DETAINEE DEATH REVIEW – Jose De Jesus DENIZ-Sahagun
JICMS #201506640

SYNOPSIS

Thirty-one year old ICE detainee Jose De Jesus DENIZ-Sahagun, a citizen and national of Mexico, died on May 20, 2015, at the Eloy Detention Center, Eloy, Arizona. The Pima County Office of the Medical Examiner determined DENIZ-Sahagun's cause of death to be asphyxia due to choking, and his manner of death to be suicide.

DETAILS OF REVIEW

DENIZ-Sahagun was in U.S. Immigration and Customs Enforcement (ICE) custody at the Eloy Detention Center (EDC) at the time of his death. EDC opened in 1994 and is owned and operated by Corrections Corporation of American (CCA). EDC is contracted for use by ICE through an Intergovernmental Service Agreement (IGSA) with the city of Eloy. EDC houses male and female 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). IHSC contracts with InGenesis to supplement their medical staffing at EDC. EDC is required to comply with the ICE Performance Based National Detention Standards (PBNDS) 2011.

From June 30 to July 2, 2014, Supervisory Inspections and Compliance Specialist [redacted], and Inspections and Compliance Specialist [redacted] both assigned to the ICE Office of Professional Responsibility (OPR), Office of Detention Oversight (ODO), visited EDC to examine the circumstances of DENIZ-Sahagun's death. 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 EDC, as well as ICE Office of Enforcement and Removal Operations (ERO) staff. ODO also reviewed immigration, medical, and detention records[1] pertaining to DENIZ-Sahagun.

ODO determined the following timeline of events, from the time of DENIZ-Sahagun's apprehension by U. S. Border Patrol (USBP), through his detention and eventual death at EDC.

NARRATIVE SUMMARY OF EVENTS

On May 15, 2015, at approximately 11:00 p.m., Jose De Jesus DENIZ-Sahagun was encountered by Border Patrol Agents (BPAs) when he attempted to enter the United States at Douglas, Arizona. He was reportedly hysterical and visibly emotional when he entered the pedestrian lane at the Port of Entry (POE) and expressed fear that someone was going to kill him. DENIZ-

[1] During this review, the ODO review team took note of any deficiencies observed in the detention standards as they relate to the care and custody of the deceased detainee, and documented those deficiencies herein for informational purposes only. Their inclusion in the report should not be construed in any way as indicating the deficiency contributed to the death of the detainee.

Sahagun was interviewed by a BPA on May 16, 2015 and charged as inadmissible to the United States under §212(a)(7)(A)(i)(I) of the Immigration and Nationality Act. DENIZ-Sahagun attempted to enter the United States on two previous occasions. He had no prior criminal convictions.[2]

May 17, 2015

On May 17, 2015, DENIZ-Sahagun was transported by USBP to the Banner University Medical Center, Tucson, AZ, after twice jumping from a concrete bench in a Border Patrol hold room and landing on his head.[3] DENIZ-Sahagun told the emergency room physician he was attempting to break his own neck because he feared his life was in danger by both Mexican coyotes and USBP. The emergency room physician noted DENIZ-Sahagun had a faint scalp abrasion on the top of his head and that his neurological and physical examinations were normal. The physician also documented that he consulted with the social work and psychiatry departments but was told DENIZ-Sahagun could not be seen by either department since he was in USBP custody. DENIZ-Sahagun was discharged later that day into USBP custody; his condition at the time of discharge was documented as "stable." ODO has been unable to determine whether a medical discharge summary or other medical documentation was provided to the BPAs who escorted DENIZ-Sahagun from the hospital.

May 18, 2015

On May 18, 2015, two BPAs escorted DENIZ-Sahagun to EDC, and he was admitted to the facility at 8:26 a.m.[4] ODO notes the Medical Alert section of his Alien Booking Record[5] was blank, and no medical or mental health documentation accompanied him to EDC. ODO learned during interviews with EDC staff that the transporting BPAs asked to speak to medical staff regarding their concerns about DENIZ-Sahagun's behavior. IHSC [redacted], Registered Nurse (RN), who was in the booking area at the time of DENIZ-Sahagun's intake, spoke to the BPAs. During her interview with ODO,[6] RN [redacted] stated that the BPAs informed her the detainee was taken to the Tucson Medical Center, Tucson, AZ, the previous day after jumping from a bench in a Border Patrol hold room. They also reported he was observed banging his head against a wall at the Border Patrol Station and behaved erratically during his transport to EDC that morning, stating the cartel was after him, alternating speaking in Spanish and English, and intermittently becoming agitated then calm. The BPAs stated DENIZ-Sahagun was given a neck brace by the hospital, which he was wearing when he arrived at EDC, to prevent him from swinging his neck.[8]

