

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

SYNOPSIS

On November 25, 2016, Wenceslau Esmerio CAMPOS (CAMPOS), who was a forty-nine year old citizen and national of Brazil, died while in the custody of U.S. Immigration and Customs Enforcement (ICE) at Methodist Hospital, San Antonio, Texas (TX). The Bexar County Medical Examiner's Office, in San Antonio, TX, documented CAMPOS' cause of death as complications of myocardial infarction with atherosclerotic cardiovascular disease.¹

CAMPOS was detained at the South Texas Detention Complex (STDC), in Pearsall, TX, from October 27, 2016 to November 25, 2016. STDC is a Contract Detention Facility (CDF), owned and operated by the GEO Group, Inc. (GEO), and is required to comply with the ICE Performance Based National Detention Standards (PBNDS) 2011. At the time of CAMPOS' death, STDC housed approximately 1,635 male and 114 female detainees of all classification levels for periods in excess of 72 hours. Medical care at STDC is provided by ICE Health Service Corps (IHSC) and supported by InGenesis, a contract company.

DETAILS OF REVIEW

From January 10 to 12, 2017, ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited STDC to review the circumstances surrounding CAMPOS' 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. As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to CAMPOS, in addition to conducting in-person interviews of individuals employed by STDC, InGenesis, and ICE Office of 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 CAMPOS' apprehension by U.S. Customs and Border Protection (CBP), through his detention at STDC, and eventual death at Methodist Hospital.

IMMIGRATION AND DETENTION HISTORY

On July 15, 2003, CAMPOS unlawfully entered the United States near Hidalgo, TX.²

On July 17, 2003, CAMPOS was encountered and apprehended by the U.S. Border Patrol (USBP), near Falfurrias, TX.³

¹ "Myocardial infarction" is the medical term referring to a heart attack, or death of the heart muscle. "Hypertensive atherosclerotic cardiovascular disease" refers generally to heart disease.

² See Form I-213, Record of Deportable/Inadmissible Alien, dated July 18, 2003.

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

On July 18, 2003, USBP served CAMPOS with a Notice to Appear, charging him with inadmissibility pursuant to Section 212(a)(6)(A)(i) of the Immigration and Nationality Act (INA), as an alien present in the United States without admission or parole.⁴

On July 19, 2003, CAMPOS was transferred to ICE custody at the Port Isabel Detention Center, Texas (PIDC).⁵ On August 27, 2003, CAMPOS was released from ICE custody at PIDC pursuant to an approved and accepted immigration bond.⁶ CAMPOS was scheduled for a March 17, 2004 master hearing before the Immigration Court.⁷ On March 17, 2004, CAMPOS failed to appear for his scheduled hearing, and the immigration judge ordered CAMPOS removed from the United States to Brazil.⁸

On May 25, 2008, CAMPOS was arrested by the Marlborough, Massachusetts (MA) Police Department for multiple motor vehicle offenses.⁹ On May 27, 2008, ICE lodged an immigration detainer on CAMPOS with the Marlborough Police Department.¹⁰ On August 13, 2008, CAMPOS entered ICE custody and was booked into the Plymouth County House of Corrections in Plymouth, Massachusetts.¹¹ On October 29, 2008, ICE removed CAMPOS to Brazil.¹²

On an unknown date, CAMPOS unlawfully reentered the United States.

On October 23, 2016, at approximately 9:30 a.m., USBP encountered and apprehended CAMPOS near Hidalgo, Texas.¹³ On October 26, 2016, CAMPOS' prior order of removal was reinstated pursuant to Section 241(a)(5) of the Immigration and Nationality Act, as a removable alien who illegally reentered the United States after a prior removal.¹⁴

On October 27, 2016, CAMPOS was transferred to ICE custody and booked into STDC.¹⁵

CRIMINAL HISTORY

On June 23, 2008, CAMPOS was convicted by the Marlborough District Court of operating a vehicle under the influence of liquor, operating a vehicle after a suspension or revocation of a driver's license, and providing a false address with intent to hinder police duty. CAMPOS was sentenced to 60 days, 10 days, and 30 days confinement, respectively.¹⁶

³ See *Id.*

⁴ See Form 862, Notice to Appear, dated July 18, 2003.

⁵ See ICE ENFORCE Alien Detention Module (EADM) Detention Details, book-in date July 19, 2003.

⁶ See Form I-352, Immigration Bond, dated August 27, 2003; See EADM Detention Details.

⁷ See Notice of Hearing in Removal Proceedings, dated February 13, 2004.

⁸ See Order of the Immigration Judge, dated March 18, 2004.

⁹ See Form I-213, Record of Deportable/Inadmissible Alien, dated May 27, 2008.

¹⁰ See Form I-247, Immigration Detainer – Notice of Action, dated May 27, 2008.

¹¹ See ICE EADM Detention Details, book-in date August 13, 2008.

¹² See ICE EADM Detention Details, book-out date October 29, 2008.

¹³ See Form I-213, Record of Deportable/Inadmissible Alien, dated October 26, 2016.

¹⁴ See Form I-871, Notice of Intent/Decision to Reinstate Prior Order, dated October 26, 2016.

¹⁵ See ICE EADM Detention Details, book in date October 27, 2016.

¹⁶ See NCIC and NLETS Query Service, generated May 24, 2017.

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

NARRATIVE

ERAU determined the following timeline of events, from the time CAMPOS was admitted to STDC on October 27, 2016, through his death at Methodist Hospital on November 25, 2016.

On October 27, 2016, at 6:00 p.m., CAMPOS was admitted to STDC.¹⁷ Officer [redacted] [redacted] inventoried and receipted CAMPOS' funds and personal property, which included the following: one pair of shoes, one pair of pants, one shirt, one jacket, two pairs of underwear, one belt, \$300.00 in U.S. currency, and 279 Brazilian reals.¹⁸ According to Office [redacted] arriving detainees place their personal clothing in a clear bin, and then shower and change into a facility uniform.¹⁹ Detainee clothing and other personal property items are inventoried in the presence of the detainee. Following inventory, items are placed in a numbered blue bin with a copy of the inventory sheet affixed to the outside.²⁰ A uniquely numbered, locking, and tamper-proof plastic tag is attached to the closed bin, but the bin is sealed only after property department officers launder the detainee's personal clothing items. Opening property bins after this process is complete requires cutting the tag. Once cut, the tag cannot be reused. CAMPOS' property was sealed in bin number 1382 with tag number 0495293.²¹

During intake, Office [redacted] interviewed CAMPOS in Spanish and completed his initial custody classification.²² Although CAMPOS' proficiency in Spanish was not documented and is unknown, ERAU notes his native language was later determined to be Portuguese. Officer [redacted] classified CAMPOS as low custody, but a supervisor did not review and approve this determination.

