

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

SYNOPSIS

On May 1, 2016, Igor ZYAZIN, who was a forty-six year-old citizen and national of Russia, died while in the custody of U.S. Immigration and Customs Enforcement (ICE), at the Otay Mesa Detention Center (OMDC)¹ in San Diego, California. The County of San Diego Certificate of Death documented the cause of ZYAZIN's death as hypertensive² and atherosclerotic cardiovascular disease,³ and his manner of death as natural.

ZYAZIN was detained at the San Luis Regional Detention Center (SLRDC) in San Luis, Arizona (AZ) from April 24 to 29, 2016. SLRDC is owned by the City of San Luis and operated by Emerald Correctional Management (Emerald), under a U.S. Marshals Service (USMS) Inter-Governmental Agreement (IGA), which requires the facility to comply with the ICE National Detention Standards (NDS) 2000. At the time of ZYAZIN's detention, SLRDC housed approximately 225 male detainees of all classification levels. Medical care at SLRDC is provided by Emerald. On April 29, 2016, ERO transferred ZYAZIN to OMDC.

ZYAZIN was detained at OMDC from April 29, 2016, until his death. OMDC is owned and operated by the Corrections Corporation of America (CCA), under a USMS IGA, which requires the facility to comply with the ICE Performance-Based National Detention Standards (PBNDS) 2011. At the time of ZYAZIN's death, OMDC housed approximately 826 male and female detainees of all classification levels for periods in excess of 72 hours. Medical care at OMDC is provided by the ICE Health Service Corps (IHSC), supported by contractor InGenesis and sub-contractor STG International, Incorporated.

DETAILS OF REVIEW

From June 6 to 9, 2016, ICE Office of Professional Responsibility (OPR), Office of Detention Oversight (ODO) staff visited SLRDC and OMDC and, with the assistance of contract subject matter experts (SME) in correctional healthcare and security, reviewed the circumstances of ZYAZIN'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 ZYAZIN, in addition to conducting in-person interviews of individuals employed by Emerald, CCA, 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 ZYAZIN's apprehension by ICE, through his detention at both SLRDC and OMDC, and his eventual death at OMDC.

¹ This facility is also known as the San Diego Contract Detention Facility.

² A heart condition caused by high blood pressure.

³ Commonly referred to as "heart disease", this condition develops when plaque builds up on the walls of the arteries in the heart, hardening and narrowing them.

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

IMMIGRATION AND DETENTION HISTORY

Igor ZYAZIN entered the United States on February 27, 2002, at Chicago, Illinois, as an exchange visitor with a J-1 visa.⁴ On September 28, 2009, ZYAZIN voluntarily arrived at the ERO Los Angeles office and requested to be removed from the United States to Russia. On October 2, 2009, ERO served ZYAZIN with a Form I-862, Notice to Appear, charging him with removability pursuant to section 237 (a)(1)(B) of the Immigration and Nationality Act (INA) as a nonimmigrant overstay, and detained him at the Mira Loma Detention Center in Lancaster, California. On October 9, 2009, ERO Los Angeles transferred ZYAZIN to ERO San Diego's custody at OMDC.⁵ On December 9, 2009, an immigration judge ordered ZYAZIN removed from the United States.⁶ ZYAZIN was removed by ERO San Diego to Russia on December 28, 2009.⁷

On April 20, 2016, ZYAZIN appeared before a U.S. Customs and Border Protection (CBP) Officer at the Port of Entry at San Ysidro, California, seeking admission into the United States from Mexico, presented his Russian passport, and stated he was seeking asylum from Russia. ZYAZIN was found to be inadmissible to the United States pursuant to §212(a)(7)(A)(i)(I) of the Immigration and Nationality Act (INA), as amended, as an immigrant without an immigrant visa. A criminal record was not found. During his interview with a CBP officer, ZYAZIN stated he had no health problems and was not taking any medications.⁸

On April 24, 2016, CBP transferred ZYAZIN to ERO custody at SLRDC, and on April 29, 2016, he was transferred by ERO to OMDC.

CRIMINAL HISTORY

None.

SAN LUIS REGIONAL DETENTION CENTER (April 24, 2016 to April 29, 2016)

NARRATIVE

ODO determined the following timeline of events, from the time ZYAZIN was admitted to SLRDC on April 24, 2016, until his transfer to OMDC on April 29, 2016.

On **April 24, 2016**, ZYAZIN was booked into SLRDC at 8:47 p.m.⁹ Because ZYAZIN was scheduled for transfer to the Northwest Detention Center (NWDC), in Tacoma, Washington,

⁴ See Form I-205, Warrant of Removal/Deportation, dated December 28, 2009; ICE Significant Incident Report, dated May 2, 2016.

⁵ See Detainee Transfer Notification form, dated October 9, 2009.

⁶ See Order of Immigration Judge, San Diego, CA, dated December 9, 2009.

⁷ See Form I-216, Record of Person(s) and Property Transferred, dated December 28, 2009.

⁸ See Form I-213, Record of Deportable/Inadmissible Alien, dated April 23, 2016.

⁹ See San Luis Regional Detention Center Inmate Cell History/Movement Report, dated May 27, 2016.

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

within 72 hours of his arrival to SLRDC,¹⁰ he was designated as an OMDC detainee. At the time of ZYAZIN's detention, SLRDC was used strictly as a "short term" facility, meaning all individuals housed at SLRDC are pending transport to another facility and that most of the individuals stay for an average of seven days or less. Case management for detainees scheduled for transfer to another facility within 72 hours of arrival at SLRDC is the responsibility of ERO at OMDC; case management for detainees scheduled for transfer to another facility after more than 72 hours is the responsibility of ERO at the El Centro Service Processing Center.

In accordance with standard practice, booking forms, including an information sheet and an initial suicide prevention screening form, were completed for ZYAZIN, by Officer [REDACTED] prior to his arrival.¹¹ Officer [REDACTED] erroneously recorded ZYAZIN's marital status as single on the information sheet.¹² She also documented negative responses to the suicide screening questions even though ZYAZIN was not present at the time the form was completed. Nor was he subsequently asked the screening questions upon his arrival at the facility.¹³

ZYAZIN's admission and processing was conducted by Officer [REDACTED].¹⁴ It is noted Officer [REDACTED] did not sign off on any of ZYAZIN's intake forms. During his interview, Officer [REDACTED] stated that he did not change any entries to the initial suicide prevention screening form prepared by Officer [REDACTED]. He stated that intake officers only ask suicide prevention screening questions if a detainee's appearance or behavior is "abnormal."¹⁵ Officer [REDACTED] classified ZYAZIN as a low custody detainee using the facility's custody assessment form.¹⁶ According to ERO personnel at SLRDC, criteria for detention at SLRDC is that the individual must be a low-level detainee, with few or no known medical or mental health conditions. Prior to placing a detainee at SLRDC, ERO conducts a Risk Classification Assessment (RCA) to determine his/her appropriate classification level and to ensure assignment to SLRDC is appropriate. SLRDC officers interviewed by ODO stated standard intake practice includes classifying all detainees as low custody per ERO's RCA rating and housing them accordingly. Although ZYAZIN's low custody determination was appropriate because he had no criminal record or escape history, his custody assessment form was not approved by a supervisor.

During her interview with ODO, Assistant Warden (AW) [REDACTED] stated she expects officers to evaluate detainee custody levels objectively and not pre-determine that all detainees are low custody, in accordance with ICE NDS, Detainee Classification System.¹⁷ She also confirmed that a supervisor is required to approve all classification determinations. However, Officer [REDACTED] stated that intake officers are instructed to classify all detainees as low custody in accordance with ERO's custody determination, and that supervisors do not approve detainee

¹⁰ See Enforcement and Removal Module Case Comments.

¹¹ ODO interview with Officer [REDACTED] June 6, 2016.

¹² See Exhibit 1: SLRDC Information Sheet and initial Suicide Prevention Screening Form, dated April 24, 2016.

