC received CALDERON's varicella test results which showed she was not infectious,³⁶ and medical staff accordingly cleared her for housing in general population. Medical staff did not, however, reschedule CALDERON's physical examination prior to her death.³⁷ Security assigned CALDERON to an upper bunk in the Bravo 300 Unit,³⁸ and at approximately 10:27 a.m.,³⁹ an officer escorted her to Bravo 300, for placement in the general population.⁴⁰ EDC's pharmacy also reopened the morning of November 25, 2016, processed Calderon's prescription orders, and a pharmacy technician unsuccessfully attempted to deliver

²⁸ See Telephone Encounter by NP [] November 23, 2016.

²⁹ ERAU interview with HSA [] January 31, 2017.

³⁰ ERAU interview with RN [] January 31, 2017.

³¹ See Medical Progress Note by RN [] dated November 24, 2016.

³² EDC's pharmacy is closed on Saturday, Sunday, and holidays, including Thanksgiving.

³³ See Medical Progress Note by RN [] dated November 24, 2016.

³⁴ See Medical Progress Note by RN [] dated November 24, 2016.

³⁵ ERAU interview with NP [] January 31, 2017.

³⁶ See EDC Varicella Laboratory Results Report, dated November 25, 2016.

³⁷ ERAU interview with HSA [] January 31, 2017.

³⁸ As noted, RN [] did not issue CALDERON a special needs form for either crutches or a bottom bunk during her intake screening.

³⁹ CCTV Footage, dated November 25, 2016.

⁴⁰ See EDC Bravo Unit Movement Log, dated November 25, 2016.

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the medication to CALDERON in Echo 600 not knowing she already relocated to Bravo 300. The pharmacy technician returned to the clinic and placed the medications in a pharmacy bin marked for later delivery but ended his shift early and closed the pharmacy without informing a nurse the medications needed to be delivered. As a result, CALDERON never received the medications.⁴¹

On Saturday, November 26, 2016, at approximately 9:30 a.m., Officer [redacted] the medical officer on duty, received a call from the Bravo Unit desk officer who stated CALDERON was on her way to the medical unit because she was in a lot of pain and needed to be seen. At approximately 9:38 a.m., CALDERON reported to the medical unit.⁴² Shortly after her arrival, RN [redacted] checked CALDERON's vital signs which were normal with the exception of a significantly elevated pulse of 120,⁴³ and an oxygen saturation of 96 percent, which was lower than previous readings. RN [redacted] documented the detainee reported her pain at a level nine, and that she walked slowly and with difficulty, using her hand to support herself against a wall. RN [redacted] examined CALDERON's injured right foot and ankle and observed non-pitting edema⁴⁴ and swelling on the outside of the right ankle. Because of CALDERON's abnormal vital signs and the intensity of her pain, RN [redacted] directed the detainee to wait in the clinic for a provider evaluation. ERAU notes RN [redacted] did not use an interpreter for this encounter, and her notes indicate she communicated with Calderon primarily through hand motions.⁴⁵

After the assessment, RN [redacted] notified NP [redacted] that CALDERON reported to the clinic on her own accord and needed to see a provider, that she did not receive her scheduled physical examination on November 25, 2016, and that she was recently hospitalized and diagnosed with an ankle sprain, soft tissue knee contusion, and headache pain.⁴⁶ According to RN [redacted] after she described CALDERON's symptoms to NP [redacted],⁴⁷ NP [redacted] stated would evaluate the detainee after seeing his higher priority patients.⁴⁸

At 11:30 a.m., approximately two hours after CALDERON entered the clinic, Officer [redacted] asked RN [redacted] if the detainee could go to the dining room for lunch. RN [redacted] stated that if CALDERON could walk, she could go; otherwise, security staff needed to bring a food tray to her. Officer [redacted] checked with CALDERON who said she was able to walk, and then

⁴¹ See Medical Progress Note by RN [redacted] dated November 24, 2016.