CAMPOS received a Prison Rape Elimination Act (PREA) Risk Assessment which found no risk of sexual victimization.²³ ERAU notes the assessment form also recorded CAMPOS' language as Spanish, rather than Portuguese.

At approximately 6:48 p.m., Licensed Vocational Nurse (LVN) [redacted] performed CAMPOS' medical pre-screening and documented the following:²⁴

- CAMPOS reported no pain.
- CAMPOS reported no current illness or health problems, and no prescribed medications.
- CAMPOS reported he did not want to hurt himself and did not fear harm from others.
- CAMPOS was normal in appearance and behavior, his state of consciousness was alert, and he had no noticeable restrictions or difficulties in movement.

¹⁷ See GEOTrack STDC Subject Profile Form, dated October 28, 2016.

¹⁸ See Exhibit 1: STDC Property Record, dated October 27, 2016; See Exhibit 2: STDC Funds Receipt, dated October 27, 2016.

¹⁹ ERAU interview with Detention Office [redacted] January 11, 2016.

²⁰ *Ibid.*

²¹ See STDC Subject Profile Form, dated October 28, 2016.

²² See Exhibit 3: STDC Custody Classification Worksheet, dated October 27, 2016.

²³ See STDC PREA Risk Assessment, dated October 27, 2016.

²⁴ See Exhibit 4: STDC eClinicalWorks Telephone Encounter (Intake prescreening), dated October 27, 2016.

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

- CAMPOS' breathing was normal, and no skin abnormalities were observed.

At approximately 6:50 p.m., CAMPOS signed the IHSC consent for medical treatment form, which was printed in English and Spanish.²⁵ At 10:20 p.m., Registered Nurse (RN) [REDACTED] [REDACTED] conducted a purified protein derivative (PPD) tuberculin skin test on CAMPOS and, in the absence of other associated symptoms, medically cleared him for housing.²⁶

On October 28, 2016, at 12:40 a.m., STDC custody staff and LVN [REDACTED] cleared CAMPOS for housing in general population.²⁷ At 2:06 a.m., LVN [REDACTED] performed CAMPOS' medical and mental health intake screening and documented the following:²⁸

- CAMPOS' primary language was Portuguese, and telephonic interpretation assistance was utilized.
- CAMPOS' vital signs were within normal limits.²⁹
- CAMPOS reported varicose vein surgery to both legs four months earlier, in June of 2016. He reported no related pain or discomfort.
- CAMPOS denied a history of thrombophlebitis.³⁰
- CAMPOS was wearing compression stockings on both legs.³¹ He stated the stockings were ordered by his doctor.
- CAMPOS reported no other medical problems and no medications.

According to LVN [REDACTED] CAMPOS wore his personal stockings under his facility uniform during the intake screening, and they appeared in good condition.³² LVN [REDACTED] completed a Special Needs form which notifies security personnel of medical authorization for CAMPOS to maintain possession of his stockings until evaluated by a provider. She stated she provided one copy of the form to CAMPOS and two copies to an intake officer, but she could not recall the officer's name.³³ A copy of the Special Needs form prepared by LVN [REDACTED] was not included in CAMPOS' detention file at the time of ERAU's review.

ERAU notes CAMPOS' compression stockings were not inventoried and recorded at intake, nor any time thereafter. During her interview with ERAU, Officer [REDACTED] stated that if the stockings were present in CAMPOS' bin along with his other clothing when she completed the

²⁵ See IHSC Form 793, Medical Consent Form, dated October 27, 2016.

²⁶ See STDC eClinicalWorks Telephone Encounter (PPD Placement), dated October 27, 2016.

²⁷ See STDC Intake Process Log, dated October 27, 2016.

²⁸ See Exhibit 5: STDC eClinicalWorks Telephone Encounter (Intake screening), dated October 28, 2016.

²⁹ 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.

³⁰ Thrombophlebitis is an inflammatory process that causes a blood clot to form and block one or more veins, usually in the legs. The affected vein might be near the surface of the skin (superficial) or deep within a muscle (deep vein thrombosis, or DVT).

³¹ A photograph of the stockings, taken after CAMPOS' death, shows they were one-piece and waist-high.

³² ERAU interview with LVN [REDACTED] January 10, 2017.

³³ See ICE Special Needs form, dated October 28, 2016.

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

inventory, they would be listed on the inventory form.³⁴ Based on available documentation and interviews with intake staff, ERAU determined CAMPOS maintained physical possession of his stockings throughout the shower and clothing change process, and unbeknownst to Officer [REDACTED] was wearing them when she inventoried his property.³⁵

At 2:49 a.m., CAMPOS was assigned to a lower bunk in Dorm A, where he remained through his detention at STDC.³⁶

At 12:19 p.m., Commander (CDR [REDACTED]) Nurse Practitioner (NP), conducted CAMPOS' initial health appraisal and physical examination and documented the following:³⁷

- Portuguese interpretation assistance was used to conduct the examination.
- CAMPOS' vital signs were within normal limits.
- CAMPOS stated his outside physician instructed him to wear his compression stockings for three months following his June 2016 surgery but reported that those stockings were placed with his personal property.
- Because CAMPOS was not wearing any stockings at the time of this exam, CDR [REDACTED] provided him with new facility-issued thrombo-embolic deterrent (TED) hose.³⁸
- A clinical follow-up was scheduled for three months, as needed.

At the conclusion of the initial health appraisal and physical examination, CDR [REDACTED] issued a (second) Special Needs form authorizing CAMPOS to receive TED hose or Jobst stockings, as well as a bottom bunk assignment.³⁹ According to CDR [REDACTED] he intended the order to cover either the facility-issued TED hose or CAMPOS' own personal compression stockings.⁴⁰ Classification Office [REDACTED] received the (second) Special Needs form and entered it into the facility's computer system.⁴¹

Based on available documentation from both LVN [REDACTED] and CDI [REDACTED] ERAU concludes CAMPOS' personal compression stockings were taken from him at some point between the two medical appointments and sealed with the rest of his personal belongings in his property bin. ERAU was unable resolve exactly when, why, or by whom the stockings were confiscated and

³⁴ *Ibid.*

³⁵ ERAU interview with Detention Office [REDACTED] January 11, 2016.

³⁶ See GEO movement log, accessed December 8, 2016.

³⁷ See Exhibit 6: STDC eClinicalWorks Telephone Encounter (Initial physical exam), dated October 28, 2016.