[2] I-213, Record of Deportable/Inadmissible Alien.
[3] *See* EXHIBIT 1: DENIZ-Sahagun's medical record from Banner University Medical Center.
[4] EDC Booking Record.
[5] Form I-385, Alien Booking Record.
[6] ODO interview with RN [redacted] uly 1, 2015.
[7] The detainee was actually taken to Banner University Medical Center, which is also located in Tucson, AZ.
[8] RN [redacted] did not document her conversation with the BPAs in DENIZ-Sahagun's medical record.

RN [redacted] stated she attempted to talk with DENIZ-Sahagun, but he gave no coherent answers to her questions, and just repeatedly stated the cartel was after him and he needed to be safe. According to RN [redacted] she informed InGenesis RN [redacted] who was responsible for conducting intake screenings, that she should refer DENIZ-Sahagun for a mental health evaluation and have the detainee sign a statement authorizing release of his hospital records. RN [redacted] stated although DENIZ-Sahagun appeared fearful, she had no urgent concerns about his mental health as it is not unusual for detainees to be upset and afraid upon admission. RN [redacted] stated she presumed DENIZ-Sahagun would be seen by mental health staff either the same or next day as a routine referral.[9]

During her interview with ODO,[10] RN [redacted] stated RN [redacted] told her DENIZ-Sahagun appeared anxious and was fearful of the cartel. RN [redacted] did not recall RN [redacted] sharing any observations about his mental health, or information received from BPAs concerning the detainee's erratic behavior during transport; however, she did remember RN [redacted] stating the detainee was reportedly banging his head at the Border Patrol Station prior to arrival.

RN [redacted] completed DENIZ-Sahagun's pre-screening interview at 9:42 a.m.[11] The pre-screening interview is designed to identify any immediate medical and mental health concerns requiring priority attention. RN [redacted] documented DENIZ-Sahagun answered "no" to the following questions: *are you afraid someone is going to hurt you, and do you want to hurt yourself.* She documented DENIZ-Sahagun acknowledged he was admitted to a hospital in Tucson the previous day where he was given a neck brace, he did not know why he was given a neck brace, and he removed the neck brace shortly after entering the facility. She also documented she had no difficulty communicating with him because she is fluent in Spanish. Per the pre-screening interview documentation, DENIZ-Sahagun did not have any immediate concerns requiring priority attention.

Immediately following the pre-screening, RN [redacted] completed DENIZ-Sahaugn's full medical and mental health intake screening.[12] The intake screening form indicates DENIZ-Sahagun stated he spoke both English and Spanish, that he was carrying the neck brace at the time of the screening and denied any neck pain, and that his vital signs were within normal limits. DENIZ-Sahagun reported he had a stomach ulcer and colitis and had been taking omeprazole *(a medication used to treat heartburn, stomach ulcers, and gastroesophageal reflux disease)*, but denied other medical concerns. ODO notes DENIZ-Sahagun did not have omeprazole or any other medication with him upon intake.

As documented by RN [redacted] DENIZ-Sahagun reported to her that he was taken to a hospital the previous day after throwing himself off a table to try to kill himself.[13] He stated he wanted to

[9] RN [redacted] did not document any information she learned about DENIZ-Sahagun on May 18, 2015, in his medical record.
[10] ODO interview with RN [redacted] July 2, 2015.
[11] *See* EXHIBIT 2: Pre-screening by RN [redacted], May 18, 2015.
[12] *See* EXHIBIT 3: Medical intake screening, May 18, 2015.
[13] ODO notes that the RN [redacted] documented the detainee threw himself from a table versus a bench, as reported by the BPAs.

break his neck and die because his life was threatened, and he would rather kill himself than allow someone else to do it. Furthermore, DENIZ-Sahagun indicated that while this was the first time in his life he felt desperate enough to kill himself, he felt safer since arriving at EDC, and no longer wanted to kill himself. RN [redacted] documented DENIZ-Sahagun did not demonstrate any abnormal behaviors during his intake screening. ODO notes the screening documentation makes no reference to the information shared by RN [redacted] concerning the detainee banging his head at the Border Patrol station.

