

# DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez

## JICMS #201607857

---

### SYNOPSIS

On June 13, 2016, Luis Alonso FINO-Martinez (FINO), who was a fifty-four-year-old citizen and national of Honduras, died while in the custody of U.S. Immigration and Customs Enforcement (ICE), at the University of Medicine and Dentistry Rutgers (UMDR) Hospital in Newark, New Jersey. The New Jersey Department of Health Certificate of Death documented the cause of FINO's death as hypertensive and atherosclerotic cardiovascular disease with congestive heart failure, and his manner of death to be natural.

FINO was detained at the Essex County Correctional Facility (ECCF) in Newark, New Jersey (NJ), at the time of his death. ECCF is operated by the Essex County Department of Corrections under an Intergovernmental Service Agreement (IGSA), which requires the facility to comply with the ICE Performance Based National Detention Standards (PBNDS) 2011. At the time of FINO's death, ECCF housed approximately 550 male detainees of all classification levels for periods in excess of 72 hours. Medical care at ECCF is provided by the Center for Family Guidance (CFG) Health Systems, LLC.

### DETAILS OF REVIEW

From August 9 to 11, 2016, ICE Office of Professional Responsibility (OPR), Office of Detention Oversight (ODO) staff visited ECCF and, with the assistance of contract subject matter experts (SME) in correctional healthcare and security, reviewed the circumstances of FINO's death. ODO's contract SMEs are employed by Creative Corrections, a national management and consulting firm contracted by ICE to provide subject matter expertise in detention management and compliance with detention standards, including health care and security. As part of its review, ODO reviewed immigration, medical and detention records pertaining to FINO, in addition to conducting in-person interviews of individuals employed by ECCF, CFG, and the ICE Office of Enforcement and Removal Operations (ERO).

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

### IMMIGRATION HISTORY

At an unknown location and on an unknown date in 1993, FINO unlawfully entered the United States.<sup>1</sup>

On January 10, 2003, FINO was encountered at the Houston Intercontinental Airport while seeking admission to the United States as a returning Legal Permanent Resident. During this

---

<sup>1</sup> ICE Significant Incident Report, dated June 13, 2016.

## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez JICMS #201607857

---

encounter, FINO stated he knowingly and intentionally married a United States citizen in order to fraudulently obtain Legal Permanent Residence in the United States.<sup>2</sup> On the same day, FINO was served with a Notice to Appear (Form I-862) for violating § 212(a)(6)(C)(i) and § 212(a)(7)(A)(i)(I) of the Immigration and Nationality Act (INA), as amended.<sup>3</sup>

On August 28, 2003, an immigration judge administratively closed FINO's removal proceedings due to a pending Temporary Protective Status (TPS) application.<sup>4</sup>

On December 8, 2004, United States Citizenship and Immigration Services (USCIS) terminated FINO's conditional residence status as a result of his failure to appear for an interview related his Petition to Remove the Condition on Residence.<sup>5</sup>

On June 19, 2015, ERO Newark served FINO with a Notice to Appear (Form I-862),<sup>6</sup> and on June 22, 2015, upon his release from the Northern State Prison, Newark, NJ, FINO was placed in the custody of ERO Newark and transferred to the ECCF where he was detained until his death.<sup>7</sup>

On May 10, 2016, an Immigration Judge (IJ) ordered FINO removed from the United States to Honduras, and on June 6, 2016, FINO appealed the IJ's order to the Board of Immigration Appeals.<sup>8</sup>

### CRIMINAL HISTORY

On November 29, 2004, FINO was convicted of harassment by the Municipal Court of Elizabeth, NJ, and sentenced to 20 days incarceration, one year of probation, and a fine.<sup>9</sup>

On February 27, 2006, FINO was convicted of possession of a firearm for unlawful purpose, possession of a weapon for unlawful purpose and criminal attempted murder by the Union County Superior Court, and was sentenced to 12 years confinement at the Northern State Prison, Newark, NJ.<sup>10</sup> On June 22, 2015, the Northern State Prison released FINO to ICE custody in Newark, NJ.

### NARRATIVE

ODO determined the following timeline of events, from the time FINO entered ICE custody on June 22, 2015, through his detention at ECCF and death at UMDR Hospital.

---

<sup>2</sup> Form I-213, Record of Deportable/Inadmissible Alien, dated June 17, 2015.

<sup>3</sup> Form I-213, Record of Deportable/Inadmissible Alien, dated June 17, 2015.

<sup>4</sup> ICE Significant Incident Report, dated June 13, 2016.

<sup>5</sup> See Id.

<sup>6</sup> See ICE Enforcement and Removal Module (EARM) Report for FINO, June 19, 2015.

<sup>7</sup> See Id.

<sup>8</sup> See Id.

<sup>9</sup> See Id.

<sup>10</sup> Form I-213, Record of Deportable/Inadmissible Alien, dated June 17, 2015.

## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez JICMS #201607857

---

On June 22, 2015, at 4:11 p.m., upon his arrival ECCF,<sup>11</sup> an ECCF booking officer completed FINO's Prison Rape Elimination Act (PREA) Risk Assessment<sup>12</sup> and classification officer, [REDACTED] used the ICE Custody Classification Worksheet to appropriately rate FINO as high custody based on the severity of his most recent charge and conviction, his prior convictions, and his history of assault.<sup>13</sup> ODO notes this rating was never approved by a supervisor, as required by the ICE PBNDS 2011.

At 5:45 p.m., Licensed Practical Nurse (LPN [REDACTED]) performed FINO's medical pre-screening and documented the following:<sup>14</sup>

- FINO reported no injuries, no physical limitations, and no allergies.
- FINO reported being previously prescribed Lipitor,<sup>15</sup> Lopid,<sup>16</sup> aspirin, Metformin,<sup>17</sup> and Novolin insulin.<sup>18</sup>

At 5:58 p.m., LPN [REDACTED] performed FINO's full medical and mental health intake screening, and documented the following:<sup>19</sup>

- FINO reported a history of high cholesterol, hypertension, and Type 1 diabetes.<sup>20, 21</sup>
- FINO's vital signs were within normal limits.
- FINO's mental health examination was normal.
- FINO reported no history of smoking or substance abuse.
- FINO denied symptoms of tuberculosis. A chest x-ray was performed by ECCF's mobile x-ray service, Mobilex. The results ruled out active pulmonary disease and showed normal size and contour of his heart.

FINO was scheduled for a next-day health assessment with a provider due to his chronic medical conditions.

---

<sup>11</sup> See New Jersey County Correction Information System, Inmate Summary Report, dated June 22, 2015.

<sup>12</sup> See Essex County Department of Corrections Sexual Violence Screening Form, dated June 22, 2015. FINO was determined to be at no risk of being a victim or perpetrator of sexual assault or abuse.

<sup>13</sup> See Exhibit 1: ICE Detainee Classification System – Primary Assessment Form, dated June 22, 2015.

<sup>14</sup> See Exhibit 2: Medical Prescreening by LPN [REDACTED] June 22, 2015.

<sup>15</sup> Medication to treat high cholesterol and triglycerides to reduce the risk of stroke, heart attack, and heart and blood vessel problems.

<sup>16</sup> Medication similar to Lipitor, a commonly prescribed statin.

<sup>17</sup> Oral medication to treat diabetes.

<sup>18</sup> Long acting injectable insulin which helps control blood sugar in persons with diabetes.

<sup>19</sup> See Exhibit 3: Initial Intake Screening Medical/Mental Health History, June 22, 2015.

<sup>20</sup> Child onset form of diabetes, in which the pancreas produces little or no normal insulin to move glucose into the body's cells for fuel.

<sup>21</sup> During separate ODO interviews, Medical Director Dr. [REDACTED] and staff physician Dr. [REDACTED] both stated they believe FINO likely had Type 2 diabetes (*a condition wherein the body is able to produce insulin, but it is not efficiently used to control blood sugar*), rather than Type 1. ODO could not affirmatively determine whether FINO reported he had Type 1 diabetes, or whether LPN [REDACTED] mistakenly documented Type 1 instead of Type 2. During her interview, LPN [REDACTED] stated she "assumed" she documented what the detainee reported, but she did not recall trying to confirm whether FINO understood the difference between Type 1 and Type 2 diabetes.

# DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez

## JICMS #201607857

---

During her interview with ODO, LPN [ ] stated that because she believed FINO spoke and understood English adequately, she conducted the medical pre-screening and the full medical intake screening in English, without the assistance of an interpreter.<sup>22</sup> During FINO's detention, only one patient encounter was completed using an interpreter. The medical staff interviewed stated they completed encounters without an interpreter because FINO spoke and understood sufficient English. All medical staff interviewed stated they use the language interpretation service when a detainee's English language proficiency is lacking or not sufficient to competently complete the encounter. Health Services Administrator (HSA) [ ] expressed confidence that medical staff utilize language services when necessary.<sup>23</sup>

Following intake processing, FINO was assigned and transferred to bed 39<sup>24</sup> in Dorm 2.<sup>25</sup> Dorm 2 is a 60-bed, direct supervision barrack on the third floor of the facility, housing medium-high and high security detainees. The correctional officer's station consists of a desk and chair situated adjacent to a concrete support pillar, just inside the dorm entrance door. [ ]

[ ] According to [ ] an investigator assigned to ECCF's Internal Affairs Bureau (IAB), there are approximately [ ] cameras throughout the interior and exterior of the facility, including [ ] Essex County Department of Corrections (ECDOC) Director Alfaro Ortiz stated that there are [ ]

**On June 23, 2015**, at 9:19 a.m., Dr. [ ] conducted FINO's practitioner health assessment and documented the following:<sup>28</sup>

- FINO appeared well nourished, well hydrated, and in no acute distress.
- FINO's physical exam was normal.
- FINO was diagnosed with hypercholesterolemia<sup>29</sup> and insulin-dependent diabetes.<sup>30</sup>
- FINO was assigned to the diabetes and dyslipidemia<sup>31</sup> chronic care clinic and ordered a 2,400 calorie diabetic diet. Dr. [ ] also ordered Accucheck testing<sup>32</sup> twice daily for 30 days, as well as Novolin, Metformin, low dose aspirin, Lopid, and Zocor.<sup>33</sup>

---

<sup>22</sup> ODO interview with LPN [ ] August 10, 2016.