¹³ See Id.

¹⁴ ODO interview with Officer [REDACTED] June 7, 2016. Officer [REDACTED] stated he remembered conducting ZYAZIN's intake.

¹⁵ Officer [REDACTED] acknowledged "abnormal" appearance and/or behavior is a subjective determination.

¹⁶ See Exhibit 2: SLRDC Initial Custody Assessment form, dated April 24, 2016.

¹⁷ ODO interview with Assistant Warden [REDACTED], June 7, 2016.

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

classification levels unless something unusual is noted during completion of SLRDC's custody assessment. It is noted that although Officer [] completed the custody assessment form, the officer named on the form is Lieutenant []¹⁸ ODO interviewed Lieutenant [] who acknowledged that he did not classify or approve ZYAZIN's classification level, and agreed that officers routinely use his account name and password when completing intakes.¹⁹ AW [] stated that account names and passwords were created for all officers after ZYAZIN's detention.

As part of the intake process, Officer [] was also responsible for inventorying ZYAZIN's property, which included his personal clothing as well as a backpack containing various items.²⁰ While ZYAZIN's clothing was properly inventoried, the backpack and its contents were not included on the inventory receipt.²¹ SLRDC officers interviewed by ODO stated standard intake practice dictates that the only property inventoried for detainees scheduled for transfer within 72 hours is clothing and currency. All other personal property is tagged with the detainee's name and stored in the facility's property room without being inventoried, and sent with the detainee upon transfer. Both Officer [] and AW [] stated during interview that in accordance with established practice, the backpack was not inventoried because ZYAZIN was scheduled for transfer to another facility within 72 hours of his intake.²² They explained that, per standard practice, ZYAZIN's backpack was sealed in the manner in which it arrived, stored in the property room without being inventoried, and subsequently sent with the detainee upon transfer.²³ In addition to clothing and the backpack, ZYAZIN also arrived at SLRDC with \$1,165.00 in U.S. currency.²⁴ The currency was collected and stored in a safe, and a receipt was generated for ZYAZIN. AW [] explained during her interview that accounts are not typically created for ICE detainees due to the short amount of time they are housed at SLRDC.

Officer [] did not remember whether he communicated with ZYAZIN in English during the intake process but stated he regularly utilizes Google Translate to communicate with non-English speaking detainees and may have done so with ZYAZIN.²⁵ AW [] stated during her interview that at the time of ZYAZIN's detention, SLRDC used an ICE language interpretation service that was only available during regular working hours (8:00 a.m. to 5:00 p.m.). By the time of ODO's review, SLRDC had since contracted with a 24-hour language interpretation

¹⁸ See Exhibit 2. Officer [] explained he and other officers routinely use Lieutenant [] account and password when using the facility's booking system which automatically populates Lieutenant [] name on intake forms. See ODO interview with Officer [] June 7, 2016.

¹⁹ ODO interview with Lieutenant [] June 7, 2016.

²⁰ See Exhibit 3: SLRDC Property Withheld Receipt, dated April 25, 2016; ODO interview with Officer [] June 6, 2016. Although not documented on his SLRDC property inventory, ZYAZIN's property inventory receipt from OMDC shows a backpack was included in his personal property. Additionally, Officer [] who transported ZYAZIN from SLRDC to OMDC, remembered that a backpack accompanied the detainee during transport.

²¹ See Exhibit 3.

²² ODO interview with Officer [] June 7, 2016; ODO interview with Assistant Warden [] June 7, 2016.

²³ Id.

²⁴ See Exhibit 4: SLRDC Cash Receipt, dated April 24, 2016.

²⁵ ODO interview with Officer [] June 7, 2016.

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

service. AW[] stated officers are instructed to use the 24-hour service, not Google Translate, whenever English proficiency is questionable.

After his intake processing was complete, ZYAZIN underwent a medical intake screening by Medical Assistant (MA) [] MA [] also completed the mental health intake screening, which included questions related to suicide risk.²⁷ MA [] did not document the time the intake screening was conducted, but during her interview with ODO, she stated it was completed before midnight.²⁸ MA [] stated ZYAZIN spoke English, so telephonic interpretation was not necessary. MA [] documented ZYAZIN denied having any medical or mental health conditions or pain and stated he was not taking any medication. She also documented that his vital signs were within normal limits. Although MA [] documented that tuberculosis (TB) screening questions were asked during the intake screening, she did not document whether a purified protein derivative (PPD) skin test or chest x-ray were completed. Health Services Administrator (HSA) [] Registered Nurse (RN), stated during her interview with ODO that SLRDC does not place a PPD or perform chest x-rays on detainees scheduled for transfer within 72 hours.²⁹ As noted below, ZYAZIN's transfer to NWDC was cancelled on April 25, 2016,³⁰ yet he did not receive TB screening by PPD or chest x-ray until April 29, 2016, immediately prior to this transfer to OMDC, in contravention of the ICE NDS, Medical Care.³¹

On April 25, 2016, at 3:04 a.m., ZYAZIN's intake was completed, and he was transferred to general population housing Unit 2.³² At an undocumented time, the ERO Seattle Field Office informed the ERO San Diego Field Office that NWDC could not accept ZYAZIN, and ZYAZIN was removed from the travel manifest.³³

ZYAZIN's record contains no documented medical encounters or detention-related events until April 28, 2016.

On April 28, 2016, at 8:39 p.m., ZYAZIN was transferred from Unit 2 to the Juliet Pod.³⁴ Juliet Pod is a dormitory style housing unit accommodating up to 32 detainees. Supervision is indirect, provided by [] officers stationed [] including Juliet Pod. Officers are required to make rounds every [] minutes.

²⁶ See Exhibit 5: San Luis Regional Detention Center Medical Intake Screening, dated April 24, 2016.

²⁷ See Exhibit 6: San Luis Regional Detention Center Mental Health Screening form, dated April 24, 2016.

²⁸ ODO interview with Medical Assistant [] June 6, 2016.

²⁹ ODO interview with Health Services Administrator [] Registered Nurse, June 6, 2016.

³⁰ See ICE Significant Incident Report, dated May 2, 2016.

³¹ See Exhibit 7: Prisoner in Transit Medical Summary form, dated April 29, 2016.

³² See San Luis Regional Detention Center Inmate Cell History/Movement Report, dated May 27, 2016.

³³ ODO was unable to determine why NWDC could not accept ZYAZIN, and notes the detainee's record lacks documentation on the scheduling and subsequent cancellation of the transfer.

³⁴ See San Luis Regional Detention Center Inmate Cell History/Movement Report, dated May 27, 2016. ODO learned during the onsite review that only five detainees were housed in Unit 2 at the time, so they were consolidated with other detainees housed in Juliet Pod.

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

At 9:55 p.m., ZYAZIN was seen by Nurse Practitioner (NP) [] in response to an April 26, 2016 sick call request for a sore throat.³⁵ ZYAZIN indicated to NP [] that his sore throat resolved on its own after submitting the request; however, during the encounter, he complained of back pain radiating down his leg, a history of chronic low back and leg pain due to a traumatic injury, and a pre-existing heart condition.³⁶ ZYAZIN did not report this medical history during his intake screening. NP [] documented in a May 2, 2016 e-mail to HSA [] that ZYAZIN stated he took heart medications but only knew the Russian names of the medications.³⁷ NP [] also documented that it was “his impression” that ZYAZIN’s medical records were with his personal belongings. NP [] documented his initial assessment during this encounter as a heart murmur,³⁸ cardiomyopathy,³⁹ heart failure, or both. He also noted ZYAZIN was experiencing low back pain with associated sciatica⁴⁰ and paresthesia.⁴¹ NP [] ordered a cardiac evaluation and also noted in the initial assessment that ZYAZIN’s medical records be retrieved from his property. During his interview, NP [] stated ZYAZIN did not appear healthy during the encounter, but the detainee was more concerned with his low back pain than with his heart condition.⁴² NP [] described ZYAZIN’s English language proficiency as fair, but stated he did not use the facility’s telephonic language line service because he was under the impression telephonic interpretation services were unavailable after 5:00 p.m.⁴³

In an SLRDC General Statement prepared May 3, 2016, after notification of ZYAZIN’s death, NP [] documented the following additional information regarding the April 28, 2016 encounter:⁴⁴

- ZYAZIN’s vital signs were stable, his lungs were clear to auscultation⁴⁵ and a systolic murmur⁴⁶ was observed. It is noted that although the April 28, 2016 Provider Exam Sheet includes a section for recording vital signs, NP McNair did not record them during the encounter.
- ZYAZIN reported taking heart medications but did not know the English names for them. ZYAZIN reported his Russian medical records, including electrocardiograms⁴⁷ (EKG), were in his personal property.