RN [redacted] documented DENIZ-Sahagun was medically cleared for placement in a general population housing unit, and made routine electronic referrals to IHSC [redacted] Nurse Practitioner (NP), for the detainee's ulcer and colitis, and to InGenesis Licensed Clinical Social Worker (LCSW) [redacted] for the mental health evaluation that was recommended by RN [redacted] due to his suicide attempt the day before.

RN [redacted] stated during her interview with ODO that although DENIZ-Sahagun's mental health referral was classified as routine rather than urgent,[14] she telephoned LCSW [redacted] and left a voicemail message asking her to call back regarding the detainee. LCSW [redacted] returned the call at approximately 1:20 p.m., whereupon RN [redacted] informed her of DENIZ-Sahagun's suicide attempt the day before. During her interview with ODO,[15] LCSW [redacted] stated RN [redacted] indicated DENIZ-Sahagun was not presently suicidal, symptomatic, or urgent, and described him as appearing "stable." LCSW [redacted] determined DENIZ-Sahagun's behavior as described did not indicate a need for an immediate mental health evaluation, and she decided to schedule his evaluation for the following day.[16] RN S[redacted] did not tell LCSW [redacted] DENIZ-Sahagun was reported to have been banging his head at the Border Patrol Station and behaving erratically during transport to EDC. ODO notes although LCSW [redacted] did not have these two pieces of information, she was aware he had attempted suicide the day before, and her decision to defer a mental health evaluation to the next day was based solely on the observations RN [redacted] relayed during their telephone conversation.

During his intake screening, DENIZ-Sahagun signed a general consent for treatment form,[17] and a Freedom of Information Act form[18] authorizing release of his medical records for his hospital visit the day before.[19]

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[14] The PBNDS 2011, *Significant Self-Harm and Suicide Prevention and Intervention* requires assessment of detainees determined at risk within 24 hours, with housing in a secure environment with one-on-one observation. RN [redacted] determined DENIZ-Sahagun did not require a 24 hour assessment and one-on-one observation, thus his mental health referral was deemed "routine," and not "urgent."

[15] ODO interview with LCSW [redacted] July 1, 2015.

[16] *See* EXHIBIT 4: Note from LCSW [redacted] regarding scheduling of mental health evaluation. ODO notes although this note is entitled "Telephone Encounter," it does not refer to a telephone encounter but is merely a default.

[17] General consent for treatment form, signed May 18, 2015.

[18] Freedom of Information Act form, signed May 18, 2015.

[19] The request for DENIZ-Sahagun's medical records was erroneously sent to the Tucson Medical Center on May 18, 2015; however, the records were received by EDC from Banner University Medical Center on May 21, 2015. EDC medical staff inferred the request was routed to Banner University Medical Center by Tucson Medical Center without EDC's involvement.

Documentation in DENIZ-Sahagun's detention file demonstrates he identified his sister as his emergency contact and provided her telephone number.[20] ODO reviewed EDC's procedures regarding provision of a telephone call to detainees upon admission to the facility and found new admissions routinely receive a three minute telephone call during admission processing, and these calls are documented. ODO notes DENIZ-Sahagun's detention file does not contain documentation that he placed a three minute telephone call and it is unknown whether one was offered to him. ODO also notes documentation in both the detention and alien files indicates the detainee was given a list of pro bono attorneys and had no counsel of record.

As part of ODO's review, video surveillance footage of EDC's intake area showing DENIZ-Sahagun's intake was viewed.[21] The footage shows DENIZ-Sahagun appears calm and cooperative when he arrives and undergoes initial processing. However, at approximately 11:38 a.m., he appears to become agitated. He points aggressively and seems to argue with staff about his intake documents. At 11:47 a.m., he is placed in a holding cell with the door open where he can be observed speaking to staff from the open doorway before being sent back into the room. He later stands in the doorway to the cell and a staff member approaches and closes the door. At 11:52 a.m., DENIZ-Sahagun returns to the intake officer's desk and again appears to disagree with the officer about his intake documents.