<sup>23</sup> ODO interview with Health Services Administrator [ ] August 9, 2016.

<sup>24</sup> Bed 39 is an upper bunk.

<sup>25</sup> See New Jersey County Correction Information System, Inmate Summary Report, June 22, 2015.

<sup>26</sup> ODO interview with Investigator [ ] August 10, 2016. Fraternal Order of Police (FOP) Union Representative [ ] and Union Counsel [ ] were present for the interview.

<sup>27</sup> ODO interview with Director [ ] August 11, 2016.

<sup>28</sup> See Exhibit 4: Medical Screening by Dr. [ ] June 23, 2015.

<sup>29</sup> High levels of cholesterol in the blood.

<sup>30</sup> Creative Corrections notes that Type 1 diabetes is a chronic condition in which the pancreas produces little or no insulin to allow sugar to enter the cells to produce energy. People with Type 1 diabetes require insulin injections. In Type 2 diabetes, the pancreas produces insulin, but it is not readily used by the body to transport sugar to the cells. People with Type 2 diabetes may require insulin injections, or may be able to control the condition with diet and/or oral medication. Dr. [ ] diagnosis of insulin-dependent diabetes implies that regardless of whether FINO had Type 1 or Type 2 diabetes, he believed at the time that insulin was necessary. ODO notes that during his interview, Dr. [ ] stated he believed FINO was never Type 1.

<sup>31</sup> Abnormally high levels of fat and cholesterol in the blood.

## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez

### JICMS #201607857

---

- A physician should be notified if FINO's Accucheck blood sugars tested lower than 60 or higher than 400.

ODO notes CFG Clinical Practice Guidelines for diabetes call for the completion of an electrocardiogram (EKG) for patients.<sup>34</sup> Dr. [ ] did not order an EKG, nor did any of the other providers who saw FINO for chronic care appointments throughout his detention. During his interview with ODO, Medical Director Dr. [ ] stated EKGs are performed once per year for diabetes patients. He stated he is considering requiring that a baseline EKG be performed at the time of the initial chronic care evaluation.<sup>35</sup>

**On June 24, 2015**, FINO's lab results were electronically received and reviewed by Dr. [ ] and copied to a flow sheet.<sup>36</sup> ODO notes the use of a flow sheet allows providers to efficiently access and review laboratory and diagnostic results over the course of detention. FINO's lab results were normal, with the exception of an elevated blood glucose level for which he was receiving diabetes medication.

**On July 20, 2015**, FINO was seen by Physician Assistant (PA) [ ] in response to his July 17, 2015 request for special shoes.<sup>37</sup> PA [ ] stated she used the telephonic language interpretation service during this encounter because she wanted to ensure accurate communication between FINO and herself.<sup>38</sup> FINO stated he required therapeutic shoes because his feet were swollen as a combined result of diabetes and an old injury to his left foot. PA [ ] informed FINO that while she could not prescribe therapeutic shoes, she could refer him to the podiatrist who would evaluate his need for special shoes.<sup>39</sup> FINO subsequently became angry and walked away, refusing an examination. A foot examination and collection of vital signs were not completed.

Although PA [ ] did not have the opportunity to assess FINO, she documented a treatment plan which included finger stick blood sugar testing twice daily and administration of regular insulin<sup>40</sup> based on a standardized sliding scale<sup>41</sup> for a period of 30 days. The basis for this order was not documented.

---

<sup>32</sup> Finger stick blood sugar test.

<sup>33</sup> A medication used to treat high cholesterol and triglycerides levels.

<sup>34</sup> A test that checks for problems with the electrical activity of the heart.

<sup>35</sup> ODO interview with Dr. [ ] August 10, 2016.

<sup>36</sup> See Lab Report, June 24, 2015.

<sup>37</sup> See Id.

<sup>38</sup> ODO interview with PA [ ] August 10, 2016. ODO notes this was the only medical encounter for which an interpreter was utilized.

<sup>39</sup> Dr. [ ] informed ODO that ECCF does not permit providers to order specialized shoes for medical conditions. Detainees who require special shoes are referred to the contract orthopedic physician. In addition to requiring an order by the orthopedic physician, special shoes must also be authorized by the Warden, and medical staff must present a compelling case for their need.

<sup>40</sup> Short acting insulin used to augment long acting insulin when finger stick testing shows blood sugar is elevated. The need to administer regular insulin and the dose amount are determined using a standardized sliding scale.

<sup>41</sup> A scale which prescribes the dose of regular insulin to be given in accordance with the finger stick blood sugar level obtained at the same time.

## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez JICMS #201607857

---

**On July 23, 2015**, PA [ ] reviewed the lab results ordered by Dr [ ] during FINO's initial physical examination.<sup>42</sup> PA [ ] noted FINO's hemoglobin A1c result on June 23, 2015, was 8.4 percent,<sup>43</sup> which is an abnormal level suggesting uncontrolled diabetes.<sup>44</sup> She also noted that between June 23 and July 23, 2015, daily finger stick results showed FINO's blood sugars were well controlled, ranging from 120 to 159.<sup>45</sup> During her interview, PA [ ] stated blood sugar levels in this range generally correlate to an A1c of 6 to 6.7 percent.<sup>46</sup> A urine test done on July 23, 2015 showed glucose was abnormally present in FINO's urine, which is an indicator of uncontrolled diabetes.

**On August 24, 2015**, FINO's first reclassification review was conducted by Officer [ ]<sup>47</sup> Office [ ] applied two fewer points in the Prior Indictable Convictions category than were applied during initial classification, and one fewer point than was initially applied in the Serious Offense History category. As a result, FINO's new score classified him as medium custody. Officer [ ] nevertheless recommended retaining FINO as high custody based on his serious offense history, and an unspecified supervisor approved the override to do so. Although ODO could not affirmatively determine why the points applied in the two categories changed, it may be attributable to differences in the classification systems used by ICE in the initial classification and ECCF in subsequent reclassifications.

**On September 8, 2015**, FINO was seen by NP [ ] for his initial chronic care clinic appointment. NP [ ] documented the following:<sup>48</sup>

- FINO denied chest pain, heart palpitations, shortness of breath, tachycardia,<sup>49</sup> dizziness, diaphoresis,<sup>50</sup> shaking, and changes in mental status.
- FINO had no medical concerns at that time.
- Vital signs were within normal limits.
- All assessment findings were normal.

Medications were continued as previously prescribed. NP [ ] did not order an EKG despite it being an outstanding requirement for FINO as per the Clinical Practice Guidelines for diabetes. Follow-up lab tests were ordered, and NP [ ] documented review of the results on September 15, 2015.<sup>51</sup> The results were normal and were discussed with FINO on that date.

---

<sup>42</sup> See Lab Results, June 24, 2016.

<sup>43</sup> Per the Mayo Clinic, a normal hemoglobin A1c is less than 5.7 percent. A hemoglobin A1c greater than 8 percent may be seen in a patient who has had uncontrolled diabetes for a long time.

<sup>44</sup> Hemoglobin A1c are not specific to Type 1 or Type 2 diabetes.

<sup>45</sup> ODO notes three daily finger stick readings taken between June 23 and July 23, 2015, were greater than 159.

<sup>46</sup> ODO interview with PA [ ] August 10, 2016.

<sup>47</sup> See New Jersey Correction Information System, Custody Reassessment, August 24, 2015.

<sup>48</sup> See Chronic Care Visit by NP [ ] September 8, 2015.

<sup>49</sup> Rapid pulse.

<sup>50</sup> Excessive sweating.

<sup>51</sup> See Lab Report, September 15, 2015.

## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez

### JICMS #201607857

---

**On October 21, 2015**, FINO was seen by PA [ ] in response to the detainee's request<sup>52</sup> to discontinue morning finger stick checks.<sup>53</sup> PA [ ] did not use an interpreter during this encounter or for any subsequent encounters. During the encounter, FINO stated he was not taking his insulin and his blood sugars remained well controlled. PA [ ] confirmed FINO's blood sugars were well controlled, but kept the detainee's order for long acting insulin (Novolin) active.

PA [ ] noted she did not find any documentation of FINO's insulin refusal in the electronic medical record, but that after FINO's visit, she discussed the issue with a nurse (identity unknown), who confirmed that although FINO continued taking his oral medication, Metformin, he consistently refused his insulin, Novolin. After speaking with the nurse, PA [ ] reviewed FINO's morning blood sugars, saw they were well controlled on the Metformin, and decided to discontinue Novolin. She continued Metformin and with a note that insulin be given in the event FINO's blood sugars elevated, based on finger stick testing and the standardized sliding scale.