³⁵ See San Luis Regional Detention Center Sick Call Request Form, dated April 26, 2016.

³⁶ See San Luis Regional Detention and Support Center Provider Exam Sheet, dated April 28, 2016.

³⁷ See NP []-mail to HSA [] dated May 2, 2016.

³⁸ A heart murmur is an unusual sound between heartbeats which sometimes signifies a heart condition.

³⁹ A chronic disease of the heart muscle in which the muscle is abnormally enlarged, thickened, and/or stiffened and the weakened heart muscle loses the ability to pump blood effectively.

⁴⁰ Pain extending down the sciatic nerve in the lower extremities.

⁴¹ This condition is manifested with a numbness or tingling on the skin.

⁴² ODO interview with Nurse Practitioner [] June 6, 2016.

⁴³ Id.

⁴⁴ See SLRDC General Statement by NP [] dated May 3, 2016.

⁴⁵ The practice of listening to breath sounds with a stethoscope.

⁴⁶ A heart murmur heard at the time the heart muscle contracts, usually due to mitral or tricuspid regurgitation/backflow of blood when the valves are not functioning properly.

⁴⁷ A record of the heart’s electrical impulses which can identify problems with heart rate and rhythm.

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

On April 29, 2016, at approximately 7:15 a.m.,⁴⁸ ZYAZIN knocked on the Juliet housing unit door to obtain the attention of an officer. Officer [] was making a round in the corridor outside the dorm when she heard the knock and opened the door to the Juliet pod.⁴⁹ ZYAZIN told Officer [] he felt unwell, that he was dizzy, and that his chest hurt. Officer [] stated she did not call a medical emergency because ZYAZIN did not specifically state that his heart hurt. Instead, she called the medical unit via telephone and spoke to RN [] RN [] stated during her interview with ODO that Officer [] reported ZYAZIN was experiencing chest pains.⁵⁰ RN [] instructed Officer [] to bring ZYAZIN to the medical unit immediately, and informed Officer [] that ZYAZIN would be moved to medical housing.⁵¹ Officer [] instructed ZYAZIN to pack his belongings, and then escorted him to the medical unit.⁵² Officer [] stated ZYAZIN was able to carry his own property bin during the escort.

At approximately 7:30 a.m., ZYAZIN arrived in the medical unit and was assessed by MA [] MA [] stated during her interview that ZYAZIN initially complained of low back pain, not chest pain. She stated she obtained ZYAZIN's vital signs and, although she did not record them in the medical record, she remembered the detainee's pulse rate was very elevated.⁵⁴ After MA [] obtained his vital signs, ZYAZIN was assessed by RN [] at 7:55 a.m.⁵⁵ During her interview, RN [] stated ZYAZIN reported a history of cardiac problems, and complained he was being denied the opportunity to make phone calls.⁵⁶ She remembered the detainee speaking English well. RN [] documented the following during the encounter:⁵⁷

- Auscultation⁵⁸ of ZYAZIN's heart sounds found a loud audible murmur, but he did not complain of any radiating pain.
- ZYAZIN rated his pain level as six out of ten, with ten being the most severe.
- ZYAZIN's blood pressure and pulse were slightly elevated, but his respirations were normal.
- ZYAZIN was administered nitroglycerin⁵⁹ 0.4 mg under his tongue for chest pain.

⁴⁸ This time is not documented in ZYAZIN's record but was approximated by ODO based on subsequent events.

⁴⁹ ODO interview with Officer [], June 6, 2016.

⁵⁰ Id.

⁵¹ Id.; ODO interview with Registered Nurse [], June 6, 2016.

⁵² ODO interview with Officer [], June 6, 2016.

⁵³ Id.; ODO interview with Medical Assistant MA [], June 7, 2016.

⁵⁴ In a General Statement prepared by MA [] on May 2, 2016, she documented that based on memory, the detainee's pulse was approximately 117 (a normal resting heartbeat for adults ranges from 60 to 100 beats per minute), and his blood pressure was mildly elevated at 130/85 (normal blood pressure is considered to be below 120/80).

⁵⁵ ODO interview with Medical Assistant MA [], June 7, 2016; see General Statement to Medical Record by RN [] dated May 2, 2016.

⁵⁶ ODO interview with Registered Nurse [], June 6, 2016.

⁵⁷ See General Statement to Medical Record by RN [] dated May 2, 2016.

⁵⁸ A term used in reference to the practice of listening to breath sounds with a stethoscope.

⁵⁹ Nitroglycerin is used to treat episodes of chest pain in people who have coronary artery disease. It works by relaxing and widening blood vessels so blood can flow more easily to the heart.

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

At approximately 8:10 a.m., ZYAZIN was reassessed by RN [] and stated his pain was a level four out of ten. A second dose of nitroglycerin 0.4 mg was administered sublingually, and his vital signs were retaken and found to be within normal limits.⁶⁰ At 10:03 a.m., ZYAZIN was officially transferred to the medical housing unit (MHU) for continued monitoring.⁶¹

Due to a lack of documentation by both SLRDC and ERO, ODO relied primarily on verbal reports by interviewed security, medical, and ERO staff to determine the course of events leading up to ZYAZIN's transfer to OMDC, described below.

After reassessing ZYAZIN and establishing that he was stable, RN [] left the medical unit to distribute medications in the housing units.⁶² She encountered ERO Deportation Officer (DO) [] during medication distribution and informed the DO that ZYAZIN experienced a cardiac issue that morning and was moved to the MHU. DO [] immediately visited ZYAZIN in the MHU and spoke to the detainee using telephonic interpretation.⁶³ As reported by DO [] ZYAZIN expressed concern about the welfare of his wife, and desired to speak with the U.S. Central Intelligence Agency (CIA).

After speaking with ZYAZIN, DO [] recommended to an SLRDC lieutenant that ZYAZIN be transferred to OMDC to ensure appropriate care of his cardiac issues. DO [] explained to the review team that communications concerning the transfer of a detainee generally must occur between SLRDC staff and the DO responsible for the detainee, depending upon whether the detainee is assigned to OMDC or to El Centro SPC.⁶⁴ At the time of ZYAZIN's detention, DO [] was responsible for detainees assigned to El Centro SPC, and DO [] was responsible for detainees assigned to OMDC.

DO [] stated during his interview that he learned ZYAZIN was in the MHU due to cardiac issues the morning of April 29, 2016.⁶⁵ DO [] stated ERO does not house detainees with medical issues at SLRDC, so he initiated the process to transfer ZYAZIN to OMDC. Although a transport to OMDC was scheduled for the following day, April 30, 2016, DO [] decided to transfer ZYAZIN to OMDC immediately, provided he was medically stable enough to make the trip. Upon notification of ZYAZIN's pending transfer to OMDC, RN [] completed a Prisoner in Transit Medical Transfer Summary, noting the detainee was diagnosed with cardiomyopathy and had nitroglycerin for chest pain on his person.⁶⁶ She also documented ZYAZIN was not yet cleared for tuberculosis. MA [] placed a PPD skin test in ZYAZIN's arm and documented the test should be read by the receiving facility on May 1, 2016.⁶⁷

⁶⁰ See General Statement to Medical Record by RN [] dated May 2, 2016.