EDC Intake Officer, [redacted], stated during his interview with ODO that DENIZ-Sahagun was nervous when he arrived at EDC and accused Officer [redacted] of tricking him into signing deportation orders.[22] DENIZ-Sahagun also wanted the receipt for his foreign currency to list every bill individually, rather than listing the total number, and was unhappy and argued when Officer [redacted] explained the bills would be accounted for and placed in a safe.[23]

At 2:29 p.m., upon completion of intake processing and clearance for general population by medical staff, DENIZ-Sahagun was placed in Delta Unit, cell 514.[24] Delta Unit holds detainees classified as low and medium security risks. At 9:56 p.m., DENIZ-Sahagun was transferred to Echo Unit, cell 103, after requesting protective custody because he believed his cellmate, [redacted] was going to kill him.[25] [redacted] was interviewed by Delta Unit Case Manager [redacted] the next day and stated that when their cell door was locked for count, DENIZ-Sahagun talked about how a radio cord, like one in their cell, could be used to strangle someone.[26] After count was over [redacted] asked to be moved to a new cell. ODO notes an email was sent from CCA to ERO at 10:11 p.m. notifying DENIZ-Sahagun had been placed in protective custody at 9:30 p.m.[27] ODO notes DENIZ-Sahagun's record did not contain an administrative segregation order for this placement.

[20] Emergency contact form.
[21] Video surveillance footage of EDC's intake area, May 18, 2015.
[22] ODO interview with Officer [redacted], July 1, 2015.
[23] Receipt for Money and Valuables.
[24] *See* EXHIBIT 5: Housing record.
[25] *Id.*
[26] ODO interview with Delta Unit Manager [redacted], July 1, 2015.
[27] *See* EXHIBIT 6: May 18, 2015 email regarding DENIZ-Sahagun's placement in protective custody.

May 19, 2015, Day Prior to Death

At approximately 6:00 a.m., Officer [redacted] arrived in Echo Unit where he was assigned for the day shift. During his interview with ODO, Officer [redacted] stated Officer [redacted], who was coming off the previous shift, mentioned DENIZ-Sahagun was angry earlier and should be watched.[28] Officer [redacted] stated DENIZ-Sahagun requested to make a phone call shortly after his shift started, and he brought a mobile telephone cart to the detainee's cell. Officer [redacted] stated DENIZ-Sahagun attempted to make a telephone call but was unsuccessful, and Officer [redacted] was unsure why the call failed. During the onsite review, ODO learned new detainees are generally given orientation the day after their admission. Telephone personal identification numbers (PINs), which are necessary to operate EDC's telephone system, are issued to each detainee during orientation. Because DENIZ-Sahagun had not yet been to orientation, he did not have a PIN on the morning of May 19, 2015. Officer [redacted] stated during his interview that throughout the morning, DENIZ-Sahagun continued to stand at his cell door asking to use a telephone and saying his rights were being denied. Officer [redacted] stated he explained to DENIZ-Sahagun that he could use the telephone in Unit Manager [redacted] office once [redacted] arrived for work.

DENIZ-Sahagun was medically cleared for placement in protective custody at 7:07 a.m. on May 19, 2015, when he was encountered by InGenesis RN [redacted].[29] RN [redacted] progress note states the detainee did not receive medical clearance upon placement in segregation the day before. ODO notes this delay contravenes the PBNDS 2011 which require medical staff be immediately informed when a detainee is placed in a special management unit. RN [redacted] documented DENIZ-Sahagun denied suicidality, was calm and cooperative, and spoke English, but expressed concern that he did not have a lawyer. RN [redacted] determined DENIZ-Sahagun had no medical condition that would prevent segregation housing, and medically cleared him. During his interview with ODO, RN [redacted] stated he was in Echo Unit the morning of May 19, 2015, to check on another detainee when Officer [redacted] advised him DENIZ-Sahagun was transferred from Delta to Echo Unit the previous evening and documentation of medical clearance could not be found. According to RN [redacted], medical staff is typically notified immediately when a detainee is placed in segregation, so medical clearance can occur as quickly as possible. He also stated the medical record is typically reviewed as part of the clearance process; however, since DENIZ-Sahagun's clearance was late, he proceeded with his assessment of the detainee without returning to the clinic to review the record. As a result, RN [redacted] was unaware of the detainee's recent suicide attempt and pending mental health evaluation.