ODO notes FINO's Medication Administration Records (MARs) show the detainee refused over 100 insulin doses throughout July, August, September, and October of 2015.<sup>54</sup> Additionally, an average of ten doses during each of those months were left blank on the MARs, making it impossible to know whether FINO refused or accepted his dose on those dates. During her interview with ODO, HSA [ ] stated it is her expectation that detainees are referred to a provider when three doses of the same medication are refused, and that a signed refusal form is filed at that time.<sup>55</sup> FINO was not referred to the provider for repeatedly refusing his long acting insulin over the course of four months, and no refusal forms were found in his medical record.

**On October 26, 2015**, FINO was seen by Dr [ ] in response to his sick call request for eyeglasses.<sup>56</sup> FINO reported an inability to read documents over the past four months. An eye chart examination found FINO's vision to be 20/25, slightly less than normal visual acuity.<sup>57</sup> A referral was sent to the optometrist.

**On December 6, 2015**, FINO was seen by PA [ ] after submitting a sick call request for painful and swollen feet during the past month.<sup>58</sup> During the visit, FINO denied any previous history of trauma or edema<sup>59</sup> and reported he was taking his medication as ordered. During the

---

<sup>52</sup> There is no documentation of the date of this request, and it was likely a verbal request communicated during the daily pill line.

<sup>53</sup> See Practitioner's Sick Call by PA [ ] October 21, 2015.

<sup>54</sup> See FINO Medication Administration Record, July-October, 2015.

<sup>55</sup> ODO interview with HSA [ ] August 9, 2016. It is noted ECCF has no policy requiring that detainees are referred to a provider after refusing three doses of a medication; however, the IISA stated she is emphasizing the practice as part of the quality improvement program for medical staff.

<sup>56</sup> See Practitioner's Sick Call by Dr [ ] October 26, 2015. The date of FINO's sick call request is not documented.

<sup>57</sup> The clarity or sharpness of vision.

<sup>58</sup> See Practitioner's Medical Record by PA [ ] December 6, 2015. The date of FINO's sick call request is not documented.

<sup>59</sup> The medical term for swelling.

## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez

### JICMS #201607857

---

encounter, PA [ ] found FINO had mild pitting edema<sup>60</sup> of both feet, as well as leg pain. FINO was provided hydrochlorothiazide<sup>61</sup> to treat the edema and was advised to keep his legs elevated. PA [ ] noted in the medical record that FINO should be assigned a bottom bunk as part of the practitioner plan, but the detainee's record contains no documentation security was informed of the bunk assignment. PA [ ] ordered that FINO receive blood pressure checks daily for one week and included an instruction for nurses to hold the detainee's blood pressure medication if his blood pressure was lower than 100/70. According to FINO's December MAR, blood pressure checks were only completed three times during the following week: December 10, 11, and 13, 2015.<sup>62</sup> FINO's blood pressure was within normal limits on each of the three occasions. During her interview, HSA [ ] stated blood pressure checks should always be done when medications are given, and the results should be documented on a MAR.<sup>63</sup>

ODO notes that although FINO was due for a chronic care clinic appointment by December 8, 2015 (90 days following his last visit), PA [ ] closed out the chronic care appointment during the December 6, 2015 sick call encounter, described above.<sup>64</sup> As noted, PA [ ] medical entry indicates she addressed the detainee's complaint of edema and his elevated blood pressure during the encounter; she did not address or assess his diabetes and dyslipidemia, the conditions for which he was being monitored as a chronic care patient. She also did not order an EKG which, as noted previously, is required under the CFG Clinical Practice Guidelines for diabetes.<sup>65</sup> An EKG is also required by the CFG Clinical Practice Guideline for hypertension.<sup>66</sup>

Because the December 8, 2015 90 day chronic care clinic appointment was closed out, FINO was not due for another chronic care clinic appointment until April 4, 2016.<sup>67</sup>

**On December 17, 2015**, FINO was seen by PA [ ] in response to a December 16, 2015 sick call request in which he complained of not yet receiving a bottom bunk.<sup>68</sup> PA [ ] documented she would resubmit the request that FINO be assigned a bottom bunk.<sup>69</sup> As noted, the detainee's record contains no documentation that the December 6, 2015 request regarding a bottom bunk assignment was communicated to security staff; however, a Medical Transfer form directed to Processing/Counts was completed and faxed to Master Control on the date of this encounter, December 17, 2015.<sup>70</sup>

During this encounter, FINO also complained of pain under his right arm over the previous two days, due to reaching to ascend the top bunk. PA [ ] assessment findings, including those

---

<sup>60</sup> When pressure is applied to a swollen area, an indentation results and persists for some time after the release of pressure. Pitting edema typically occurs as a result of fluid accumulation due to the body's retention of excess salt.

<sup>61</sup> Anti-hypertensive (high blood pressure) medication.

<sup>62</sup> See Medication Sheet & Administration Record, December 2015.

<sup>63</sup> ODO interview with HSA [ ] August 9, 2016.

<sup>64</sup> ODO interview with Physician Assistant [ ] August 10, 2016.

<sup>65</sup> See CFG Clinical Practice Guidelines, 2015.

<sup>66</sup> See Id.

<sup>67</sup> See Practitioner's Sick Call by PA [ ] December 6, 2015.

<sup>68</sup> See Practitioner's Sick Call by PA [ ] December 17, 2015.

<sup>69</sup> See Id.

<sup>70</sup> See Medical Transfer form, December 17, 2015.



## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez JICMS #201607857

---

relating to arm pain, were documented as within normal limits. PA [ ] ordered the muscle relaxant Flexeril for FINO and instructed the detainee to perform range of motion exercises, as tolerated.

**On December 23, 2015**, FINO's second reclassification review was completed by Officer [ ] [ ] As with the first reclassification, fewer points were applied in two categories, resulting in a rating of medium custody. A supervisor (identity unknown) approved Officer [ ] recommendation to retain FINO at high custody.

**On December 28, 2015**, FINO was transferred from an upper to a lower bunk (bunk 12).<sup>72</sup> ODO notes this transfer occurred 22 days after PA [ ] first ordered that he be assigned a lower bunk, and 11 days after the Medical Transfer form authorizing a bottom bunk was provided to Master Control. During his interview, Dr. [ ] stated he concurred fully with the lower bunk order, but there are often challenges to fulfilling these orders.<sup>73</sup> Specifically, Dr. [ ] stated security staff often require medical staff to provide a justification for a bunk transfer, and sometimes are unable to fulfill such requests due to unavailability of bottom bunks.

**On January 18, 2016**, FINO was seen by Dr. [ ] in response to his same day sick call request for flu-like symptoms.<sup>74</sup> The only vital sign taken was temperature, which was normal. FINO was diagnosed with allergic rhinitis<sup>75</sup> and prescribed Chlor-Trimeton<sup>76</sup> for 14 days.

**On February 21, 2016**, a third reclassification review was completed by Officer [ ] [ ]<sup>77</sup> As with the first and second reclassifications, a lower point total resulted in a rating of medium custody. A supervisor (identity unknown) again approved retaining FINO at high custody.

**On March 7, 2016**, FINO was seen by Dr. [ ] in response to a same day sick call complaint of watery eyes, runny nose, and throat pain which the detainee rated at a level two on a scale of zero to ten.<sup>78</sup> His vital signs were normal. He was diagnosed with recurring allergic rhinitis and prescribed Chlor-Trimeton for 14 days.

**On April 4, 2016**, FINO received his second chronic care clinic assessment (the first since September 8, 2015) from NP [ ] During the assessment, FINO reported compliance with medications and exercise, and denied chest pain, palpitations, shortness of breath, tachycardia, increased urination, thirst, or hunger. Assessment findings were normal, and no recurrence of edema to the lower extremities was noted. FINO denied having any

---

<sup>71</sup> See New Jersey Correction Information System, Custody Reassessment, December 23, 2015.

<sup>72</sup> See Cell Assignment Sheet, December 28, 2015.

<sup>73</sup> ODO interview with Dr. [ ] August 10, 2016.

<sup>74</sup> See Practitioner's Sick Call by Dr. [ ] January 18, 2015.

<sup>75</sup> Seasonal allergies or hay fever.

<sup>76</sup> Allergy medication.

<sup>77</sup> See New Jersey County Correction Information System, Custody Reassessment, February 21, 2016.

<sup>78</sup> See Practitioner's Sick Call by Dr. [ ] March 7, 2016.

<sup>79</sup> See Chronic Care Visit by NP [ ] April 4, 2016.

## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez JICMS #201607857

---

hypoglycemic<sup>80</sup> episodes since his visit. FINO's vital signs were all within normal limits. NP [ ] ordered continuation of FINO's current medications, with the exception of hydrochlorothiazide, as well as blood pressure monitoring on an indefinite basis.

During the assessment, FINO informed NP [ ] that he saw an optometrist in January and was prescribed glasses but never received them. NP [ ] documented that a note in FINO's chart showed the detainee saw an optometrist on January 19, 2016 and received a prescription for glasses. NP [ ] logged a note in the medical record stating she would follow up with the assistant HSA and the administrative assistant regarding FINO's prescription eyeglasses.