⁶¹ See San Luis Regional Detention Center Inmate Cell History/Movement Report, dated May 27, 2016.

⁶² ODO interview with Registered Nurse [] June 6, 2016.

⁶³ ODO interview with Deportation Officer [] June 6, 2016. DO [] stated ZYAZIN's English was very broken.

⁶⁴ ODO interview with Deportation Officer [] June 6, 2016.

⁶⁵ ODO interview with Deportation Officer [] June 8, 2016. DO [] did not remember whether he was contacted by SLRDC staff or DO [] regarding ZYAZIN.

⁶⁶ See Exhibit 7.

⁶⁷ See Exhibit 7. See also SLRDC TB Screening and Testing form, dated April 29, 2016.

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

Officer [] and Officer [] were assigned to transport ZYAZIN to OMDC. During her interview with ODO, Officer [] stated upon receiving the transport assignment, she went to the medical unit and instructed ZYAZIN to prepare for his release from SLRDC.⁶⁸ ZYAZIN returned his facility issued property and changed into the personal clothing inventoried upon intake. It is noted the SLRDC Property Released Receipt for ZYAZIN lists his clothing items but does not document the release of the backpack.⁶⁹ However, during his interview, Officer [] stated he recalled retrieving ZYAZIN's backpack from intake and transporting it to OMDC.⁷⁰ It is also noted both ZYAZIN's release report and currency receipt document ZYAZIN had \$0 in funds to transfer.⁷¹ AW [] informed the review team that SLRDC staff checked for an account when ZYAZIN was booked out, found none, and notated that he had no funds to transfer accordingly.⁷² As noted, SLRDC does not create accounts for detainees due to their short length of stay. DO [] informed ODO that while reviewing ZYAZIN's record following the death, he saw a notation in the detainee's I-213 showing ZYAZIN declared \$1,165.00 in currency when he was interviewed and processed by CBP on April 23, 2016. DO [] contacted SLRDC to confirm whether the detainee had any funds upon admission.⁷³ This call prompted SLRDC to review ZYAZIN's detention file which contained a copy of the currency receipt showing the detainee had \$1,165.00. The \$1,165.00 was then located in the facility safe, and sent to OMDC during a detainee transport.⁷⁴

Officer [] stated he and Officer [] received an envelope with ZYAZIN's medical records to take to OMDC, but that neither were aware ZYAZIN had nitroglycerin in his possession. At 11:17 a.m., ZYAZIN departed SLRDC for OMDC.⁷⁵ Officer [] and [] both stated the detainee did not appear to be in pain or discomfort and remained awake for the entire drive to OMDC, which takes an estimated three to four hours.⁷⁶

Upon arrival at OMDC, Officer [] was met by an unidentified ICE officer, a correctional officer, and a nurse.⁷⁷ Officer [] stated he removed ZYAZIN's restraints and carried the detainee's backpack into the facility. Officer [] stated a nurse asked ZYAZIN how he felt, and ZYAZIN responded by holding his chest and stating that his chest hurt. The SLRDC transportation officers then left OMDC.

⁶⁸ ODO interview with Officer [] June 7, 2016.

⁶⁹ See Exhibit 8, SLRDC Property Released Receipt, dated April 29, 2016.

⁷⁰ ODO interview with Officer [] June 6, 2016.

⁷¹ See Exhibit 9, SLRDC Release Report, dated April 29, 2016.

⁷² ODO interview with Assistant Warden [] June 7, 2016.

⁷³ ODO interview with DO [] June 8, 2016.

⁷⁴ Id. SLRDC did not document the date of DO [] call or the subsequent transport of ZYAZIN's funds.

⁷⁵ See San Luis Regional Detention Center Inmate Cell History/Movement Report, dated May 27, 2016.

⁷⁶ ODO interview with Officer [] June 6, 2016; ODO interview with Officer [] June 7, 2016.

⁷⁷ ODO interview with Officer [] June 6, 2016.

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

MEDICAL CARE AND SECURITY REVIEW

Creative Corrections, a national management and consultant firm contracted by ICE to provide subject matter expertise in detention management including medical care and security, reviewed the medical care ZYAZIN was provided at SLRDC, as well as his safety and security while detained at the facility. Creative Corrections found deficiencies in SLRDC's compliance with the following Standards in the ICE NDS 2000: Medical Care, Admission and Release, Detainee Classification System, Funds and Personal Property, and Detainee Transfers.⁷⁸

FINDINGS

ODO found SLRDC deficient in the following area of the ICE NDS 2000:

1. **ICE NDS 2000, Medical Care, section (III)(D)**, which states, "all new arrivals shall receive TB screening by PPD (mantoux method) or chest x-ray."

Although appropriate TB symptom screening questions were asked during the medical intake, ZYAZIN did not receive a PPD or chest x-ray upon admission to SLRDC on April 24, 2016. A PPD was planted by SLDC staff on April 29, 2016, prior to his transfer to OMDC.

2. **ICE NDS 2000, Admission and Release, section (III)(A)(1)**, which states, "every new arrival shall undergo screening interviews, complete questionnaires and other forms, attend the facility's site-specific orientation program, and comply with other admission procedures (issuance of clothing, towels, bedclothes, etc.)."

Staff reported the information sheet and suicide screening form were completed prior to ZYAZIN's arrival at SLRDC.

3. **ICE NDS 2000, Detainee Classification System, section (III)(A)(3) and (III)(C)**, which state, "the first-line supervisor will review and approve each detainee's classification."

A supervisor did not approve ZYAZIN's classification.

4. **ICE NDS 2000, Detainee Classification System, section (III)(E)**, which states, "under no circumstances will issues of facility management or other factors external to the detainee classification system influence a detainee's classification level."

Staff reported that they were instructed to classify every detainee as minimum custody.

5. **ICE NDS 2000, Funds and Personal Property, section (III)(A)**, which states, "staff shall inventory, and maintain a record of, detainee personal property being shipped from the facility, with a copy of the record placed in the detainee's detention file."

⁷⁸ See Exhibit 10: Creative Corrections Medical Compliance Analysis.

DETAINEE DEATH REVIEW – Igor ZYAZIN JICMS #201606226

Staff did not include ZYAZIN's backpack or its contents on the property inventory.

6. **ICE NDS 2000, Detainee Transfers, section (III)(D)(6)**, which states, "prior to transfer, medical personnel will provide the transporting officers with instructions and, if applicable, medication(s) for the detainee's care in transit. Medications will be placed in a property envelope with the detainee's name and A-number on it. Medications will accompany the transfer and be turned over to an officer at the receiving field office."

ZYAZIN was given nitroglycerin by medical staff. The transporting officers were unaware he had the medication with him.

7. **ICE NDS 2000, Detainee Transfers, section (III)(E)(1)**, which states, "the following items shall always accompany a detainee to the receiving SPC, CDF or IGSA facility: cash and small valuables such as jewelry, address books, phone lists, correspondence, dentures, prescription glasses, small religious items, pictures, etc.

Funds belonging to ZYAZIN did not accompany him when transferred from SLRDC to OMDC.