During the morning of May 19, 2015, over the course of approximately three hours, a series of events took place during which force was used to control DENIZ-Sahagun on four separate occasions. ODO notes the entire period was video recorded on stationary security and/or a handheld camera. Careful analysis of all video found no gaps or evidence of tampering. Unless

[28] ODO interview with Officer [redacted], July 1, 2015.
[29] *See* EXHIBIT 7: Progress note by RN [redacted], May 19, 2015.

otherwise noted, all events described through interviews and incident statements[30] are corroborated by the available video footage.[31] A summary of those events follows.

At approximately 9:30 a.m., CCA's Security Threat Groups (STG)[32] Coordinator Sergeant [redacted] and Case Manager [redacted] went to Echo Unit to interview DENIZ-Sahagun[33]. During their interviews with ODO, Sergeant [redacted] and Case Manager [redacted] stated they initially took DENIZ-Sahagun from his cell and attempted to interview him in a medical room inside Echo Unit. During the interview, DENIZ-Sahagun stated he did not feel he could speak freely in that room, so he was escorted to Unit Manager [redacted] office located in a vestibule area outside the housing unit area of Echo Unit. Unit Manager [redacted] had arrived by this time and participated in the interview when it was moved to his office.

According to Case Manager [redacted] and Sergeant [redacted], DENIZ-Sahagun remained uncooperative with the interview when they moved to the office, refusing to answer any questions. He insisted his attorney be present and would not provide any information as to why he had requested protective custody. Case Manager [redacted] stated he told DENIZ-Sahagun he could speak with his attorney later and re-stated the purpose of the interview. However, because the detainee continued refusing to answer questions, the interview was terminated. According to Case Manager [redacted], as he and Sergeant [redacted] started escorting DENIZ-Sahagun back to his cell, the detainee panicked and attempted to run out the main door of Echo Unit.

When DENIZ-Sahagun broke away and ran toward the door, Officer [redacted] who was assigned to the desk in the vestibule area of Echo Unit, heard Case Manager [redacted] and Sergeant [redacted] yell "Hey, get back over here."[35] Officer [redacted] responded with his canister of oleo capsicum (OC) spray which he pointed at DENIZ-Sahagun, and instructed the detainee to face the wall and place his hands behind his back. DENIZ-Sahagun complied with orders, and allowed Sergeant [redacted] to handcuff him. Because DENIZ-Sahagun was compliant, Officer [redacted] did not deploy the OC spray. After he was handcuffed, DENIZ-Sahagun attempted to break away toward the Unit's door again. Case Manager [redacted] stated when DENIZ-Sahagun made a move toward the door a second time, he and Sergeant [redacted] decided they needed to take DENIZ-Sahagun to the ground in order gain control of him. Unit Manager [redacted] described their take-down maneuver as one of the easiest he has seen in his ten years in corrections. According to Case Manager [redacted], Sergeant [redacted] and Unit Manager [redacted] DENIZ-Sahagun continued to resist when he was on the ground and repeatedly screamed the cartel was after him and wanted to kill him. They described DENIZ-Sahagun as completely uncompliant, uncooperative, and aggressive during this incident.

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[30] Incident packet describing all uses of force, May 19, 2015.
[31] Unless otherwise noted, all officers involved completed incident statements documenting the events of May 19, 2015. Selected incident statements are noted in this report.
[32] EDC's STG is focused on gang-related behaviors and incidents.
[33] ODO learned when a detainee is placed in protective custody at EDC, the facility's standard practice is for the assigned case manager and the STG Coordinator to conduct an interview of the detainee to determine whether segregation is necessary or whether additional action is warranted.
[34] ODO interviews with Case Manager [redacted] and Sergeant [redacted] July 1, 2015.
[35] ODO interview with Officer [redacted], July 1, 2015.

ODO notes that because this was an immediate use-of-force incident, it was not recorded with a handheld video camera. Although the area is under video surveillance by two stationary security cameras, ODO's review of the video found it of limited use for two reasons: first, there was bright sunlight coming through the window on the side of the entry door, obscuring clear view; and second, some of the incident took place in a blind spot, out of view of either camera. Review of the footage nonetheless corroborates the progression of events as described by interviewed staff.[36] This use-of-force incident, the first of the four, occurred at 9:38 a.m.