**On April 5, 2016**, NP [ ] called FINO to the clinic to follow up on his request for eyeglasses.<sup>81</sup> She informed the detainee that ICE denied his request for eyeglasses because there was no clinical indication for them. NP [ ] encouraged FINO to purchase eyeglasses, strength +2.0,<sup>82</sup> from the commissary. FINO agreed with the plan of care and verbalized his understanding. ODO notes that contrary to what NP [ ] stated, ICE did not deny the request. The Immigration Health Services Corp Medical Payment Authorization Request (MedPAR) for prescription eyeglasses was closed upon notification by ECCF that reading glasses of the strength he needed were available through commissary.<sup>83</sup>

**On May 22, 2016**, a fourth reclassification review was completed by Officer [ ]<sup>84</sup> As with the previous three reclassifications, a lower point total resulted in a rating of medium custody. A supervisor (identity unknown) again approved retaining FINO at high custody.

**On June 3, 2016**, a chest x-ray was performed on FINO to screen for Tuberculosis,<sup>85</sup> in accordance with the ICE PBNDS 2011 requirement to perform chest x-rays annually.<sup>86</sup> The following day, Dr. [ ] electronically signed FINO's medical record documenting the detainee had normal chest x-ray results, without TB.

There were no subsequent patient encounters until the day of FINO's death.

### **June 13, 2016, Day of Death**

The following narrative chronicles the events of June 13, 2016, based on written documentation, verbal reports of involved security and medical staff, and video surveillance footage from cameras covering the corridor outside FINO's dorm (Dorm 2), and cameras showing portions of the route taken by responding medical staff. ODO notes there are no cameras within FINO's dorm.

---

<sup>80</sup> Low blood sugar.

<sup>81</sup> See Practitioner's Sick Call by NP [ ] April 5, 2016.

<sup>82</sup> Reading glasses of mid-strength on a scale of +1.00 to +3.25.

<sup>83</sup> See MedPar regarding FINO's eyeglass prescription dated January 19, 2016.

<sup>84</sup> See New Jersey County Correction Information System, Custody Reassessment, May 22, 2016.

<sup>85</sup> An infectious bacterial disease characterized by the growth of nodules in the tissues, especially the lungs.

<sup>86</sup> See TB Test Results by Registered Nurse (RN [ ]), June 6, 2016.

## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez JICMS #201607857

---

On June 12, 2016, Officer [ ] was assigned to Dorm 2 from 10:00 p.m. to 6:00 a.m. on June 13, 2016. Officer [ ] logged that he completed security rounds precisely at the top of each hour and at exactly 30 minutes past each hour; for example, at 1:00 a.m., 1:30 a.m., and 2:00 a.m.<sup>87</sup> Performing security rounds in this manner are in violation of the Essex County Department of Corrections (ECDC) Housing Unit Post Orders which require that ICE detainees be personally observed by an officer twice per hour, but no more than forty minutes apart, on an irregular schedule, for all housing units.<sup>88</sup> ODO reviewed randomly selected logs from Dorm 2, and found Officer [ ] logged completion of security rounds precisely on the hour and half hour on at least one other date, June 7, 2016.<sup>89</sup>

At 5:30 a.m. on June 13, 2016, Officer [ ] logged a security round in Dorm 2.<sup>90</sup> At 5:39 a.m., a nurse (identity unknown) entered Dorm 2 to collect sick call requests and departed the dorm seconds later.<sup>91</sup> At 5:43 a.m. Officer [ ] exited Dorm 2, leaving it unsupervised;<sup>92</sup> the video surveillance footage does not show another officer arriving to relieve him, nor is there a logbook entry documenting Officer [ ] departure or relief by another officer. Officer [ ] returned to Dorm 2 at 5:47 a.m.<sup>93</sup> Detainees in Dorm 2 were left unsupervised for approximately four minutes and 27 seconds. ODO notes the Essex County Department of Corrections Rules and Regulations Manual prohibits leaving detainees “unattended and unsupervised at any time, unless dictated by department policy or at the command of the appropriate supervisory.”<sup>94</sup> Further, ECCF’s General Housing Unit Post Order states “all ECDOC staff members are prohibited from leaving their assigned posts without being properly relieved or otherwise dismissed by a superior officer.”<sup>95</sup>

During his interview with ODO, Officer [ ] stated that at 5:45 a.m. on June 13, 2016, he heard an intercom announcement for line-up, signifying the oncoming shift was gathering for check-in and assignments.<sup>96</sup> Officer [ ] stated he then turned on the main dorm lights and did a “walk around,” although review of the logbook found no entry documenting this action (the last round Officer [ ] documented was at 5:30 a.m.). Officer [ ] stated FINO was on his bunk during his final undocumented walk around. ODO notes that although Officer [ ] stated during his

---

<sup>87</sup> See Dorm 2 logbook, June 12-13, 2016.

<sup>88</sup> Creative Corrections notes that making rounds precisely 30 minutes apart is not a sound security practice as it allows for detainees to conform their behavior to the timing of the rounds. The most effective means of preventing sexual assaults, other assaults, escape attempts and other rule violations is for detainees to be unable to predict when an officer may come by their area.

<sup>89</sup> See Dorm 2 logbook, June 7, 2016.

<sup>90</sup> See Dorm 2 logbook, June 13, 2016.

<sup>91</sup> See video surveillance footage, June 13, 2016, and Dorm 2 logbook, June 13, 2016. Although ECCF is in the Eastern Time zone, the time stamp on all video footage is set to Central Standard Time. The times for video referenced in this report have been adjusted to Eastern Standard Time.

<sup>92</sup> See video surveillance footage, June 13, 2016.

<sup>93</sup> See Id.

<sup>94</sup> See Essex County Department of Corrections Rules and Regulations Manual, section 3:8.13, CONSTANT SUPERVISION.

<sup>95</sup> See ECCF General Housing Unit Post Order.

<sup>96</sup> ODO interview with Correctional Officer [ ], August 9, 2016. Policeman’s Benevolent Association (PBA) union representative [ ] and attorney [ ] were present for the interview.

## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez

### JICMS #201607857

---

interview that he conducted the walk around at 5:45 a.m., video surveillance footage shows that Officer [ ] was not in Dorm 2 at 5:45. Since he never made another security round after 5:45 a.m., according to both his log and his statement during interview, his final round must have been completed prior to leaving Dorm 2 at 5:43 a.m.

During this observation round, Officer [ ] stated he pulled down any sheets left hanging on the bunk beds from the previous night.<sup>97</sup> Officer [ ] stated detainees often hang the sheets in order to keep the dorm lights from interfering with their sleep. ODO notes the ECCF Inmate Handbook and Disciplinary Rulebook, most recently revised on January 14, 2016, specifically prohibits detainees from hanging sheets on their bunks.<sup>98</sup> Further, the ECCF Housing Unit Post Orders maintain it is the responsibility of the officer to enforce inmate and detainee rules and regulations.<sup>99</sup> During his interview with ODO, Sergeant [ ] stated detainees are not permitted to hang blankets or sheets, but he is aware that some officers allow them to do so.<sup>100</sup> Sergeant [ ] stated that allowing detainees to obstruct the view of security staff increases the risk and opportunity for a suicide attempt or an assault to occur. This information was shared with Director [ ] at the conclusion of the site visit, who stated corrective actions would be immediately taken.

During his interview with ODO, Officer [ ] stated after he made his 5:45 a.m. round, he sat at his desk waiting to be relieved from his post.<sup>101</sup> While waiting, he heard a detainee say aloud, “What are you doing?” Officer [ ] walked in the direction of the voice, also the direction of FINO’s bunk, which was approximately 15 feet from the officer’s desk, to see what was happening. Officer [ ] stated he observed FINO’s upper body on the floor, face up, with his feet and lower body still on his bunk. Officer [ ] stated he then walked back to his desk and used the telephone to notify Master Control of a medical emergency. Officer [ ] logged the time of the call as 5:45 a.m. which, as noted, was the time he reported to ODO that he conducted an observation round.<sup>102</sup> More significantly, video surveillance footage of the corridor outside Dorm 2 shows he was not in the dorm at that time at all.<sup>103</sup>

ODO notes Officer [ ] decision to use the telephone to call a medical emergency, rather than to use the radio on his person is in contravention of facility policy. The ECCF Housing Unit Post Orders state “in the event of an emergency situation, report the conditions and/or circumstances to Center Control by the most expeditious means possible...and then take reasonable action to arrest the situation or to remove the persons from harm until such time as more specific instruction from supervisory personnel/Center Control is received.”<sup>104</sup> Calling a

---

<sup>97</sup> See Id.

<sup>98</sup> See ECCF Inmate Handbook and Disciplinary Rulebook, revised January 14, 2016.

<sup>99</sup> See ECCF Housing Unit Post Orders.

<sup>100</sup> ODO interview with Sergeant [ ] August 10, 2016.

<sup>101</sup> ODO interview with Correctional Officer [ ] August 9, 2016. PBA union representative [ ] and attorney [ ] were present for the interview.

<sup>102</sup> See Dorm 2 logbook, June 13, 2016.

<sup>103</sup> See video surveillance footage, June 13, 2016.

<sup>104</sup> See ECCF Housing Unit Post Orders.

## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez

### JICMS #201607857

---

medical emergency by radio would have been more expeditious than walking back to the desk to use the telephone.