AREAS OF NOTE

1. SLRDC does not have a designated clinical medical authority or physician coverage. Although a clinical director is not expressly required by the NDS, the position is referenced throughout the ICE medical care standards. Creative Corrections advises that oversight of clinical decision making and care is critical in a correctional health care operation.
2. On May 3, 2016, four days after ZYAZIN's transfer from SLRDC and two days after his death, NP [] completed a General Statement, supplementing information documented in the Provider Exam Sheet for his April 28, 2016 sick call encounter. The General Statement documents the detainee's vital signs were stable, lungs were clear to auscultation, and a systolic murmur was noted. This information was not recorded on the Provider Exam Sheet, nor were the detainee's specific vital signs. Also, on April 29, 2016, MA [] did not document ZYAZIN's vital signs when he was brought to medical with chest pains. In a General Statement dated May 2, 2016, MA [] documented that based on memory, ZYAZIN's blood pressure was approximately 130/85 and pulse 117. NP [] and MA [] entries to the medical record documenting their encounters should have been completed at the time they were made.
3. Accountability for completion of intake functions was compromised by Officer [] use of a supervisor's log-on information. Based on reported information, this was not an isolated occurrence.
4. According to interviewed intake officers, several intake forms are commonly completed prior to a detainee's physical arrival and intake. In ZYAZIN's case, a general detainee

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

information form and a suicide prevention screening form were completed in advance of his arrival to SLRDC. The information form inaccurately recorded his marital status as single, and the suicide prevention screening form had “no” marked for every suicide prevention screening question. Although subsequent intake screening by medical staff included assessment of suicide risk, security’s completion of the initial suicide prevention screening form without the detainee being present nullified its value.

5. Pertinent to both medical and security functions, SLRDC staff interviewed by ODO had discrepant understandings of the availability of SLRDC’s telephonic interpretation service and expectations for use thereof.

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

OTAY MESA DETENTION CENTER (April 29, 2016 to May 1, 2016)

NARRATIVE

ODO determined the following timeline of events, from the time ZYAZIN was admitted to OMDC on April 29, 2016, through his death at OMDC on May 1, 2016.

On April 29, 2016, at 3:25 p.m., ZYAZIN arrived at OMDC.⁷⁹ Intake Office [] initiated ZYAZIN's intake processing by verifying his identification, taking his fingerprints and photographs, and creating his file in the computer system.⁸⁰ During her interview, Officer [] recalled ZYAZIN spoke with a heavy accent and had limited English proficiency.⁸¹

At approximately 3:33 p.m.,⁸² IHSC Lieutenant [] RN, performed ZYAZIN's medical pre-screening and documented the following:⁸³

- ZYAZIN reported a heart condition and that he was taking heart medications.
- ZYAZIN reported no pain.

RN [] immediately performed ZYAZIN's full intake medical screening and documented the following:⁸⁴

- ZYAZIN spoke English and no interpreter was needed.
- ZYAZIN's vital signs were within normal limits.
- ZYAZIN reported a heart problem requiring a stent.
- ZYAZIN stated he was in possession of nitroglycerin issued to him at SLRDC for heart palpitations, left chest pain, and right arm numbness.
 - RN [] contacted Physician Assistant (PA) [] and obtained an order for ZYAZIN to continue to keep the nitroglycerin on his person.
- ZYAZIN reported he had spinal surgery in 2004.
- A chest x-ray was taken to screen for tuberculosis. The results were still pending at the completion of the intake screening.
 - ODO notes OMDC screening for TB via chest x-ray removed the need to read the PPD previously planted at SLRDC.
- Due to his chronic conditions, ZYAZIN was scheduled for a physical examination by the physician the following morning.

⁷⁹ See ICE Form I-216, Manifest of Persons and Property Transferred, dated April 29, 2016.

⁸⁰ ODO interview with Officer [] June 8, 2016.

⁸¹ Id.

⁸² ODO notes the electronic medical record records times in Mountain Standard Time (MST), while OMDC is in the Pacific Time Zone (PST). All times in this report are provided in local time, and adjustments have been made where necessary.

⁸³ See Exhibit 11: Otay Mesa Detention Center Medical Intake Screening, dated April 29, 2016. Although the appointment was stamped completed at 3:40 p.m. local time, the record documents vital signs were taken at 3:33 p.m. The medical pre-screening is presumed to have begun approximately at this time.

⁸⁴ See Exhibit 11.

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

- Consent for medical, dental, and mental health services form was signed.⁸⁵
- ZYAZIN was cleared for general population housing.

The intake screening form was reviewed and signed on April 29, 2016, at 5:40 p.m. by RN [REDACTED]

Following the completion of his full medical intake screening, ZYAZIN returned to general admission processing. During his interview with ODO, Officer [REDACTED] stated ZYAZIN received his medical intake screening prior to completion of general admission processing because he was identified as a medical priority during the medical pre-screening.⁸⁷ Officer [REDACTED] stated he utilized the telephonic language translation service to complete ZYAZIN's intake.⁸⁸ Officer [REDACTED] used the ICE Custody Classification Worksheet to classify ZYAZIN, but failed to sign and date the form.⁸⁹ Officer [REDACTED] appropriately applied a rating of low, which was approved by a supervisor on April 29, 2016. All property was inventoried in detail, including the laptop computer, tablet, and flash drive contained in his backpack.⁹⁰ ODO notes no paper documents were included on the inventory; however, it is possible the medical records ZYAZIN stated were in his property while at SLRDC may have been on his electronic devices. No currency was inventoried during ZYAZIN's intake.

At 9:42 p.m., ZYAZIN was issued facility property and clothing.⁹¹ After the completion of admissions processing, ZYAZIN was transferred from intake to P-Pod, a two level, direct supervision, low security housing unit with a capacity of 128.⁹² Two ceiling-mounted security cameras provide continuous monitoring and recording of activity in dayroom area of the pod. ZYAZIN was assigned to Dorm 206, an open bay on the second floor, containing four sets of bunk beds. ZYAZIN was assigned to a lower bunk bed positioned on the back, right side wall.

On April 30, 2016, at 10:12 a.m., Commander (CDR) [REDACTED] MD, Clinical Director, conducted ZYAZIN's physical examination and documented the following:⁹³

- ZYAZIN reported a prior myocardial-infarction⁹⁴ while in Russia in 2015, and a related diagnosis of aortic regurgitation.⁹⁵
- ZYAZIN reported decreased sensitivity to his right lower extremity due to a herniated⁹⁶ disc, which he stated was diagnosed by magnetic resonance imaging in Russia in 2015.
- ZYAZIN reported spine surgery in 2004.

⁸⁵ See IHSC Medical Consent Form, dated April 29, 2016.

⁸⁶ See Exhibit 11.

⁸⁷ ODO interview with Officer [REDACTED] June 9, 2016.

⁸⁸ Id.

⁸⁹ See ICE Custody Classification Worksheet, dated April 29, 2016.

⁹⁰ See Exhibit 12: OMDC Valuable/Money Receipt, dated April 29, 2016.

⁹¹ See Clothing Issued Receipt, dated April 29, 2016.

⁹² See OMDC Inmate/Detainee Commitment Summary, dated April 29, 2016.

⁹³ See Exhibit 13: Initial Physical Exam appointment record, dated April 30, 2016.

⁹⁴ Commonly referred to as a heart attack due to death of the cells of an area of the heart muscle as a result of oxygen deprivation caused by obstruction of the blood supply.

⁹⁵ Backflow of blood from the aorta into the left ventricle due to insufficiency of the aortic valve.

⁹⁶ Bulging.

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

- ZYAZIN's vital signs were within normal limits.
- ZYAZIN's lungs were clear to auscultation. His heart rate and rhythm was regular, although a murmur was heard.

Dr. [] assessment of ZYAZIN was coronary atherosclerosis⁹⁷ and cardiomegaly.⁹⁸ He ordered an EKG and prescribed the following medications, to be kept on ZYAZIN's person:

- Chewable Aspirin 81 milligram (mg) tablet daily;⁹⁹
- Atorvastatin Calcium tablet 80 mg tablet daily;¹⁰⁰
- Metoprolol Succinate Extended Release 25 mg tablet every morning;¹⁰¹
- Lisinopril¹⁰² five mg tablet every morning; and
- Bacitracin ointment¹⁰³ to the affected area as needed four times per day.
 - ODO notes the physical examination documentation does not address why the Bacitracin ointment was prescribed.

As part of the treatment plan, ZYAZIN agreed to have the pneumovax¹⁰⁴ and influenza vaccinations. He was scheduled to return in three weeks.