After DENIZ-Sahagun was handcuffed and placed on the floor, Unit Manager [redacted] called for the assistance of EDC's Emergency Response Team (ERT) via handheld radio. Once the ERT was activated, handheld video recording of all subsequent events commenced and continued for the next three hours.[38] The handheld video recording was viewed in its entirety as part of ODO's review.

The handheld video recording opens with DENIZ-Sahagun on the floor in the vestibule of Echo Unit. He is surrounded by staff and he is crying out and screaming. Per the video timer at the one minute, 20 second (0:01:20) mark, he is brought to his feet and officers use a hands-on escort technique to walk DENIZ-Sahagun to the medical unit for the required post-use-of-force medical examination.

At the three minute (0:03:00) mark on the video, DENIZ-Sahagun is seated on a gurney in a medical unit examination room, and the post-use-of-force medical examination is initiated by InGenesis RN [redacted].[39] According to the written report of Sergeant [redacted],[40] RN [redacted] instructed the camera operator, Officer [redacted], to stop recording during the medical examination. Sergeant [redacted] instead told the Officer [redacted] to aim the camera away, and it was focused on DENIZ-Sahagun's feet for the remainder of the examination. Although neither the nurse nor the detainee's entire body were pictured in the recording, the video continued without lapse and with audio recording. During her interview with ODO,[41] RN [redacted] confirmed she directed Officer [redacted] to stop the video recording and stated she did so for privacy reasons.

During his interview with ODO,[42] Security Chief [redacted] told the review team he discussed the issue of recording DENIZ-Sahagun's examination with Health Services Administrator (HSA) [redacted] because both EDC policy and the ICE PBNDS 2011, Use of Force and Restraints,

[36] Video surveillance footage of Echo Unit vestibule area, May 19, 2015.
[37] ODO learned that at the start of each shift, staff members are assigned to the ERT with a particular role, including responsibility for the emergency keys, the fire extinguisher, the Cardio Pulmonary Resuscitation (CPR) mask, or the handheld video camera. The person assigned responsibility for the camera receives it at the start of the shift and carries it on his or her duty belt.
[38] EXHIBIT 8: Handheld video camera recording, May 19, 2015.
[39] *See* EXHIBIT 9: Progress note by RN [redacted] May 19, 2015.
[40] Incident Report by Sergeant [redacted], May 19, 2015.
[41] ODO interview with RN [redacted] July 2, 2015.
[42] ODO interview with Chief [redacted] June 30, 2015.

require post-use-of-force medical examinations be recorded. During her interview with ODO,[43] HSA [redacted] acknowledged her conversation with Chief [redacted] and provided a copy of an e-mail dated April 20, 2015,[44] in which she directed healthcare staff to allow video recording of use-of-force assessments, with the exception of invasive procedures.

During her interview with ODO, RN [redacted] stated the detainee was in handcuffs during her encounter with him and was initially calm, but started to escalate after approximately five minutes. She remembered DENIZ-Sahagun being verbally combative, agitated, not making sense, and demanding his lawyer be called. She also stated he refused to answer any of her medical questions, and did not allow her to take his vital signs or examine him. She stated she was only able to determine he had no visible signs of bleeding.

Audio recording from the handheld video documents DENIZ-Sahagun refusing to cooperate with the medical examination and repeatedly stating "This is brutality. I need my lawyer." When RN [redacted] eventually directs officers to take DENIZ-Sahagun back to segregation, the handheld camera is re-aimed at the detainee. As seen in the recording, as security staff attempt to walk DENIZ-Sahagun from the examination room, the detainee becomes physically resistant. Officers again place DENIZ-Sahagun face-down on the floor of the medical unit to control his movements.[45] This, the second of the four use-of-force incidents, occurred at 9:47 a.m.

The handheld video recording shows DENIZ-Sahagun struggling on the floor as four officers hold him in place. He screams in English and Spanish, "Help me," "Call my lawyer," "This is brutality," and "They want to kill me." RN [redacted] who was present in the clinic at the time and witnessed DENIZ-Sahagun's distress, documented the detainee became combative in the clinic, yelled and screamed that the cartel was coming to kill him, asked for protection, and said he would not move until he was permitted to call his lawyer.[46]

IHSC Commander (CDR) [redacted], Medical Doctor (MD), was also in the clinic at this time. He stated during his interview with ODO that he was in his office when he heard DENIZ-Sahagun screaming loudly.[47] When he stepped into the hallway, he observed the detainee lying face-down on the floor with his hands restrained behind his back. Dr. [redacted] approached an officer and asked to speak to DENIZ-Sahagun in Spanish. He then knelt beside the detainee, patted his shoulder, and asked how he could help him. Dr [redacted] stated during his interview he advised DENIZ-Sahagun he could help him if he would just let him, but the detainee kept screaming. According to Dr. [redacted], he told a nurse the detainee likely needed a mental health referral, placement on suicide watch, and possibly medication to calm him down. Dr.

