

DEPARTMENT OF HOMELAND SECURITY Immigration and Customs Enforcement

1. CASE NUMBER

201302544

PREPARED BY

REPORT OF INVESTIGATION 2. R

HB 4200-01 (37), Special Agent Handbook

2. REPORT NUMBER 002

3. TITLE

COTA-Domingo, Manuel/Unknown/0109 Detainee/Alien - Death (Known Cause -Terminal Illness)/ELOY, PINAL, AZ

4. FINAL RESOLUTION

Management Notification Only

5. STATUS	6. TYPE OF REPORT	7. RELATED CASES
Closing Report	Other	

8. TOPIC

Detainee Death Review - Manuel COTA-Domingo

9. SYNOPSIS

On December 23, 2012, the Joint Intake Center, Washington, D.C., was notified of the death of Immigration and Customs Enforcement Detainee Manuel COTA-Domingo (Alien Number COTA-Domingo was a citizen of Guatemala who was born on January 12, 1978, and died on December 23, 2012, at St. Joseph's Hospital and Medical Center located at 350 West Thomas Road, Phoenix, Arizona. COTA-Domingo was 34 years old when he died. The Maricopa County medical examiner reported the immediate cause of death as complications of hypertrophic and atherosclerotic cardiovascular disease. Other significant conditions contributing to COTA-Domingo's death were reported as diabetic ketoacidosis and pneumonia.

On January 7, 2013, the ICE Office of Professional Responsibility, Office of Detention Oversight initiated a Detainee Death Review of Manuel COTA-Domingo's death. This report documents the findings of the review.

10. CASE OFFICER (Print Name & Title)	11. COMPLETION DATE	14. ORIGIN OFFICE		
L - ICE OPR Analyst Plus	10-JUN-2013	ICE OPR Office of Detention Oversight (ODO)		
12. APPROVED BY(Print Name & Title)	13. APPROVED DATE	15. TELEPHONE NUMBER		
- ICE-OPR Special Agent Supervisor	10-JUN-2013	No Phone Number		

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10. NARRATIVE

On December 23, 2012, the Joint Intake Center (JIC), Washington, D.C., was notified of the death of Immigration and Customs Enforcement (ICE) Detainee Manuel COTA-Domingo (Alien Number COTA-Domingo was a citizen of Guatemala who was born on January 12, 1978, and died on December 23, 2012, at St. Joseph's Hospital and Medical Center located at 350 West Thomas Road, Phoenix, Arizona (AZ). COTA-Domingo was 34 years old when he died.

At the time of his death, COTA-Domingo was in ICE custody at the Eloy Detention Center (EDC), Eloy, AZ. EDC has been open since 1994, and is owned and operated by Corrections Corporation of America (CCA) for the City of Eloy, AZ. The EDC is an Intergovernmental Service Agreement (IGSA) facility contracted for use by ICE from the City of Eloy. EDC houses ICE detainees of all classification levels for periods in excess of 72 hours. Medical care at EDC is provided by the ICE Health Service Corps (IHSC).

On March 5 to 8, and 13, 2012, Management and Program Analyst (MPA) and Special Agents (SA) and and assigned to ICE Office of Professional Responsibility (OPR), Office of Detention Oversight (ODO), conducted a Detainee Death Review regarding the death of COTA-Domingo. ODO was assisted by Registered Nurse (RN) and subject matter expert (SME) RN sie employed by Creative Corrections, a national management and consulting firm contracted by ICE to provide subject matter expertise in detention management, including health care. As part of the review, ODO interviewed individuals employed by CCA at EDC, as well as employees of IHSC and the ICE Office of Enforcement and Removal Operations (ERO). On March 14, 2012, ODO also interviewed Border Patrol Agents (BPA) employed by Customs and Border Protection (CBP), assigned to the Tucson Sector Border Patrol Station, Tucson, AZ. Additionally, ODO reviewed immigration, medical, and detention records pertaining to COTA-Domingo.

The following is a time-line of events regarding COTA-Domingo from the time of his apprehension by Border Patrol through his detention at EDC.

ODO interviewed BPA on March 14, 2013, at the Tucson Sector Centralized Processing



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Facility (TCA/TCC). BPA stated that at approximately 1:30 p.m. on December 8, 2013, physical movement across the United States/Mexico border near Sasabe, AZ, was detected.

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When she responded with BPA states and BPA and BPA she observed a group of approximately 20 individuals. BPA stated that she and the other BPAs immediately called for assistance, and began to chase the individuals. BPA stated that she was one of two BPAs who physically apprehended COTA-Domingo at a location documented as "Antonio Tank," which is reflected on COTA-Domingo's Form 826 with BPA stated that BPAs were only able to apprehend 15 of the estimated 20 individuals. After apprehending the 15 individuals, BPAs used flexi-ties to restrain the individuals wrists, and escorted them to Border Patrol vehicles where their property was searched, they were interviewed, and their Forms 826 were prepared. BPA did not specifically remember COTA-Domingo and did not remember who searched his property. Once all individuals were searched, interviewed, and had a Form 826, BPAs drove them to milepost 16-286 where they were picked up by G4S transportation officers. G4S, formerly Wackenhut, is a security contractor used by Border Patrol to provide a variety of services for the Agency including transportation of aliens.	it
ODO interviewed BPA on March 14, 2013, at the TCA/TCC. BPA confirmed that she was the second BPA who physically apprehended COTA-Domingo, which is documented on COTA-Domingo's Form 826 with her Star # (See Exhibit 2). BPA did not specifically remember COTA-Domingo and did not remember who searched his property.	
COTA-Domingo's Form 826 documents his time-of-entry to the United States at 1:30 p.m., and his time-of-arrest at 5:00 p.m., December 8, 2012 (See Exhibit 2).	S
ODO interviewed BPA at the TCA/TCC on March 14, 2013. BPA stated that during apprehensions and arrests at the border, including the one involving COTA-Domingo, participating BPAs always search apprehended individuals' property to look for contraband. BPA stated that if medication is found among an individual's property, it is standard practice for at Emergency Medical Technician (EMT) to be called immediately to examine the medication and consult with the individual. BPA stated that an EMT was called during the December 8, 2012, apprehension to treat an individual who had foot injuries, but not in response to any medications found among the aliens' property. BPA stated that during large apprehensions, including the one involving COTA-Domingo, BPAs may focus their property searches to look specifically for dangerous contraband. BPA did not specifically remember COTA-Domingo, and did not remember who searched his property.	



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ODO interviewed BPA on March 14, 2013, at the TCA/TCC. BPA confirmed his Star # on COTA-Domingo's Form 826, noting that he was the Field Processing Agent during COTA-Domingo's apprehension. BPA did not specifically remember COTA-Domingo, and did not remember who searched his property.

On December 8, 2012, after being searched and processed in the field, COTA-Domingo and the other individuals apprehended were picked up by G4S transportation officers and transported to the TCA/TCC. Border Patrol was unable to locate trip logs showing the times that the aliens were picked up and dropped off.

After arriving at the TCA/TCC, a G4S officer searched COTA-Domingo's property and tagged it with a baggage claim check marked with claim number 5039028. A portion of the baggage claim check, marked with the same claim number, was affixed to COTA-Domingo's Form 826 (See Exhibit 2). Baggage claim checks do not list the items contained in an alien's property.

The Standard Operating Procedure for the G4S officers addresses searches of alien property, but does not specifically discuss the handling of medications found during property searches (Exhibit 3).

ODO interviewed BPA	Branch Chief, Tucson Coordination Center (TCC), on
March 14, 2013. BPA	stated that during preliminary processing of aliens at the TCA/TCC
G4S officers search aliens' pro	pperty for contraband including weapons, drugs, and other
dangerous items. TCA/TCC of	loes not keep a record of the G4S officer who searches a particular
alien's property. BPA	stated that if a G4S officer finds medication among an alien's
property, that officer will typica	ally leave the medication with the property and will not inform Border
Patrol. BPA also stat	ed that finding medications on or with an alien would not typically
trigger any response by Borde	er Patrol; however, if an alien discloses a medical condition to a staff
member at the TCA/TCC, Bor	der Patrol automatically sends that alien to the hospital for
evaluation. BPA state	ed that aliens have access to an EMT during both the day and swing
shifts at the TCA/TCC. Addition	onally, ODO observed that holding cells at the TCA/TCC contain
posters, in both English and S	panish, advising aliens to tell an officer if they are sick, hungry or
thirsty.	

According to BPA COTA-Domingo was escorted to a holding cell to await booking and processing by a BPA after he underwent preliminary processing by a G4S officer and received a baggage claim check.



