SYNOPSIS

On October 24, 2013, the Joint Intake Center, Washington, D.C., was notified of the death of 34-year-old Immigration and Customs Enforcement detainee Tiombe Kimana CARLOS. CARLOS was a citizen of Antigua and Barbuda, born on November 21, 1978. She died on October 23, 2013, at the York County Prison located at 3400 Concord Road, York, Pennsylvania. The York County Coroner reported CARLOS's cause of death as self-inflicted hanging, and her manner of death as suicide.

On December 10, 2013, the ICE Office of Professional Responsibility, Office of Detention Oversight initiated a Detainee Death Review of CARLOS's death. This report documents the findings of the review.

NARRATIVE

On October 24, 2013, the Joint Intake Center (JIC), Washington, D.C., was notified of the death of 34-year-old U.S. Immigration and Customs Enforcement (ICE) detainee Tiombe Kimana CARLOS. CARLOS was a citizen of Antigua and Barbuda, born on November 21, 1978. She was pronounced dead at the WellSpan York Hospital on October 23, 2013, after she was found hanging in her cell at the York County Prison (YCP). The York County Coroner reported CARLOS's cause of death as self-inflicted hanging, and her manner of death as suicide.

CARLOS was in ICE custody at YCP at the time of her death. YCP was opened in 1979 and is owned and operated by the County of York, PA. YCP is an Intergovernmental Service Agreement (IGSA) facility contracted to house ICE detainees of all classification levels for periods exceeding 72 hours. PrimeCare Medical, Inc. provides medical care at YCP. YCP is required to comply with the ICE 2008 Performance-Based National Detention Standards (PBNDS).

From December 10 to 12, 2013, Supervisory Inspections and Compliance Specialist [redacted] Management and Program Analyst (MPA) [redacted], Inspections and Compliance Specialist [redacted], and Inspections and Compliance Specialist [redacted], all assigned to the ICE Office of Detention Oversight (ODO), visited YCP in furtherance of the Detainee Death Review (DDR). Registered Nurse (RN) [redacted], a subject matter expert (SME) in correctional health care, and [redacted], an SME in correctional security, assisted ODO with the death review. RN [redacted] and SME [redacted] 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. ODO interviewed individuals employed by YCP, as well as employees of PrimeCare Medical, Inc., and the ICE Office of Enforcement and Removal Operations (ERO). ODO also reviewed immigration, medical, and detention records pertaining to CARLOS.

During this review, ODO staff 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 information purposes only. Their inclusion in the report should not be construed in any way as meaning the deficiency contributed to the death of the detainee.

I. TIMELINE OF EVENTS

ODO determined the following timeline of events, from the time of CARLOS's apprehension, throughout her detention at YCP. Because CARLOS was detained by ICE at YCP for over two and a half years, the narrative below is divided into two parts. The first part is a summary of the first 28 months of her detention, and the second part is a detailed narrative of her final two and a half months at the facility.

Detention Summary: February 4, 2008 – August 10, 2013

On February 4, 2008, Deportation Officer (DO) [redacted] encountered CARLOS at the York Correctional Institution (YCI), Niantic, Connecticut (CT), where she was serving an eight year sentence for assault issued by the Connecticut Superior Court, Waterbury, CT.[1, 2] DO [redacted] learned of CARLOS after she was referred to the Criminal Alien Program (CAP) by ICE ERO Fugitive Operations Supervisor DO [redacted] DO [redacted] interviewed CARLOS in English, and documented that CARLOS was removable from the United States under sections 237(a)(2)(A)(ii) and 237(a)(2)(A)(iii) of the Immigration and Nationality Act. DO [redacted] placed a detainer on CARLOS, and documented he expected her to come into ICE custody at the conclusion of her CT state sentence. DO [redacted] documented CARLOS's expected date of release from CT state custody as February 28, 2008.

On February 28, 2008, CARLOS was released from CT state custody to ICE custody, but remained housed at YCI. On the same date, CARLOS was served with a Notice to Appear (NTA) charging removability pursuant to sections 237(a)(2)(A)(ii) and 237(a)(2)(A)(iii) of the Immigration and Nationality Act, as an alien convicted of two crimes involving moral turpitude at any time after entry, and as an alien convicted of an aggravated felony.[3, 4] On June 2, 2008, ICE released CARLOS to the Connecticut State Police after CARLOS assaulted a YCI Correctional Officer (CO).[5, 6]

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[1] Exhibit 1, p. 2.

[2] CARLOS's criminal history contains additional convictions between April 2002 and December 2003, including breach of peace, probation violation, third degree assault, petit larceny, possession of stolen property, resisting arrest, and disorderly conduct.

[3] Exhibit 2.

[4] CARLOS was a mandatory detention case due to her removability under these two sections of the Immigration and Nationality Act.

[5] Exhibit 3.

[6] Exhibit 47, p. 2.

On February 3, 2011, the State of Connecticut released CARLOS to ICE custody, and CARLOS was transferred by ICE to the Bristol County Jail and House of Corrections (BCJHC), North Dartmouth, CT.[7]

On April 14, 2011, CARLOS was transferred by ICE from BCJHC to YCP.[8]

1. Admission to YCP

On April 14, 2011, at 1:44 PM, CARLOS was admitted to YCP,[9] and classified as a Level 3 detainee.[10] A mental health evaluation requested by security was initiated by Licensed Professional Counselor (LPC) [redacted] on April 14, 2011, who documented[11] CARLOS had a mental health history and took Haldol[12] by injection every two weeks. LPC [redacted] also documented[13] that although CARLOS was cooperative, LPC [redacted] could not complete her mental health assessment. LPC [redacted] directed CARLOS be placed on psychiatric observation (PO)[14] status in the Female Behavioral Adjustment Unit (BAU).[15, 16]

CARLOS was placed on psychiatric observation status per LPC [redacted] order, and housed in the female housing unit, BAU-5.[17] According to Correctional Counselor notes[18] from April 14, 2011, CARLOS's housing decision was based on a variety of factors including six prior assault charges; charges for robbery, disorderly conduct, and resisting an officer; and disruptive behavior on the bus that transported her to YCP. Creative Corrections notes[19] that although the documented reasons for placing CARLOS in the Behavioral Adjustment Unit meet criteria set forth in the ICE PBNDS, Special Management Units, an administrative segregation order was not completed for or issued to CARLOS, as required by the standard.

On April 16, 2011, CARLOS's medical and mental health intake screenings[20] were completed by Certified Medical Assistant (CMA) [redacted], and reviewed by the charge nurse, Registered Nurse (RN) [redacted]. CARLOS's medical record documents that medical staff were unable to conduct her medical and mental health intake screenings on April 14, 2011,

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[7] Exhibit 47,. p. 2.
[8] Id.
[9] Exhibit 5.
[10] Exhibit 6.
[11] Exhibit 8.
[12] Exhibit 7, p.5 for description of Haldol.
[13] Exhibit 8.
[14] Exhibit 9. A detailed analysis of YCP's mental health observation levels outlined in Exhibit 9, can be found in the Creative Corrections Review, Exhibit 7, pp. 2-3.
[15] Exhibit 10, p. 1.
[16] Exhibit 11, p. 2 A detailed analysis of YCP's segregation program as it relates to CARLOS's detention can be found in Exhibit 7, pp. 3-4.
[17] Exhibit 10, p. 1.
[18] Id.
[19] Exhibit 7, p. 5.
[20] Exhibit 12.

because she was not cooperative. Medical staff were also unable to conduct the screenings on April 15, 2011, because CARLOS was combative and because security instructed medical staff not to conduct the screenings on that date.[21] CARLOS's medical and mental health intake screening forms show all medical intake screening questions were answered in the negative, and three mental health screening questions related to suicide risk were answered in the affirmative: significant loss of a family member within the past six months, mental health history, and history of drug abuse. CMA [redacted] initiated a mental health referral for CARLOS.[22]

On April 18, 2011, CARLOS refused her biweekly Haldol injection.[23]