⁴² CCTV Footage, dated November 26, 2016.

⁴³ Creative Corrections notes that standard nursing practice is to assess possible causes of an abnormally rapid heart rate, with the priority of identifying symptoms that could suggest a heart condition, e.g. chest pain or shortness of breath. RN [redacted] stated she attributed CALDERON's elevated heart rate of 120 to pain and did not consider possible cardiac involvement including chest pain, shortness of breath, and dizziness.

⁴⁴ Non-pitting edema is swelling in which an indentation is not left in the skin after pressing finger into it.

⁴⁵ ERAU interview with RN [redacted] January 31, 2017.

⁴⁶ See Medical Progress Note by RN [redacted] dated November 26, 2016 [Late Entry on November 29, 2016].

⁴⁷ NP [redacted] stated during interview that he did not see CALDERON right away because RN [redacted] did not describe the detainee's distress as urgent and because he had four other patients with urgent conditions. NP [redacted] also remarked that staffing was short on this date because of a high rate of provider turnover.

⁴⁸ ERAU interview with RN [redacted] January 31, 2017.

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released her to the dining room with instructions to return to the clinic after lunch.⁴⁹ CALDERON left the clinic at 12:07 p.m. and returned at 12:32 p.m.⁵⁰ RN [] saw CALDERON upon her return to the clinic and directed the detainee to continue to wait for a provider.⁵¹ RN [] did not recheck CALDERON's vital signs upon her return.

At 2:00 p.m., shift change for security staff occurred and Officer [] was relieved by Officer [] CALDERON was still waiting to be seen by a provider at this time. Prior to shift change, Officer [] left two stacks of detainee identification (ID) cards for Officer [] ID cards for detainees authorized by medical staff to return to their housing units in the first stack, and ID cards for detainees waiting to be seen by the provider in the second stack.⁵³ At some point prior to or during shift change, CALDERON's ID card inadvertently ended up in the first stack, and at 2:24 p.m., Officer [] believing CALDERON was cleared by medical to return to her housing unit, sent the detainee back to Bravo 300.⁵⁴ Officer [] reported that at no time during her shift did a provider ask to have CALDERON returned to the clinic.⁵⁵

Officer [] who was the Bravo 300 officer on this date, reported that CALDERON was upset when she returned to the unit and stated that medical staff saw her but did not treat her and she was still in pain. Officer [] reported to Officer [] the Bravo desk officer,⁵⁶ that although CALDERON recently returned from the clinic, she was crying and still in pain, and Officer [] agreed to contact medical.⁵⁷ According to Officer [] due to a variety of distractions, he forgot to contact medical after his conversation with Officer []

On November 27, 2016, Officer [] who was assigned to Bravo 300 from 6:00 a.m. to 2:00 p.m., observed CALDERON's mattress on the floor of her cell during a routine security check. Officer [] later learned Officer [] gave CALDERON permission to place the mattress on the floor because of the detainee's leg discomfort.⁵⁹ At 9:19 a.m., CALDERON and other detainees exited Bravo 300 for their outdoor recreation period.⁶⁰ At 9:24 a.m., CALDERON fell to the ground just outside to the entrance gate to the recreation yard. Officer [] the assigned recreation officer, observed CALDERON fall forward, saw another detainee assist CALDERON to the ground, and noticed CALDERON appeared to be having a seizure. Officer [] immediately placed a medical emergency call

⁴⁹ ERAU interview with Officer [] February 1, 2017.

⁵⁰ CCTV Footage, dated November 26, 2016.

⁵¹ ERAU interview with Officer [] February 1, 2017.

⁵² See Medical Officer Post Logbook, dated November 27, 2016.

⁵³ ERAU interview with Officer [] February 1, 2017.

⁵⁴ ERAU interview with Officer [] February 1, 2017.

⁵⁵ ERAU interview with Officer [] February 1, 2017.