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On December 9, 2012, at 10:19 p.m., COTA-Domingo was booked into the TCA/TCC by BPA During booking, BPA took COTA-Domingo's fingerprints, and completed an I-213, Record of Deportable/Inadmissible Alien (See Exhibit 1).
On December 11, 2012, COTA-Domingo was processed by BPA at the TCA/TCC. During processing, BPA completed a Form I-867A, Record of Sworn Statement in Proceedings under Section 235(b)(1) of the Immigration and Nationality Act (Exhibit 4), and served COTA-Domingo with a Form I-860, Notice and Order of Expedited Removal (Exhibit 5), as well as a Form I-296, Notice to Alien Ordered Removed/Departure Verification (Exhibit 6). BPA also completed a "Medical Screening Form," for COTA-Domingo which was signed by COTA-Domingo and documents that he had no medical complaints at that time (Exhibit 7).
ODO interviewed BPA on March 14, 2013. BPA confirmed that he was the BPA who processed COTA-Domingo and who signed the processing forms. BPA did not specifically remember COTA-Domingo.
On December 12, 2012, at 1:30 a.m., Border Patrol contacted ICE Immigration and Enforcement Agent (IEA) at the Florence Processing Center, Florence, AZ, to inform him that several aliens, including COTA-Domingo were being held at the TCA/TCC and were awaiting transfer into ICE custody, as documented in a Florence Placement Log maintained at the TCA/TCC (Exhibit 8). IEA is the TCA/TCC's ICE point of contact in Florence who coordinates placement of recently apprehended illegal aliens into area ICE detention facilities.
Deputy Patrol Agent in Charge (DPAC), advised ODO that once an alien has been fully processed at the TCA/TCC, it is Border Patrol's practice to then inform ICE, via IEA that the alien is awaiting transfer to ICE custody. Depending upon whether ICE has bed space in an area facility, ICE may or may not accept the alien immediately. Border Patrol will continue to call IEA one to two hours before daily transport buses carrying aliens depart the TCA/TCC to determine whether bed space has become available and whether an alien can be placed on the bus for transfer to ICE. The Florence Placement Log is updated with a time and date stamp each time ICE is called regarding an alien's transfer. The time and date stamp documented on the Florence Placement Log regarding COTA-Domingo reflects that ICE provided a positive response for his placement during the call placed at 1:30 a.m., on December 12, 2012. DPAC stated that aliens may be held at the TCA/TCC anywhere from one to ten days depending upon a number of factors including availability of bed space at an area ICE facility.

According to a Manifest of Persons and Property Transferred, COTA-Domingo was scheduled to



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be transferred from the TCA/TCC to EDC by G4S on December 12, 2012, at 1:55 a.m (Exhibit 9). The G4S Transportation Officer Trip Log from December 12, 2012, indicates that the G4S bus left the TCA/TCC at 3:45 a.m., and arrived at EDC at 7:45 a.m. (Exhibit 10). BPA advised that although the drive from the TCA/TCC to EDC takes approximately one hour, the buses transporting aliens often have to wait, holding the aliens on the bus, until the facility has enough officers on a shift to facilitate processing of the aliens. EDC's Receiving and Discharge Log from December 12, 2012, shows that COTA-Domingo was received at the facility at 8:10 a.m. (Exhibit 11). During ODO's review, EDC staff indicated that after disembarking the G4S transport bus, all detainees, including COTA-Domingo, were searched and placed in a holding cell to await admission to the facility.

At 9:33 a.m., on December 12, 2012, COTA-Domingo was offered a telephone call which he made to his father, Mateo Cota Domingo (Exhibit 12).

After COTA-Domingo made the telephone call to his father, CCA Correctional Officers (COs) and and completed his admission to EDC, which included searching and logging his property. According to a Disposition of Non-Allowable Property Form, signed by both CO and CO COTA-Domingo's non-allowable property, which was stored at the facility, included a "bag of meds." The form contains a box labeled "medication to be forwarded to health services" which was left blank (Exhibit 13).

ICE ERO Assistant Field Office Director (AFOD) for Phoenix/Eloy, provided ODO with surveillance footage of COTA-Domingo's admission to EDC (Exhibit 14). ODO reviewed the surveillance footage, and noted the following admission events occurring at the documented time stamps (Note: During ODO's review, facility personnel indicated that time stamps on the surveillance footage from the intake area are often not in sync with real time):

10:59:00 – CO pulls a bag from COTA-Domingo's property bin and places it on the intake desk.

10:59:25 – COTA-Domingo approaches the intake desk.

10:59:52-11:05:10 – CO empties the contents of the bag on the intake desk and pulls additional items from the bin. CO searches and sorts each item of property including the contents of a backpack. While COTA-Domingo's property is searched by CO seated behind the intake desk at the computer, completes COTA-Domingo's admission paperwork.



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11:05:10-11:06:37 – CO holds up a green plastic bag that was found inside COTA-Domingo's backpack. He empties the contents of the green bag on the desk, sorts the items, and appears to ask COTA-Domingo questions before placing the items back in the green bag and returning the bag to COTA-Domingo's property bin.
11:06:40 – CO takes an item from the desk and gives it to CO
11:06:53 – CO takes the item he received from CO and walks to a room to his right where medical intake screenings are being conducted. CO enters the medical intake screening room, and then exits to another room behind it; he appears to still be holding the item as he moves between the rooms. During the review, ODO observed that showers and restrooms were contained in the room behind the medical intake screening room.
11:07:30-11:07:50 – CO reenters the intake area from the second room, still holding the item, and approaches Licensed Practical Nurse (LPN) CO gives LPN the item and points to COTA-Domingo, who is still standing at the intake desk, before walking back over to COTA-Domingo. Registered Nurse (RN) who is conducting medical screenings outside of the medical intake screening room, watches the interaction between LPN and CO approaches LPN and appears to examine the item LPN received from CO
11:07:51 – RN returns to the medical screenings and LPN enters the medical intake screening room.
11:08:23 – CO takes COTA-Domingo's fingerprints.
11:08:28-11:08:52 – LPN approaches COTA-Domingo at the intake desk, holds an item up for him to see, and talks with both COTA-Domingo and CO before returning to the medical intake screening room with the item.
11:11:30 – COTA-Domingo's admission process concludes.
ICE ERO Detention Operations Supervisor (DOS) provided ODO with the green plastic bag seen in the surveillance footage described above, on March 5, 2013. DOS stated the bag was found in COTA-Domingo's stored property bin after his death. ODO examined the contents of the bag and found the following: one tube of piroxicam (non-steroidal



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anti-inflammatory cream); two unidentifiable pills in packaging containing the brand name "Merck;" one clear plastic bag containing unidentifiable white pills; four unidentifiable pills in a blister package; four blister packages of pills with the following printed on the back, "Tratamineto de Diabetes Tipo 2, Glibenclamida + Metformina, Tablets 5 mg + 500 mg"; and, five blister packages of pills with following printed on the back, "Glibenclamida, Tabletas BP 5 mg" (Exhibit 15). RN advises that the "Glibenclamida + Metformina" and "Glibenclamida" are both medications for the treatment of type II diabetes.

ECD's Post Order #14, Intake/Release, issued March 14, 2007, states that "The Property Officer or designee will confiscate any medication that the inmate resident has in their possession upon admission. The Property Officer or designee will record the medication on the 14-6A and will ensure all medication is forwarded to the Health Services Department" (Exhibit 16). Additionally, CCA Policy #14-6, Inmate/Resident Property, issued April 23, 2012, contains the exact language in EDC's Post Order #14, above, and contains a statement in bold print that reads "MEDICINE ACCOMPANYING ARRIVING INMATE/DETAINEE WILL BE FORWARDED TO THE FACILITY MEDICAL STAFF FOR DISPOSITION" (Exhibit 17). This language echoes the ICE PBNDS, Contraband, section V(A)(1), which states that "medicine the detainee brings into the facility upon arrival shall be forwarded to facility medical staff for disposition."

ODO interviewed CO on March 7, 2013, regarding COTA-Domingo, and showed him both the surveillance footage of COTA-Domingo's admission, as well as the green plastic bag and the medication inside. CO stated that he did not have any memory of COTA-Domingo or the bag of medication. CO stated that he has worked at EDC for 14 years and ten months, and that he has been conducting admissions for four years. He is not fluent in Spanish, but stated that he uses an interpreter through Interpretalk, a telephonic translation service contracted by ICE, when necessary. CO confirmed his signature on COTA-Domingo's Disposition of Non-Allowable Property Form. CO stated that he was unsure what the Post Orders for Intake/Release require, but that prior to COTA-Domingo's death, he did not regularly provide medical intake personnel with any medications that appeared to be over-the-counter (OTC) and that were found during a search of a detainee's property during intake. He stated that after COTA-Domingo's death, all intake staff were advised that any and all medications found in a detainee's property during intake must be given to medical intake staff. This order was distributed via email and flyer, and is posted in the intake area (Exhibit 18).

ODO interviewed CO on March 7, 2013, and showed him both the surveillance footage of COTA-Domingo's admission, as well as the green plastic bag and the medication inside. CO stated that he did not have any memory of COTA-Domingo or the bag of medication. CO



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stated that if a detainee comes through admission with medication in his property, the CO conducting intake will examine the medication and give it to medical personnel conducting medical intake screenings unless it appears to be an OTC. CO confirmed his signature on COTA-Domingo's admission paperwork, including the Disposition of Non-Allowable Property Form.
ODO interviewed Senior Correctional Officer (SCO) on March 6, 2013. SCO has been supervising the intake process at EDC since April 2012. SCO stated that EDC's policy and practice for COs conducting intake is to give all medications, including OTCs, to intake medical staff during a detainee's admission. SCO stated that prior to COTA-Domingo's death, the practice of giving all medications to intake medical staff may have been more informal, but currently, whenever a medication of any kind is found, it is immediately placed in a plastic bag which is labeled with the detainee's identifying information, and given to intake medical staff.
ODO interviewed LPN on March 5, 2013. LPN has worked as a nurse at EDC for six years, and in corrections for 14 years. LPN stated that while she was performing intake medical screenings on December 12, 2012, CO gave her a bottle of insulin that he found during a search of COTA-Domingo's property. CO told told her that COTA-Domingo, who was still undergoing the intake process at the time, denied to officers that the insulin belonged to him. LPN stated that after receiving the bottle of insulin from CO she approached COTA-Domingo and questioned him about it. She stated that COTA-Domingo denied the insulin was his and claimed that it belonged to one of his companions. LPN stated that COTA-Domingo was very convincing when he denied ownership of the insulin. She also indicated that she often sees medications in the intake area that remain unclaimed and, as a result, did not question COTA-Domingo's denial. LPN said that COTA-Domingo stood out in her memory because he was much taller than most Guatemalans she had encountered in the past during the course of her duties as a nurse, and that he was noticeably thin. LPN stated that she communicated with COTA-Domingo in Spanish, and she believes he understood. LPN stated that she never saw the bag of medication found in COTA-Domingo's property, and that she does not remember what happened to the bottle of insulin.
During CO interview, ODO asked him whether the bottle of insulin described by LPN may have been on the intake desk prior to the search of COTA-Domingo's property. CO responded that he did not believe so and that he "wouldn't just leave a bottle of insulin lying

around."