Between April 16, and April 20, 2011, CARLOS remained on psychiatric observation in the Behavioral Adjustment Unit and was seen by LPC [redacted] on April 19, and April 20, 2011.[24] CARLOS was removed from psychiatric observation by LPC [redacted] on April 20, 2011.[25] LPC [redacted] noted[26] he discontinued CARLOS's psychiatric observation status and recommended her transfer to female general population unit B-6-B. CARLOS's detention record shows that on April 20, 2011, the Program Review Committee[27] recommended she not be transferred to general population because the reasons for her assignment to the Behavioral Adjustment Unit remained valid.[28]

On April 20, 2011, CARLOS agreed to resume her Haldol injections.[29] CARLOS received 100mg of Haldol by injection, to be repeated every two weeks, per order of contract psychiatrist [redacted].[30]

On April 25, 2011, CARLOS received an initial mental health evaluation from Dr. [redacted] Dr [redacted] noted CARLOS had a history of mental health issues prior to incarceration; and was violent, moody, and behaved like a different person when she was not taking her medications. Dr. [redacted] assessed that CARLOS had schizoaffective disorder, was stable when she took her medications, and denied having any suicidal ideations. Dr [redacted] determined CARLOS should continue taking her medications and receive a follow-up evaluation in six weeks.[31] Creative Corrections notes[32] Dr. [redacted]

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21 Exhibit 13.
22 Exhibit 12, p. 9.
23 Exhibit 14, p. 1.
24 Exhibit 14, pp. 2-3.
25 Exhibit 10, p. 2.
26 Id.
27 Exhibit 15. Deputy Warden Clair Doll stated during his December 11, 2013, interview that the PRC consists of a Deputy Warden, a Captain, medical and mental health staff representatives, a Correctional Treatment Supervisor, and an ICE ERO employee. PRC records for CARLOS did not consistently document that mental health staff participated in her reviews.
28 Exhibit 16.
29 Exhibit 13.
30 Exhibit 17.
31 Exhibit 18.
32 Exhibit 7, p. 24.

evaluation contains, "no documentation of a treatment plan at this or any other point during the period of detention at YCP."

ODO interviewed Dr. on December 11, 2013. Dr. stated CARLOS had a diagnosis of schizophrenia prior to her arrival at YCP, and characterized CARLOS as stable, not psychotic, but requiring chronic treatment. Dr stated CARLOS was "low-functioning" and exhibited "impulse control issues." Specifically, CARLOS "exploded" easily and her mood escalated and de-escalated quickly. Dr stated housing CARLOS was problematic because of her volatile moods. Dr. stated she sincerely believes CARLOS did not intend to kill herself on October 23, 2013, but instead reacted impulsively after she got upset, the consequence of which was her death.

On April 29, 2011, CARLOS received a physical examination by RN which was reviewed by Doctor of Osteopathic Medicine, [33] RN documented CARLOS did not have any medical conditions. Creative Corrections notes[34] the physical examination was completed more than 14 days from CARLOS's date of admission, however, "It is presumed the examination was scheduled to occur 14 days after the intake screening which as noticed previously, was deferred for two days."

2. Medical and Mental Health History

CARLOS received intake medical and mental health screenings two days after her admission to YCP, because she refused to cooperate upon admission, as noted earlier.[35] Six days after CARLOS's admission, Haldol 100mg was ordered and administered upon her agreement.[36] CARLOS received a mental health assessment by Dr. within 11 days of her admission.[37] CARLOS received a physical examination within 14 days of her intake medical screening, 16 days after her admission.[38] Creative Corrections notes, [39] "per the medical record and staff interviews, detainee CARLOS's medication compliance was high overall. When she refused, compliance was gained through staff encouragement. The order for Haldol 100 mg IM was continually renewed without change for the duration of the detention period."

CARLOS's medical record reflects she was routinely monitored by mental health professionals throughout her detention at YCP, but the record does not demonstrate, "an overall treatment plan with measureable goals and objectives" was ever developed for her.[40] Additionally, CARLOS's

[33] Exhibit 19.
[34] Exhibit 7, p. 24.
[35] Exhibit 13.
[36] Exhibit 17.
[37] Exhibit 18.
[38] Exhibit 19.
[39] Exhibit 7, p. 24.
[40] Id., p. 7.

medical record does not contain any, "documentation of communication with ICE concerning her treatment, or exploration of alternative placement until shortly before her death."[41]

CARLOS's medical record reflects she was treated for several routine sick call complaints throughout her stay at YCP, but did not require ongoing treatment for any medical conditions.[42] Additionally, CARLOS's medical record shows she received annual physicals in compliance with the ICE PBNDS, Medical Care.[43]

3. Suicide Watch

CARLOS was placed on suicide watch five times while detained at YCP. The first four instances occurred on the following dates:[44, 45]

- June 8, 2011[46]
- November 11, 2012[47]
- December 13, 2012[48]
- July 11, 2013[49]

CARLOS's first four placements on suicide watch occurred after her involvement in a physical altercation with other detainees or facility staff. CARLOS's final placement on suicide watch occurred as a result of a suicide attempt on August 13, 2013, discussed later in this report.

Deputy Warden Clair Doll stated during his interview that the facility follows a practice of automatically placing detainees who are involved in physical altercations, on suicide watch if those detainees are also taking any kind of psychotropic medication. This practice started approximately ten years ago after two detainees on psychotropic medications, who were separately involved in physical altercations, committed suicide when they were placed in disciplinary segregation.

Creative Corrections notes[50] CARLOS's medical record reflects regular monitoring by medical and mental health staff during all periods she was on suicide watch or psychiatric observation, in compliance with the ICE PBNDS, Medical care; and, the ICE PBNDS, Suicide Prevention and Intervention.

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[41] Exhibit 7, p. 8.
[42] Id.
[43] Id.
[44] CARLOS's fifth placement on suicide watch occurred on August 13, 2013, and is described within the section of this report entitled "Narrative of Events: August 10, 2013 – October 23, 2013."
[45] Exhibit 20.
[46] Id., pp. 1-2.
[47] Id., pp. 3-4.
[48] Id., pp 5-7.
[49] Id., pp 8-9.
[50] Exhibit 7, p. 8.

4. Disciplinary History

CARLOS's detention record contains eight disciplinary reports for actions which violated YCP rules of conduct including refusing orders, using abusive or obscene language, disrespect, and assault on staff and other detainees. The dates of those offenses are listed below:[51]

- June 8, 2011
- January 18, 2012
- March 16, 2012
- March 21, 2012
- April 4, 2012
- November 11, 2012
- December 13, 2012
- July 11, 2013

Immediate force involving the use of oleoresin capsicum (OC) spray was used in the offenses occurring on June 8, 2011, November 11, 2012, and July 11, 2013. These instances are discussed in more detail under item 5, below.

CARLOS's detention record contains documentation showing CARLOS was either already on disciplinary segregation, or was assigned to administrative segregation pending a disciplinary hearing following each incident. Additionally, documentation shows in each instance, CARLOS was apprised of the charges against her, provided an opportunity to request witnesses and to appear at a hearing, provided with a written record of the disciplinary committee's decision, and provided an opportunity to appeal the decision. Creative Corrections notes[52] that aside from CARLOS's last term in disciplinary segregation, her record contains no documentation of segregation status reviews every seven days, as required by the ICE PBNDS, Special Management Units.

5. Use of Force

On three occasions, force was used to gain CARLOS's compliance at YCP: June 8, 2011; November 11, 2012; and, July 11, 2013. CARLOS's record contains documentation showing ICE ERO was notified in each instance. Details of those instances are described below.

- June 8, 2011:[53] CARLOS argued with another detainee and refused to comply with Captain [redacted] orders to be placed in wrist restraints. Captain [redacted] deployed OC spray, and when CARLOS continued to resist, he applied an Electronic Body

[51] Exhibit 21.
[52] Exhibit 7, p. 6.
[53] Exhibit 22.