³⁸ TED hose are tight fitting two-piece thigh-high stockings (typically eight to 15 millimeters in strength) that place mild static pressure on the legs to prevent blood clots, which can wedge in an artery when a patient is bedridden. Compression stockings are typically 20 to 30 millimeters in strength and provide greater venous pressure for ambulatory patients who have venous return disorders, and received varicose vein surgery.

³⁹ See ICE Special Needs form, dated October 28, 2016. Jobst is a brand of TED and compression stockings. Also, CAMPOS was already assigned to a lower bunk; therefore, no changes to his housing or bunk assignment were made. See ICE Special Needs form, dated October 28, 2016.

⁴⁰ ERAU interview with CDI [REDACTED] January 12, 2017.

⁴¹ ERAU interview with Officer [REDACTED] January 12, 2017; See ICE Special Needs form, dated October 28, 2016.

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

placed with the detainee's property. [redacted] a GEO supervisor whom ERAU interviewed for clarification on the processing of Special Needs forms and the handling of detainee personal property, stated officers are trained that any item not considered standard issue is considered contraband and may be seized and placed with the individual's property, absent an authorization from either security or medical.⁴² [redacted] surmised that an officer who was unaware of LVN [redacted] Special Needs form and consequently confiscated CAMPOS' stockings at some point during the 12 hours between the intake screening and physical examination.

On October 29, 2016, at 10:55 p.m., the results of CAMPOS' PPD skin test were returned as positive.⁴³

On November 1, 2016, at 9:42 a.m., a chest x-ray was ordered for CAMPOS.⁴⁴ The results showed CAMPOS had no evidence of heart disease or tuberculosis.⁴⁵

On November 14, 2016, at 10:06 a.m., RN [redacted] evaluated CAMPOS' during sick call in response to the detainee's request for his personal stockings. RN [redacted] documented the following:⁴⁶

- Portuguese interpretation assistance was used.
- CAMPOS denied pain.
- CAMPOS' vital signs were within normal limits.
- CAMPOS reported that after receiving varicose vein surgery in his home country, he was provided with waist high compression stockings, but STDC provided him with only thigh-high stockings. He requested new waist high compression stockings or the stockings in his property.

At 10:10 a.m., RN [redacted] sent a telephone encounter to CDR [redacted] via the electronic medical record system, requesting authorization for CAMPOS to retrieve his own compression stockings from his personal property. At 10:41 a.m., CD [redacted] responded to the telephone encounter and authorized CAMPOS to receive his personal stockings after medical cleared them, provided medical did not have similar stockings available for issuance. The medical record contains no documentation of any follow-up to CDR [redacted] response.

According to Health Services Administrator (HSA [redacted]) at the time of CAMPOS' detention, providers erroneously assumed telephone encounters were two-way communications with nursing staff.⁴⁷ Telephone encounters are instead primarily used by nurses to alert providers of the need for patient follow-up, and nurses do not typically review telephone encounters for provider response.

⁴² ERAU interview with [redacted] January 11, 2017.

⁴³ See STDC eClinicalWorks Progress Note by RN [redacted] dated October 29, 2016.

⁴⁴ See Frio Regional Hospital Radiology Report, dated November 1, 2016.

⁴⁵ See Ibid.

⁴⁶ See STDC eClinicalWorks Telephone Encounter by RN [redacted] dated November 14, 2016.

⁴⁷ ERAU interview with HSA [redacted] January 11, 2017.

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

On November 16, 2016, CAMPOS submitted an urgent sick call request to either retrieve his personal stockings or receive a new pair of facility-issued stockings, and at 10:42 p.m., he was seen by RN [redacted]. According to RN [redacted] CAMPOS showed her that his facility-issued TED hose contained runs and holes and were bunched below the knees and requested to retrieve his stockings from his personal property.⁴⁹ RN [redacted] documented the following:⁵⁰

- Portuguese interpretation assistance was used.
- CAMPOS stated the TED hose issued to him by STDC were not sufficiently tight, resulting in lower extremity swelling and tingling in his left leg.
- CAMPOS displayed non-pitting edema⁵¹ on both lower legs.
- CAMPOS' feet had abnormal positive edema and thick discolored toenails.
- CAMPOS denied any pain.

RN [redacted] informed Supervisory Detention and Deportation Officer (SDDO) [redacted] who was in the clinic at the time, that CAMPOS' needed to retrieve his personal compression stockings from property, and SDDO [redacted] agreed to assist.⁵² RN [redacted] stated -- because she believed CAMPOS would receive his personal compression stockings -- she did not issue a new pair of TED hose to replace the damaged pair he wore.⁵³ RN [redacted] also stated she believed wearing his personal compression stockings would resolve CAMPOS' edema and therefore did not schedule a follow-up appointment with a provider.⁵⁴

SDDO [redacted] stated that after speaking with RN [redacted] he directed a Lieutenant (later identified as Lieutenant [redacted]) to escort CAMPOS to the property room to identify his stockings and then bring the stockings to the medical unit for inspection.⁵⁵ SDDO [redacted] further stated he expected Lieutenant [redacted] to handle this request personally and presumed the Lieutenant would bring the stockings to medical staff for inspection and issuance to CAMPOS.

According to Property Office [redacted] CAMPOS was escorted to the property area by an officer (identity unknown) other than Lieutenant [redacted].⁵⁶ Officer [redacted] stated CAMPOS arrived at the property area with a Special Needs form authorizing the stockings. Before Officer [redacted] broke the seal on the property bin, CAMPOS informed him that in addition to his stockings he also wanted a corresponding piece of cloth fabric.⁵⁷

⁴⁸ See Medical Traffic logbook, dated November 16, 2016; See STDC eClinicalWorks Telephone Encounter by RN [redacted] dated November 16, 2016.

⁴⁹ ERAU interview with RN [redacted] January 12, 2017.

⁵⁰ See STDC eClinicalWorks Telephone Encounter by RN [redacted], dated November 16, 2016.

⁵¹ Edema is a medical term for swelling.

⁵² ERAU interview with RN [redacted] January 12, 2017.

⁵³ *Ibid.*

⁵⁴ *Ibid.*

⁵⁵ ERAU interview with SDDO [redacted] January 11, 2017.

⁵⁶ ERAU interview with Officer [redacted] January 12, 2017.