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When asked about typical procedures regarding medications found during intake, LPN stated that whenever a detainee arrives with medication, intake officers must give that medication to one of the nurses conducting intake medical screenings. LPN stated that whenever she receives a medication from an intake officer, or when a detainee identifies that he or she takes medication, she is required to place the detainee on a priority list to be seen by the on-call medical provider. LPN stated that when the on-call provider is notified that there are detainees on the priority list, that provider typically evaluates the detainees while they are still in the intake area. LPN stated that after COTA-Domingo's death, it was made clear to all intake staff that any medications arriving with a detainee, including OTCs and foreign medications, must be given to intake medical staff for evaluation.
ODO interviewed RN stated that she did not remember COTA-Domingo, and had no recollection of LPN discussing any medication with her on December 12, 2012. RN stated that if a detainee arrives with medication, but denies ownership of it, it is standard practice for the intake nurse to make a notation in the detainee's medical file and refer the detainee to the on-call provider. RN stated that if the on-call provider determines that the detainee needs to start or continue a medication, a new order for that medication is prepared and the medication is dispensed from the onsite pharmacy. RN stated that EDC's pharmacy fills all prescriptions via telephone order, and that the facility's pill room contains an overstock of medications to meet any immediate needs. RN stated that medication arriving with the detainee is returned to his or her property.
EDC's Local Operating Procedure (LOP) for intake screenings states that all medications arriving with a detainee are to be placed in a clear zip lock bag and labeled with the detainee's identifying information. The LOP also states that once the detainee has been evaluated by a provider, the medications are returned to security staff to be placed in the detainee's personal property (Exhibit 10)

medications are returned to security staff to be placed in the detainee's personal property (Exhibit 19).

ICE ERO informed ODO that any medication found in a detainee's property at intake will be stored with that detainee's property regardless of whether he or she denies ownership of the medication.

with that detainee's property regardless of whether he or she denies ownership of the medication. If an item found during intake screening is suspected to be a narcotic or a controlled substance, it will be retained as evidence or destroyed per the PBNDS Contraband standard by EDC, as stated in CCA Policy 9-6, Contraband Control (Exhibit 20).

On December 12, 2012, at 10:40 a.m., COTA-Domingo underwent an intake medical screening by LPN Lopez, as documented on the ICE Health Service Corps (IHSC) Intake Screening form (IHSC



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795-A) (Exhibit 21). LPN documented on the intake screening form that COTA-Domingo stated that he felt "fine," and had no pain and no significant medical problems. Additionally, he responded in the negative when asked if he used medications and if he was currently or had ever been treated by a doctor for a medical condition. COTA-Domingo's vital signs were recorded as the following: Temperature, 98.6; Respirations, 14; Blood Pressure, 135/89; Height, 5'3" (Note: This measurement conflicts with LPN memory of COTA-Domingo being tall, as well as COTA-Domingo's autopsy report which documents his height as 5'6" (Exhibit 22)); Weight, 133.2. COTA-Domingo's intake screening form indicates that he was scheduled for a physical exam. Additionally, RN observed that COTA-Domingo appeared "to have normal physical/emotional characteristics and no barriers to communication." During COTA-Domingo's intake screening, he was given a chest x-ray (CXR) to screen for the presence of tuberculosis. The results of the CXR were negative, and the report was signed, but undated by PA LCDR (Exhibit 23).
During ODO's interviews with LPN and RN LPN confirmed her signature on the intake screening forms documenting that she conducted COTA-Domingo's intake screening, and RN confirmed her signature as the second reviewer of COTA-Domingo's intake screening forms.
On December 12, 2012, at 2:26 p.m., COTA-Domingo was placed in housing unit Alpha, Block 2, Cell 3, according to an EDC Housing Unit Assignment Log (Exhibit 24). An EDC record entitled Inmate Housing History with Cellmates indicates that COTA-Domingo's cellmate was (Exhibit 25).
On December 13, 2012, COTA-Domingo met with his assigned Deportation Officer (DO), During the meeting, COTA-Domingo signed a form indicating that he wished to have his consulate notified that he was detained (Exhibit 26).
On December 13, 2012, at 9:40 a.m., a facsimile transmission from ICE ERO at EDC to the Consulate of Guatemala listed COTA-Domingo as one of five detainees at EDC who requested the consulate be notified of their detention at EDC (Exhibit 27).
ODO interviewed DO on March 5, 2013. DO has worked for ICE ERO at EDC since March 2003. DO stated that he typically interviews new detainees within 24 hours of their arrival to EDC. DO did not specifically remember COTA-Domingo, but upon looking at his alien file, stated that his primary role in COTA-Domingo's case was to provide consular notification. He stated that his meeting with COTA-Domingo would have been short



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because COTA-Domingo had no criminal history. DO stated that he uses Interpretalk to translate when he communicates with non-English speaking detainees.
On December 13, 2012, at 4:45 p.m., COTA-Domingo underwent a physical examination provided by RN as documented in IHSC Form 795-B, Physical Examination/Health Appraisal (Exhibit 28). According to the IHSC Form 795-B, COTA-Domingo did not display any medical conditions aside from "congestion" and complaints of a cough, for which he was prescribed a decongestant and a cough suppressant.
ODO interviewed RN on March 6, 2013. RN has worked as an RN at EDC for approximately one year. RN confirmed that he conducted COTA-Domingo's physical examination and signed the Form 795-B. RN did not specifically remember COTA-Domingo, but reviewed the Form 795-B and stated that the form indicates that he personally took COTA-Domingo's vital signs during the physical examination, and that COTA-Domingo's only complaint related to upper respiratory problems. COTA-Domingo's vital signs on the Form 795-B were recorded as the following: Temperature, 99.6; Pulse, 76; Respirations, 16; Blood Pressure, 133/68; Height, 5'3" (Note: RN acknowledged that he likely took this measurement from the Intake Screening form); Weight 137. COTA-Domingo's Form 795-B indicates that COTA-Domingo denied both a personal and family history of diabetes. RN stated that he is fluent in Spanish, and that he tries to ascertain the level of understanding when working with a detainee who speaks a dialect of Spanish. If necessary, RN uses Interpretalk to communicate with detainees. RN stated that he believes some detainees are afraid to disclose medical conditions because they fear it will either cause them to be held in detention longer, or speed up their removal. COTA-Domingo's physical examination was reviewed and stamped by Captain (CAPT) MD, on December 20, 2012.
ODO interviewed Dr. via teleconference on March 21, 2013. Dr. indicated that the Clinical Director (CD) position at EDC has been vacant since 2009, but that he provides clinical oversight as the Western Regional Clinical Director. Dr. stated that the facility also currently has an unfilled staff physician position. To fill this vacancy until a permanent physician is hired, IHSC rotates physicians through EDC on a biweekly basis. Dr. was the physician on rotation at EDC on December 20, 2012. Dr. stated that the seven days that passed between COTA-Domingo's physical examination and his review was a reasonable timeframe for review of a physical examination conducted by an RN.
On December 19, 2012, LPN signed off on COTA-Domingo's Medical Summary of Federal



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10. NARRATIVE
Prisoner/Alien in Transit, medically clearing him to be removed (Exhibit 29). During ODO's interview with LPN she stated that she cleared him after reviewing his medical chart. COTA-Domingo was tentatively scheduled to be removed via ICE AIR on December 26, 2012 (Exhibit 30).
ODO interviewed COTA-Domingo's cellmate, speaks Spanish with very limited English, interpretation was provided by ICE IEA stated that when COTA-Domingo first arrived on December 12, 2012, he seemed to be coming down with a cold. stated that after seeing medical on December 13, 2012, COTA-Domingo received cough medicine which he took during the duration of his stay at EDC.
During the interview with COTA-Domingo including his behavior and apparent health during the time the two men were housed together. Stated that while they were housed together, he noticed that COTA-Domingo spent most of his time lying down, did not go out for recreation often, and picked at his food. Stated that for a few days prior to December 19, 2012, he noticed that COTA-Domingo had a "strong rotten odor" which caused their whole cell to smell foul and which other detainees complained they could smell outside of the cell. Stated he suspected that COTA-Domingo had diabetes, because he has family members with diabetes and was familiar with the smell their urine would sometimes create. He stated COTA-Domingo never mentioned diabetes to him. Stated he same time as COTA-Domingo, told that COTA-Domingo's cousin, who was detained at EDC at the same time as COTA-Domingo, told that COTA-Domingo had diabetes. According to COTA-Domingo's cousin encouraged COTA-Domingo to talk to medical personnel about his condition but COTA-Domingo refused. Selieves that COTA-Domingo was worried he would have to pay for medical care which he could not afford.
stated that during the day on December 19, 2012, COTA-Domingo was coughing heavily and fell while trying to climb into his bunk (Note: COTA-Domingo used the top bunk because is vision impaired and must use the bottom bunk). When he asked COTA-Domingo what was wrong, COTA-Domingo said he did not know and mentioned that he was worried about his meeting with the consulate the following day. believes that COTA-Domingo was very concerned that being sick would cause his meeting with the consulate to be cancelled. also noticed that COTA-Domingo had been drinking a lot of water, even though the water tasted bad, and was using the bathroom often.