Immobilizing Device (EBID) to her left inner thigh. Upon application of the EBID, CARLOS stopped resisting and was restrained. CARLOS was examined by medical staff following the use of force, and photographs were taken of marks left on her thigh by the EBID. Captain ███ documented in his incident statement that he was unaware CARLOS was an ICE detainee when he used the EBID. Captain ███ stated during his interview with ODO on December 11, 2013, he understands both YCP policy and the ICE PBNDS prohibit the use of electronic devices on ICE detainees.

- November 11, 2012:[54] CARLOS became combative with an officer who was placing her on suicide watch, and the officer deployed OC spray in her face. Creative Corrections notes[55] CARLOS's record does not contain documentation she was seen by medical following the use of OC spray, or that decontamination protocols were followed. Additionally, a disciplinary report prepared by Officer ███ documents CARLOS was, "instructed on how to decontaminate herself in her cell by using the water in her sink."

- July 11, 2013:[56] CARLOS was involved in a physical altercation with another detainee and then refused staff orders to sit down. OC spray was deployed on CARLOS to gain compliance and prevent staff injury. CARLOS's record reflects she was seen by medical staff and proper decontamination protocols were followed after the use of force.

6. <u>Segregation</u>

Upon admission to YCP, CARLOS was placed on psychiatric observation status, and housed in the Female Behavioral Adjustment Unit. [57] CARLOS was also housed in disciplinary segregation on the eight occasions described above, and in the Intensive Custody Unit (ICU)[58] on two occasions: January 23, 2013, to June 7, 2013; and, August 13, 2013, until her death on October 23, 2013.[59] CARLOS was placed in the Intensive Custody Unit on January 23, 2013, for behavioral reasons which Correctional Counselor ███ documented in a January 22, 2013, note, [60] stating CARLOS, "has been written up seven times since June of 2011 and her actions have become progressively more violent. She has established a pattern of poor adjustment, violence, assaultive behavior, and clearly cannot live in general population."

[54] Exhibit 23.
[55] Exhibit 7, p. 9.
[56] Exhibit 24.
[57] Exhibit 10.
[58] Exhibit 11, p.2.
[59] Exhibit 10, pp. 5-7.
[60] Exhibit 10, p. 5.

CARLOS was placed in the Intensive Custody Unit on August 13, 2013, after completing a 30-day sentence in disciplinary segregation for assaulting another inmate.[61]

CARLOS's detention record does not contain any administrative segregation orders, or documentation of 72-hour reviews of administrative segregation status. Documentation of required seven-day status reviews for administrative segregation is only present from July to October 2013.[62, 63] On August 13, 2013, Deputy Warden Doll issued a memorandum[64] requiring administrative segregation orders be prepared and provided to detainees per the ICE PBNDS, Special Management Units. Regarding periodic reviews, CARLOS's record reflects that prior to June 2013, reviews were conducted on a monthly basis only. Deputy Warden Doll stated during his interview that starting June 2013, he required the PRC to conduct weekly status reviews for all detainees on any type of segregation status. Creative Corrections notes[65] weekly reviews of CARLOS's status were present after June 2013, but, "were not signed on a consistent basis and there is no documentation the detainee received a copy of the decision". Creative Corrections also notes,[66] "notification to ICE at required intervals was not documented in the records provided, and segregation logs were not completed consistently". Failure to conduct both seven-day and 72-hour reviews violates both the ICE PBNDS, Special Management Units, and Deputy Warden Doll's December 13, 2011, memorandum[67] which established the PRC and declared, "Detainees will be reviewed within 72 hours of segregation placement, every seven days for the first 60 days, and then once every 30 days".

7. Grievance and Appeal History

CARLOS filed ten grievances while detained at YCP. One grievance[68] filed on January 23, 2013, concerned her placement on Intensive Custody Unit status. On January 24, 2013, the grievance officer instructed CARLOS to follow the classification appeal process and provided her with a classification appeal form. CARLOS submitted the classification appeal form that same day. The appeal was denied in an undated response which states, "You have a total of 7 writeups [sic] since 6/8/11 including assault on staff, fighting & assault on an inmate. You will remain on ICU until the [Deputy Warden] or the PRC decide you can come off."

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[61] Exhibit 10, p.6.
[62] Exhibit 4.
[63] Exhibit 25. Although the EARM Case Comments for CARLOS (Exhibit 4) show that she received PRC reviews from July 18 through October 16, 2013, her record only contained PRC review forms for September 18, 2013; September 25, 2013; October 2, 2013; October 9, 2013; and, October 16, 2013.
[64] Exhibit 26.
[65] Exhibit 7, p. 7.
[66] Id.
[67] Exhibit 15.
[68] Exhibit 27.

CARLOS's additional nine grievances concerned a variety of issues including meal shortages, cell conditions, and staff treatment. Two grievances were found to have merit:[69] one concerning cell temperature, and another concerning meal shortages. Corrective action was documented in both cases. CARLOS's record shows all grievances were investigated and responded to in a timely manner.

Narrative of Events: August 10, 2013 – October 23, 2012

On August 10, 2013, CARLOS was removed from Behavioral Adjustment Unit status after serving a 30-day term for a July 11, 2013, altercation with another detainee in general population.[70] CARLOS remained in administrative segregation housing on psychiatric observation.[71] CARLOS's record does not contain an administrative segregation order showing her movement from behavioral adjustment unit to administrative segregation on this date.

On August 12, 2013, CARLOS was removed from psychiatric observation status,[72] and was seen by LPC who documented CARLOS was not suicidal on this date.[73]

On August 13, 2013, CARLOS was placed on Intensive Custody Unit status by Deputy Warden Doll as a result of her "continued assaultive behavior."[74] CARLOS's record does not contain an administrative segregation order for her placement on Intensive Custody Unit status on this date.

On August 13, 2013, at approximately 1:20 p.m., CARLOS attempted suicide by tying a bed sheet around her neck, securing the sheet to a safety bar across her cell window, and stepping off a stool near the window.[75] An incident report prepared by Officer documents when officers in the housing unit observed CARLOS standing on the stool, they entered her cell; as they entered, she stepped off the stool.[76] An incident report prepared by Officer documents she called a medical emergency via radio when she observed CARLOS step off the stool.[77] An incident report prepared by Officer documents he physically caught CARLOS, who was "completely secured to the make shift noose" as she "jumped" off the stool (Officer used the term "table" in his report to refer to the surface upon which she was standing," and he, "pushed her against the wall to keep her from hanging."[78] Officer documented CARLOS, "did not lose consciousness nor did she hang by her full weight at anytime." Officer documented officers attempted to untie the sheet from CARLOS's

[69] Exhibit 28.
[70] Exhibit 24.
[71] Exhibit 10, p. 6.
[72] Exhibit 29.
[73] Exhibit 30.
[74] Exhibit 10, p. 6.
[75] Exhibit 31.
[76] Id., p.3.
[77] Id., p. 5.
[78] Id., p. 8.

neck, but were unable to do so and called for a cut-down tool. Officer [redacted] documented that when the cut-down tool arrived, "CARLOS was cut down and placed on her back per medical instructions." A medical note[79] prepared by LPN [redacted] documents, "911 called at approx 1330." LPN [redacted] also noted that medical staff took over treatment from security staff, and that Dr. [redacted] was informed of the incident. A medical note[80] by LPN [redacted] documents CARLOS, "was attempting to hang herself and jumped as officers were entering her cell." LPN [redacted] also noted that when CARLOS was found hanging, security staff cut her down, and placed her on the floor to be assessed. LPN [redacted] noted[81] CARLOS was crying and said "its not fair, I don't wanna live." LPN [redacted] noted CARLOS was placed on a back board, moved to medical for further assessment and treatment, and then transported to the hospital.[82]

On August 13, 2013, at 1:40 p.m., an ambulance arrived to YCP and transported CARLOS to York Hospital, York, PA.[83] A YCP Out and Return Body Receipt documents CARLOS returned to YCP at 3:39 p.m.[84] Upon her return to YCP, CARLOS was placed on suicide precautions.[85] LPC [redacted] stated during his interview that CARLOS's behavior was often childlike and impulsive, and he considered her action on August 13, 2013, a suicidal gesture, not a suicide attempt, because she waited for officers to enter her cell before dropping from the stool. LPC [redacted] also stated CARLOS's mood was volatile, and she could instantly shift from calm to angry and back to calm.