Lieutenant [ ] posted to Master Control at the time of Officer [ ] telephone call, logged the time of the call and subsequent announcement of a Code White (medical emergency) over the intercom system as occurring at 5:54 a.m.<sup>105</sup> This timing, which is nine minutes later than the time logged by Officer [ ] is supported by events observed on the video surveillance footage.

Officer [ ] reported that after calling Master Control, he walked back to the scene and found FINO lying on the floor next to his bunk while another detainee, [ ] performed chest compressions on FINO.<sup>106</sup> Officer [ ] stated [ ] appeared in control of the situation and was doing what Officer [ ] believed was necessary. Officer [ ] stated he did not intervene because a recent ECCF refresher class in cardio pulmonary resuscitation (CPR) instructed officers that chest compressions should be taken over only if the person performing them becomes tired. Officer [ ] acknowledged that at no time after discovering FINO on the floor did he check for a pulse. He also acknowledged he did not know or inquire whether [ ] was certified in CPR.

[ ] was assigned to a bunk diagonal to FINO. ODO interviewed [ ] who stated that during the night of June 12-13, 2016, FINO was awake until around 4:00 a.m., which was unusual.<sup>107</sup> [ ] stated that when he heard FINO make a loud noise, as if he was going to vomit, he looked over and observed FINO leaning out of his bed. [ ] got up and helped FINO to the floor. [ ] stated because FINO had a faint pulse but no breath, he initiated chest compressions which he continued until ordered to return to his bunk, as described below.

During their interviews with ODO, both Dr. [ ] and Dr. [ ] stated they were surprised when they heard a detainee was permitted to perform CPR, and both stated it was not appropriate.<sup>108</sup> Dr. [ ] stated that even if trained, a detainee should not have been allowed to perform CPR. ODO notes in addition to failing to initiate action as a first responder and allowing [ ] to continue CPR, Officer [ ] took no action to secure the area, including directing other detainees to move away.

During his interview, Officer [ ] stated that the first responder to arrive in Dorm 2 following the Code White call was Officer [ ] he was quickly followed by medical staff and Sergeant [ ].<sup>109,110</sup> Video surveillance footage shows that at 5:55 a.m., approximately one minute after the Code White was called, two officers were standing in the

---

<sup>105</sup> See Master Control log, June 13, 2016.

<sup>106</sup> ODO interview with Correctional Officer [ ] August 9, 2016. PBA union representative [ ] and attorney [ ] were present for the interview.

<sup>107</sup> ODO interview with detainee [ ] August 10, 2016.

<sup>108</sup> ODO interview with Medical Director Dr. [ ] August 10, 2016; ODO interview with Dr. [ ] August 10, 2016.

<sup>109</sup> Sergeant [ ] was not available for interview during the site visit.

<sup>110</sup> ODO interview with Correctional Officer [ ] August 9, 2016. PBA Local 382 president [ ] and union counsel [ ] were present for the interview.

## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez

### JICMS #201607857

---

corridor looking into Dorm 2, while a third officer walked through the corridor past Dorm 2. None of these officers responded to the Code White. ODO was unable to identify any legitimate reason why none of the three officers responded. Facility command staff, including Director Ortiz and the facility's ICE Program Director [REDACTED] stated it is their expectation that all available officers respond to a Code White.<sup>111</sup> ODO notes ECCF's General Housing Unit Post Order states, "In the event of an emergency situation," and officer shall "report the conditions and/or circumstances to Center Control by the most expeditious means possible...and then take reasonable action to arrest the situation or to remove persons from harm until such time as more specific instruction from supervisory personnel/Center Control is received." Further, the facility's Emergency Response Policy, section (IV)(C), states, "In the event of an emergency condition, the staff member who first becomes aware of the incident shall immediately alert Master Control (Center Control) in the most expeditious means possible," and "immediately thereafter...take action necessary to preserve life and limb, to protect property, and to restore order."<sup>112</sup>

Officer [REDACTED] was assigned to work Dorm 2, his regular assignment, from 6:00 a.m. to 2:00 p.m. on June 13, 2016. During his interview with ODO, Officer [REDACTED] stated he heard the Code White call during morning line-up,<sup>113</sup> and once morning line-up concluded, he walked to Dorm 2 to assume his post.<sup>114</sup> At 5:57:12 a.m., approximately three minutes after the Code White was called, Officer [REDACTED] entered Dorm 2.<sup>115</sup> The video surveillance footage from the corridor camera shows Officer [REDACTED] approaching the dorm in an unhurried manner.<sup>116</sup> ODO notes Officer [REDACTED] reported to the dorm because it was his post; not in response to the medical emergency.

At 5:57:34 a.m., a uniformed staff person, presumed to be Sergeant [REDACTED] entered the dorm.<sup>117</sup> Although Sergeant [REDACTED] was not available for interview, documents and interviews with other staff suggest he simply observed the response and did not participate.

Upon arrival in Dorm 2, Officer [REDACTED] immediately ordered a group of detainees who had gathered in the area around FINO to return to their bunks.<sup>118</sup> At this time, [REDACTED] discontinued

---

<sup>111</sup> Discussed during ODO site visit closeout with ECCF and ERO leadership, August 11, 2016.

<sup>112</sup> Creative Corrections notes that just as law enforcement officers and fire fighters are considered "first responders" and are expected to initiate life-saving care, so too are correctional officers. More often than not, they are more proximate to detainees than medical personnel. The fact that no officers responded during shift change, the time when the most security staff are present in the facility, and that several officers stood in the hallway and watched, or simply walked past the site of the medical emergency, suggests it is not an unusual practice for security staff to fail to respond to a medical event.

<sup>113</sup> Also known as "roll call," when the oncoming shift gathers to receive their post assignments and to receive any information they need to know about significant events during the previous shift, as well as any planned events for their shift. It is noted because the off-going shift is still on post, and the incoming shift is now present, "line-up" is the time during a shift when a facility has the most officers present at one time.

<sup>114</sup> ODO interview with Correctional Officer [REDACTED] August 9, 2016. PBA local 382 president [REDACTED] and union counsel [REDACTED] were present for the interview.

<sup>115</sup> See video surveillance footage, June 13, 2016.

<sup>116</sup> See Id.

<sup>117</sup> See Id.

## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez

### JICMS #201607857

---

CPR in order to comply with Office [ ] orders. After [ ] stopped performing chest compressions, neither Office [ ] nor Officer [ ] checked FINO's pulse to determine if CPR should be continued.<sup>119</sup> Officer [ ] stated that although he is trained in CPR, during a medical emergency, he calls Master Control to initiate a Code White and then waits for medical personnel to arrive. He does not initiate CPR on his own.<sup>120</sup>

During his interview with ODO, Lieutenant [ ] Commander of Training and Professional Services, stated correctional officers are trained to start CPR only if the area is secure.<sup>121</sup> Lieutenant [ ] further stated that because the dorms at Essex do not have cells, an officer who is alone in a dorm should not initiate CPR. This position was confirmed by Lieutenant [ ]<sup>122</sup> HSA [ ] stated custody staff do not initiate CPR at ECCF and are generally hands off regarding medical emergencies.<sup>123</sup> Similarly, Dr. [ ] spoke to what he called officers' reluctance to perform CPR and noted the medical department endeavors to compensate for it by continually working to improve the response time of medical personnel.<sup>124</sup> He acknowledged that because minutes and even seconds matter in a medical emergency, he supports officers initiating CPR.

At 5:57:39 a.m., in response to the Code White call, PA [ ] and RN [ ] entered the first floor elevator with an empty gurney, automated external defibrillator (AED), and emergency bag, while LPN [ ] and Pharmacy Technician [ ] took the stairs to Dorm 2 (Dorm 2 is on the third floor of the facility, and the medical unit is on the first floor).<sup>125</sup> The elevator [ ]  
[ ] The medical team waited inside the elevator for 23 seconds before security closed the door at 5:58:02 a.m.<sup>126</sup> At 5:58:16 a.m., the medical staff exited the elevator and walked toward the dorm. At 5:58:57 a.m., medical staff arrived on the scene and entered Dorm 2 with the gurney, approximately four and half minutes after the Code White was called.<sup>127</sup>

---

<sup>118</sup> ODO interview with Correctional Officer [ ] August 9, 2016. ODO interview with Correctional Officer [ ] August 9, 2016. PBA Local 382 president [ ] and union counsel [ ] were present for the interviews.

<sup>119</sup> Id.

<sup>120</sup> ODO interview with Correctional Officer [ ] August 9, 2016. PBA local 382 president [ ] and union counsel [ ] were present for the interview.

<sup>121</sup> ODO interview with Lieutenant [ ] August 10, 2016. FOP union counsel [ ] was present for the interview.

<sup>122</sup> ODO interview with Lieutenant [ ] August 10, 2016. FOP union representative [ ] and union counsel [ ] were present for the interview.

<sup>123</sup> ODO interview with Health Services Administrator [ ] August 9, 2016.

<sup>124</sup> ODO interview with Medical Director Dr. [ ] August 10, 2016.

<sup>125</sup> ODO interview with Registered Nurse [ ] August 9, 2016; Licensed Practical Nurse [ ] August 9, 2016; Licensed Practical Nurse [ ] August 9, 2016; PA [ ] was not available for interview during the site visit; surveillance video.

<sup>126</sup> See video surveillance footage, June 13, 2016.