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told ODO that starting around 10 p.m., on December 19, 2012, he heard COTA-Domingo having very labored breathing. At approximately 11 p.m., attempted to alert the COs working the graveyard shift that COTA-Domingo was ill by banging on their cell door and yelling "CO" and "sick." stated that he waited for the COs to walk by the cell he shared with COTA-Domingo during their rounds so that he could get their attention, but that they walked by so quickly he would miss them. stated that a CO did not respond to him until around 2 a.m. on December 20, 2012. He stated that it is typical for COs to not observe detainees closely when conducting rounds.
During the review, ODO toured the Alpha building which contains three housing units with an officer desk centrally located so that a CO has a line of sight into each housing unit from the desk. ODO asked an ERO officer to yell from inside cell 203 where COTO-Domingo was housed, with the door closed, and to bang on the cell door. ODO determined that this noise was easily audible from the officer's desk. Said that when a CO finally responded, it was during one of the CO's rounds, and that the CO had to get another CO to communicate in Spanish. did not remember the names of the COs. remembered that the CO asked COTA-Domingo to wait until the morning chow time to go to medical.
stated that he woke up around 4:00 a.m. on December 20, 2012, when the cell doors were unlocked prior to chow time, and observed COTA-Domingo lying on the floor of their cell. stated that he woke COTA-Domingo up, walked him to the tables in the dayroom, and observed him sit down and put his head on a table. stated that when the detainees were called to line up for chow, another detainee helped COTA-Domingo walk to the pill line where he followed a group of detainees to the medical unit.
ODO interviewed Detainee on March 7, 2013. Both were housed in the Alpha 200 housing unit with COTA-Domingo. Both detainees independently corroborated statement that he tried to get the COs' attention during the night of December 19-20, 2012, by banging on his cell door and yelling to COs. Detainee confirmed that the banging and yelling started around 11:00 p.m. and lasted for three to four hours.
During interviews with COs at EDC, ODO learned that the graveyard shift starts at 10 p.m. and ends at 6 a.m. ODO also learned that during the graveyard shift, detainee counts are conducted at 11:00 p.m., 1:00 a.m., and 3:00 a.m., by two COs, and security checks are conducted every 30 minutes by either one or two COs.



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According to EDC's Post Order #24 for Housing Officers, during detainee counts, two officers must be present and counting at the same time and they each must start at an opposite end of a tier and cross in the middle so that each cell is checked by both officers. After detainee count is complete, both CO's are required to sign the count sheet to verify the accuracy of the count. According to the same Post Order, routine security checks are to be conducted at random times every 30 minutes, and are to include "a walk-by inspection of each cell for obvious security breaches or inmates in need of assistance," as well as "answering inquiries made by detainees" (Exhibit 31).

ICE ERO provided ODO with surveillance camera footage of the Alpha 200 housing unit during the graveyard shift on December 19-20, 2012 (Exhibit 32). COTA-Domingo's cell door is the second door seen in the bottom left corner of the bottom tier of the housing unit. Officers in the footage were identified as CO CO and and CO EDC's Detention Center Daily Shift Roster for the graveyard shift on December 19, 2012, shows that CO and and CO on duty in the Alpha Building, and that CO was assigned to report for duty at 2:00 a.m. (Exhibit 33). ODO reviewed the surveillance footage and noted the following events occurred at the documented time stamps: 23:04:27-23:07:15 – CO and and CO enter from the right, where the doorway leading to the officer's desk is located, and conduct a detainee count. Although they both pass by each cell on both the top and bottom tiers of the housing unit, it appears that they only pause to look inside cells sporadically. The Alpha Unit Security Log documents that a facility count was conducted at 11:00 p.m. (Exhibit 34). (Note: The Security Log documents CO and and CO conducting the count, however CO was was determined to not be in the facility at the time of the footage; ICE ERO advised that this was a documentation mistake and that CO conducted the count with CO 23:33:17-23:33:50 – CO enters from the bottom left and conducts a security check. CO walks past all cells without pause on the bottom tier before exiting through a door on the far end of the housing unit. The Alpha Unit Security Log documents that CO conducted a security check at 11:30 p.m. (See Exhibit 34). 00:03:08-00:03:37 - CO and and CO both enter from the bottom left and conduct a security check. CO is seen on the bottom tier and CO is on the top tier as they walk by each cell without pause. CO is seen exiting through a door on the far end of the housing unit. The Alpha Unit Security Log documents that CO and and CO conducted a security check at 12:00 a.m. (See Exhibit 34).



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01:04:37-01:06:38 – CO enters from the right and conducts detained count. He starts at the far side of the housing unit, walking past all cells on the bottom tier, before walking to the top tier and walking past all cells. He does not appear to pause at any cell while conducting the count. The Alpha Unit Security Log documents that CO conducted a detained count at 1:00 a.m. (See Exhibit 34).
01:07:06-01:07:36 – CO enters from the right and walks to the bottom of the staircase which leads to the top tier of the housing unit. CO descends the staircase and the two men exit to the right together. The Alpha Unit Security Log documents that CO conducted a fire exit check at 12:50 a.m. (See Exhibit 34).
01:31:38-01:32:04 – CO enters from bottom left and conducts a security check of the top tier. At 01:36:35, he reenters from a door on the far side of the housing unit and conducts a security check of the bottom tier. CO does not appear to pause at any cell during the security check. The Alpha Unit Security Log documents that CO conducted a security check at 1:30 a.m. (See Exhibit 34).
02:00:58-02:01:53 – CO and CO conduct a security check. Both enter from the bottom left with CO on the bottom tier, and CO on the top tier. Just as CO passes by COTA-Domingo's cell door, he stops, returns to the door and appears to look into the cell for a few seconds before finishing the security check. The Alpha Unit Security Log documents that CO and CO conducted a security check at 2:00 a.m. (See Exhibit 34).
02:04:17-02:05:25 – CO enters from the right, walks to COTA-Domingo's cell door, and stands facing the door for approximately one minute before exiting to the right.
02:05:29-2:05:58 – CO reenters from the right, walks to COTA-Domingo's cell and stands facing the door for a few seconds before exiting to the right.
02:30:42-02:31:27 – CO and and CO conduct a security check. Both enter from the bottom left with CO on the bottom tier, and CO on the top tier. CO pause pauses for a few seconds in front of COTA-Domingo's door while conducting the check. The Alpha Unit Security Log documents that CO and CO Felix conducted a security check at 2:30 a.m. (See Exhibit 34).
03:05:29-03:08:38 – CO and and CO enter from the right and conduct a detainee count.



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starts at the bottom left and does not appear to pause at any cell; CO sissing to look into cells including COTA-Domingo's. The Alpha Unit Security Log documents that CO signal and CO conducted a detainee count at 3:00 a.m. (See Exhibit 34).
03:29:15-03:29:54 – CO enters from the bottom left and conducts a security check. He does not appear to pause at any cell while conducting the check. The Alpha Unit Security Log documents that CO conducted a security check at 3:30 a.m. (See Exhibit 34).
03:55:31-03:56:50 – CO and and CO conduct a security check. Both enter from the bottom left with CO on the bottom tier, and CO on the top tier. Both officers pause at each cell while conducting the check. The Alpha Unit Security Log documents that CO and CO conducted a security check at 3:50 a.m. (See Exhibit 34).
03:59:38 – COTA-Domingo exits his cell alone and walks slowly to a row of chairs on the right where he sits and puts his head back (Note: This conflicts with the account provided by
04:07:16 – COTA-Domingo stands up and walks out of the housing unit to the right with a group of detainees. He appears to struggle while getting out of the chair.
ODO interviewed CO stated that he does not specifically recall COTA-Domingo, and does not remember any interaction concerning COTA-Domingo on the night of December 19-20, 2012. CO stated that on December 19-20, 2012, he worked an abbreviated graveyard shift from 10 p.m. until 2 a.m. He stated that while working the graveyard shift, he is required to perform security checks every 30 minutes, and detainee counts at 11:00 p.m. and 1:00 a.m. He also stated that it is easy to hear detainees banging on their doors and calling out from the officer's desk, and he does not recall hearing either during his shift that night. CO stated that during his shift on December 19-20, 2012, he escorted a different detainee from the Alpha building to medical and waited in medical until approximately 1:00 a.m., which he believes could account for CO conducting the 1:00 a.m. detainee count alone. CO also also stated that he is on EDC's Emergency Response Team (ERT) and that he was called out for an ERT drill on the morning of December 20, 2012. EDC's Control Log shows that a drill occurred from 1:40-1:56 a.m. on December 20, 2012 (Exhibit 35).
ODO interviewed CO on March 6, 2013. CO has worked at EDC for