May 1, 2016, Day of Death

The following narrative chronicles the events of May 1, 2016, based on written documentation, verbal reports of involved security and medical staff, and video surveillance footage from cameras covering P-Pod and portions of the route taken by responding medical staff.

On May 1, 2016, at 10:43 a.m., ZYAZIN reported to the medical unit to receive the ordered EKG.¹⁰⁵ RN [] performed the EKG.¹⁰⁶ LCDR [] NP, reviewed the results and provided the reports to Dr. [] who documented his review the day following ZYAZIN's death, on May 2, 2016. During his interview with ODO, Dr. [] stated the EKG results were unremarkable considering ZYAZIN's cardiac history, and the results did not suggest ZYAZIN was at imminent risk for a cardiac event.¹⁰⁷ Dr. [] stated he contacted IHSC cardiologist Dr. [] (first name and rank unavailable) to discuss the EKG results, who concurred with his conclusions.¹⁰⁸

⁹⁷ A medical term used to describe a hardening and narrowing of the arteries of the heart.

⁹⁸ A term used to reference an enlarged heart.

⁹⁹ Aspirin is often prescribed because it may prevent recurrent heart attacks and stroke.

¹⁰⁰ This medication is known to lower lipid/fat levels in the blood.

¹⁰¹ This medication is commonly prescribed to treat hypertension and congestive heart failure.

¹⁰² Id.

¹⁰³ Antibiotic ointment.

¹⁰⁴ Vaccination to protect against bacterial blood infections, pneumonia, and meningitis.

¹⁰⁵ See P-Pod logbook, dated May 1, 2016.

¹⁰⁶ See EKG appointment record, dated May 1, 2016.

¹⁰⁷ ODO interview with CDR [] MD, Clinical Director, with June 9, 2016. A detailed description of the EKG results can be found in Exhibit 10.

¹⁰⁸ ODO interview with CDR [] MD, Clinical Director, with June 9, 2016.

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

Although the P-Pod logbook documents ZYAZIN returning at 12:07 p.m., video surveillance footage shows ZYAZIN was in the P-Pod dayroom at noon.¹⁰⁹ The officer (name unknown) assigned to P-Pod conducted security rounds as required by the OMDC Housing Unit Post Orders.¹¹⁰ However, upon review of surveillance video from P-Pod on May 1, 2016, ODO observed the officer did not make three of the rounds he documented in the logbook.¹¹¹ Specifically, completion of rounds at 1: [redacted] are documented but not supported by the surveillance video.¹¹² This discrepancy was also noted by OMDC Investigator [redacted] in the OMDC Incident Investigative Report concerning ZYAZIN's death.¹¹³

At 3:15 p.m., Officer [redacted] assumed the P-Pod officer post.¹¹⁴ During much of Officer [redacted] shift, ZYAZIN watched television in the dayroom.¹¹⁵ At 7:10 p.m., ZYAZIN went inside Dorm 206. At 7:12 p.m. Officer [redacted] stopped at Dorm 206 and spoke with ZYAZIN.¹¹⁶ During his interview with ODO, Officer [redacted] stated there were no other detainees in Dorm 206 at the time.¹¹⁷ Officer [redacted] stated ZYAZIN indicated he was worried about his wife. Officer [redacted] stated he was aware ZYAZIN had medical issues but did not know what they were.

Between 7:23 p.m. and 9:22 p.m., other detainees entered and exited Dorm 206 on ten occasions, and Officer [redacted] conducted five security checks at irregular thirty minute intervals.¹¹⁸ Specifically, rounds were made at 7:39 p.m., 8:08 p.m., 8:24 p.m., 8:52 p.m. and 9:22 p.m. ODO observed the rounds made by Officer [redacted] were thorough.

ODO interviewed detainees who were housed with ZYAZIN in Dorm 206 including [redacted]. Both stated that during the evening hours of May 1, 2016, they observed ZYAZIN lying quietly on his bunk with his eyes open. Detained [redacted] who was assigned to the bunk directly across from ZYAZIN's, stated that during the late evening of May 1, 2016, he entered Dorm 206 and observed ZYAZIN lying on his bed and facing the wall.¹²⁰ Detainee [redacted] stated he called out to ZYAZIN, received no response, and left ZYAZIN alone, but that when he next looked at ZYAZIN, the detainee was facing him with white fluid coming out of his mouth. [redacted] stated he shook and called to ZYAZIN, but ZYAZIN did not respond.

¹⁰⁹ See video surveillance footage, May 1, 2016, and P-Pod logbook, May 1, 2016.

¹¹⁰ See OMDC Housing Unit Post Orders.

¹¹¹ See video surveillance footage, May 1, 2016, and P-Pod logbook, May 1, 2016.

¹¹² It is noted the OMDC Housing Unit Post Orders require officers to conduct rounds at [redacted] minute intervals on an irregular schedule, and the P-Pod officer exceeded this requirement by conducting rounds at [redacted] minute intervals on an irregular schedule. As a result, even though he logged rounds not conducted, he still completed the minimum required rounds.

¹¹³ See Exhibit 14: Incident Investigative Report by [redacted] completed May 5, 2016.

¹¹⁴ See P-Pod logbook, May 1, 2016.

¹¹⁵ See video surveillance footage, May 1, 2016.

¹¹⁶ See Id.

¹¹⁷ ODO interview with Officer [redacted] June 8, 2016.

¹¹⁸ See video surveillance footage, May 1, 2016.

¹¹⁹ ODO interview with detainee [redacted] June 9, 2016. ODO interview with detainee [redacted] June 9 2016, conducted using a Soman interpreter via telephonic interpretation service.

¹²⁰ ODO interview with detainee [redacted] June 9, 2016.

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

At 9:28 p.m., detainee [] walked out of Dorm 206, leaned over the railing, and called down to Officer [] on the first floor.¹²¹ During his interview with ODO, detainee [] stated he told Officer [] that ZYAZIN did not appear to be breathing.¹²² Officer [] immediately went upstairs to Dorm 206, found ZYAZIN lying on his back with his eyes partially open, checked for a pulse, but did not detect one.¹²³ At 9:29 p.m., Officer [] called a medical emergency over his radio,¹²⁴ and at 9:30 p.m., OMDC's Emergency Response Team (ERT) was activated.¹²⁵ During his interview, Officer [] stated after calling the medical emergency, he directed all the detainees in the pod to lock down (go to their assigned dorms), and immediately began cardiopulmonary resuscitation (CPR) and rescue breathing on ZYAZIN. Approximately 30 seconds later, Officer [] entered P-Pod, also directed detainees to lock down, and proceeded to Dorm 206.¹²⁶ Officer [] stated during his interview that he observed what he believed to be a small amount of vomit near ZYAZIN's mouth, and that the detainee was pale in appearance. Officer [] stated he checked for a pulse and found none, and he noticed the detainee's skin was cool to the touch. Officer [] assisted with chest compressions while Officer [] continued rescue breathing.

At approximately 9:31 p.m., Officer [] IHSC Lieutenant [] RN, and Lieutenant [] entered P-Pod.¹²⁷ During his interview, Officer [] stated a few remaining detainees were not locked down when he entered P-Pod, so he directed them to do so and then proceeded directly to Dorm 206.¹²⁸ Officer [] confirmed Officers [] and [] were performing CPR, and noted ZYAZIN was blue in color and appeared to be vomiting as chest compressions were performed. RN [] stated during interview that when she reached Dorm 206, the officers were performing CPR and informed her they were unable to find a pulse.¹²⁹ RN [] also checked and found no pulse, and she immediately instructed Lieutenant [] the commander of the ERT, to call 911. The Central Control log shows 911 was called at 9:32 p.m.¹³⁰ The record from Mercy Medical shows the call for emergency medical assistance was received from OMDC at 9:34 p.m.,¹³¹ and an ambulance was dispatched at 9:35 p.m.¹³²

Approximately one minute after Lieutenant [] Officer [] and RN [] responded, STG RN [] and InGenesis RN [] entered P-Pod with a wheelchair, emergency bag, and an automated external defibrillator (AED).¹³³

¹²¹ See video surveillance footage, May 1, 2016; ODO interview with detainee [] June 9, 2016.