⁵⁶ The desk officer is the only officer in the unit with access to a phone, all other officers are issued radios.

⁵⁷ ERAU interview with Officer [] February 1, 2017.

⁵⁸ ERAU interview with Officer [] February 1, 2017.

⁵⁹ See Incident Statement by Officer [] dated November 28, 2016.

⁶⁰ CCTV Footage, dated November 27, 2016.

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on her radio.⁶¹ Officer [redacted] who was also assigned to the recreation yard, cleared other detainees away from CALDERON after Officer [redacted] placed the emergency call.⁶²

Control Office [redacted] immediately activated the Emergency Response Team (ERT)⁶³ when she heard Officer [redacted] call, and requested via radio that both security and medical staff respond. At approximately 9:25 a.m., Officer [redacted] a member of the ERT, heard the emergency call and was first to arrive on scene.⁶⁴ She was quickly followed by Officer [redacted] the ERT assigned Team Leader, who found CALDERON lying on her back, and observed that she urinated on herself and was foaming at the mouth.⁶⁵ Over the next approximately three minutes, four additional officers responded to CALDERON including one supervisor, Sergeant [redacted]

At approximately 9:28 a.m., NP [redacted] arrived on the scene,⁶⁶ followed by InGenesis RN [redacted] who brought a wheelchair, and InGenesis LPN [redacted] who brought an emergency bag.⁶⁷ RN [redacted] and LPN [redacted] rolled CALDERON to her side to avoid fluid aspiration,⁶⁸ and NP [redacted] took the detainee's vital signs which were within normal limits, with the exception of an elevated pulse of 130 and low oxygen saturation of 95 percent.⁶⁹ NP [redacted] stated he verbally directed officers to call 911 and then waited for CALDERON to stop seizing.⁷⁰ While waiting, NP [redacted] requested the detainee's medical history, and was informed CALDERON was admitted to EDC four days prior and that she reported an ankle sprain.⁷¹

At approximately 9:34 a.m., Central Control called 911.⁷² Sergeant [redacted] who went to Central Control after medical staff responded to CALDERON, was present when the 911 dispatch operator called back requesting additional information. Sergeant [redacted] informed the operator that CALDERON had a possible seizure.⁷³ At approximately 9:38 a.m., as CALDERON's seizure abated, RN [redacted] assisted the detainee into a sitting position and asked her to state her first name, which she did.⁷⁴ NP [redacted] then spoke to CALDERON in Spanish and asked whether she had any medical issues, including seizures.⁷⁵ CALDERON denied any history of

⁶¹ ERAU interview with Officer [redacted] February 1, 2017.

⁶² ERAU interview with Officer [redacted] February 2, 2017.

⁶³ The ERT consists of officers designated each day to respond to emergencies and perform specified duties related thereto.

⁶⁴ See Incident Statement by Officer [redacted] dated November 27, 2016.

⁶⁵ ERAU interview with Officer [redacted] February 1, 2017.

⁶⁶ CCTV Footage, dated November 27, 2016.

⁶⁷ *Id.*

⁶⁸ Fluid aspiration occurs when fluid, such as saliva or vomit, is breathed into the airway, potentially causing obstruction of breathing.

⁶⁹ See Medical Progress Note by NP [redacted] dated November 27, 2016.

⁷⁰ ERAU interview with NP [redacted] January 31, 2017.

⁷¹ ERAU interview with NP [redacted] January 31, 2017.

⁷² See West Central Control Log, dated November 27, 2016. ERAU notes the EMS record shows the ambulance was dispatched at 9:32 a.m.

⁷³ ERAU interview with Sergeant [redacted] February 2, 2017.

⁷⁴ See Medical Progress Note by RN [redacted] dated November 27, 2016.

⁷⁵ ERAU interview with NP [redacted] January 31, 2017.

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seizures or drug allergies but stated she had a history of asthma and chest pain. She also stated she had abdominal pain, her ankle hurt, and that she could not breathe.