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got his attention during a security check by knocking on the cell door (Note: This account conflicts with the surveillance footage which shows CO as the first officer to respond to complete that this was the first time during the night of December 19-20, 2012, that attempted to get his attention. CO stated that he spoke with who told him that COTA-Domingo was breathing hard and was either hot or cold (Note: CO could not remember whether COTA-Domingo was lying on his top bunk and did not appear to be behaving in an unusual manner. CO stated that he called medical and reported COTA-Domingo's symptoms to the medical officer exactly as described them. CO stated that the medical officer called him back approximately 15 minutes later and told him to send COTA-Domingo to medical during the 4:00 a.m. chow time. CO did not log his conversations with the medical officer. CO stated that COTA-Domingo went to medical during the 4:00 a.m. chow time, but that he did not log COTA-Domingo's movement to medical.
During ODO's review, a Detainee Movement Log showing COTA-Domingo's movement from his housing unit to the medical unit was requested. During interviews with COs, ODO learned that EDC does not maintain Movement Logs during the graveyard shift and that COTA-Domingo's movement to the medical unit was not recorded by the housing unit officers.
EDC Post Order #24 for Housing Officers states that, "during individual movements such as library, court, medical, or visitation," the housing unit officer, "will be responsible for issuing a colored pass and documenting the movement on the Movement Log Sheet." Further, the housing unit officer, "must be able to verify the whereabouts of all detainees that have left the pod" (See Exhibit 31).
In an incident report prepared by CO on December 28, 2012, she documented that at 2:30 a.m. on December 20, 2012, she was assigned to the Alpha Building and that CO was in charge. She documented that CO told her that COTA-Domingo was complaining of chest pains, and that he called medical to advise them of COTA-Domingo's symptoms. She documented that CO told her that medical advised him to send COTA-Domingo to the medical unit after morning chow time commenced (Exhibit 36).
ODO interviewed CO on March 7, 2013. CO worked as the medical officer during the graveyard shift on December 19-20, 2012. The designation "medical officer" is given to the EDC CO post of duty in the medical unit. The medical officer's primary functions are



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to provide security in the medical unit and to monitor the movements of detainees into and out of the unit. CO stated that he remembers receiving a call about COTA-Domingo during the early morning hours of December 20, 2012, but did not log the call and does not remember any details particular to COTA-Domingo. He stated that although he writes down information during medical calls, including the detainee's name, identification number, location, and symptoms, medical officers do not typically log any of this information. CO stated that he remembers COTA-Domingo arriving at the medical unit around 4:00 a.m. on December 20, 2012, with a group of diabetic detainees who regularly come at that time to receive their blood glucose monitoring Accu-Chek prior to eating. He stated that he does not remember very much about COTA-Domingo, but does remember that COTA-Domingo was moving slowly and appeared to be a little shaky. CO also also noted that COTA-Domingo appeared to be very apprehensive about receiving medical care. CO stated that he observed RN stated that he overheard a translator on the telephone translating between RN and COTA-Domingo.
ODO interviewed RN stated that during the night of December 19-20, 2012, she was scheduled with an LPN who helped her with pill line. She remembers that at approximately 2:00 a.m., on December 20, 2012, CO received a call from a CO in the Alpha 200 housing unit reporting that COTA-Domingo's roommate alerted the CO that COTA-Domingo was breathing hard. RN stated that she told CO that COTA-Domingo could come up to medical immediately, before the 3 a.m. detainee count, or wait until the 4:00 a.m. chow time. She also stated that she pulled COTA-Domingo's medical chart and did not see anything abnormal in his intake screening or physical examination that would alert her to the potential for a serious medical issue. RN stated that she did not log the call regarding COTA-Domingo and that it is not standard practice to log these types of calls.
According to RN, COTA-Domingo arrived at the medical unit around 4:00 a.m. on December 20, 2012, with a group of detainees who were there to receive Accu-Cheks. She state that she met him at the entrance to the medical unit, asked him general questions about how he felt, and determined that he was stable enough to wait until after she finished conducting the Accu-Cheks to be evaluated.
At 4:30 a.m., on December 20, 2012, COTA-Domingo was evaluated by RN as documented in his Chronological Record of Medical Care. RN recorded his vital signs as the following: Blood Pressure, 169/109 and 146/102 left-arm-manual (as opposed to a digital machine) (RN advises that a normal blood pressure is considered to be 120/80); Pulse,



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advises that 60-100 is considered a normal blood pressure, with 174 being dangerously high); Oxygen, 93% on room air (RN advises that 100% is considered a normal oxygen reading); Respirations, 34 (RN advises that 8-16 is considered a normal range for respirations). RN advises documented that COTA-Domingo presented to the clinic with a complaint of "7/10 pain in my heart" for "one week" on a pain scale of 0-10 with 10 being the worst pain the patient has ever experienced. She also noted that the "detainee states he drank 5 cups of water today, has a sore throat and wants more cough syrup, denies coughing." RN advises that 100% is considered a normal advises that 8-16 is considered a normal range for respirations).
During her interview, RN stated that after taking COTA-Domingo's vital signs, she determined that all were high. As a result, she took him to a treatment room to conduct a cardio-pulmonary assessment. She stated that she used Interpretalk to provide translation. She stated that during the evaluation, COTA-Domingo talked about his family and seemed distressed about not being able to reach them. He also expressed concern about missing either a court date or a meeting regarding his release. RN stated that his high blood pressure, in conjunction with his expressed concern about reaching his family and getting released, led her to believe that he was having an anxiety attack. She also stated that COTA-Domingo looked a little underweight and that his breath smelled as if "he had not brushed his teeth in five days."
stated that she started her employment at EDC on July 9, 2012, and received New Hire Orientation on July 12-13, 2012. During orientation, she was placed in a room with several training binders, containing all of EDC's medical policies and protocols, which she was required to read thoroughly. The training binders included a segment entitled, "Blood Pressure and Heart Rate Monitoring," which directs an RN to perform an electrocardiogram (EKG) and notify the provider in any case where a patient presents with a heart rate of below 50 or above 120 (Exhibit 38). In accordance with the "Blood Pressure and Heart Rate Monitoring" segment, EDC's Chest Pain Protocol also requires an EKG for an elevated heart rate (Exhibit 39). RN indicated that she had never seen the chest pain protocol, but that it was her understanding that an EKG could not be performed without an onsite provider to interpret the results.
On December 20, 2012, at 4:45 a.m., RN took another set of vital signs which she recorded in the Chronological Record of Medical Care as the following: Blood Pressure, 132/90;

Pulse, 166; Oxygen, 94%; Respirations, 34. She also documented that the on-call provider, Physician's Assistant (PA) Lieutenant Commander (LCDR) was notified of COTA-Domingo's condition and vital signs, and provided orders to administer oxygen to

COTA-Domingo and provide an update on COTA-Domingo's status in 20 minutes (See Exhibit



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ODO interviewed PA LCDR on March 5, 2013. PA LCDR stated that he remembers receiving a call from RN at approximately 4:00 a.m. on December 20, 2012, concerning COTA-Domingo who was experiencing chest pain and difficulty breathing. RN provided COTA-Domingo's vital signs and informed PA LCDR that she had only given COTA-Domingo water. PA LCDR stated that he recognized COTA-Domingo's vital signs were abnormal and determined that the detainee could be experiencing anything from anxiety to atrial fibrillation (according to the Mayo Clinic, atrial fibrillation is an, "irregular heartbeat often associated with abnormally high heart rate, shortness of breath and weakness," and is a, "serious medical condition that often requires emergency medical treatment"). PA LCDR advised RN to administer oxygen to COTA-Domingo and report back on his status. PA LCDR stated that RN called back approximately 10-15 minutes later and reported that COTA-Domingo's symptoms had not improved with oxygen. PA LCDR then instructed RN to send COTA-Domingo to the emergency room by van. PA LCDR stated that he recommended COTA-Domingo be transported by van, instead of by ambulance, because he did not feel any sense of urgency from RN who reported that COTA-Domingo was stable.
On December 20, 2012, at 5:15 a.m., RN documented that COTA-Domingo did not have any change in pain. She noted that PA LCDR was updated on COTA-Domingo's status and recommended that he be sent to the hospital by van. She also documented that COTA-Domingo was escorted to the intake area by wheelchair, and sent to Florence Anthem Hospital, Florence, AZ, by van (See Exhibit 37).
During her interview, RN stated that at 5:15 a.m., PA LCDR advised her to send COTA-Domingo to Florence Anthem Hospital by van. She stated that she notified CO that COTA-Domingo needed to be transported to the hospital, and that CO coordinated the logistics of the transport.
During their interviews, RN separately asked both RN and PA LCDR whether RNs are permitted to perform an electrocardiogram (EKG). Both stated that RNs may only perform EKGs with a provider's order. In the instance where a provider is not present on-site, an on-call provider must be called and issue a verbal order prior to an RN performing an EKG.
ODO interviewed Lieutenant (Lt.) on March 5, 2013. Lt. is EDC's Health