⁵⁷ *Ibid.* ERAU notes the previously mentioned photograph of the stockings also show a cloth item which was not attached to the stockings, and appeared to be cut in an irregular, lightbulb shape, with stitching along the bottom and sides. The cloth fabric was imprinted with the name Venosan, a company which supplies clinical-quality

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

Officer [] stated because the cloth item was not included on the Special Needs form, he called Lieutenant [] for guidance.⁵⁸ Officer [] stated Lieutenant [] advised him if the item was not on the form, CAMPOS was not permitted to have it. The record contains no documentation Lieutenant [] conferred with medical regarding the additional piece of fabric before denying it. Officer [] stated when he conveyed this information to CAMPOS, the detainee responded that he did not want the stockings without the cloth. Officer [] stated because CAMPOS declined the stockings, the plastic tie sealing the property bin was never broken. ERAU notes Officer [] did not document CAMPOS' visit to the property room in the post logbook.

As documented in the Dorm A logbook, and confirmed by both RN [] and RN [] CAMPOS was escorted directly from the property area to Dorm A at approximately 11:20 p.m., and did not return to medical that night.⁵⁹

According to Lieutenant [] he personally escorted CAMPOS to the property area where he observed the property officer break the seal on CAMPOS' property bin and remove the detainee's stockings. Lieutenant [] stated when CAMPOS was informed he could only retrieve the one item noted on the Special Needs form, the detainee became angry and stated he did not want the stockings anymore. According to the Lieutenant [] the stockings were returned to the bin, and the bin was resealed. Lieutenant [] stated he then escorted CAMPOS back to medical where he left the detainee. ERAU notes Lieutenant [] account is discrepant with Officer [] and conflicts with the fact that the property bin had its original seal intact at the time of CAMPOS' death. His account also conflicts with documentation showing CAMPOS did not return to medical the night of November 16, 2016.

Because the original seal on CAMPOS' property remained intact until after his death, ERAU presumes the compression stockings were never evaluated by Lieutenant [] or any other personnel on this date. However, following CAMPOS' visit to property, medical was informed Lieutenant [] denied CAMPOS' request to use his personal compression stockings because they contained holes.⁶⁰ The record contains no evidence to support this assertion, and the photograph of CAMPOS' stockings even shows they had no holes or pockets. ERAU was unable to reconcile Lieutenant [] discrepant account or his inaccurate report to medical regarding the quality of the stockings.

On November 17, 2016, at 2:15 a.m., RN [] submitted a telephone encounter notifying CAMPOS' provider, Lieutenant CDR [] NP, that GEO denied approval for CAMPOS' personal compression stockings.⁶¹ NP [] responded on the telephone encounter

compression stockings. Because waist high, high-compression stockings can cause sweating, chafing, and itching, ERAU's medical SME believes CAMPOS may have used the cloth item as a protective lining against groin discomfort.

⁵⁸ *Ibid.*

⁵⁹ See Dorm A Logbook, November 16, 2016.

⁶⁰ ERAU interview with RN [] January 11, 2017.

⁶¹ See STDC eClinicalWorks Telephone Encounter by RN [] dated November 17, 2016.

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

with an order that CAMPOS continue to wear the facility-issued TED hose.⁶² As discussed above, providers erroneously believed telephone encounters were two-way communications allowing nurses to receive and transcribe any orders in their responses. NF [redacted] telephone encounter response was not received or reviewed by a nurse, and no action was taken to issue CAMPOS new TED hose. NF [redacted] stated he did not question GEO's decision to deny CAMPOS' personal stockings because safety is the top priority at STDC.

On November 23, 2016, during the early evening hours, Officers [redacted] and [redacted] [redacted] were posted to the Dorm A housing unit.⁶³ Officer [redacted] was responsible for control of the front of the dorm and maintaining the post logbook, while Officer [redacted] was responsible for control of the back of the dorm and control of the radio. At approximately 5:40 p.m., Officer [redacted] overheard a detainee inform Officer [redacted] that CAMPOS was ill, and Officer [redacted] respond that CAMPOS was fine. Officer [redacted] asked the detainee if she could assist, and the detainee stated CAMPOS was vomiting and having bad chest pains.⁶⁴ Officer [redacted] approached CAMPOS in his bunk, located towards the front of the dorm near the officer's station, and observed he was pale and sweating, and held his hands to his chest. Officer [redacted] immediately asked Officer [redacted] to call a medical emergency on his radio, telling him CAMPOS was having a heart attack, but Officer [redacted] refused, stating the detainee was fine because he could walk around. Officer [redacted] asked a second time, and Officer [redacted] again refused, so Officer [redacted] asked for the radio to call the emergency herself, but Officer [redacted] refused to give it to her.⁶⁵ Officer [redacted] completed two incident reports following CAMPOS' death, wherein he stated he did not call a medical emergency, or provide the radio to Officer [redacted] because he did not believe CAMPOS required emergency attention.⁶⁶

After Officer [redacted] refused to hand over the radio, Officer [redacted] used the telephone in the Dorm A officer's station to notify the Medical Officer [redacted] that CAMPOS was ill.⁶⁷ During the call, Officer [redacted] described to both Officer [redacted] and IHSC RN [redacted] that CAMPOS had chest pains and was vomiting. RN [redacted] stated she would call a medical emergency and then proceed to Dorm A.⁶⁸ ERAU notes no available documentation show RN [redacted] called a medical emergency.

⁶² *Ibid.*

⁶³ ERAU's account of the events on November 23, 2016 is based upon written and verbal reports of security and medical staff involved, as well as video surveillance footage from ten security cameras. Although the time stamps on the video footage vary from camera to camera, and ERAU was unable to determine which, if any, of the time stamps are accurate, the video footage was used to determine elapsed time between key events.

⁶⁴ ERAU interview with Officer [redacted] January 12, 2017.

⁶⁵ See Officer [redacted] Incident Report, dated November 23, 2016; ERAU interview with Officer [redacted] [redacted] January 12, 2017.

⁶⁶ See Officer [redacted] Incident Report, dated November 27, 2016, and Officer [redacted] Incident Report, no date. During his interview with ERAU, Officer [redacted] was unable to answer and respond to basic questions, including those about his general job duties and questions relating to the events on November 23, 2016. His answers were largely disjointed and incoherent.

⁶⁷ See Officer [redacted] Incident Report, dated November 23, 2016; ERAU interview with Officer [redacted] [redacted] January 12, 2017.

⁶⁸ ERAU interview with Officer [redacted] January 12, 2017.