At approximately 9:39 a.m., medical staff assisted CALDERON into the wheelchair and departed for the medical unit, accompanied by Officer [redacted].⁷⁶ While en route to the medical unit, CALDERON had a second seizure, and NP [redacted] directed the group to stop.⁷⁷ NP [redacted] assessed the detainee, waited for the seizure to stop, and then directed the group continue on to the medical unit.⁷⁸ Upon arrival to the medical unit, NP [redacted] started taking CALDERON's vital signs and quickly placed her on oxygen when he saw her oxygen saturation was severely low at 76 percent.

At approximately 9:45 a.m., an Eloy Fire District (EFD) ambulance arrived at EDC, and at approximately 9:50 a.m., before NP [redacted] finished taking CALDERON's vital signs, EFD Emergency Medical Services personnel entered the medical unit and assumed care of the detainee.⁷⁹ NP [redacted] noted CALDERON was conscious, alert to person, slightly anxious, and confused when EMS arrived.⁸⁰ Officers reported that CALDERON told EMS she was in pain, that EMS placed an oxygen mask on her, and that she was awake when EMS placed her on a gurney and loaded her into an ambulance.⁸¹

At 10:06 a.m., the ambulance departed for the BCGRMC, which is located approximately 16 miles from EDC.⁸² Officer [redacted] who accompanied CALDERON in the ambulance, stated that shortly after departing EDC, CALDERON started screaming that she had stomach pains and then appeared to lose consciousness.⁸³ As documented in the EMS report, after the ambulance departed EDC, CALDERON indicated she had pain in her lower back and winced and cried out. A few moments later, CALDERON's body tensed, and the detainee appeared to have another seizure. Before the EMS responders could administer seizure medication, CALDERON stopped moving and was unresponsive. The EMS responders determined CALDERON's heart rate and rate of respirations were both abnormally low, though her carotid pulse⁸⁴ was still detectable. They administered atropine⁸⁵ and continued monitoring the detainee's heart rate until they arrived at the hospital.⁸⁶

At approximately 10:20 a.m., the ambulance arrived at BCGRMC, and hospital staff immediately initiated CPR.⁸⁷ Officer [redacted] who followed the ambulance in a chase vehicle, arrived at the hospital shortly after EMS and remained there with Officer [redacted] Officers [redacted]

⁷⁶ CCTV Footage, dated November 27, 2016.

⁷⁷ See Medical Progress Note by NP [redacted] dated November 27, 2016.

⁷⁸ See Medical Progress Note by RN [redacted] dated November 27, 2016.

⁷⁹ See Eloy Fire District Report, dated November 27, 2016.

⁸⁰ See Medical Progress Note by NP [redacted] dated November 27, 2016.

⁸¹ ERAU interviews with Officer [redacted] February 2, 2017; and Officer [redacted] February 1, 2017.

⁸² See West Central Control Log, dated November 27, 2016.

⁸³ ERAU interview with Officer [redacted] February 2, 2017.

⁸⁴ A carotid pulse is a pulse taken over the carotid artery, on the right side of the neck..

⁸⁵ Atropine is a medication used to treat slowed heart rate.

⁸⁶ See Eloy Fire District Report, dated November 27, 2016.

⁸⁷ ERAU interview with Officer [redacted] February 2, 2017.

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and [] took turns logging events, specifically noting that over the course of the next approximately one hour, CALDERON cycled through having a heartbeat for a few moments to having no heartbeat.⁸⁸ The hospital record documents CALDERON was in cardio-respiratory arrest⁸⁹ and unresponsive when she arrived at the hospital, that CPR was initiated, and that CALDERON's pulse was reestablished three times before she expired.⁹⁰

At 11:17 a.m., CALDERON was pronounced dead by BCGRMC []⁹¹

At 12:08 a.m., Casa Grande Police Department Officer [] arrived at the hospital and took statements from Officers [] Office [] contacted the Pinal County Medical Examiner's office, and Medical Examiner [] arrived shortly thereafter.⁹² Office [] and Medical Examiner [] inspected CALDERON's body to rule out any external signs of trauma, and at 1:55 p.m., Medical Examiner [] took custody of the body. Officers [] then returned to EDC.⁹³

Following CALDERON's death, Core Civic procured a trauma counselor to meet with security staff involved in the emergency response, and IHSC brought an Employee Assistance Program counselor to the facility to meet with involved medical staff.