<sup>127</sup> Although a response timeframe is not directly prescribed, the ICE PBNDS 2011, Medical Care, section (V)(R)(1)(c), states that "all detention and health care personnel shall be trained annually to respond to health-related situations within four minutes." ODO notes the ECCF medical team made a concerted effort to respond to FINO in a timely manner, but were delayed by the elevator which may only be operated by security staff in Master

## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez

### JICMS #201607857

---

When the responding medical staff arrived in Dorm 2, FINO was on the floor and was unresponsive.<sup>128</sup> An initial assessment found:<sup>129</sup>

- a faint pulse,
- fixed and dilated pupils, and
- an elevated blood sugar of 148, low blood oxygen at 86 percent,<sup>130</sup> and low respirations of four.

ODO was unable to determine through interviews or documentation whether FINO was still breathing when medical staff arrived. Medical staff placed FINO onto the gurney and provided oxygen, and the medical team departed Dorm 2 for the medical unit.<sup>131</sup>

At 6:02:08 a.m., approximately three minutes after arriving at the scene, the medical team exited the dorm with FINO on the gurney.<sup>132</sup> During her interview with ODO, LPN [REDACTED] stated that rather than entering the elevator, she stopped at the Dorm 2 officer's desk and called Master Control to inform security that FINO would need to go to the hospital.<sup>133</sup> At 6:03:05 a.m., the rest of the medical team entered the elevator with FINO.<sup>134</sup> The elevator door remained open for 40 seconds [REDACTED]

[REDACTED] The elevator door closed at 6:03:45 a.m.<sup>135</sup> During his interview with ODO, RN [REDACTED] stated the battery in the automated external defibrillator (AED),<sup>136</sup> which was connected to FINO after he was placed on the gurney, shifted out of position more than once during the trip back to the medical unit, hindering its ability to operate. He attributed the problem with the battery to the AED being moved around during transport.<sup>137</sup>

At 6:04:18 a.m., the medical staff exited the elevator on the first floor and pushed the gurney carrying FINO towards the medical unit.<sup>138</sup> At 6:05:18 a.m., medical staff entered a curtained examination room and placed an intravenous (IV) line in FINO's right forearm.<sup>139</sup>

---

Control. ECCF's Emergency Response policy, section (IV)(G)(1)(a), states, "Master control will make an elevator (S1 or S2) available for responding medical personnel and their equipment."

<sup>128</sup> See Exhibit 5: Practitioner Urgent/Emergent Care by PA [REDACTED] dated June 13, 2016; ODO interviews with CFG medical staff, August 9-11, 2016.

<sup>129</sup> See *Id.*

<sup>130</sup> Normal blood oxygen levels are considered 95-100 percent.

<sup>131</sup> See Exhibit 5.

<sup>132</sup> See video surveillance footage, June 13, 2016.

<sup>133</sup> ODO interview with Licensed Practical Nurse [REDACTED] August 9, 2016.

<sup>134</sup> See video surveillance footage, June 13, 2016.

<sup>135</sup> See *Id.*

<sup>136</sup> An AED is a portable device that checks the heart rhythm and can send an electric shock to the heart to try to restore a normal rhythm.

<sup>137</sup> ODO interview with RN [REDACTED] August 9, 2016.

<sup>138</sup> See video surveillance footage, June 13, 2016.

<sup>139</sup> See video surveillance footage. See Provider note by RN [REDACTED] dated June 13, 2016.



## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez

### JICMS #201607857

---

PA [ ] documented that at approximately 6:09 a.m., medical staff attempted to get a pulse from FINO, but no pulse was detected.<sup>140</sup> During his interview, RN [ ] stated he and another member of the medical team (identity unknown) took turns performing chest compressions, and that 15 shocks were delivered by AED prior to the arrival of Emergency Medical Services (EMS).<sup>141</sup> ODO notes no medical staff was designated to record and document the events and actions taken during the emergency response.

While medical staff responded to FINO, Lieutenant [ ] in Master Control facilitated a three-way call between a medical staff member (identity unknown), the 911 call center, and herself.<sup>142</sup> During her interview with ODO, Lieutenant [ ] stated that following the 911 call, she selected Officer [ ] and [ ] to escort FINO and the ambulance to the hospital.<sup>143</sup>

At 6:09 a.m., Sergeant [ ] called a “Code Green” over his radio signifying to facility staff that the emergency in Dorm 2 was over.<sup>144</sup>

At 6:20 a.m., the first of two ambulances arrived; the second arrived at 6:21 a.m.<sup>145</sup> EMS personnel arrived in the medical unit at 6:23:52 a.m.<sup>146</sup> ODO notes their arrival was approximately 12 minutes after the 911 call was made. During his interview with ODO, RN [ ] stated that in his experience, EMS typically arrives within approximately five minutes of being called;<sup>147</sup> HSA [ ] reported the typical response time is between nine and 15 minutes.<sup>148</sup>

FINO’s care was immediately turned over to the EMS responders upon their arrival.<sup>149</sup> During his interview with ODO, RN [ ] stated EMS responders replaced the IV line and AED with their own equipment.<sup>150</sup> EMS responders continued performing CPR on FINO until they departed.<sup>151</sup> Dr. [ ] was notified of the medical emergency once EMS took control of FINO’s care.<sup>152</sup>

At 6:38:27 a.m., the EMS responders exited the medical unit with FINO on a gurney, and at 6:46:59 a.m., the ambulance departed ECCF.<sup>153</sup> Officer [ ] accompanied FINO in the

---

<sup>140</sup> See Exhibit 5.

<sup>141</sup> ODO interview with RN [ ] August 9, 2016.

<sup>142</sup> ODO interview with Lieutenant [ ] August 10, 2016. FOP union representative [ ] and union counsel [ ] were present for the interview. See also Shift Commander Log notation by Lieutenant [ ] June 13, 2016.

<sup>143</sup> ODO interview with Lieutenant [ ] August 10, 2016. FOP union representative [ ] and union counsel [ ] were present for the interview.

<sup>144</sup> See Sergeant [ ] Incident Report, dated June 13, 2016.

<sup>145</sup> See Shift Commander log notation by Lieutenant [ ] June 13, 2016.

<sup>146</sup> See video surveillance footage, June 13, 2016.

<sup>147</sup> ODO interview with RN [ ] August 9, 2016.

<sup>148</sup> ODO interview with HSA [ ] August 9, 2016.

<sup>149</sup> See Exhibit 5.

<sup>150</sup> ODO interview with RN [ ] August 9, 2016.

<sup>151</sup> See Exhibit 5.

<sup>152</sup> See Provider note by RN [ ] dated June 13, 2016.

<sup>153</sup> See video surveillance footage, June 13, 2016.

## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez JICMS #201607857

---

ambulance while Officer [ ] followed in a chase vehicle. ODO notes Officer [ ] did not complete an incident report.

At 6:55 a.m., Sergeant [ ] ped off the area around FINO's bunk.<sup>154</sup> During his interview with ODO, Sergeant [ ] stated he was in his office when the Code White was called.<sup>155</sup> He reported that after stopping at the medical unit, he went to Dorm 2 and spoke to detainee [ ] who was assigned to the bunk above FINO. [ ] stated to Sergeant [ ] that FINO appeared fine the night before and stayed up watching a movie until approximately 2:00 a.m.<sup>156</sup>

At 7:02 a.m., the ambulance carrying FINO arrived at UMDR,<sup>157</sup> and at 7:07 a.m., FINO was pronounced dead by a UMDR physician.<sup>158</sup>

Lieutenant [ ] incident report states she was notified by Officer [ ] of FINO's death at 7:08 a.m. and subsequently notified Lieutenant [ ]<sup>159</sup> Lieutenant [ ] then notified the Warden and ICE Program Director [ ]<sup>160</sup>

Officer [ ] documented that at 9:41 a.m., FINO's body was "cleared"<sup>161</sup> by Lieutenant [ ] of the Essex County Prosecutor's Office.<sup>162</sup> At 9:51 a.m., Supervisory Detention and Deportation Officer (SDDO) [ ] notified the Consulate General of Honduras in New York City of FINO's death.<sup>163</sup> At 12:40 p.m., ICE, with the assistance of the Consulate, notified FINO's adult daughter [ ] of her father's death.<sup>164</sup> At 9:56 a.m., the Medical Examiner took custody of FINO's body.<sup>165</sup>

### ECCF Internal Affairs Investigation

During his interview with ODO, Sergeant [ ] supervisor of the ECCF Special Investigations Division/Internal Affairs Bureau (SID/IAB), stated he was notified of FINO's death at 9:00 a.m. on June 13, 2016.<sup>166</sup> He stated he then notified the Essex County Prosecutor's

---

<sup>154</sup> See Dorm 2 logbook, June 13, 2016.

<sup>155</sup> ODO interview with Sergeant [ ] August 11, 2016.

<sup>156</sup> [ ] was deported prior to ODO's site visit and could not be interviewed. ODO interview with Sergeant [ ] August 11, 2016.

<sup>157</sup> See c-mail message from Lieutenant [ ] to ICE Program Director [ ] sent at 10:45 a.m. on June 30, 2016.

<sup>158</sup> See Exhibit 6: Officer [ ] Incident Report, dated June 13, 2016. See also c-mail message from Lieutenant [ ] to Director [ ] al., sent June 13, 2016, at 7:24 a.m.

<sup>159</sup> See Lieutenant [ ] Incident Report, dated June 13, 2016.

<sup>160</sup> ODO interview with Lieutenant [ ] August 10, 2016. FOP union representative [ ] and union counsel [ ] were present for the interview.