[43] ODO interview with HSA [redacted], June 30, 2015.
[44] *See* EXHIBIT 10: April 20, 2015 email from HSA [redacted] regarding recording of post-use-of-force medical examinations.
[45] At some point during the time he was held on the floor of the clinic, DENIZ-Sahagun was placed in leg restraints. Because the handheld camera was primarily aimed at his upper body, ODO is unable to determine the exact time the leg restraints were applied.
[46] *See* EXHIBIT 11: Progress note by RN [redacted], May 19, 2015.
[47] ODO interview with Dr. [redacted] conducted telephonically on July 8, 2015.

[redacted] stated he did not offer DENIZ-Sahagun any medication and believed any medication administered would have to be done so involuntarily given the detainee's emotional state.

InGenesis psychologist Dr. [redacted] was also in his office in the clinic when he heard the commotion from DENIZ-Sahagun. During his interview with ODO, Dr. [redacted] stated he stepped into the hallway to see what was happening but did not approach DENIZ-Sahagun because he believed the detainee was so out of control that psychological intervention would not be effective or even possible until he calmed down.[48] Dr. [redacted] documented in DENIZ-Sahagun's medical record that the detainee was "brought to the Clinic for medical services but on arrival immediately threw himself on the floor and began to scream about being killed."[49] ODO notes that when Dr [redacted] stepped into the hallway, he may have heard DENIZ-Sahagun make statements expressing fear of being killed; however, the detainee did not throw himself on the floor upon arrival in the clinic, and there is no information Dr. [redacted] even observed the detainee's arrival.

After being held on the clinic floor for approximately 14 minutes, officers attempted to place the detainee in a wheelchair to take him back to Echo Unit. DENIZ-Sahagun refused to cooperate and instead tried to slide out of the wheelchair. As seen in the handheld video recording, Assistant Shift Supervisor [redacted] applied a pressure point technique to the base of the detainee's neck for five seconds and a second pressure point to his hypoglossal nerve, which is located between the chin and the rear of the jaw for two seconds. Upon release of the pressure points, DENIZ-Sahagun was no longer resisting and four officers, one holding each of his limbs, carried him face down back to Echo Unit. Although DENIZ-Sahagun stopped resisting, he continued to sob. This was the third of the four use-of-force incidents.[50]

While DENIZ-Sahagun was in the clinic, select medical and security staff, including Unit Manager [redacted] and HSA [redacted] were attending a regular morning meeting to discuss detainees in segregation. During his interview, Unit Manager [redacted] stated the group discussed DENIZ-Sahagun, including his behavior in Delta Unit leading to his placement on protective custody, his behavior in Echo Unit after he was moved there, and his behavior when he was interviewed by Sergeant [redacted] and Case Manager [redacted] which led to the multiple uses-of-force. Unit Manager [redacted] stated he emphasized to the group that DENIZ-Sahagun seemed very unstable and needed to be seen by mental health.

HSA [redacted] confirmed during her interview that after discussing DENIZ-Sahagun at the morning meeting, a mental health referral was determined the appropriate course of action. She stated she knew nothing about the detainee prior to the meeting, including his prior suicide attempt or his scheduled evaluation with LCSW [redacted]. HSA [redacted] stated she called Dr. [redacted] following the meeting to discuss DENIZ-Sahagun, and Dr. [redacted] told her the detainee

[48] ODO interview with Dr. [redacted] July 1, 2015.
[49] EXHIBIT 12: Progress note by Dr. [redacted] m, May 19, 2015.
[50] During his interview, ODO asked [redacted] to provide his assessment of this third use-of-force on DENIZ-Sahagun. [redacted] stated he reviewed the video and talked to the involved officers, and he thinks DENIZ-Sahagun could have been moved from the clinic earlier, but the officers otherwise acted appropriately and in compliance with facility policy.

was already in the clinic, though he did not clarify that he was there for a post-use-of-force incident medical evaluation rather than mental health assessment, and she did not inquire into the reason for his being there.