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Services Administrator (HSA). Lt. stated that it is EDC's policy that any medical personnel may conduct an EKG with a provider's order, and that an order can be provided telephonically when necessary. Lt. also stated that when PA LCDR learned that COTA-Domingo had a heart rate in the 160s, he should have ordered an EKG.
During their interviews, both RN and PA LCDR also stated that RNs are not permitted to independently call 911, and that all calls to 911 by an RN must be done pursuant to a provider's order. During the interview with Lt. he confirmed that medical personnel must receive a provider's order, in person or telephonically, before calling 911 per EDC's Local Operating Procedure (LOP), "Emergency Medical Services." The LOP is a new undated procedure which requires authorization from the on-call provider before transporting a detainee to an outside hospital (Exhibit 40).
During ODO's interview with CO he stated that after being told by RN that COTA-Domingo needed to be transported by van to the emergency room at Florence Anthem Hospital, he notified his shift captain, Captain who coordinated the transport arrangements. Captain prepared COTA-Domingo's transport orders and assigned officers to both transport him to the hospital and stand watch. COTA-Domingo's transport orders show that SCO were the initial designated transport officers (Exhibit 41).
In an incident statement prepared by SCO she she documented that on December 20, 2012, at approximately 5:15 a.m., she received a call informing her that COTA-Domingo needed to be transported by van to the Florence Anthem Hospital Emergency Room. SCO noted that she retrieved COTA-Domingo from the medical unit while CO went to pick up a van (Exhibit 42). The Medical Officer's Log shows that at 5:35 a.m., on December 20, 2012, SCO escorted COTA-Domingo from the medical unit to intake (Exhibit 43). SCO documented that when COTA-Domingo arrived at the intake area, he changed into a jumpsuit and sat down in a wheelchair (Exhibit 42).
sco incident statement documents that at 6:00 a.m. she received a call from SCO who informed her that he would accompany COTA-Domingo and CO to the hospital so that she could stay at EDC and assist with receiving and discharge of detainees. SCO documented that SCO and CO left in a van with COTA-Domingo at approximately 6:10 a.m. (Exhibit 42).
ODO interviewed SCO on March 7, 2013. SCO is primarily responsible for assisting with transports, and receiving and discharge of detainees at EDC. SCO stated



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that at approximately 5:30 a.m. on December 20, 2012, he received a telephone call informing him that he was needed to accompany CO in transporting COTA-Domingo to Florence Anthem Hospital instead of SCO SCO was instructed that COTA-Domingo was to be transported to the hospital as soon as possible, and needed to be out of the facility prior to the 6:15 a.m. detainee count. SCO stated that after receiving the call, he immediately went to pick up a transport van. SCO stated that he does not speak Spanish.
The EDC Van Log shows that SCO and and CO checked out a van bound for Florence Anthem Hospital on December 20, 2012, and it also shows the van's mileage before and after the transport, but does not document the time that the van was checked out (Exhibit 44).
EDC's Post Order #18, Transportation, requires that prior to departure, the following must be logged: names of transporting officers, time, vehicle mileage, destination, number of inmates/detainees on board, and the name of the person who approved the escort (Exhibit 45). During his interview, SCO stated that EDC does not use Transport Logs, and that officers are only required to sign a van out and record mileage.
ODO interviewed CO on March 7, 2013. CO stated that on the morning of December 20, 2012, after being informed that he would escort COTA-Domingo to the Florence Anthem Hospital, he picked up a van with SCO and then met COTA-Domingo inside the intake area of EDC. CO stated that he placed COTA-Domingo in restraints and escorted him to the boarding area where he helped COTA-Domingo board the van. CO stated that he remembered COTA-Domingo having very bad breath, but did not notice any labored breathing. CO stated that he does not speak Spanish.
The EDC Rear Gate Log documents that at 6:15 a.m. on December 20, 2012, SCO and a detainee exited the rear gate in an EDC van (Exhibit 46).
During SCO interview, he stated that he often transports detainees from EDC to Florence Anthem Hospital by van, and that the trip takes approximately 45 minutes. He stated that during COTA-Domingo's transport, he noticed that COTA-Domingo started out sitting upright, but gradually slouched down in his seat until he was laying down. SCO stated that he and CO attempted to talk to COTA-Domingo a few times during the ride, but that COTA-Domingo was not very responsive. SCO remembers CO commenting on how bad COTA-Domingo's breath smelled throughout the ride. SCO stated that COTA-Domingo's breathing became noticeably more labored during the trip, and that when they arrived at Florence Anthem Hospital, COTA-Domingo required assistance walking into the emergency room. SCO



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stated that he removed COTA-Domingo's leg irons at the hospital so that medical staff could work on him. SCO remembers that medical staff had changed COTA-Domingo into a hospital gown, placed him in a bed, and had him receiving intravenous fluids (IVs) within five minutes of his arrival. SCO also also remembers overhearing medical staff speaking to COTA-Domingo in Spanish and believes that they asked him if he was diabetic. SCO stated that a few hours after arriving at the hospital with COTA-Domingo, he witnessed hospital staff shock the detainee with a defibrillator. SCO stated that a few hours after being shocked, COTA-Domingo was moved to the Intensive Care Unit (ICU), and he and CO were relieved from hospital watch shortly thereafter.
During their interviews, SCO and and CO both confirmed that they are trained in first aid and are CPR certified.
In an incident statement prepared by CO were assigned to make an emergency medical run of COTA-Domingo to the Florence Anthem Hospital. CO documented that medical staff at Florence Anthem Hospital evaluated and began working on COTA-Domingo immediately upon his arrival, and that COTA-Domingo was moved between two different rooms before being moved to the ICU approximately four hours after his admission to the hospital (Exhibit 47).
On December 20, 2012, 12:35 p.m., PA LCDR documented in a medical progress note that COTA-Domingo was admitted to the Florence Anthem Hospital ICU with a diagnosis of diabetic ketoacidosis (DKA), and that there was no discharge plan at the time (See Exhibit 37). According to COTA-Domingo's admission documentation to Florence Anthem Hospital, he was diagnosed with DKA, respiratory failure, and pneumonia (Exhibit 48).
On December 20, 2012, at 2:00 p.m., CO and SCO were relieved by CO and CO as a documented in EDC's Hospital Log (Exhibit 49).
On December 21, 2012, at 1:20 a.m., RN documented in a medical progress note that, "detainee is unresponsive" (See Exhibit 37).
On December 21, 2012, at 2:00 a.m., CO and and CO assumed hospital watch of COTA-Domingo (See Exhibit 49). In an incident statement, CO accorded to documented that COTA-Domingo was unresponsive, and that an attending doctor indicated that although COTA-Domingo was not stable enough to conduct a brain death test, his prognosis did not look good (Exhibit 50).



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On December 21, 2012, at 5:20 a.m., RN documented in a medical progress note that COTA-Domingo was "without sedation and unresponsive" (See Exhibit 37).

On December 21, 2012, at 2:00 p.m., CO and and CO assumed hospital watch of COTA-Domingo at Florence Anthem Hospital (See Exhibit 49).

On December 21, 2012, at 11:30 p.m., LPN documented in a medical progress note that a computerized tomography (CT) scan of COTA-Domingo's head was complete and results were pending. She noted that the detainee was still unresponsive and that all of his extremities were cold and mottling from umbilicus to knees (See Exhibit 37). RN detail advises that mottling refers to patchy skin discoloration which can be a sign of approaching death.

On December 22, 2012, at 12:25 a.m., LPN documented in a medical progress note that she received a call from Florence Anthem Hospital notifying her that the CT scan showed diffuse brain anoxia (total oxygen deprivation), and that COTA-Domingo would be transferred to St. Joseph's Hospital, Phoenix, AZ, to be evaluated by a neurologist and receive a higher level of care (See Exhibit 37).

On December 22, 2012, at 1:50 a.m., CO and and CO assumed the hospital watch of COTA-Domingo at Florence Anthem Hospital (See Exhibit 49).

On December 22, 2012, at 6:35 a.m., LPN documented in a medical progress note that the flight crew at Florence Anthem Hospital was preparing to transport COTA-Domingo to St. Joseph's Hospital (See Exhibit 37).

ODO interviewed CO were assigned hospital watch for COTA-Domingo from 2:00 a.m. to 2:00 p.m. When he arrived at Florence Anthem Hospital on December 22, 2012, he was informed that COTA-Domingo would be transported via helicopter to St. Joseph's Hospital. stated he rode in the helicopter with COTA-Domingo while CO drove to St. Joseph's Hospital in a vehicle.

EDC's Hospital Watch Log from December 22, 2012, documents that CO left for St. Joseph's Hospital at 7:25 a.m., and that the helicopter carrying COTA-Domingo and CO left Florence Anthem Hospital at 7:45 a.m. and arrived at St. Joseph's Hospital at 8:10 a.m (See Exhibit 49).