¹²² ODO interview with detainee [] June 9, 2016.

¹²³ See video surveillance footage, May 1, 2016; ODO interview with Officer [] June 8, 2016.

¹²⁴ See Central control logbook, May 1, 2016.

¹²⁵ See Exhibit 14.

¹²⁶ See video surveillance footage, May 1, 2016. ODO interview with Officer [] June 8, 2016.

¹²⁷ See video surveillance footage, May 1, 2016.

¹²⁸ ODO interview with Officer [] June 8, 2016.

¹²⁹ ODO interview with IHSC Lieutenant [] RN, June 8, 2016.

¹³⁰ It is noted that at OMDC any staff member, security or medical, may direct a call to 911 in event of an emergency.

¹³¹ The two minute discrepancy in the timing of the call is unknown, but was presumably due to clocks at OMDC and Mercy Medical not being synced.

¹³² See Mercy Medical Medic Run Sheet, dated May 1, 2016.

¹³³ See video surveillance footage, May 1, 2016.

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

RN [] stated that as staff were responding and the call to 911 was made, officers moved ZYAZIN to the floor to provide a firm foundation for chest compressions.¹³⁴ Once he was on the floor, RN [] placed the AED leads on ZYAZIN's chest. The AED did not detect a heart rhythm so a shock was not delivered, but CPR and rescue breathing were continued. Officers [] continued to provide chest compressions, alternating to avoid fatigue. RN [] also performed one round of chest compressions.¹³⁵

At 9:36:08 p.m., RN [] arrived in P-Pod and began counting chest compressions for the officers and documenting chronological events.¹³⁶ As CPR continued, RN [] returned to the medical unit to retrieve ZYAZIN's medical record for the medical staff and the emergency responders.¹³⁷ RN [] stated during her interview that she sent the documentation back to P-Pod with an unidentified officer.¹³⁸

As emergency care was rendered to ZYAZIN, Officer [] (first name unknown) and Sergeant [] managed P-Pod and ensured detainees remained in their dorms for the duration of the emergency response.¹³⁹

Officer [] who was posted to the receiving and discharge area on the night of May 1, 2016, stated during his interview that when he heard the emergency call over his radio, he stepped outside to meet the emergency medical services (EMS) responders.¹⁴⁰ Both an EMS ambulance and a San Diego Fire Department (SDFD) truck arrived at approximately 9:41 p.m.¹⁴¹ SDFD staff parked the truck outside the gate and followed the ambulance into the vehicle sally port, on foot, at 9:43 p.m.¹⁴² Officer [] announced the arrival of the EMS responders via radio, proceeded to log the required vehicle and responder identification into the logbook, and escorted the responders through the facility to P-Pod. At 9:46 p.m., the EMS responders entered P-Pod and took over control of the response effort.¹⁴³

The following actions were documented by the EMS responders:¹⁴⁴

- An electrocardiogram¹⁴⁵ (EKG) was placed on ZYAZIN, but found no heartbeat.
- CPR was continued and a bag valve mask¹⁴⁶ was attached.
- After two attempts, ZYAZIN was intubated.¹⁴⁷

¹³⁴ ODO interview with IHSC Lieutenant [] RN, June 8, 2016.

¹³⁵ ODO interview with RN [] June 9, 2016.

¹³⁶ See video surveillance footage, May 1, 2016, and RN [] Incident Statement, dated May 1, 2016.

¹³⁷ See RN [] Incident Statement, dated May 1, 2016.

¹³⁸ ODO interview with RN [] June 8, 2016.

¹³⁹ ODO interview with Officer [] June 8, 2016; ODO interview with Sergeant [] June 8, 2016.

¹⁴⁰ ODO interview with Officer [] June 8, 2016.

¹⁴¹ See video surveillance footage, May 1, 2016, and Back dock logbook, dated May 1, 2016.

¹⁴² See video surveillance footage, May 1, 2016.

¹⁴³ See Id.

¹⁴⁴ See Mercy Medical Medic Run Sheet, dated May 1, 2016.

¹⁴⁵ A test that checks for problems with the electrical activity of the heart.

¹⁴⁶ Similar to an ambu bag.

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

- A significant amount of mucus, saliva and blood were present in ZYAZIN's airway and required suction removal before he could be intubated. The increased amount of blood noticed during the resuscitation efforts may have been due to a gastro-intestinal bleed¹⁴⁸ or an acute aortic aneurysm.¹⁴⁹
- An intravenous line¹⁵⁰ (IV) was started and a total of four doses (1mg) of Epinephrine¹⁵¹ were administered, but ZYAZIN did not respond.
- ZYAZIN's blood sugar was checked revealing a low blood sugar of 58mg/dL,¹⁵² and a dose of Dextrose¹⁵³ was administered via IV but had no effect.

During the response, the paramedics were in contact by mobile phone with Emergency Room physician Dr. [redacted] (first name not documented) at the Grossmont Hospital, La Mesa, CA. Based on the information verbally provided by the paramedics, and through the transmission of the EKG reading, Dr. [redacted] ordered the paramedics to discontinue resuscitation efforts, and pronounced ZYAZIN dead at 10:06 p.m.¹⁵⁴

During his interview, Lieutenant [redacted] stated after ZYAZIN was pronounced dead, he instructed Sergeant [redacted] to secure the scene and take photographs.¹⁵⁵ He also noted a bottle of nitroglycerin was on the step of the ladder used to access the bed above ZYAZIN'S lower bunk.¹⁵⁶ The detainees assigned to Dorm 206 were separated to write statements, and security and medical staff in P-Pod were required to stay onsite until they were interviewed and released by the San Diego County Sheriff's Department (SDCSD) deputies. ODO notes the EMS responders departed the facility without ZYAZIN's body. RN [redacted] stated during interview that after EMS departed, he placed a sheet over ZYAZIN's body and remained in the pod until SDCSD deputies arrived and allowed the medical staff to return to the clinic.¹⁵⁷ During her interview with ODO, RN [redacted] stated she notified the HSA, Assistant HSA, Clinical Director and nurse managers of ZYAZIN's death by phone.¹⁵⁸

It is noted that although OMDC's Central Control log documents the EMS responders departed the facility at 10:31 p.m., the Mercy Medical ambulance report states they departed the scene at 11:18 p.m. ODO notes discrepant times were also documented for the following subsequent events involving outside authorities:

¹⁴⁷ Placement of a tube into the trachea to maintain an open airway, aspirate secretions, ventilate lungs.

¹⁴⁸ Bleeding in the digestive tract.

¹⁴⁹ An abnormal bulge occurring in the wall of the major blood vessel (aorta) that carries blood from your heart to your body.

¹⁵⁰ Flexible catheter inserted into a vein to provide fluids and medication.

¹⁵¹ A medication to raise blood pressure, increase cardiac output, and increase heart rate.

¹⁵² Normal is 70 to 115 mg/dL.

¹⁵³ A sugar water solution typically administered to treat low blood sugar or dehydration.

¹⁵⁴ See Mercy Medical Medic Run Sheet, dated May 1, 2016.

¹⁵⁵ ODO interview with Lieutenant [redacted], June 8, 2016.

¹⁵⁶ Id.

¹⁵⁷ ODO interview with RN [redacted], June 9, 2016.

¹⁵⁸ ODO interview with RN [redacted], June 8, 2016.