<sup>161</sup> ODO did not interview Lieutenant [ ] and cannot speculate as to what "clearing" the body means.

<sup>162</sup> See Exhibit 6.

<sup>163</sup> See c-mail message from SDDO [ ] June 13, 2016.

<sup>164</sup> See c-mail message from ICE Assistant Field Office Director [ ] to ECCF Director [ ] and ICE Program Director [ ] sent June 13, 2016, at 1:16 p.m. EST.

<sup>165</sup> See Shift Commander log notation by Lieutenant [ ] June 13, 2016

<sup>166</sup> ODO interview with Sergeant [ ] August 10, 2016. FOP union representative [ ] and union counsel [ ] were present for the interview.

# DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez

## JICMS #201607857

---

Office and took reports from Lieutenant [redacted] Sergeant [redacted] and Officer [redacted] Sergeant [redacted] did not obtain reports from responding medical staff at the facility. During his interview with ODO, Investigator [redacted] the assigned investigator, stated that although he was the on-call investigator on June 13, 2016, the notification of FINO's death went directly to Sergeant [redacted]. He stated once notified, he reviewed FINO's electronic facility records for information related to his criminal history and time in custody. Investigator [redacted] so requested video surveillance footage for the dorm and the adjacent hallways spanning the hours of 5:00 a.m. to 10:00 a.m. on June 13, 2016.<sup>168</sup> Investigator [redacted] stated additional information gathered for the investigation included FINO's medical record, the complete roster for Dorm 2, the dorm logbook, officers' reports, and staff schedules. He froze FINO's funds account and secured his property in the IAB office as directed by ERO. On June 22, 2016, [redacted] received FINO's property and funds (\$5.05) and signed an IAB form acknowledging their receipt.

ODO was provided with a copy of the six page IAB Investigation Report dated June 21, 2016, signed by both Investigator [redacted] and Sergeant [redacted]. The report documents that Sergeant [redacted] of the Essex County Prosecutor's Office (ECPO) Professional Standards Bureau (PSB) and ECPO Crime Scene Detective [redacted] responded to ECCF on June 13, 2016 at approximately 9:30 a.m.<sup>169</sup> ICE OPR Senior Special Agents [redacted] and [redacted] also responded. The IAB report indicates the responding group visited Dorm 2 to photograph the scene, collect logbooks and reports, and interview detainees.<sup>170</sup> During his interview with ODO, Investigator [redacted] stated Sergeant [redacted] selected ten detainees to interview, choosing them based on their proximity to FINO at the time of the emergency.<sup>171</sup> Sergeant [redacted] ultimately interviewed only five detainees, including detainee [redacted]. The interviews were audio recorded and were observed by Investigator [redacted].

The IAB Investigation Report documented the following conclusions: all witness statements were consistent with the fact that FINO was not assaulted while in Dorm 2 on the day of the incident; FINO leaned over from his bed on the morning of June 13, 2016, and had a medical emergency; and, witnesses reported that a Sergeant and medical staff responded to FINO and he was removed from Dorm 2 by medical staff.

Both Sergeant [redacted] and Director [redacted] stated that the IAB is responsible for determining if any policy violations occurred as part of their investigation; however, the report includes no other conclusions and does not indicate whether or not any violations of policy were identified.<sup>172</sup>

---

<sup>167</sup> ODO interview with Investigator [redacted] August 10, 2016. FOP union representative [redacted] and union counsel [redacted] were present for the interview.

<sup>168</sup> Id.

<sup>169</sup> See IAB Investigation Report, dated June 21, 2016.

<sup>170</sup> See Id.

<sup>171</sup> ODO interview with Sergeant [redacted] August 10, 2016. FOP union representative [redacted] and union counsel [redacted] were present for the interview.

<sup>172</sup> ODO interview with Sergeant [redacted] August 10, 2016. FOP union representative [redacted] and union counsel [redacted] were present for the interview; ODO interview with Director [redacted] August 11, 2016.

# DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez

## JICMS #201607857

---

Sergeant [ ] stated the IAB report was submitted to Director [ ] and that an addendum would be submitted upon receipt of the autopsy results. Director [ ] stated he had not yet reviewed the IAB report.<sup>173</sup>

During his interview with ODO, Investigator [ ] shared the following recommendations and observations not captured in the IAB report: [ ] have made it possible to review the incident and response [ ] officer in a 60-bed dorm may be insufficient coverage, and notification to the IAB of FINO's death was delayed.<sup>174</sup>

### Post-Death Events

On June 14, 2016, an autopsy was conducted by [ ] MD, Assistant Medical Examiner, Northern Regional Medical Examiner Office.<sup>175</sup> FINO's manner of death was determined to be natural, due to hypertensive and atherosclerotic cardiovascular disease with congestive heart failure. A New Jersey Department of Health Certificate of Death was issued November 3, 2016.<sup>176</sup>

Director [ ] informed ODO that ECCF did not prepare an after-action report. Director [ ] and Dr. [ ] held a meeting following FINO's death, attended by HSA [ ] Director of Nursing [ ] and Shift Commander Lieutenant [ ].<sup>177</sup> Surveillance footage of the corridors showing the medical and custody staff response was reviewed during the meeting. Director [ ] stated he was not fully satisfied with the urgency in response from responding medical staff. He did not comment on the reluctance of security staff to respond or assist, only stating that in future situations he would like the shift supervisor to report to the scene.<sup>178</sup>

HSA [ ] informed ODO that an internal Mortality and Morbidity review was conducted with CFG and ECCF staff.<sup>179</sup> As a result of this review, five AEDs were replaced or upgraded, and oxygen gauges were upgraded. HSA [ ] stated medical documentation was an area also needing improvement. During her interview, Dr. [ ] stated timely performance of EKGs was identified as an area requiring improvement.<sup>180</sup> Both HSA [ ] and Dr. [ ] stated the Mortality and Morbidity review identified medical response time and the medical response itself as strengths.

### HEALTHCARE AND SECURITY REVIEW

---

<sup>173</sup> ODO interview with Director [ ] August 11, 2016.

<sup>174</sup> ODO interview with Investigator [ ] August 10, 2016. FOP union representative [ ] and union counsel [ ] were present for the interview.

<sup>175</sup> See Exhibit 7: Autopsy Report.

<sup>176</sup> See Exhibit 8: Certificate of Death.

<sup>177</sup> ODO interview with Director [ ] August 11, 2016.

<sup>178</sup> Id.

<sup>179</sup> ODO interview with HSA [ ] August 9, 2016.

<sup>180</sup> ODO interview with Medical Director [ ] August 10, 2016.

## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez JICMS #201607857

---

ICE contract SMEs from Creative Corrections Creative Corrections found ECCF did not fully comply with the requirements of ICE PBNDS 2011 Standards on Medical Care, Custody Classification System, and Facility Security and Control. The Creative Corrections Medical and Security Compliance Analysis is included as an Exhibit to this report.<sup>181</sup>

### FINDINGS

ODO found ECCF deficient in the following areas of the ICE PBNDS 2011:

1. ICE PBNDS 2011, Medical Care, section (V)(A)(2) 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.”
  - Although required by Clinical Practice Guidelines, an EKG was not conducted during the term of FINO’s detention.
  - A quarterly chronic care clinic was not conducted as scheduled on December 8, 2015.
  - Nurses failed to carry out blood pressure checks the week of December 6-12, 2015, as ordered by the provider.
2. ICE PBNDS 2011, Medical Care, section (V)(G)(12) states, “Each detention facility shall have and comply with written policy and procedure for the management of pharmaceuticals, to include: documentation of accountability for administering or distributing medications in a timely manner, and according to licensed provider orders.”
  - Over a period of approximately four months, a provider was not notified of FINO’s refusal to take long-acting insulin, and refusal forms were not completed.
  - During the period of July 1 to October 31, 2015, over 40 insulin doses were not documented as having been given, refused, or otherwise accounted for.
3. ICE PBNDS 2011, Custody Classification System, section (V)(A)(4) states, “Each detainee’s classification shall be reviewed and approved by a first-line supervisor or classification supervisor.”
  - A supervisor did not approve the initial classification completed on FINO on June 22, 2015.
4. ICE PBNDS 2011, Facility Security and Control, Section (V)(D)(2) states, “No detainee may ever be given authority over, or be permitted to exert control over, any other detainee.”
  - By allowing detainee [ ] to perform CPR, Officer [ ] gave him control over detainee FINO’s care.

### AREAS OF NOTE

---

<sup>181</sup> See Exhibit 9: Creative Corrections Medical and Security Compliance Analysis.

## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez

### JICMS #201607857

---

1. The ICE PBNDS 2011, Medical Care, section (V), subsections (R)(1)(d) and (e), require that the facility's emergency plan include the mandate that all detention and medical staff receive CPR/AED and emergency first aid training annually; further, that detention and health care personnel be trained to respond to health related situations within four minutes. ODO confirmed compliance with these requirements. However, information gained through interviews and documentation review firmly indicates that in practice, sole responsibility for medical emergency response falls to medical personnel. Security staff at ECCF do not act as responders and are responsible only for providing notification during a medical emergency.
2. Officer [ ] abdicated his responsibility to provide emergency care to FINO to another detainee. While [ ] motivations are not questioned based on the evidence, his qualification to perform CPR was not known.
3. Using the telephone rather than radio to call the medical emergency delayed the response, as did routing the notification of a medical emergency through a lieutenant. As explained by Lieutenant [ ] the rationale for using the telephone to notify Master Control assures the notification is received. ODO notes it should be no less likely that a radio call directed to Master Control is received, whereupon Code White should be announced immediately over the facility's intercom system. ODO also notes because officers are trained to recognize health-related emergencies, no vetting of their identification of an emergency situation by a lieutenant should be necessary.
4. Medical personnel were delayed in responding to FINO by a total of 63 seconds due to the failure of Master Control to operate the elevator doors in a manner that assured the most expeditious access to and from the scene. Once a medical emergency is called, priority should be given to facilitating medical staff's movement throughout the facility.
5. Officer [ ] and [ ] both left Dorm 2 unsupervised. Officer [ ] left for approximately four and half minutes shortly before FINO's medical emergency; Officer [ ] left twice after the emergency, the first time for four minutes and the second for approximately eight minutes. Leaving a post unsupervised puts detainees at risk.
6. Officer [ ] stated that he allows detainees to hang sheets on the bunks to shut out light. Sergeant [ ] acknowledged that although not allowed per policy, many officers on the overnight shift exercise their judgment and permit detainees to hang sheets and blankets. For the same reasons leaving a post unsupervised puts detainees at risk, allowing detainees to obstruct the officer's view of bunks is an unsafe practice.
7. Officer [ ] recorded security rounds ever [ ] minutes, [ ].  
[ ] Conducting rounds in this fashion defeats the purpose of assuring detainee safety. When detainees can predict the timing of rounds, they may plan and execute actions which are self-injurious, and carry out assaultive behavior toward other detainees. It is critical that rounds be random so that detainees cannot predict when an officer will be making a round.

## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez

### JICMS #201607857

---

8. The internal investigation conducted by IAB appears to have had as its sole focus whether or not FINO was assaulted prior to his death. The IAB's investigation determined that no crime was committed, and no further review of the incident was documented. Based on analysis of the IAB report and information provided by Sergeant [ ] and Investigator [ ] ODO identified the following flaws in the internal investigation:

- No ECCF security or medical staff were interviewed during the investigation. Both Sergeant [ ] and Investigator [ ] stated that they typically conduct interviews only when they find discrepancies in the written incident reports of involved staff. During his interview, Director [ ] stated that accepting written reports from staff was not sufficient for purposes of the IAB's investigation.
- Incident reports were not collected from medical staff.
- The IAB report inaccurately and inconsistently documents the name of the doctor who performed FINO's autopsy.
- The IAB report documents video surveillance footage was reviewed, and that "the incident was not captured." While this is an accurate statement because there is no camera in Dorm 2, the report contains no discussion of any findings related to footage from the corridor camera, even though the footage was obtained as part of IAB's investigation. As noted in the narrative of this report, the corridor camera footage shows Officer [ ] leaving his post without being relieved, as well as officers not responding to the medical emergency.
- There is no indication the IAB attempted to reconcile the Dorm 2 logbook with the footage of the corridor outside Dorm 2, develop a timeline of the emergency response, evaluate compliance with post orders and policies prior to and during the incident, or determine whether security staff responded appropriately to the emergency. As noted, these records and documentation clearly show that rounds logged by Officer [ ] were exactly [ ] minutes apart, in violation of his post orders; that Officer [ ] left Dorm 2 unsupervised; that neither officer took detainee FINO's pulse or otherwise attempted to render aid; and, that available officers near the scene did not respond to assist.
- The IAB report does not document that video footage from the elevator was requested or viewed by the IAB as part of its investigation. Had the IAB viewed

---

<sup>182</sup> Although not discussed in the narrative of this report, during review of video surveillance footage, ODO observed Officer [ ] leave Dorm 2 without being relieved by another officer on two occasions on June 13, 2016, after the emergency response was over. He first left at 6:13 a.m. and was gone for approximately three minutes; he left a second time at 6:17 a.m. and was gone for approximately eight minutes.

## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez

### JICMS #201607857

---

the video, they may have identified the delay closing the elevator doors as a factor impacting timeliness of the medical emergency response.

9. ODO noted numerous violations of ECCF policies and post orders with respect to FINO, identified below.
- General Housing Unit Post Order, which states, “In the event of an emergency situation, report the conditions and/or circumstances to Center Control by the most expeditious means possible (telephone, internal 9-1-1, radio, PPD, etc.)... and then take reasonable action to arrest the situation or to remove persons from harm until such time as more specific instruction from supervisory personnel/Center Control is received.”
  - Emergency Response Policy, Section (IV)(C), which states, “In the event of an emergency condition, the staff member who first becomes aware of the incident shall immediately alert Master Control (Center Control) in the most expeditious means possible. The reporting staff member shall provide an accurate, factual account of all available information regarding the incident. Immediately thereafter it is the reporting staff member’s responsibility to take action necessary to preserve life and limb, to protect property, and to restore order.”
  - General Housing Unit Post Order, which states, “All ECDOC staff members have the responsibility to take appropriate action during an emergency (including physical restraint) and to perform assignments as necessitated or dictated by competent authority.”
  - The Corrections Officers-Security Assignments policy, which states, “The Security Officer, under the direction and supervision of the First Line Supervisor, Sergeant, shall assume responsibility for his/her physical area of assignment, providing general security within the area of assignment, supervising all inmates and their activities associated with the area of assignment, assisting staff, inmates, visitors, and guests, as First Responders, upon direction from Center Control and/or supervisory personnel, to address emergent conditions.”
  - The Corrections Officers-Security Assignments policy, which states, “In the event an inmate or inmates sustain injury during the course of their routine activities and/or during an incident, the Pod Officer shall alert Floor Housing Control and/or Center Control to request medical attention; correctional personnel, trained in First Aid, may be dispatched to the scene of the medical emergency to provide assistance, until the services of more qualified health care providers can be obtained. However, in any event where an inmate exhibits any of the following signs and/or symptoms:
    - BLEEDING, OTHER THAN MINOR CUTS OR SCRAPES;
    - SHORTNESS OF BREATH;



## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez

### JICMS #201607857

---

- SIGNIFICANT PAIN OR ANY KIND;
- BURNS, OTHER THAN MINOR BURNS WITHOUT COMPLAINTS;
- EYE INJURIES, WITH ANY INMATE COMPLAINT;
- SEIZURES; OR
- IF IN THE OFFICER'S OPINION, AN INMATE HAS A MEDICAL PROBLEM THAT WARRANTS IMMEDIATE MEDICAL ATTENTION.

Then, the officer shall immediately contact the Medical Department and allow the inmate to speak directly with a health care provider. Further, the officer shall alert Floor Housing Control/Center Control for assistance and where feasible, render First Aid until the services of more qualified medical personnel becomes available.”

- General Housing Unit Post Order, which states, the Officer shall “Enforce inmate/detainee rules and regulations.”
- The ECCF Detainee Handbook, page 6, which states, “Inmates are not permitted to cover, hang, or attach blankets, sheets, towels, clothing, or any other item to walls, windows, bunks, air vents, doors or light fixtures anywhere within the ECCF. Adequate lighting and unobstructed vision must be maintained for officers at all times throughout the facility.”
- The ECCF Detainee Handbook, page 26, which states, “Inmates are not permitted to cover, hang, or attach blankets, sheets, towels, clothing, or any other item to walls, windows, bunks, air vents, doors or light fixtures anywhere within the ECCF. Adequate lighting and unobstructed vision must be maintained at all times throughout the facility.”
- The ECCF Detainee Handbook, page 5, which states, “At no time will any inmate exert or be allowed to exert authority over any other inmate or group of inmates”.
- The Corrections Officers-Security Assignments policy, which states, the officer shall “Complete all reports before ending tour of duty.”
- The Emergency Response policy, section (IV)(G)(1)(a), which states, “Master control will make an elevator (S1 or S2) available for responding medical personnel and their equipment.”
- Essex County Department of Corrections Rules and Regulations Manual, section 3:8.13 CONSTANT SUPERVISION, which states, “Inmates shall not be left unattended and unsupervised at any time, unless dictated by department policy or at the command of the appropriate supervisor.”

## DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez

### JICMS #201607857

---

- General Housing Unit Post Order, which states, “All ECDOC staff members are prohibited from leaving their assigned posts without being properly relieved or otherwise dismissed by a superior officer.”
- General Housing Unit Post Order, which states, “Inmates/ICE Detainees shall be personally observed by an officer [redacted] but no more than [redacted]  
[redacted]”
- Classification Policy, which states, “Each ICE Detainee’s initial classification worksheet shall be reviewed and approved by a the [sic] classification supervisor or designee from the ICE Field Office.”

DETAINEE DEATH REVIEW – Luis Alonso FINO-Martinez  
JICMS #201607857

---

**EXHIBITS**

1. ICE Detainee Classification System – Primary Assessment Form, June 22, 2015
2. Medical Prescreening by LPN [REDACTED] June 22, 2015
3. Initial Intake Screening Medical/Mental Health History, June 22, 2015
4. Medical Screening by Dr [REDACTED] June 23, 2015
5. Practitioner Urgent/Emergent Care by P [REDACTED] June 13, 2016
6. Office [REDACTED] Incident Report, June 13, 2016
7. Autopsy Report
8. Certificate of Death
9. Creative Corrections Medical and Security Compliance Analysis