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IO. NARRATIVE
On December 22, 2012, at 10:34 a.m., RN documented in a medical progress note that St. Joseph's Hospital would perform a urine toxic screening and brain death test (See Exhibit 37).
ODO interviewed Supervisory Deportation and Detention Officer (SDDO) on March 7, 2012. SDDO has been an SDDO at EDC since 2007. SDDO stated that during the time COTA-Domingo was in the hospital, he was receiving updates on COTA-Domingo's status every 8-12 hours. SDDO stated that on December 22, 2012, between 10:00 -10:30 a.m., he received information from CCA that COTA-Domingo had failed a neurological test. Accordingly, a note in EDC's Hospital Watch Log made at 10:15 a.m. on December 22, 2012, states that a doctor on site at St. Joseph's Hospital pronounced COTA-Domingo brain dead (See Exhibit 49). SDDO called EDC medical personnel to confirm this information, and learned that COTA-Domingo had not, in fact, failed a neurological test and the information from CCA was inaccurate.
On December 22, 2012, at 2:30 p.m., CO and and CO assumed the hospital watch of COTA-Domingo at St. Joseph's Hospital (See Exhibit 49).
On December 22, 2012, at 9:40 p.m., RN documented in a medical progress note that the results from a brain death test conducted on COTA-Domingo were not good enough to proclaim brain death and that the test would be repeated in a little while (See Exhibit 37).
On December 23, 2012, at 12:45 a.m., LPN documented in a medical progress note that she spoke with an RN at St. Joseph's Hospital who informed her that an apnea (cessation of breathing) test would be conducted on COTA-Domingo to determine whether he was brain dead (See Exhibit 37).
On December 23, 2012, at 1:15 a.m., LPN documented in a medical progress note that she was notified that COTA-Domingo's apnea test was done at 12:53 a.m., and he was declared dead at 12:57 a.m She also documented that she notified Lt. of COTA-Domingo's death (See Exhibit 37). Accordingly, EDC's Hospital Watch Log documents COTA-Domingo's time-of-death at 12:57 a.m. on December 23, 2012 (See Exhibit 49).
During his interview, SDDO state stated that at approximately 1:00 a.m. on December 23, 2012, he was notified by Lt. that COTA-Domingo had died. SDDO immediately called the Joint Intake Center (JIC) to report COTA-Domingo's death. He then drove to St. Joseph 's Hospital where he signed COTA-Domingo's body over to the coroner's office (Exhibit 51)



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At approximately 1:12 a.m. on December 23, 2012, as documented in an incident statement, EDC Shift Supervisor was notified by medical staff at St. Joseph's Hospital that COTA-Domingo was pronounced dead by Dr. at 12:57 a.m., on December 23, 2012 (Exhibit 52).
On December 23, 2012, at 2:05 a.m., CO and and CO assumed hospital watch of COTA-Domingo at St. Joseph's Hospital (See Exhibit 49).
On December 23, 2012, also at 2:05 a.m., Lt. documented in a medical progress note that LPN informed him of COTA-Domingo's death and that he, in turn, notified IHSC via Commander and Captain and ICE via SDDO (See Exhibit 37).
On December 23, 2012, at approximately 6:30 a.m., SCO arrived at St. Joseph's Hospital (See Exhibit 49). SCO took COTA-Domingo's fingerprints before COTA-Domingo's body was turned over to the medical examiner (Exhibit 53, Exhibit 54).
On December 23, 2012, at 5:05 p.m., SDDO submitted a Significant Incident Report (SIR) #2013SIR0003698 to the JIC summarizing COTA-Domingo's apprehension by Border Patrol, detention by ICE, and subsequent death (Exhibit 55).
On December 26, 2012, an autopsy of COTA-Domingo was performed by MD. The autopsy report documents COTA-Domingo's cause of death as "complications of hypertrophic and atherosclerotic cardiovascular disease." Other significant conditions contributing to COTA-Domingo's death were documented as "diabetic ketoacidosis; pneumonia" (See Exhibit 22).
On December 28, 2012, ICE notified the Consulate General of Guatemala of COTA-Domingo's

MEDICAL COMPLIANCE REVIEW

Creative Corrections, a national management and consultant firm, contracted by ICE to provide subject matter expertise in detention management including health care, reviewed the medical care of COTA-Domingo while he was housed at the EDC. Creative Corrections found that EDC was not fully compliant with the ICE Performance Based National Detention Standard (PBNDS) for medical care. The Creative Corrections report is attached to this ROI (Exhibit 57).

IMMIGRATION AND DETENTION HISTORY

passing (Exhibit 56).



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On December 8, 2012, Manuel COTA-Domingo, a native and citizen of Guatemala, was arrested by United States Border Patrol near Sasabe, AZ, after unlawfully entering the United States of America from Mexico.

On December 11, 2012, COTA-Domingo was served a Form I-860, Notice and Order of Expedited Removal, charging COTA with violation of Section 212a(7)(A)(i)(II) of the Immigration and Nationality Act, as an alien who is not in possession of a valid unexpired immigrant visa, re-entry permit, border crossing card, or other valid entry document.

On December 12, 2012, COTA-Domingo was transferred to EDC. COTA was tentatively scheduled for removal to Guatemala on December 26, 2012.

COTA-Domingo had no prior immigration history.

CRIMINAL HISTORY

COTA-Domingo had no prior criminal history.

INVESTIGATIVE FINDINGS

COTA-Domingo came into ICE custody on December 12, 2012. The health care provided to COTA-Domingo by EDC was not fully compliant with the ICE PBNDS, Medical Care, which ensures that detainees have access to emergent, urgent, or non-emergent medical care so that their health needs are met in a timely an efficient manner. During the review of COTA-Domingo's death, ODO determined that EDC also failed to fully comply with the following ICE PBNDS: Funds and Personal Property, Contraband, and Facility Security and Control.

The ICE PBNDS, Medical Care, Section (II)(I) requires that detainees, "have access to a continuum of health care services, including prevention, health education, diagnosis, and treatment."

The ICE PBNDS, Funds and Personal Property, Section (V)(D), Admission, states that, "staff shall search all arriving detainees' personal property for contraband," and that, "Medical staff shall determine the disposition of all medicine accompanying an arriving detainee."

The ICE PBNDS, Contraband, Section (V)(A)(1), reinforces this point by stating that, "medicine the detainee brings into the facility upon arrival shall be forwarded to the facility medical staff for



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disposition."

In accordance with the ICE PBNDS, both CCA's Policy #14-6, Inmate/Resident Property, and ECD's Post Order #14, Intake/Release, state that "the Property Officer or designee will confiscate any medication that the inmate resident has in their possession upon admission. The Property Officer or designee will record the medication on the 14-6A and will ensure all medication is forwarded to the Health Services Department."

As seen in the surveillance footage of COTA-Domingo's intake on December 12, 2012, when CO searched COTA-Domingo's property, he came across a green plastic bag containing several small items which he emptied onto the intake desk and examined. During the onsite review, ODO obtained the green plastic bag, and determined the contents to consist of various diabetic medications issued in Latin America. The surveillance footage shows CO returning the items to the green plastic bag, and placing the bag among COTA-Domingo's property to be stored.

Review of the surveillance footage demonstrates that EDC failed to comply with the ICE PBNDS, Funds and Personal Property, Section (V)(D), Admission; the ICE PBNDS, Contraband, Section (V)(A)(1); CCA's Policy #14-6; and, EDC's Post Order #14.

Further, by failing to deliver COTA-Domingo's bagged medications to intake medical staff for evaluation, DO prevented medical staff from conducting an assessment of COTA-Domingo and his diabetic medications. This represents a failure to provide a continuum of treatment as required by the ICE PBNDS, Medical Care, section (II)(I), discussed above.

ODO learned through interviews with EDC staff, that since COTA-Domingo's death, EDC has issued a memorandum to all intake staff reiterating the policy that any and all medications found in a detainee's property during intake must be provided to medical intake staff.

The ICE PBNDS, Medical Care, Section (II)(2), requires that detainees' health care needs, "be met in a timely and efficient manner."

The following actions, undertaken by RN and PA LCDR, failed to comply with the above standard:

1. When RN received notification that COTA-Domingo was experiencing labored breathing at approximately 2:00 a.m., on December 20, 2012, she determined that he could wait



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two hours, until the 4:00 a.m. chow time, to be assessed, instead of having him escorted to the medical unit immediately;

- 2. During her assessment of COTA-Domingo on December 20, 2012, RN failed to take COTA-Domingo's temperature, which is standard procedure, and which was elevated when he was admitted to the Florence Anthem Hospital;
- 3. When COTA-Domingo presented with significantly elevated vital signs on December 20, 2012, RN French not only failed to accurately assess COTA-Domingo's cardiopulmonary status, but also neglected to follow written Chest Pain Protocol to take his pulse apically;
- 4. When PA LCDR learned that COTA-Domingo's pulse was in the 160's, he instructed RN to monitor vital signs and administer oxygen to COTA-Domingo instead of ordering an EKG; and,
- 5. While examining COTA-Domingo on December 20, 2012, RN failed to recognize the distinct odor of the ketones that he aspirated as result of his DKA, and instead remarked only that his breath smelled as though his teeth had not been brushed in several days.

The ICE PBNDS, Medical Care, Section (II)(7), requires that, "a detainee who needs health care beyond facility resources will be transferred in a timely manner to an appropriate facility where care is available."

On December 20, 2012, PA LCDR and RN failed to send COTA-Domingo to the emergency room via ambulance after COTA-Domingo presented with significantly elevated pulse and respiration rates for at least two hours prior. Instead, COTA-Domingo was transported to the hospital via medical transport van which did not leave EDC until approximately one hour after the transport order was given, and which required approximately 45 minutes to reach the hospital.

The ICE PBNDS, Medical Care, Section (II)(10), requires that detainees have, "access to specified 24-hour emergency medical...services."