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

At approximately 5:46 p.m., after speaking with RN [redacted] Officer [redacted] saw Officer [redacted] [redacted] a “medical rover,” walking past Dorm A, and asked him to enter and assist in taking CAMPOS to medical.⁶⁹ When Officer [redacted] entered the dorm, he observed a crowd of detainees surrounding CAMPOS at his bunk.⁷⁰ ERAU notes that at the same approximate time, video surveillance footage shows Officer [redacted] walk to the back of the dorm and change the channels on the dorm television.⁷¹ CAMPOS informed Officer [redacted] he was experiencing chest pains and weakness, and Officer [redacted] who immediately recognized the situation was a medical emergency, called Officer [redacted] for the status on medical’s response to Officer [redacted] initial call for assistance.⁷²

Officer [redacted] told Officer [redacted] that medical was on their way to Dorm A, but if CAMPOS required more urgent attention, Officer [redacted] should call a medical emergency.⁷³ At approximately 5:55 p.m., Officer [redacted] called a medical emergency via radio.⁷⁴ Officer [redacted] who simultaneously entered Dorm A to deliver paperwork, immediately secured the area by instructing detainees to return to their bunks.⁷⁵ Sergeant [redacted] the first supervisor at the scene, arrived approximately one and a half minutes after Officer [redacted] initially entered the dorm.⁷⁶ Sergeant [redacted] proceeded to CAMPOS’ bunk, where he found CAMPOS sitting up on his bed, sweating profusely, and complaining of chest pains and weakness.⁷⁷ Sergeant [redacted] used his radio to request a wheelchair and the assistance of additional officers and medical personnel. Captain [redacted] shift supervisor, and Officer [redacted] responded to Dorm A shortly after Sergeant [redacted].⁷⁸ They were followed by RN [redacted] NP [redacted] and Officer [redacted].⁷⁹ ERAU notes responder arrival times were not documented in the Dorm A logbook.⁸⁰

Upon his arrival, RN [redacted] found CAMPOS lying on his bunk, sweating, and short of breath.⁸¹ CAMPOS sat up and RN [redacted] assessed him, noting the detainee’s pupils were sluggish, but equal and reactive to light, and his pulse was weak, but he had no evidence of an abnormal heart

⁶⁹ Ibid.

⁷⁰ ERAU interview with Officer [redacted], January 11, 2017.

⁷¹ See Dorm A video surveillance footage, November 23, 2016; ERAU interview with Officer [redacted], January 10, 2017.

⁷² ERAU interview with Officer [redacted], January 11, 2017.

⁷³ ERAU interview with Officer [redacted], January 11, 2017.

⁷⁴ See Master Control Log, November 23, 2016; See Medical Post Log, November 23, 2016; See Officer [redacted] Incident Report, not dated.

⁷⁵ ERAU interview with Officer [redacted], January 10, 2017.

⁷⁶ ERAU interview with Sergeant [redacted], January 11, 2017.

⁷⁷ Ibid.

⁷⁸ ERAU interview with Captain [redacted], January 11, 2017; See Officer [redacted] Incident Report, not dated.

⁷⁹ See Dorm A video surveillance footage, November 23, 2016; See Officer [redacted] Incident Report, not dated.

⁸⁰ See Dorm A post log, November 23, 2016.

⁸¹ See STDC eClinicalWorks Telephone Encounter by RN [redacted] dated November 23, 2016; ERAU notes 5:55 p.m. is the time security personnel documented the medical emergency was called.

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

beat.⁸² RN [] also noted some difficulty communicating with CAMPOS because the detainee spoke Portuguese. When NP [] arrived, approximately 30 seconds after RN []⁸³ she ordered CAMPOS be brought to the medical unit by wheelchair.⁸⁴ NP [] noted CAMPOS walked to the wheelchair on his own and without problem. At approximately 5:59 p.m., CAMPOS departed the dorm and was escorted to the medical unit via wheelchair by Officer []

At approximately 6:01 p.m., CAMPOS arrived in the medical unit.⁸⁶ NP [] examined CAMPOS and documented the following:⁸⁷

- Portuguese language interpretation assistance was used.
- CAMPOS was alert, oriented, and cooperative.
- CAMPOS appeared pale, ill, and diaphoretic.⁸⁸
- CAMPOS complained of abrupt, constant, and dull left-side chest pain. He rated the pain as a level five on a scale of zero to ten.
- CAMPOS complained of numbness, tingling, nausea, and shortness of breath.
- CAMPOS' blood sugar and vital signs were within normal limits, with the exception of an abnormally elevated blood pressure of 152/106.⁸⁹
- An electrocardiogram (EKG) test was completed and demonstrated an elevated electrical ST wave.⁹⁰
- CAMPOS' heart rate and rhythm were regular, and his lungs were clear.

According to NP [] CAMPOS was not wearing his TED hose during the event but had no swelling in his lower extremities.⁹¹ NP [] determined CAMPOS was suffering from a heart attack and directed his transport to the hospital by air ambulance.⁹² NP [] gave CAMPOS four 81 milligram (mg) chewable aspirin tablets and one sublingual⁹³ tablet of nitroglycerin.⁹⁴

⁸² See STDC eClinicalWorks Telephone Encounter by RN [] dated November 23, 2016; Arrhythmia is a medical term referring to an abnormal heart beat.

⁸³ ERAU interview with RN [] January 10, 2017.

⁸⁴ ERAU interview with NP [] January 11, 2017.

⁸⁵ See Dorm A post log, November 23, 2016.

⁸⁶ See Medical Post Log, November 23, 2016.

⁸⁷ See STDC eClinicalWorks Telephone Encounter by NP [] dated November 23, 2016.

⁸⁸ Diaphoretic is a medical term for sweating.

⁸⁹ Normal blood pressure is 120/80, with readings from 90/60 to 139/89 considered within normal range.

⁹⁰ An ST Wave is a segment of the heart's electrical activity, as registered on the EKG, which represents the interval between depolarization and repolarization. An abnormality of the ST wave can indicate a heart attack.

⁹¹ ERAU interview with NP [] January 11, 2017.

⁹² See STDC eClinicalWorks Telephone Encounter by NP [] dated November 23, 2016; See STDC eClinicalWorks Transfer Summary by RN [] dated November 23, 2016. An air ambulance is a mode of air transportation used to move patients to and from healthcare facilities and accident scenes. Air-based emergency medical service (EMS) often provide a higher level of care and faster transport.

⁹³ Sublingual is a medical term meaning under the tongue.

⁹⁴ Nitroglycerin is medication used to treat and prevent chest pain.