On August 14, 2013, CARLOS was seen by Dr. [redacted] who noted[86] CARLOS had been doing well until the morning of August 13, 2013, when she made requests that her Intensive Custody Unit status be changed. Dr. [redacted] noted that CARLOS was informed security staff made the decision to maintain her on Intensive Custody Unit status, not mental health. Dr. [redacted] also documented[87] CARLOS was medically cleared, but refused to be evaluated and stated she would no longer take her prescribed mental health medication. Dr. [redacted] noted[88] that CARLOS should continue taking her medications, be maintained on suicide precautions with constant observation, and receive a follow-up evaluation in one week. Creative Corrections notes[89] no treatment plan was established for CARLOS following her suicide

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79 Exhibit 32, p. 1.
80 Id., p. 2.
81 Id., p.1.
82 ODO notes that the incident packet prepared in response to the suicide attempt does not include statements from any medical staff who responded to the scene, with the exception of LPN [redacted] Further, Captain [redacted] incident statement lists "medical officer" as an individual involved in responding to the scene, but neglects to provide the name of that medical officer or any other medical staff.
83 Exhibit 32., p.3.
84 Exhibit 33.
85 Exhibit 32, p. 2.
86 Exhibit 34, p. 2.
87 Id.
88 Id.
89 Exhibit 7, p. 10.

attempt. Dr. [redacted] stated during her interview she did not believe CARLOS was truly attempting suicide on August 13, 2013, but was instead trying to get attention because she was upset about her housing decision.

On August 15, 2013, LPC [redacted] noted[90] CARLOS was uncooperative and refused to take her psychotropic medications. LPC [redacted] assessed CARLOS as being a suicide risk, and determined that she should stay on suicide precautions with constant observation.

On August 16, 2013, LPC [redacted] noted[91] he talked to CARLOS about the "behavioral expectations" in order for her to be removed from suicide precautions with constant observation, and that she could not agree to meet those expectations. LPC [redacted] noted CARLOS's thought process was impaired, that she had limited insight and judgment, and that she was "unable to commit to safety." LPC [redacted] assessed that CARLOS remained a suicide risk, and that she should be maintained on suicide precautions with constant observation."

On August 17, 2013, LPC [redacted] documented[92] CARLOS "refused to sit up and speak," and was "unable to commit to safety." LPC [redacted] assessed CARLOS as a suicide risk, and determined she should be maintained on suicide precautions with constant observation.

On August 18, 2013, Mental Health Counselor (MHC) [redacted] documented[93] CARLOS did not come to her cell door but was "doing ok." MHC [redacted] noted that CARLOS's status on suicide precautions with constant observation would be reviewed.

On August 19, 2013, LPC [redacted] noted[94] CARLOS "contracted for safety and agreed to cooperate with treatment."

On August 20, 2013, CARLOS was removed from suicide precautions by LPC [redacted] and placed on psychiatric observation. LPC [redacted] documented[95] CARLOS was cooperative and "contracted for safety." CARLOS was also seen by contract psychiatrist, Dr. [redacted], on this date. Dr. [redacted] documented CARLOS, "vented anger at system for not either releasing her or deporting her. She says they won't release her because of assault charges. She minimized her psychiatric history and declined any med changes or increases."[96] Dr. [redacted] described CARLOS as "animated" and "angry," and ordered no change in her treatment with follow up in eight

[90] Exhibit 34, p. 2.
[91] Id., pp. 2-3.
[92] Id., p. 3.
[93] Id.
[94] Id.
[95] Id., p. 4.
[96] Id.

weeks. Creative Corrections highlights[97] that Dr. [redacted] note about CARLOS's medication is the first reference in her medical record to a possible change or increase in her medication.

From August 20, to October 2, 2013, CARLOS remained on Intensive Custody Unit/psychiatric observation status.[98] During this period, CARLOS received weekly reviews by the PRC, which included LPC [redacted] August 28, September 11,[99] September 18, September 25, and October 2.[100]

On September 4, 2013, CARLOS refused her Haldol injection.[101] Creative Corrections notes[102] CARLOS continued to be offered the Haldol until she accepted it on September 18, 2013.

On September 18, 2013, CARLOS was upset during the PRC round, and stated she could no longer handle Intensive Custody Unit status. LPC [redacted] documented[103] in his September 19, 2013, note that CARLOS denied suicidal ideations, and coping mechanisms were discussed with her. LPC [redacted] documented[104] CARLOS was to remain on psychiatric observation in the Intensive Custody Unit.

On September 25, 2013, CARLOS was cooperative during the PRC round. LPC [redacted] documented in his September 26, 2013, note[105] that CARLOS was "appropriate and cooperative". LPC [redacted] noted CARLOS was to remain on psychiatric observation in the Intensive Custody Unit.

On October 2, 2013, CARLOS requested to be removed from psychiatric observation during a PRC round. LPC [redacted] documented[106] CARLOS requested removal from psychiatric observation, and noted "sustained time without negative incidents." LPC [redacted] noted CARLOS would remain on Intensive Custody Unit status, and would be removed her from psychiatric observation per the PRC.

On October 3, 10, and 17, 2013, CARLOS underwent required weekly mental health segregation checks.[107] No problems were identified during these checks. ODO interviewed LPN [redacted] on December 11, 2013, who conducted the October 10, 2013, check. LPN [redacted] stated she interacted with CARLOS often during the weekly mental health segregation checks,

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[97] Exhibit 7, p. 11.
[98] Id.
[99] The September 11 PRC review was not recorded in the medical record as the other four PRC reviews during this period were. Documentation of the September 11 PRC review was recorded in the EARM Case Comments and is included as the last page of Exhibit 34.
[100] Exhibit 34, pp. 4-6.
[101] Exhibit 35.
[102] Exhibit 7, p. 11.
[103] Exhibit 34, p. 5.
[104] Id.
[105] Id.
[106] Id.
[107] Exhibit 32.

and often administered CARLOS's biweekly Haldol injections as CARLOS was more cooperative with LPN [redacted] than other medical staff. LPN [redacted] stated she remembered CARLOS being more agitated than usual during the two to three weeks leading up to her death, and stated CARLOS was frustrated that she remained in the Intensive Custody Unit.

On October 9, and 16, 2013, PRC rounds were conducted for CARLOS.[108] The October 16, 2013, PRC review recommended CARLOS not be released from the Intensive Custody Unit based on three factors: the reason for placement remained valid; CARLOS was unwilling or unable to live in general population; and, CARLOS's habitual conduct, language or behavior was of a type which may provoke or instigate stressful/violent situations amongst the general population.[109]

On October 18, 2013, ICE Health Service Corps (IHSC) Field Medical Coordinator (FMC), [redacted], sent email correspondence[110] to ICE ERO Assistant Field Office Directors (AFOD) [redacted] stating, "In response to your request: IHSC has asked that the following information be provided by a mental health professional in order to find proper placement for ICE detainee Tiombe CARLOS…" The requested information included, "Current mental health history with current symptoms, current mental status, current diagnosis, current mental health treatment (medications, therapies), and clearance for travel."

AFOD [redacted] informed ODO that several days prior to October 18, 2013, Deputy Warden Doll asked ERO to look into placing CARLOS in a long-term mental health facility. AFOD [redacted] stated that during a weekly meeting with representation from ERO and IHSC, he raised with FMC [redacted], the issue of moving CARLOS to a mental health facility. AFOD [redacted] stated FMC [redacted] sent the October 18, 2013, email request in order to obtain necessary documentation to pursue alternative placement for CARLOS. AFOD [redacted] stated that, on October 22, 2013, ERO Field Operations East informed him that the request to transfer CARLOS had been reviewed, but an appropriate alternative facility was not available at that time.