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

May 1, 2016

- The Control Center logbook documents SDCSD deputies arrived at OMDC at 11:29 p.m. to secure the scene. However, video surveillance footage and the OMDC Incident Investigation Report document the deputies arrived and secured the scene at 11:46 p.m.,¹⁵⁹ and the final entry in P-Pod logbook documents three SDCSD deputies were present in P-Pod at 11:48 p.m.¹⁶⁰

May 2, 2016

- The Central Control logbook documents the SDCSD homicide team arrived at the facility at 2:30 a.m.¹⁶¹ The OMDC Incident Investigation Report states the homicide team was called at 2:30 a.m., but did not arrive on site until 3:16 a.m.¹⁶² No written documentation from the homicide team was available.
- The Central Control logbook documents the *Medical Examiner* arrived at the rear gate at 3:46 a.m., and the *Coroner* arrived at the front gate at 3:53 a.m.¹⁶³ The logbook also documents the *Coroner* departed OMDC at 4:15 a.m. “with (1),” presumed to refer to ZYAZIN’s body. The Central Control logbook includes no reference to the departure of the *Medical Examiner*.
- The OMDC Incident Investigation Report states *Medical Examiner* [redacted] arrived at the scene at 3:24 a.m. and removed ZYAZIN’s body from P-Pod at 4:06 a.m.¹⁶⁴ These times are corroborated by video surveillance footage from the pod. The report also states the *Coroner*’s vehicle containing ZYAZIN’s body left OMDC at 4:15 a.m. This is consistent with the time documented by Central Control.
- ODO notes it is possible Central Control staff and Investigator [redacted] may have used the titles Medical Examiner and Coroner synonymously. However, this does not clarify Central Control’s documentation of the arrival of two different persons within seven minutes of one another at two different locations.

Security Chief [redacted] stated during her interview that she reported to OMDC after the duty captain notified her of ZYAZIN’s death.¹⁶⁵ Strausbaugh ensured the scene was secure, gathered reports, made necessary notifications, and met with staff.¹⁶⁶ Chief [redacted] stated she individually met with each of the officers involved in the emergency response to provide support and information regarding the available Employee Assistance Program

¹⁵⁹ See video surveillance footage, May 1, 2016.

¹⁶⁰ See P-Pod logbook, May 1, 2016.

¹⁶¹ See Central control logbook, May 1, 2016.

¹⁶² See Exhibit 14.

¹⁶³ See Central control logbook, May 1, 2016.

¹⁶⁴ See Exhibit 14.

¹⁶⁵ ODO interview with Security Chief [redacted] June 8, 2016.

¹⁶⁶ ODO interview with Security Chief [redacted] June 8, 2016.

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

(EAP).¹⁶⁷ During his interview with ODO, Sergeant [] confirmed the staff were reminded of the availability of EAP services.¹⁶⁸ During individual interviews with ODO, responding nursing staff stated IHSC CDR [] Assistant HSA, also offered EAP services to staff.

All involved security and medical staff completed incident reports regarding the death, and statements were obtained from detainee witnesses. Video surveillance footage was appropriately obtained and maintained. During his interview with ODO, Investigator [] stated he was tasked by the Warden to prepare a timeline and review if proper rounds were made in Dorm 206.¹⁶⁹ Investigator [] viewed 24 hours of surveillance video footage, focusing on the 12 hours preceding the medical emergency. In his written report, Investigator [] documented each time ZYAZIN was outside of his dorm, including all movements and activities.¹⁷⁰ He also documented the times of officer rounds. Screen shots from the video surveillance footage are included in his report. The report concluded proper thirty minute checks were conducted and the staff responding to the medical emergency applied appropriate life saving techniques until relieved by EMS.¹⁷¹

During their individual interviews with ODO, nursing staff involved in the emergency stated they informally debriefed among themselves as they waited to be released by the investigators. A formal debriefing was not conducted.

On May 2, 2016, ZYAZIN's property was inventoried and released to ICE DO []⁷² As reported by DO [] ZYAZIN's \$1,165 in U.S. currency was sent to OMDC during a transport from SLRDC after ZYAZIN's death, and on May 4, 2016, the full amount was deposited in the commissary account of ZYAZIN's wife, who was also detained at OMDC.¹⁷³

Post-Death Events

On May 2, 2016, an autopsy was conducted by [] MD, Deputy Medical Examiner of the San Diego County Medical Examiner Office.¹⁷⁴ ZYAZIN's manner of death was determined to be natural, due to hypertensive and atherosclerotic cardiovascular disease, with aortic valve disease as a contributing condition. A San Diego County Certificate of Death was issued May 17, 2016.¹⁷⁵

MEDICAL CARE AND SECURITY REVIEW

Creative Corrections, a national management and consultant firm contracted by ICE to provide subject matter expertise in detention management including medical care and security, reviewed

¹⁶⁷ ODO interview with Security Chief [] June 8, 2016.

¹⁶⁸ ODO interview with Sergeant [] June 8, 2016.

¹⁶⁹ ODO interview with Facility Investigator [] June 8, 2016.

¹⁷⁰ See Exhibit 14.

¹⁷¹ See Exhibit 14.

¹⁷² See OMDC Inmate Property Receipt, release dated May 2, 2016.

¹⁷³ See CCA Offender Management System Transaction log for []

¹⁷⁴ See Exhibit 15: Autopsy Report.

¹⁷⁵ See Exhibit 16: Certificate of Death.

DETAINEE DEATH REVIEW – Igor ZYAZIN

JICMS #201606226

the medical care ZYAZIN was provided at OMDC, as well as his safety and security while detained at the facility. OMDC was found to be in full compliance with the ICE PBNDS 2011 Medical Care Standard, as well as with those relevant components of the ICE PBNDS 2011 pertaining to safety security.¹⁷⁶

FINDINGS

ODO found OMDC was fully compliant with the ICE PBNDS 2011.

AREAS OF NOTE

1. OMDC's emergency response to ZYAZIN on May 1, 2016, was prompt, organized, and well executed. Specifically, Officer [redacted] acted immediately when notified by a detainee that ZYAZIN was in distress by immediately reporting to the scene, calling a medical emergency over his radio, and initiating CPR. Additionally, other security and medical staff responded quickly and worked as a team to render care, and 911 was called without delay. Creative Corrections notes the response by officers and medical staff was exemplary and is reflective of proper training in responding to medical emergencies.
2. OMDC failed to fully comply with OMDC Housing Unit Post Orders, section (II)(F)(2), which states, "all security checks will be properly documented and logged in the housing unit log book." Specifically, rounds were logged by an officer on three occasions that are not supported by video surveillance footage.
3. OMDC's post orders and practical expectations concerning security rounds appear to be in conflict. The post orders require checks every 60 minutes for minimum custody detainees, whereas the expectation appears to be that rounds are conducted every 30 minutes. Consistency in written and expected practices assures clarity and supports compliance.
4. The terms Medical Examiner and Coroner appear to have been used interchangeably in logbooks and the investigative report. The integrity of documentation would be improved by assuring the current, correct title is used.
5. Officer [redacted] CPR mask fell apart when extracted from its case. Creative Corrections advises that to ensure the integrity of masks, they should be checked at least annually during CPR training, or replaced on a regular schedule.

¹⁷⁶ See Exhibit 10: Creative Corrections Medical Compliance Analysis.

DETAINEE DEATH REVIEW – Igor ZYAZIN
JICMS #201606226

EXHIBITS

1. SLRDC Information Sheet and Initial Suicide Prevention Screening Form
2. SLRDC Initial Custody Assessment Form
3. SLRDC Property Withheld Receipt
4. SLRDC Cash Receipt
5. SLRDC Medical Intake Screening
6. SLRDC Mental Health Screening Form
7. Prisoner in Transit Summary Form
8. SLRDC Property Released Receipt
9. SLRDC Release Report
10. Creative Corrections Security and Medical Compliance Review
11. OMDC Medical Intake Screening
12. OMDC Valuable/Money Receipt
13. OMDC Initial Physical Exam
14. OMDC Incident Investigative Report
15. Autopsy Report
16. Certificate of Death