On November 28, 2016, ERO notified the Guatemalan Consulate of CALDERON's death, and consulate staff then notified her family. On December 13, 2016, ERO transferred CALDERON's property to the Guatemalan Consulate.⁹⁴

On November 29, 2016, [] MD, conducted CALDERON's autopsy.⁹⁵ He documented her cause of death was pulmonary embolism⁹⁶ of the right lung, related to deep vein thrombosis⁹⁷, and her manner of death was accidental. The State of Arizona Certificate of Death issued on December 21, 2016 lists the immediate cause of death as pulmonary embolism due to a consequence of deep vein thrombosis, and manner of death as accidental.⁹⁸

⁸⁸ ERAU interview with Officer [] February 2, 2017.

⁸⁹ Cardio-respiratory arrest is a sudden stop in effective blood flow due to the failure of the heart to contract effectively.

⁹⁰ See BCGRMC Emergency Room Report, dated November 27, 2016.

⁹¹ See Hospital Transport Log, dated November 27, 2016.

⁹² See Casa Grande Police Department Report 01-16-007758, dated November 27, 2016.

⁹³ See Hospital Transport Log, dated November 27, 2016.

⁹⁴ See DHS Form I-216J "Record of Person and Property Transferred," dated December 13, 2016.

⁹⁵ See Exhibit 5: Pinal County Autopsy Report.

⁹⁶ A condition in which one or more arteries in the lungs become blocked by a blood clot.

⁹⁷ A blood clot.

⁹⁸ See Exhibit 6: State of Arizona Certificate of Death by [] M.D., certified on December 1, 2016.

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MEDICAL CARE AND SECURITY REVIEW

ERAU reviewed the medical care CALDERON was provided by EDC, as well as the facility's efforts to ensure that she was safe and secure while detained at the facility. ERAU found EDC deficient in its compliance with the following requirements in the ICE PBNDS 2011:

- 1. ICE PBNDS 2011, Medical Care, Section (V)(A)(2) and (6), *General***, which states, "Every facility shall directly or contractually provide its detainee population with the following: 2) Medically necessary and appropriate medical, dental and mental health care and pharmaceutical services; and 6) Timely responses to medical complaints."
 - Although RN [] identified CALDERON as a patient requiring expedited provider attention due to her history of childhood asthma, a sprained ankle, and reported pain during her pre-screening and intake screening, the detainee's first and only contact with a provider was during her medical emergency, four days after her arrival. Though RN [] referred CALDERON for a same-day provider assessment during her intake screening on November 23, 2016, the provider on duty did not see her that day, and instead rescheduled her for a provider visit two days later, on November 25, 2016. That evaluation did not occur, reportedly because the detainee was quarantined due to potential exposure to the varicella virus, and the provider did not reschedule the appointment. The following day, despite CALDERON reporting to the clinic on her own volition because of her ankle pain, she remained in the waiting area of the clinic for more than four hours during which time she was assessed by an RN who directed she wait to be seen by a provider, did not conduct a heart assessment, and did not retake the detainee's vital signs during the time she waited. Before CALDERON was seen by a provider, she was sent back to her housing unit by an officer.
 - Ordered pain medication for her severe ankle pain was not provided after CALDERON was given a one day supply on November 25, 2016.
- 2. ICE PBNDS 2011, Medical Care, Section (V)(E), *Translation and Language Access for Detainees with Limited English Proficiency***, which states, "Facilities shall provide appropriate interpretation and language services for LEP detainees related to medical and mental health care. Where appropriate staff interpretation is not available, facilities will make use of professional interpretation services."
 - RN [] did not use interpretation assistance to assess CALDERON when she reported to the clinic on November 26, 2016 for severe ankle pain.
- 3. ICE PBNDS 2011, Medical Care, Section (V)(J), *Medical and Mental Screening of New Arrivals***, which states, "Where there is a clinically significant finding as a result of the initial screening, an immediate referral shall be initiated and the detainee shall receive a health assessment no later than two working days from the initial screening."