On October 21, 2013, CARLOS was transferred from ICU/D-Pod to ICU/A-Pod, Cell 1.[111] During interviews with facility staff, ODO learned CARLOS's cell in D-Pod was located closer to the medical unit, and it was needed for a detainee who required the assistance of a walker.

ODO observed YCP's Female Maximum Security Block (FMSB), which is comprised of four pods in one wing of the facility. Upon entering the wing, A-pod is on the left, and is followed in a counterclockwise pattern by B-Pod, Female Control, C-Pod, D-Pod, and a medical unit. A correctional counselor's office is located in the center of the unit. A-Pod contains three double

[108] Exhibit 25, pp. 4-5.
[109] ODO notes CARLOS's record contains segregation logs only through October 16, 2013.
[110] Exhibit 36.
[111] Exhibit 37.

cells and three single suicide prevention cells within a triangular-shaped enclosed area with a central dayroom in the middle. The cells are numbered 1 through 6, from left to right. The three double cells are equipped with a bunk bed, sink, toilet, and a small desk and stool. Four metal clothes hooks are mounted on the left wall of the cells, and a mesh vent is located above the sink. ODO observed that the clothes hooks do not collapse under pressure, as they should. Creative Corrections advises that, although these three cells are not used for suicide watch, both the clothes hooks and mesh vent present potential tie-off points for a suicide attempt by hanging.[112] A window with two horizontal safety bars is located at the back of each cell, and a Plexiglas panel covers both the window and bars to prevent anything from being attached to the bars. During interviews with facility staff, ODO learned the Plexiglas panels were installed approximately one to two weeks prior to ODO's on-site review. The cell doors contain a narrow window along the left side, and a wicket in the bottom half of the door that can be covered and locked. The three suicide prevention cells are suicide prevention compliant. A control officer sits inside the FMSB's control station and electronically controls individual cell doors. The control station also houses the unit's cut-down tool. Video surveillance cameras are located in the hallways of the unit, but not within each pod. The cameras are motion sensitive and only record when they detect movement in the hallway areas of the FMSB. Officers in the unit are stationed in the central area outside of the four pods, and their responsibilities include manning the control station, monitoring hallways, and conducting security checks. The officers rotate between these responsibilities throughout their shift. Security checks are done every 15 minutes for detainees on suicide watch, and every 30 minutes for all other detainees per Female Maximum Security Block Post Orders.[113] During interviews with facility staff, ODO learned that although only 30 minute rounds were required for CARLOS on October 23, 2013, she was actually checked every 15 minutes because another detainee in A-pod required 15-minute checks. Security checks are recorded electronically using a scanning device which scans a metal bar code in each pod. Three formal counts occur at 12:30 p.m., 5:00 p.m., and 11:00 p.m.[114]

Correctional Counselor [redacted] stated during her interview with ODO on December 10, 2013, that she saw CARLOS "in passing" on October 23, 2013, and CARLOS mentioned she was frustrated with her immigration case. Correctional Counselor [redacted] stated that she interacted with CARLOS throughout the time she was detained at YCP, and that CARLOS was a "different person" every time she talked to her. Correctional Counselor [redacted] stated CARLOS was very angry at times, did not like being on Intensive Custody Unit status, and often expressed frustration over her immigration case. Correctional Counselor [redacted] stated CARLOS's August 2013 suicide attempt was done for attention, and she believes CARLOS acted similarly in October, not intending to commit suicide.

[112] Exhibit 7, p. 11.
[113] Exhibit 38.
[114] Exhibit 7, p. 12.

On October 23, 2013, security checks were completed as required from 8:00 a.m. until CARLOS was discovered at 9:17 p.m., as documented in electronic records, except for three periods where no security check was done for more than 30 minutes.[115] These three periods include the following: 12:29 p.m. to 1:07 p.m.; 4:47 p.m. to 5:44 p.m., due to an official count which was conducted between 5:00 p.m. and 5:15 p.m.; and, 8:29 p.m. to 9:00 p.m. Review of video surveillance footage shows officers entered A-pod more frequently than every 30 minutes, throughout the day and evening shifts.[116] Specifically, between 8:00 p.m. and 9:00 p.m., video footage shows an officer entering A-Pod at 8:04 p.m., 8:12 p.m., 8:28 p.m., 8:39 p.m., 8:46 p.m., and 9:00 p.m.[117] Officers interviewed by ODO stated that they check on the detainees frequently throughout their shifts, and do not always record those checks if they are not official 30-minute checks.

On October 23, 2013, Officers [redacted] worked the evening shift (4:00 p.m. to 12:00 a.m.) in the FMSB.[118]

On October 23, 2013, Officer [redacted] conducted the security checks between 4:00 p.m. and 5:45 p.m.[119] In her incident statement, prepared on October 23, 2013, Officer [redacted] documented that during these checks, CARLOS behaved normally, stated she was "fine," made jokes with the officers on duty, and ate her dinner.[120] Officer [redacted] noted CARLOS was quieter than normal during the weeks leading up to her death.

On October 23, 2013, at 8:05 p.m., Officer [redacted] finished a security check. During her interview with ODO on December 11, 2013, Officer [redacted] stated that during this security check, she turned on the A-pod dayroom television at the request of another detainee. Officer [redacted] stated CARLOS was upset and yelled at her because she could not see the television. Officer [redacted] stated after she finished her checks, she returned to A-pod and adjusted the television so CARLOS could see it. Officer [redacted] stated that before she returned to adjust the television, CARLOS argued with an inmate in A-pod, [redacted] who told CARLOS she should ask to have the television moved instead of yelling. Officer [redacted] stated during her December 11, 2013, interview with ODO that she remembered overhearing the argument between CARLOS and [redacted] and although she did not hear the exact words exchanged, other staff members stated [redacted] told CARLOS, "Why don't you go kill yourself." Officer [redacted] stated CARLOS was a very emotional and reactive individual, and she believes whatever [redacted] said to CARLOS during their argument, "set CARLOS off."

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[115] Exhibit 39.
[116] Exhibit 40.
[117] Id.
[118] Exhibit 41.
[119] Exhibit 39.
[120] Exhibit 42, p. 3-5.

On October 23, 2013, at 9:00 p.m., Officer ████ conducted a security check.[121] According to ████ incident report[122] prepared on October 23, 2013, CARLOS was sitting on her bed during this security check.

On October 23, 2013, at 9:15 p.m., Officer ████s started a security check.[123]

On October 23, 2013, at 9:17 p.m., Officer ████ entered A-Pod where she observed CARLOS, who appeared to be standing with her back to the cell door. According to her incident statement,[124] Officer ████s asked CARLOS what she was doing, and, when CARLOS failed to respond, she, "noticed a cloth tied around the bars of the window."[125] Officer ████ stated during her interview that when she realized the cloth (determined to be a bed sheet) tied to the windows was also tied around CARLOS's neck, she called out for Officer ████ to come assist her. Officer ████ stated during her interview with ODO on December 11, 2013, when Officer ████ discovered CARLOS, Officer ████ as in B-Pod with LPN ████, who was dispensing medications. In an incident statement[126] prepared on October 23, 2013, Officer ████ documented that when she arrived at A-Pod, she immediately told the FMSB control officer, Officer ████, to open the door to CARLOS's cell, and she placed a medical emergency call over her radio. The FMSB log documents at 9:18 p.m. "[Medical Emergency] called for [Inmate] Tiombe Carlos…found hanging."[127] Officer ████ stated during her interview that once Officer ████ medical emergency call was placed, the facility's main control station made a medical emergency announcement over the public address (PA) system. Officer ████ stated she locked down all detainees in the FMSB to allow first responders to move through hallways without any interference.