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

After he took the nitroglycerin, she read his blood pressure again and documented it was normal.⁹⁵

At approximately 6:20 p.m., immediately following NP [redacted] order, RN [redacted] instructed Officer [redacted] to call 911 and request an ambulance. RN [redacted] did not specify an air ambulance to Office [redacted].⁹⁶ Office [redacted] called Master Control to relay the request, and Master Control called 911 to request an ambulance at approximately 6:22 p.m. At approximately 6:35 p.m., an American Medical Response (AMR) ambulance arrived at STDC.⁹⁷ The AMR responders performed another EKG on CAMPOS, which showed continued elevated electrical ST wave. CAMPOS then moved himself from the medical examination table onto the AMR stretcher, and officers placed leg irons, a waist chain, and handcuffs on him. The AMR responders then pushed CAMPOS on the stretcher to the vehicle sallyport where he was loaded into the ambulance. According to Office [redacted] who accompanied CAMPOS in the ambulance, CAMPOS began choking and vomiting before he was placed in the ambulance.⁹⁸

At approximately 6:56 p.m., the ambulance departed STDC for Frio Regional Hospital (FRH) in Pearsall, TX.⁹⁹ Officer [redacted] traveled with CAMPOS in the ambulance, as noted, while Officer [redacted] followed in a vehicle.¹⁰⁰ According to the AMR report, CAMPOS fell into cardiac arrest during transport to FRH.¹⁰¹ Cardiopulmonary resuscitation (CPR) was initiated and continued by the AMR responders.

At 6:57 p.m., the ambulance arrived at FRH, and hospital emergency room personnel took over CPR.¹⁰² Hospital staff placed an automated external defibrillator (AED) on CAMPOS and delivered three shocks before a pulse was detected.¹⁰³ FRH made arrangements to transfer CAMPOS to Methodist Hospital in San Antonio, Texas, via medical air transport, where the detainee would be placed under the care of a cardiologist.¹⁰⁴

Officer [redacted] remained at FRH until 7:36 p.m., when he was relieved by Officer [redacted].¹⁰⁵

At 7:43 p.m., STDC Warden [redacted] arrived at the hospital.¹⁰⁶ Warden [redacted] instructed Office [redacted] to drive to Methodist Hospital with Office [redacted] who would relieve

⁹⁵ ERAU interview with NP [redacted] January 11, 2017.

⁹⁶ See Medical Post Log, November 23, 2016.

⁹⁷ See Master Control Log, November 23, 2016; ERAU notes AMR's report recorded arrival at 6:34 p.m.

⁹⁸ See Officer [redacted] Incident Statement, dated November 23, 2016. See AMR South Texas Patient Care Report, dated November 23, 2016.

⁹⁹ See Master Control Log, November 23, 2016; ERAU notes AMR's report recorded departure at 6:55 p.m.

¹⁰⁰ ERAU interview with Officer [redacted] January 10, 2017. See Officer [redacted] Incident Report, dated November 23, 2016.

¹⁰¹ See AMR South Texas Patient Care Report, dated November 23, 2016.

¹⁰² See *Ibid*; see Officer [redacted] Incident Statement, dated November 23, 2016

¹⁰³ See *Ibid*.

¹⁰⁴ See AMR South Texas Patient Care Report, dated November 23, 2016.

¹⁰⁵ See Hospital Post Log, dated November 23, 2016.

¹⁰⁶ See *Ibid*.

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

Officer [] and wait for CAMPOS to arrive via helicopter.¹⁰⁷ Officer [] relieved Officer [] at 8:25 p.m.,¹⁰⁸ and at 8:33 p.m., Officers [] departed FRH for Methodist Hospital. They arrived at 9:41 p.m.¹⁰⁹

At 9:49 p.m., CAMPOS departed FRH via air ambulance and arrived at Methodist Hospital at 10:10 p.m.¹¹⁰

Upon his arrival, CAMPOS was immediately taken to the cardiology lab for an emergency cardiac catheterization procedure, which showed evidence of blockage of the coronary artery leading to the heart.¹¹¹ According to Officer [] following the procedure, the doctor showed her several blood clots he removed from CAMPOS.¹¹² At approximately 11:20 p.m., CAMPOS was moved to the Cardiovascular Intensive Care Unit (ICU) in critical condition.¹¹³

On November 24, 2016, ERO facilitate [] visit with CAMPOS, his father, at Methodist Hospital.¹¹⁴ [] and CAMPOS were detained together at STDC. With the assistance of a video language interpreter, a hospital nurse communicated to [] that his father suffered a massive heart attack and was very weak.

STDC medical staff recorded the following four hospital updates on November 24, 2016:¹¹⁵

- At 4:29 a.m., CAMPOS was in critical condition in intensive care. His blood pressure was abnormally low at 81/76. He was intubated,¹¹⁶ set up with intravenous therapy, and placed on artificial ventilation. He was taken to the cardiac catheter lab where medical personnel evacuated blood clots and placed a stent.
- At 8:27 a.m., Methodist Hospital staff called STDC for consent to give blood products due to CAMPOS' abnormally low blood pressure, and HSA [] provided the requisite consent.

¹⁰⁷ See Officer [] Incident Report, dated November 28, 2016; See Officer [] Incident Report, not dated.

¹⁰⁸ See Hospital Post Log, dated November 23, 2016

¹⁰⁹ See *Ibid.*

¹¹⁰ See REACH Air Prehospital Care Report, dated November 23, 2016.

¹¹¹ A cardiac catheterization is a procedure in which a long thin tube (catheter) is inserted into an artery or vein in the groin, neck or arm and threaded through the blood vessels to the heart. The procedure is used to diagnose and treat cardiovascular conditions. In CAMPOS' case, the procedure showed proximal left anterior descending artery occlusion, or a total or critical blockage of the main artery down the front of the heart, at the beginning of the vessel, causing the whole artery to fail. Blood clots are often the cause of a blockage. This condition is commonly referred to as the widow maker. See Methodist Hospital consultation note, dated November 24, 2016.

¹¹² Blood clots can cause blockage to the coronary artery leading to the heart, limiting blood flow to the heart. When blood cannot reach the heart, the heart muscle does not get the oxygen it requires, causing damage to the cells. ERAU interview with Officer [] January 10, 2017.

¹¹³ See Hospital Post Log, dated November 23, 2016.

¹¹⁴ See Memorandum to [] and AFOI [] from Major [] dated November 25, 2016.

¹¹⁵ See STDC eClinicalWorks Hospital Daily Update, dated November 24, 2016.

¹¹⁶ Intubation is a medical term referring to the insertion of a tube into the trachea for ventilation.

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

- At 1:51 p.m., Methodist Hospital staff called STDC for consent to begin dialysis due to CAMPOS' lack of urination and acid buildup. His blood pressure had slightly improved, but his condition remained critical. STDC faxed Methodist Hospital the medical consent form CAMPOS signed during intake.
- At 8:16 p.m., Methodist Hospital staff reported CAMPOS received dialysis earlier that day, but his status was grave, and he was not expected to survive the night. Per AFOD [redacted] Methodist Hospital was told to obtain consent from CAMPOS' son, [redacted] [redacted] for any future treatments. [redacted] phone number was provided to the hospital. HSA [redacted] confirmed Methodist Hospital informed CAMPOS' family of his condition.