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- CALDERON was referred for a priority assessment by a provider as a result of her medical intake screening findings. However, a provider did not assess CALDERON at any point during the detention period.
4. **ICE PBNDS 2011, Medical Care, Section (V)(S)(4), *Delivery of Medication***, which states, “All prescribed medications and medically necessary treatments shall be provided to detainees on schedule and without interruption, absent exigent circumstances.”
- Keep-on-person pain medications, prescribed on November 23, 2016, were never given to the detainee.
5. **ICE PBNDS 2011, Medical Care, Section (V)(U), *Special Needs and Close Medical Supervision***, which states, “Consistent with the IHSC Detainee Covered Services Package, detainees will be provided medical prosthetic devices or other impairment aids, such as eyeglasses, hearing aids, or wheelchairs, except when such provisions would impact the security or safety of the facility.”
- Crutches, walker, or a wheelchair were never issued to CALDERON to assist with her comfort and safety while walking on her injured ankle.
6. **ICE PBNDS 2011, Security, Funds and Personal Property, section (V)(G)(1), *Officer Processing of Funds and Valuables***, which states, “For recordkeeping and accounting purposes, use of the G-589 Property Receipt form or its equivalent is mandatory to inventory any funds removed from a detainee’s possession, and a separate G-589 form or its equivalent is required for each kind of currency and negotiable instrument. Removal and inventory of detainee funds shall be conducted by at least two officers and in the presence of the detainee. Separate documentation should be made for each kind of currency and negotiable instrument, and should include detainee identification information and a description of the amount and type of currency or other negotiable instrument inventoried. Officers should then deposit the funds with a copy of the documentation in the drop safe or similarly secured depository.
- “...The G-589 shall include...4) For foreign currency, the currency amount followed by the type (e.g., 140 Japanese Yen, 300 Euros, 4,000 Mexican Pesos)...The two officers and the detainee shall sign all copies, after which the copies shall be distributed as follows:*
- a. white original/first copy to the detainee (property receipt);*
 - b. blue/second copy to detainee’s I-385 booking card or detention file (attachment), and*
 - c. pink/third copy to funds envelope (insert).”*
- The amount and type of CALDERON’s foreign currency was not documented on the EDC inventory form.
 - Detainee CALDERON did not sign the receipt for funds.

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AREA OF CONCERN

ERAU notes the following area of concern related to violation of facility policies and post orders:

- **EDC Policy 5-1, Incident Reporting, section 5-1(4)(2)(B)(i)**, which states, “All employees involved in or witnessing the incident are required to independently complete a 5-1C.” One LPN involved in the emergency wrote an incident report upon request but ultimately decided not to submit it and declined to provide his rationale for not submitting the report. .

ERAU notes the following area of concern related to EDC’s handling of CALDERON’s property following her death.

- The PBNDS 2011, Terminal Illness, Advance Directives and Death, Expected Outcomes, states “In the event of a detainee death, all property of the detainee shall be returned within two weeks...” ERO provided CALDERON’s property to the Guatemalan Consulate more than two weeks after her death.

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EXHIBITS:

1. Creative Corrections Medical and Security Compliance Analysis
2. Disposition of Non-Allowable Property
3. Medical Pre-Screening Form
4. Medical Intake Assessment
5. Pinal County Autopsy Report
6. State of Arizona Certificate of Death