Officer ████ documented in her incident statement that when CARLOS's cell door opened, she, "ran to inmate CARLOS and picked her up. Officer ████ called for the cut down tool and helped lift inmate CARLOS until the cut down tool arrived."[128] Officer ████ stated during her interview that CARLOS was cold to the touch when she lifted her. Officer ████ stated during her interview that CARLOS urinated on herself when she was lifted, and her head drooped forward. Officer ████ stated Correctional Emergency Response Team (CERT) officers responded quickly, and Officer ████ entered the cell first and assisted in holding CARLOS. Video surveillance footage shows the CERT team arriving on the scene at 9:20:20 p.m.[129] Officer ████ stated during her interview that she also responded to A-Pod after hearing the

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[121] Exhibit 39.
[122] Exhibit 42, pp. 8-9.
[123] Exhibit 39.
[124] Exhibit 42, pp. 3-5.
[125] Id.
[126] Id., pp. 6-7.
[127] Exhibit 41, p. 3.
[128] Exhibit 42, pp. 6-7.
[129] Exhibit 40.

medical emergency call and was handed the cut down tool by Officer as she passed the control station. Officer stated she handed the cut down tool to CERT Officer who cut the cloth from both CARLOS's neck and the bars. In Officer incident statement[130] prepared on October 23, 2013, he documented that after CARLOS was cut from the cloth, she was placed on the floor, and CPR was initiated by Officers and , who rotated doing chest compressions.

On October 23, 2013, at 9:20:40 p.m., , evening shift supervisor, arrived at CARLOS's cell in response to the medical emergency call.[131, 132]. documented[133] that when he arrived on the scene, officers were lowering CARLOS to the floor. documented that he radioed for main control to call 911 at 9:21 p.m. stated during his interview with ODO on December 11, 2013, that although medical staff are typically responsible for calling 911, supervisory security staff have discretion to call 911 when necessary. Creative Corrections notes,[134] "four minutes elapsed between the time detainee CARLOS was found and the call to 911," and although, " acted appropriately by directing that 911 be called upon his arrival at the scene,…the officers who preceded him may have legitimately requested a 911 call given the situation they found when entering the cell."

LPN also arrived at CARLOS's cell at 9:21 p.m. LPN stated during her interview with ODO on December 11, 2013, that when she heard Officer call for the cut down tool, she put away the medication cart, retrieved the Automated External Defibrillator (AED) machine, and ran to A-Pod. LPN documented in her incident statement[135] that when she arrived, CARLOS was lying on the floor of her cell and officers were administering CPR. LPN determined CARLOS did not have a pulse, and connected the AED machine to CARLOS at 9:23 p.m. LPN documented that the AED machine did not advise a shock.[136] Creative Corrections notes,[137] "The AED report[138]…documents the AED was connected to CARLOS at 9:22 p.m., and no shock was repeatedly advised over the course of nine minutes, until emergency medical services (EMS) responders arrived." LPN documented[139] she continued administering CPR with the officers until EMS arrived.

Video surveillance footage shows medical assistants (MA) and arrived at A-Pod at 9:21:10; and, licensed practical nurses (LPN)

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[130] Exhibit 42, p. 11.
[131] Exhibit 40.
[132] incident statement records his time of arrival as 9:21 p.m.
[133] Exhibit 42, pp. 1-2.
[134] Exhibit 7, p 14.
[135] Exhibit 42, p. 12.
[136] The AED will only advise to shock when it detects a certain type of heart electrical activity. There are other kinds of heart electrical activity that are not treated with the defibrillation shocks.
[137] Exhibit 7, p. 15.
[138] Exhibit 43.
[139] Exhibit 42, p. 12.

and [redacted] arrived at 9:22 p.m.[140] MA [redacted] were both interviewed by ODO on December 11, 2013, and stated they brought the oxygen tank to A-Pod and assisted in setting it up, but did not directly participate in resuscitative efforts. MA [redacted] stated during her interview that she did not hear the PA announcement regarding the medical emergency, and that, "sometimes there is a glitch in the PA system and it doesn't play everywhere." ODO interviewed LPN [redacted], who is also YCP's Assistant Director of Nursing, on December 11, 2013. LPN [redacted] stated he responded to A-Pod with a stretcher. LPN [redacted] also stated that when he arrived on the scene, he opened CARLOS's nasal airway by inserting a tube, and attempted to start an intravenous line (IV), but could not find a vein. ODO notes LPN [redacted] incident statement[141] prepared on October 23, 2013, records the "Offence or Subject Being Reported" as "[redacted] LPN [redacted] acknowledged during his interview with ODO that he documented the incorrect name on the form.

On October 23, 2013, at 9:28 p.m., EMS arrived on the scene.[142] [redacted], evening shift commander, stated during his interview with ODO on December 11, 2013, that he escorted EMS workers to CARLOS's cell, and brought a digital camera to the scene. [redacted] stated he took digital photographs of CARLOS and the scene. ODO notes these photographs were not made available to the DDR team. [redacted] stated he did not complete an incident statement regarding CARLOS, because only those individuals who are "hands on" are required to complete an incident statement. Creative Corrections notes,[143] "several others who were not 'hands on' wrote reports."

On October 23, 2013, at 9:32 p.m., Advance Life Support (ALS) from Memorial Hospital arrived on the scene.[144] [redacted] documented in his incident statement[145] that between 9:32 p.m. and 9:37 p.m., ALS workers applied a "C" collar, an automated CPR device, and started an IV. At 9:40 p.m., CARLOS was placed on a gurney for transport to York Hospital.[146] At 9:44 p.m., CARLOS was placed in an ambulance, and at 9:47 p.m., the ambulance departed YCP for York Hospital. Officer [redacted] rode in the ambulance with CARLOS, and Officer [redacted] followed in a chase vehicle.[147]

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140 Exhibit 40.
141 Exhibit 42, p. 14.
142 Exhibit 42, p. 2.
143 Exhibit 7, p. 15.
144 Exhibit 42, p. 2.
145 Exhibit 42, pp. 1-2.
146 Exhibit 42, p.2.
147 Exhibit 42, p. 2.

On October 23, 2013, at 9:49 p.m., [redacted] notified ICE ERO that CARLOS was sent to the York Hospital emergency room after being found in a cell with a sheet tied around her neck.[148]

RN [redacted], YCP's Health Services Administrator, stated during an interview with ODO on December 11, 2013, she received a call from LPN [redacted] at approximately 10:00 p.m., and LPN [redacted] informed her of CARLOS's medical emergency. LPN [redacted] advised RN [redacted] that CARLOS had no pulse, and that he believed she was dead.

On October 23, 2013, at 10:13 p.m., CARLOS was pronounced dead by Dr. [redacted] at the York Hospital.[149] Officer [redacted] notified [redacted] of CARLOS's death by telephone at 10:17 p.m.[150]

[redacted] stated during his interview with ODO that after CARLOS was transported to the hospital, he met with all staff who responded to the scene, both correctional and medical. [redacted] stated he debriefed staff on the incident, and provided them with his timeline of events so their incident reports would reflect consistent times; as a result, all staff incident reports reference the times documented by [redacted]

Deputy Warden Clair Doll stated during his interview with ODO on December 11, 2013, that he came to the facility the night of October 23, 2013, and met with staff to discuss the incident. Deputy Warden Doll stated he also provided staff access to a Critical Incident Stress Management (CISM) session the following Saturday. Interviewed staff told ODO they found the CISM session helpful. Deputy Warden Doll stated staff also had access to the facility's chaplain and mental health counselors following CARLOS's suicide.

Deputy Warden Doll stated the Pennsylvania State Police (PSP) conducted an investigation of CARLOS's death[151], which included viewing her cell at YCP and interviewing Officer [redacted] and LPN [redacted]. Deputy Warden Doll stated the PSP report was not made available to YCP. (NOTE: On July 21, 2014, ODO Section [redacted] contacted PSP Trooper [redacted] at the York Barrack and was able to obtain a copy of their police report[152] for this incident. The police report contains details of detainee CARLOS's death that are consistent ODO's findings described herein.)