November 25, 2016, Date of Death

The following events at Methodist Hospital were logged by Officer [redacted]¹¹⁷

- At 5:08 a.m., the hospital planned a blood transfusion for CAMPOS, due to a dropping hemoglobin¹¹⁸ level and high acidity in the blood.
- At 5:12 a.m., nurses examined CAMPOS and noted his abdomen and lower extremities were hard.
- At 5:44 a.m., [redacted] examined CAMPOS and cancelled the transfusion because fluid and blood was building up internally, causing organ problems.

At 7:00 a.m., Methodist Hospital informed STDC medical staff CAMPOS was in critical condition.¹¹⁹ The detainee's heart rate alternated between tachycardia¹²⁰ and rapidly declining bradycardia,¹²¹ and he was not responsive to any treatment.¹²²

At 8:05 a.m., Major [redacted] informed [redacted] officers assigned to the hospital, that detainee [redacted] was offered an opportunity to visit his father again but declined.¹²³

At 8:49 a.m., CAMPOS went into cardiopulmonary arrest, and hospital medical staff called a Code Blue.¹²⁴ Medical staff attempted to revive CAMPOS but were not successful, and CAMPOS was pronounced dead at 8:55 a.m. by [redacted]¹²⁵ Cardiologists [redacted]

¹¹⁷ See Hospital Post Log, dated November 25, 2016; ERAU interview with Officer [redacted], January 10, 2017.

¹¹⁸ Hemoglobin is a red protein responsible for transporting oxygen in the blood.

¹¹⁹ See STDC eClinicalWorks Hospital Daily Update, dated November 25, 2016.

¹²⁰ Tachycardia is an abnormally rapid heart rate.

¹²¹ Bradycardia is abnormally slow heart rate.

¹²² See STDC eClinicalWorks Hospital Daily Update, dated November 25, 2016.

¹²³ See Hospital Post Log, dated November 25, 2016.

¹²⁴ A code blue is a hospital code used to indicate a patient requiring immediate resuscitation. See Hospital Post Log, dated November 25, 2016; See Memorandum to Warden Castro and [redacted] from Major [redacted] dated November 25, 2016.

¹²⁵ See Methodist Hospital Clinical Note, date November 25, 2016.

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

[redacted] M.D., documented CAMPOS' cause of death as cardiac arrest and multiple organ failure.¹²⁶ At 9:45 a.m., ERO notified the Brazilian Consulate of CAMPOS' death.¹²⁷

At 10:40 a.m., CAMPOS' body was moved to the morgue,¹²⁸ and at 11:08 a.m., Major [redacted] instructed officers [redacted] to return to STDC. Following the pronouncement of death, STDC suspended CAMPOS' funds account and secured his property in Major [redacted] office.¹²⁹

Post-Death Events

On November 28, 2016, CAMPOS' property bin was brought to Warden Castro's office, and opened by Major [redacted].³⁰ In his incident report, Major [redacted] documented he broke seal number 0495293, the same number documented on CAMPOS initial property inventory form.¹³¹ Major [redacted] stated he was confident he was the first and only person to open the property bin after it was originally sealed.¹³² He also stated CAMPOS' compression stockings were physically present in his property bin but were not listed on the property inventory form.

On December 12, 2016, ERO sent CAMPOS' personal property and the \$388.22 remaining balance in his funds account to his son, [redacted] in Ashland, Massachusetts, by certified mail.¹³³

Although STDC did not complete an after action review of events surrounding CAMPOS' death,¹³⁴ Major [redacted] prepared a timeline of events based on logbook entries and information in reports from involved staff.¹³⁵ Major [redacted] stated AFOD [redacted] and HSA [redacted] concluded staff responded appropriately to the medical emergency but identified that procedures related to the processing of Special Needs forms needed to be reviewed.¹³⁶ During ERAU's review, in fact, HSA [redacted] stated the local operating procedure regarding processing of Special Needs forms was under revision to address processing issues like those that occurred with CAMPOS.¹³⁷

On November 26, 2016 [redacted] M.D., of the Bexar County Medical Examiner's Office conducted CAMPOS' autopsy.¹³⁸ She determined CAMPOS' death was due to complications of myocardial infarction with atherosclerotic cardiovascular disease. A State of Texas Certificate of Death was issued December 6, 2016.¹³⁹

¹²⁶ *Ibid.*

¹²⁷ See email from SDDO [redacted] to AFOD [redacted] sent November 25, 2016.

¹²⁸ See Hospital Post Log, dated November 25, 2016.

¹²⁹ See Memorandum to Warden Castro and [redacted] from Major [redacted] dated November 25, 2016.

¹³⁰ See *Ibid.*; ERAU interview with [redacted] January 11, 2017.

¹³¹ See Memorandum to whom it may concern from [redacted] RE: Leggings, dated November 28, 2016.

¹³² ERAU interview with Major [redacted] January 11, 2017.

¹³³ ERAU interview with ICE Deportation Officer [redacted] January 12, 2017.

¹³⁴ ERAU interview with Major [redacted] January 11, 2017.

¹³⁵ See Memorandum to Warden Castro and AFOD [redacted] from Major [redacted] dated November 25, 2016.

¹³⁶ ERAU interview with Major [redacted] January 11, 2017.

¹³⁷ ERAU interview with IISA [redacted] January 11, 2017.

¹³⁸ See Exhibit 7: Autopsy Report, Bexar County Medical Examiner's Office, dated November 28, 2016.

¹³⁹ See Exhibit 8: Certificate of Death, State of Texas, dated December 6, 2016.