As demonstrated in the surveillance footage of the Alpha unit during the graveyard shift on December 19-20, 2012, the COs on duty failed to adequately check each cell while conducting detainee counts and routine security checks. COTA-Domingo's cell was not checked until the 2:00 a.m. security check, approximately three hours after COTA-Domingo's cellmate claims that he first attempted to get the COs' attention. This represents a critical period of time during which



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COTA-Domingo could have been sent to the medical unit, and his condition been evaluated.

The ICE PBNDS, Medical Care, Section (II)(29), requires that, "health care services...be provided by a sufficient number of appropriately trained and qualified personnel..."

EDC failed to adequately familiarize RN with the facility's Chest Pain Protocol, which includes the administration of an EKG for a patient experiencing chest pain. Additionally, both at the time of COTA-Domingo's detention and ODO's review, EDC had critical nursing and provider vacancies including a clinical director, a staff physician, and a nurse practitioner/physician's assistant. Although the RN vacancy rate at EDC is currently 10 percent, 58 percent of the RNs currently on staff have been hired within the past year. Of further concern is that RN who is in her first nursing job at EDC, was scheduled to work the night shift on December 19-20, 2012, with only one other LPN scheduled to help her with pill line.

The ICE PBNDS, Medical Care, Section (II)(37), requires that, "non-English speaking detainees... will be provided with interpretation/translation services...for medical care activities."

When COTA-Domingo was transported to Florence Anthem Hospital on December 20, 2012, neither of the two COs escorting him during the 45 minute drive spoke Spanish.

The ICE PBNDS, Facility Security and Control, Section (II)(4), states that, "Information about routine procedures, emergency situations, and unusual incidents will be continually recorded in permanent post logs and shift reports." Additionally, Section (V)(D)(1), states that "for each housing unit, the facility administrator shall establish written Post Orders," which, "shall require that housing officers maintain a housing unit log for recording information regarding routine unit operations, as well as unusual and emergency incidents."

Accordingly, EDC's Post Order #24, Housing Officer (Direct Supervision), states that, "During individual movements such as library, court, medical, or visitation, you will be responsible for issuing a colored pass and documenting the movement on the movement log sheet. You must be able to verify the whereabouts of all detainees that have left the pod."

EDC's housing unit log for Alpha 200 does not contain an entry documenting that COTA-Domingo went to the medical unit during the 4:00 a.m. chow time on December 20, 2012. During interviews with staff, ODO learned that housing unit officers log detainee movements during the day and swing shifts, but not during the graveyard shift. Failure to log all detainee movements from the



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pod does not meet the requirements set forth in the ICE PBNDS Facility Security and Control, described above, nor does it meet the requirement described in EDC's Post Order #14.

AREAS OF CONCERN

EDC's Local Operating Procedure (LOP) for intake screenings states that all medications arriving with a detainee are to be placed in a clear zip lock bag and labeled with the detainee's identifying information. The LOP also states that once the detainee has been evaluated by a provider, the medications are returned to security staff to be placed in the detainee's personal property. It is EDC's practice to follow this LOP regardless of whether the detainee denies ownership of the medication.

After RN asked COTA-Domingo about the bottle of insulin found in his property, she returned it to the intake medical area and does not remember what happened to the bottle of insulin. This represents a failure of intake medical staff to follow their own LOP regarding the labeling and disposition of medications arriving with a detainee.

As stated above, EDC failed to comply with the ICE PBNDS, Contraband, Section (V)(A)(1); CCA's Policy #14-6; and, EDC's Post Order #14. All require that any medications accompanying an arriving detainee be provided to medical staff for disposition. During interviews with intake staff, ODO learned that many were unaware of this policy until a reminder was issued following COTA-Domingo's death. This lack of knowledge demonstrates an unacceptable lapse in the training and supervision of intake staff by EDC.

The ICE PBNDS, Facility Security and Control, Section (V)(F), states that, "Frequent security inspections shall be conducted to control the introduction of contraband, ensure facility safety, security and good order, prevent escapes, maintain sanitary standards, and eliminate fire and safety hazards. Each facility administrator shall establish a comprehensive security inspection system..."

Accordingly, ECD's Post Order #14, Housing Officer (Direct Supervision), states that, "Routine security checks should be conducted at random times every thirty (30) minutes. These security checks should include...a walk-by inspection of each cell for obvious security breaches or inmates in need of assistance," and, "answering inquiries made by detainees."

The Alpha Unit Security Log from the graveyard shift on December 19-20, 2012, demonstrates that security checks were conducted every 30 minutes as required by the EDC Post Order #14.



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Further, a review of surveillance footage of the Alpha 200 housing unit during the graveyard shift on December 19-20, 2012, clearly shows security checks occurring at or very near the times logged. However, the surveillance footage also clearly shows officers walked quickly by each cell, including COTA-Domingo's, without pausing to see if any detainees were in need of assistance. This supports detainee assertion to ODO that officers quickly walked by his and COTA-Domingo's cell during the time he claimed he was trying get their attention as they made rounds. Further, although the surveillance footage indicates that CO responded to during the 2:00 a.m. detainee count, and that CO returned to the and COTA-Domingo's cell door three times after CO initial response, neither CO is seen entering the cell to personally observe COTA-Domingo's condition. The ICE PBNDS, Population Counts, Section (V)(A), states that, "Formal counts are conducted at specific times of the day and night in a predetermined manner. A formal count shall be conducted at least once every eight hours, with a shift supervisor verifying its accuracy. Additional counts are encouraged at the discretion of the facility."

In accordance with the ICE PBNDS, Population Counts, EDC's Post Order #14, Housing Officers (Direct Supervision), instructs housing officers to, "Conduct detainee counts in accordance with facility policy and procedure. When counting, ensure two (2) staff are present and counting at the same time. Each staff will start at an opposite end of a tier and cross in the middle."

During interviews with staff, ODO learned that detainee counts are conducted three times during the graveyard shift at 11:00 p.m., 1:00 a.m., and 3:00 a.m, which exceeds the requirement in the ICE PBNDS. Review of the surveillance footage and the Alpha Unit Security Log from the graveyard shift on December 19-20, 2012, shows that detainee counts occurred at or very near these designated times. However, the surveillance footage also shows that only one officer, CO conducted the 1:00 a.m. detainee count, which fails to comply with EDC's policy requiring two officers to conduct detainee counts. Additionally, it is evident in the surveillance footage that while conducting the 1:00 a.m. count, CO walked through the housing unit quickly without pausing to look inside each cell. This demonstrates that these counts were perfunctory in nature, as it would have been highly unlikely that the CO would have been able to actually count the detainees at that pace.



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- 1. COTA-Domingo's Form I-213
- 2. COTA-Domingo's Form 826
- 3. SOPs for Wackenhut Transportation Officers at the Tucson Coordination Center
- 4. Record of Sworn Statement in Proceedings under Section 235(b)(1) of the Act
- 5. Notice and Order of Expedited Removal
- 6. Notice to Alien Ordered Removed/Departure Verification
- 7. Medical Screening Form Border Patrol
- 8. List of Aliens Awaiting Transfer to ICE
- 9. Manifest of Persons and Property Transferred
- 10. Transportation Officer Trip Logs
- 11. EDC Receiving and Discharge Form
- 12. Documentation of Telephone Call
- 13. Disposition of Non-Allowable Property Form
- 14. Surveillance Footage of COTA-Domingo's Intake
- 15. Photographs of Medication Found in COTA-Domingo's Property
- 16. EDC Post Order #14, Intake/Release
- 17. CCA Policy #14-6, Inmate/Resident Property
- 18. Memorandum to Intake Staff Re Disposition of Medications
- 19. Local Operating Procedure Intake Screening
- 20. CCA Policy #9-6, Contraband Control
- 21. Intake Screening Form
- 22. Autopsy Report
- 23. Chest X-Ray Lab Screening Report
- 24. Record of COTA-Domingo's Housing Assignment
- 25. Inmate Housing History with Cellmates
- 26. Request for Consular Notification
- 27. Facsimile Notification of COTA-Domingo's Detention to Consulate of Guatemala
- 28. Physical Examination/Health Appraisal Form
- 29. Medical Summary of Federal Prisoner/Alien in Transit
- 30. Documentation of COTA-Domingo's Scheduled Removal
- 31. EDC Post Order #24, Housing Office (Direct Supervision)
- 32. Surveillance Footage of Alpha 200, Graveyard Shift, December 19-20, 2012
- 33. Shift Roster, December 19, 2012
- 34. Alpha Unit Security Log
- 35. Control Log
- 36. Incident Statement:
- 37. Chronological Record of Medical Care
- 38. Training Blood Pressure and Heart Rate Monitoring



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- 39. Chest Pain Protocol
- 40. EDC's Local Operating Procedure Emergency Medical Procedures
- 41. Transport Orders
- 42. Incident Statement: SCO
- 43. Medical Unit Log
- 44. Van Log
- 45. EDC Post Order #18, Transportation
- 46. Rear Gate Log
- 47. Incident Statement: CO
- 48. Florence Anthem Hospital Admission Documentation
- 49. Hospital Watch Log
- 50. Incident Statement: CO
- 51. Human Release of Remains Form
- 52. Incident Statement: SCO
- 53. Incident Statement: SCO
- 54. COTA-Domingo's Fingerprints Deceased
- 55. JIC Notification
- 56. Notification to Consulate of Guatemala
- 57. Creative Corrections' Medical Compliance Review