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[148] Exhibit 44.

[149] Exhibit 45.

[150] Exhibit 42, p. 1.

[151] ODO requested the PSP report concerning CARLOS's death from ERO while onsite, but learned from AFOD [redacted] PSP declined to provide it to both ERO and YCP.

[152] Exhibit 51.

The ODO review team searched CARLOS's property during the onsite review and did not find a suicide note or other written record of suicidal intent. Similarly, YCP staff stated that no suicide note was found in CARLOS's cell on the night of her death.

On October 24, 2013, at 1:15 p.m., AFOD [redacted] notified the JIC of CARLOS's death.[153]

On October 24, 2014, at 6:48 p.m., AFOD [redacted] submitted an ICE Significant Incident Report[154] regarding the death of detainee CARLOS.

On October 24, 2013, Barry L. Bloss, York County Coroner, conducted an autopsy on CARLOS's body and found her cause of death to be "hanging," and her manner of death to be "suicide."[155]

On October 24, Field Office Director (FOD) Thomas R. Decker telephonically notified the Deputy Consul of Antigua of CARLOS's death.[156] FOD Decker also sent CARLOS's family a condolence letter on this date.[157]

SECURITY AND HEALTHCARE REVIEW

Creative Corrections reviewed the safety and security of CARLOS while she was detained at YCP, as well as the medical care she was provided while housed there. Creative Corrections confirmed that YCP did not fully comply with the following ICE PBNDS: Emergency Plans, Use of Force and Restraints, Special Management Units, and Medical Care.

IMMIGRATION AND DETENTION HISTORY

On May 18, 1983, CARLOS entered the United States at Charlotte Amalie, Saint Thomas, United States Virgin Islands, as a lawful permanent resident of the United States.

On February 19, 1999, and April 19, 2000, respectively, CARLOS's father and mother became naturalized citizens of the United States. CARLOS's immigration status remained that of a lawful permanent resident.

On February 20, 2008, ICE ERO encountered CARLOS at the York Correctional Institution in Niantic, Connecticut, where she was serving a sentence for a May 9, 2007, conviction.

On February 28, 2008, the York Correctional Institution released CARLOS to ICE ERO custody. ICE ERO served CARLOS a Notice to Appear, charging removability pursuant to sections 237(a)(2)(A)(ii) and 237(a)(2)(A)(iii) of the Immigration and Nationality Act, as an alien

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[153] Exhibit 46.
[154] Exhibit 47.
[155] Exhibit 48.
[156] Exhibit 49.
[157] Exhibit 50.

convicted of two crimes involving moral turpitude at any time after entry, and as an alien convicted of an aggravated felony.

On June 2, 2008, ICE ERO released CARLOS to the Connecticut State Police on a writ which was issued for an assault on a correctional officer.

On June 6, 2008, CARLOS's immigration case was administratively closed.

On February 3, 2011, CARLOS was released back into ICE ERO custody by the State of Connecticut, and was transferred to the Bristol County Jail in North Dartmouth, Massachusetts.

On March 15, 2011, ICE ERO executed CARLOS's original Warrant for Arrest, dated February 20, 2008.

On April 14, 2011, CARLOS was transferred to the York County, PA, Prison.

On April 16, 2012, CARLOS applied for asylum.

On June 21, 2012, CARLOS's application for asylum was denied, and she was ordered removed to Antigua.

On July 24, 2012, a Final Order of Removal was issued for CARLOS.

On August 6, 2012, ERO provided CARLOS's original birth certificate and original fingerprint card to the Antiguan consulate, which the consulate had requested, in furtherance of obtaining travel documents from the consulate, authorizing her return to Antigua.

On October 18, 2012, CARLOS received a Post Order Custody Review (POCR) decision from the Field Office Director to continue her detention. The POCR decision was based on CARLOS's criminal history and the likelihood she would pose a threat to the community or self if released.

On December 27, 2012, CARLOS filed a Request for Release on an Order of Supervision through her attorney.

On January 18, 2013, CARLOS's December 27, 2012, Request for Release on an Order of Supervision was denied.

On February 1, 2013, ICE ERO continued CARLOS's detention.

On March 1, 2013, a travel document request was mailed to the Embassy of Antigua and Barbuda.

On May 16, 2013, a second Request for Release on an Order of Supervision was drafted for CARLOS.

On June 11, 2013, CARLOS's May 16, 2013, Request for Release on an Order of Supervision was denied, and ICE ERO continued her detention.

On July 22, 2013, ICE ERO continued CARLOS's detention.

ERO documented from July 24, 2012, when detainee CARLOS's final order of removal was issued, until just prior to her death, that numerous contacts and attempted contacts were made with Antigua and Barbuda Embassy and Consulate personnel, in ERO's efforts to secure travel documents for detainee CARLOS to return to her country of citizenship. The last note on October 3, 2013, three weeks prior to detainee CARLOS's death, states that ERO spoke to the Antiguan Consulate office, and there was no new information on when the travel documents might be forthcoming.[158]

CRIMINAL HISTORY

According to the National Crime Information Center (NCIC), CARLOS was assigned an FBI number and had a history of arrests and convictions for misdemeanor and felony offenses. CARLOS had more than one conviction for an offense characterized as an "aggravated felony" for purposes of immigration law.

REVIEW FINDINGS

Safety and Security

CARLOS was detained at YCP from April 14, 2011, to October 23, 2013, and was housed in segregation for a substantial amount of the time she was detained at the facility due to her behavioral issues and associated mental health concerns. CARLOS's records show the rationale for placing her in segregation was valid on all occasions. ODO notes, through YCP's use of the PRC, segregation status reviews are conducted by a group of representatives from ERO, correctional, medical, and mental health staff. This practice ensures all interested parties participate in segregation status decisions. During review of CARLOS's segregation history, ODO identified deficiencies related to lack of administrative segregation orders, and timeliness of segregation reviews.

CARLOS was found hanging in her cell on October 23, 2013, by an officer conducting a routine security check. Upon the discovery, a medical emergency call was made, a cut-down tool was used to cut CARLOS down, medical staff arrived within four minutes of the emergency call, and a 911 call was promptly directed by a supervisory officer. Review of surveillance footage and electronic records show routine security checks were conducted as required during the hours preceding discovery of CARLOS.

[158] Exhibit 4, p. 1.

ODO determined YCP did not fully comply with the following security-related ICE PBNDS 2008: Emergency Plans, Use of Force and Restraints, and Special Management Units.

1. ICE PBNDS 2008, Emergency Plans, section (V)(D)(7), Video Equipment, states, "At least one video camera shall be maintained in the Control Center for use in emergency situations…"

   ODO learned YCP has a video camera available at the facility, but it was not used to record the response and rescue efforts for CARLOS on October 23, 2013. stated during his interview that the video camera is only used for planned uses of force.

2. ICE PBNDS 2008, Emergency Plans, section (V)(D)(18), Post Emergency Procedures, states, "The post-emergency part of the plan shall include the following action items: b. Collecting written reports."

   Following CARLOS's suicide, incident reports were collected from some, but not all, staff who responded including Officer and Officer [9] Additionally, LPN documented an incorrect detainee name on his incident report, which was not noticed by YCP staff until ODO's review.

   Similarly, comprehensive incident reports were not completed after CARLOS's August 13, 2013, suicide attempt, and incident statement did not provide the names of medical staff who responded to the incident.

3. ICE PBNDS 2008, Use of Force and Restraints, section (II)(6), states, "Intermediate force devices will be used only in circumstances prescribed herein, with required prior approvals." Section (V)(G)(4), Authorized Intermediate Force Devices, lists the following authorized devices: oleoresin capsicum (OC) spray; collapsible steel baton; 36 inch straight, or riot, baton; and, ICE authorized chemical and impact munitions. Section (V)(G)(5), Unauthorized Force Devices, states, "any other device or tool not issued or approved by ICE/DRO" is not authorized.