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

ERAU notes STDC's medical record for CAMPOS includes no evidence of identified heart disease prior to November 23, 2016, when CAMPOS suffered a cardiac arrest. Throughout his detention at STDC, CAMPOS' recorded vital signs were within normal limits, and the intake chest x-ray showed no acute cardiopulmonary process. Additionally, Methodist Hospital documented CAMPOS' cholesterol and triglyceride levels were within normal limits while at the hospital.¹⁴⁰

MEDICAL CARE AND SECURITY REVIEW

Creative Corrections, a national management and consultant firm contracted by ICE to provide subject matter expertise to ERAU in detention management, reviewed the medical care CAMPOS was provided at STDC, as well as measures to ensure his safety and security while in ICE custody. Upon the conclusion of the review, ERAU found deficiencies in STDC's compliance with certain requirements of the ICE PBNDS 2011.¹⁴¹

CONCLUSIONS

1. ICE PBNDS 2011, *Medical Care*, Section (V)(A)(3), which states, "Every facility shall directly or contractually provide its detainee population with the following: ... 3) Comprehensive, routine and preventive health care, as medically indicated."
 - At the time of CAMPOS' detention, providers believed their replies to telephone encounters and any instructions therein were received and acted upon by nurses. Because they were mistaken, nursing staff review of the NP [redacted] November 14, 2016 order for CAMPOS to receive his personal stockings (once cleared by medical personnel) occurred only during his medical appointment two days later. In addition, nursing staff never received or implemented NP [redacted] November 17, 2016 order to continue using TED hose. As a result, medical staff never issued CAMPOS stockings to replace the first pair he received after intake, which were at some point compromised. HSA [redacted] stated provider use of telephone encounters as a form of e-mail communication was identified as a concern following CAMPOS' death, and providers have since received necessary instruction and clarification regarding the appropriate use of telephone encounters.
2. ICE PBNDS 2011, *Medical Care*, Section (V)(A)(4), which states, "Every facility shall directly or contractually provide its detainee population with the following: ... 4) Emergency care."
 - Officer [redacted] refusal to call a medical emergency on November 23, 2016, prevented CAMPOS from receiving necessary emergency care when the need was first made known.

¹⁴⁰ See Methodist Hospital Laboratory Test Results, dated November 24, 2016.

¹⁴¹ See Exhibit 9: Creative Corrections Security and Medical Compliance Review.

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

3. ICE PBNDS 2011, *Custody Classification System*, Section (V)(A)(4), which states, “Each detainee’s classification shall be reviewed and approved by a first-line supervisor or classification supervisor.”
 - CAMPOS’ initial custody classification, conducted on October 27, 2016, was not reviewed and approved by a first-line supervisor.
4. ICE PBNDS 2011, *Funds and Personal Property*, Section (V)(E)(2), which states, “Detainees may keep a reasonable amount of personal property in their possession, provided it poses no threat to detainee safety or facility security.”
 - CAMPOS was not permitted to keep his personal compression stockings in his possession, despite the lack of an identified threat to detainee safety or facility security.
5. ICE PBNDS 2011, *Funds and Personal Property*, Section (V)(I), which states, “An itemized inventory of all detainee baggage and personal property (separate from funds and valuables) shall be completed during admissions processing using the personal property inventory form.”
 - CAMPOS’ compression stockings were not listed on the itemized inventory form though at some point they were stored with the rest of his possessions.

AREAS OF CONCERN

Although not reflective of any violation of the requirements of the detention standards, ERAU noted the following area of concern related to STDC’s handling of Special Needs forms.

- CAMPOS’ compression stockings were taken away following his medical intake screening, despite the submission of a Special Needs form authorizing CAMPOS to maintain possession of the stockings pending provider evaluation. As noted, a copy of the form was found in the detainee’s medical file, but not in his detention file, and Major [] believed the officer who confiscated the stockings was likely unaware of the form. As recognized by the AFOD, HSA, and GEO staff, closing procedural gaps in form processing is critical to assuring special needs requirements are met.

ERAU noted the following areas of concern pertaining to communication gaps between security and medical staff at STDC.

- Medical staff received inaccurate information explaining why CAMPOS’ personal stockings were not brought to medical for clinical inspection the night of November 16, 2016.
- NI [] accepted GEO security staff’s disapproval of the stockings on November 17, 2016 without question. As noted by Creative Corrections, medical may question

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

the basis of security determinations, or request more information, when a legitimate medical need is identified. In this case, inquiring as to the security concern presented by the stockings may have led to more timely identification and reconciliation of conflicting reports and system failures.

ERAU noted the following areas of concern pertaining to security documentation. As noted by Creative Corrections, documentation of events and incidents is fundamental in detention operations by providing a contemporaneous record of events and supporting accountability.

- Based on the comparison of logs, written reports, and video surveillance footage, ERAU determined the time stamps on video cameras were not synchronized and time stamp accuracy could not be verified. As noted by Creative Corrections, because surveillance video footage provides important documentation of events, synchronizing time stamps and verifying accuracy helps ensure the integrity of video evidence.
- CAMPOS' personal stockings were confiscated at some point after his property inventory was completed but before his physical examination the next day; however, there is no record of who confiscated the stockings or why; there was also no apparent indication that they were stored with the rest of his personal property.
- No GEO staff member documented the events of November 16, 2016, when, upon the request of SDDC [REDACTED] CAMPOS was taken to the property room to retrieve his stockings. Among the details missing from the documentation are: a record of who escorted the detainee to and from the property room; documentation of the events that transpired in the property room; and documentation of the aftermath, including information provided to medical personnel regarding the stockings.

In addition, ERAU found STDC did not comply with the following facility post orders and directives.

1. STDC, Male Housing Dormitory Officer Specific Post Order, section (K)(3), which states, "The officer reports any incidents that occur in the housing unit to the Shift Supervisor;" and, STDC, General Post Orders #6 which states, "Immediately report any unusual circumstance to your supervisor."
 - Neither officer assigned to Dorm A at the time of the emergency apprised the supervisor of events, including that a detainee was vomiting and ill.
2. STDC, Male Housing Dormitory Officer Specific Post Order, section (P)(1), which states, "The officer ensures security of the dayroom units as the main objective."
 - Video surveillance footage shows Officer [REDACTED] changing the channels on the dorm television, with his back to the emergency medical response, failing to assist in securing the scene.

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

3. STDC, General Directive #12 Radio Communications, which states, “In order to enhance safety and security at this facility, all officers are required to have in their possession hand-held radios while on duty.”
 - Officer was not issued a radio when assigned to Dorm A.

DETAINEE DEATH REVIEW – Wenceslau Esmerio CAMPOS
JICMS #201701894

EXHIBITS

1. STDC Property Record, dated October 27, 2016
2. STDC Funds Receipt, dated October 27, 2016
3. STDC Custody Classification Worksheet, dated October 27, 2016
4. STDC eClinicalWorks Telephone Encounter (Intake prescreening), dated October 27, 2016
5. STDC eClinicalWorks Telephone Encounter (Intake screening), dated October 28, 2016
6. STDC eClinicalWorks Telephone Encounter (Initial physical exam), dated October 28, 2016
7. Autopsy Report, Bexar County Medical Examiner's Office, dated November 28, 2016
8. Certificate of Death, State of Texas, dated December 6, 2016
9. Creative Corrections Security and Medical Compliance Review