   On June 8, 2011, an Electronic Body Immobilizing Device (EBID) was used on CARLOS to gain her compliance with staff.[160] Use of this device does not constitute an authorized intermediate force device.

4. ICE PBNDS 2008, Use of Force and Restraints, section (V)(H), Immediate Use of Force, states, "Upon gaining control of the detainee, staff shall seek the assistance of qualified health personnel to immediately: 1) Determine if the detainee requires continuing care

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[159] Exhibit 42.
[160] Exhibit 22.

and, if so, make the necessary arrangements; and, 2) Examine the detainee and immediately treat any injuries."

On November 11, 2012, CARLOS was subject to two bursts of OC spray in her face when she resisted being placed in a cell. The incident report for this event documents CARLOS was not seen by medical following the use of OC spray, and was instead, "instructed on how to decontaminate herself in her cell by using the water in her sink."[161]

5. ICE PBNDS 2008, Special Management Units, section (V)(C)(2), Administrative Segregation Order, states, "A written order shall be completed and approved by a security supervisor before a detainee is placed in Administrative Segregation," and "A copy of the order shall be given to the detainee within 24 hours…"

   CARLOS's detention record does not contain administrative segregation orders for any of the terms she served in YCP's various forms of administrative segregation. Additionally, CARLOS's record does not contain any documentation showing she was provided a copy of an administrative segregation order or notified of the reasons for her placement in administrative segregation.

6. ICE PBNDS 2008, Special Management Units, section (V)(C)(3), Review of Detainee Status in Segregation, subsection (a), states, "A security supervisor shall review the detainee's placement in Administrative Segregation within 72 hours to determine whether segregation is still warranted. This review shall include an interview with the detainee."

   CARLOS's detention record does not contain documentation showing she received 72-hour status reviews during any of the instances she was placed on administrative segregation. Failure to conduct 72-hour status reviews also violated Deputy Warden Doll's December 13, 2011, memorandum directing 72-hour and seven-day reviews.[162]

7. ICE PBNDS 2008, Special Management Units, section (V)(C)(3)(b), Review of Detainee Status in Segregation, states, "A security supervisor shall conduct the same type of review after the detainee has spent seven days in Administrative Segregation, and every week thereafter, for the first 60 days and (at least) every 30 days thereafter."

   CARLOS's detention record only contains weekly status reviews from July to October 2013. Deputy Warden Doll stated during his interview that he started making weekly reviews mandatory in June 2013. Failure to conduct weekly status reviews prior to June 2013, contravenes not only the ICE PBNDS, Special Management Units, but also Deputy Warden Doll's December 13, 2011, memorandum which states, "PRC shall see inmates

[161] Exhibit 23.
[162] Exhibit 15.

placed in BAU/SMU within the first seventy-two (72) hours of placement, then every seven (7) days for the first calendar month and then every thirty (30) days afterwards."

8. ICE PBNDS 2008, Special Management Units, section (V)(C)(3)(h), Review of Detainee Status in Segregation, states, "When a detainee has been held in Administrative Segregation for more than 30 days, the facility administrator shall notify the Field Office Director (FOD), who shall notify the ICE/DRO Assistant Director, Detention Management Division in writing."

   CARLOS's detention record does not contain documentation ICE ERO was notified on any of the occasions she was held in administrative segregation for more than 30 days. Although, ICE ERO staff participated in the PRC reviews of CARLOS's status, and presumably knew she was held in administrative segregation for more than 30 days, written notification is still required under the ICE PBNDS.

9. ICE PBNDS 2008, Special Management Units, section (V)(C)(3)(i), Review of Detainee Status in Segregation, states, "When a detainee is held in Administrative Segregation for more than 60 days, the FOD shall notify in writing, the Deputy Assistant Director, Detention Management Division. The Deputy Assistant Director shall then consider whether it would be appropriate to transfer the detainee to a facility where s/he may be placed in the general population."

   CARLOS's detention record does not contain documentation ICE ERO was notified on any of the occasions she was held in administrative segregation for more than 60 days. Although, ICE ERO staff participated in the PRC reviews of CARLOS's status, and presumably knew she was held in administrative segregation for more than 60 days, written notification is still required under the ICE PBNDS.

10. ICE PBNDS, Special Management Units, section (V)(E), Logs and Records, states, "A permanent log shall be maintained in the SMU to record all activities concerning the SMU detainees, such as the meals served, recreational time, and visitors."

    An activity log for the week of October 16 to 23, 2013, was requested by ODO during the review, but was unavailable.

    Medical

CARLOS was admitted to YCP on April 14, 2011, and received her intake medical and mental health screenings on April 16, 2011. The delay in mental health screenings was a result of CARLOS's failure to cooperate with the screening process at the time of her admission. CARLOS was promptly referred to, and evaluated by a psychiatrist after receiving her mental

health screening, and Creative Corrections notes, [163] "thereafter, she was seen routinely by mental health providers." Creative Corrections also notes[164] that although CARLOS's medical and mental health care was substantially compliant with the ICE PBNDS throughout the duration of her detention at YCP, her medical record lacks, "documentation of a treatment plan with measurable goals and objectives…to guide mental health interventions over the period of detention". Additionally, although ICE ERO staff participated in the PRC reviews of CARLOS status, and presumably knew of her mental health and behavioral issues, her medical record does not contain any documentation that YCP communicated with IHSC regarding her mental health status. The first documented communication from IHSC concerning CARLOS is an October 18, 2013, email from FMC [redacted] to ICE ERO AFODs [redacted], in which FMC [redacted] requests additional information on CARLOS's mental health issues "in order to find proper placement" for her. Creative Corrections notes[165] CARLOS's record contains, "no documentation YCP mental health staff pursued alternative placement with ERO.

On October 23, 2013, after CARLOS was found hanging in her cell by Officer [redacted] the emergency response by facility staff was in compliance with the ICE PBNDS. However, 911 was not called until [redacted] arrived at the scene, four minutes after CARLOS was discovered. Creative Corrections notes[166] that although, "officers…acted appropriately by cutting [CARLOS] down and initiating CPR, the American Heart Association and Mayo Clinic advise calling 911 before beginning CPR.

ODO determined YCP did not fully comply with the ICE PBNDS 2008, Medical Care.

1. ICE PBNDS 2008, Medical Care, section (V)(J), Health Appraisal, states, "Each facility's health care provider shall conduct a health appraisal including a physical examination on each detainee within 14 days of the detainee's arrival unless more immediate attention is required due to an acute or identifiable chronic condition, in accordance with the most recent ACA Adult Local Detention Facility standards for Health Appraisals."

   CARLOS arrived at YCP on April 14, 2011, and received her physical examination 15 days later on April 29, 2011. ODO notes that although CARLOS's physical examination occurred outside the ICE PBNDS prescribed 14-day time period, it took place within 14 days of her intake medical screening, which was delayed until April 16, 2011, due to her refusal to cooperate upon admission.

[163] Exhibit 7, p. 20.
[164] Id.
[165] Exhibit 7, p. 21.
[166] Exhibit 7, p. 20.

2. ICE PBNDS 2008, Medical Care, section (V)(K)(4), Referrals and Treatment, states, "The provider shall develop an overall treatment/management plan that may include transfer to a mental health facility if the detainee's mental illness or developmental disability needs exceed the treatment capability of the facility."

   CARLOS's medical record does not document any treatment plan for the duration of her detention at YCP.

3. ICE PBNDS 2008, Medical Care, section (V)(U)(4)(a), Medical/Psychiatric Alert, states, "Medical staff shall notify the facility administrator in writing, when they determine that a detainee's medical or psychiatric condition requires clearance by the medical staff prior to release or transfer, or medical escort during removal, deportation, or transfer."

   Because CARLOS was a mental health chronic care patient for the duration of her detention at YCP, and she attempted suicide on August 13, 2013, a psychiatric alert was appropriate for her, but none was generated.