DENIZ-Sahagun was returned to his cell in Echo Unit at approximately10:02 a.m.,[51] during and after which the handheld video recording continued uninterrupted. As seen in the video, DENIZ-Sahagun lays on the bed refusing to allow officers to remove his handcuffs and continues to cry and ask for his lawyer. Officers and RN [redacted] speak to the detainee and attempt to calm him. During her interview with ODO, RN [redacted] stated she accompanied DENIZ-Sahagun from the clinic to Echo Unit and entered the cell with him. She spoke to him in both English and Spanish and eventually, as seen in the video, he began to calm. RN [redacted] stated when DENIZ-Sahagun calmed a bit, she checked his handcuffs and noted that his position on the bed had caused one of the restraints to hit his wrist bone. RN [redacted] told DENIZ-Sahagun that once he fully calmed, an officer would remove his restraints. According to RN [redacted], this comment triggered DENIZ-Sahagun to accuse her of being "one of them." Thereafter, he resisted allowing her to check the restraints, even though he complained they hurt.

As seen in the handheld video recording, and as reported by staff during interviews, after DENIZ-Sahagun was returned to Echo Unit, he repeatedly asked to make a phone call to his attorney. Officers told DENIZ-Sahagun he would be allowed to make a phone call in the medical room next to his cell after he calmed and allowed officers to remove his wrist restraints. ICE Supervisory Immigration and Enforcement Agent (SIEA), [redacted], was called to the scene by a supervisory CCA officer, and, although not visually recorded by the handheld camera, he can be heard telling DENIZ-Sahagun he can make a phone call from the medical office once the handcuffs are removed. DENIZ-Sahagun repeatedly and pointedly states, "Sir, that phone doesn't work, sir," in very clear, well-articulated English. ODO notes DENIZ-Sahagun was apparently referring to the phone on the mobile cart he attempted to use earlier, and may not have understood the phone being offered by SIEA [redacted] was not the same. ODO also notes that during their exchange, SIEA [redacted] twice asked DENIZ-Sahaugn why he wanted to call his attorney.[52] The handheld video recording shows their exchange ended with no resolution.

At an undetermined time,[53] Dr [redacted] arrived in Echo Unit to evaluate DENIZ-Sahagun. Dr. [redacted] documented the detainee remained restrained in the cell during the evaluation.[54] The handheld video recording continued during Dr [redacted] assessment with the camera focused

[51] During his interview, Unit Manager [redacted] stated he was surprised and concerned when DENIZ-Sahagun was returned to Echo Unit rather than being placed on suicide watch or mental health observation. He commented that rounds in Echo Unit occur once every 30 minutes, whereas mental health observation requires rounds every 15 minutes, and suicide watch requires constant, one-to-one monitoring.

[52] ODO notes attorney-client communications are privileged, and asking the purpose of the call was not only inappropriate, but may have heightened the detainee's paranoia.

[53] Because the handheld video camera remained primarily focused on DENIZ-Sahagun, many of the security and medical staff who visited him in Echo during this time are not pictured, making it difficult to identify the exact time of their visit.

[54] *See* EXHIBIT 12.

on the detainee. Dr. [redacted] noted that DENIZ-Sahagun repeatedly and politely asked to talk to his lawyer, but refused to talk about anything else and avoided eye contact. Dr. [redacted] also documented DENIZ-Sahagun refused to go to the Echo Unit medical office to use the phone and instead wanted a phone brought into his cell.

Dr. [redacted] determined DENIZ-Sahagun suffered from delusional disorder.[55] Dr. [redacted] documented that because DENIZ-Sahagun reportedly attempted suicide while in USBP custody, and arrived at EDC in a neck brace due to repeated attempts to bang his head against walls, he should be considered a potential danger to himself or to others, and should thus be placed on suicide watch. ODO notes Dr. [redacted] entry is not entirely factually correct. Although DENIZ-Sahagun arrived at EDC with a neck brace, the record does not document the reason for the neck brace, nor does the record document when or how it was reported DENIZ-Sahagun was banging his head.

Dr. [redacted] ordered DENIZ-Sahagun be placed on suicide watch from May 19 to 26, 2015 and indicated the detainee should be placed in a safety cell and issued a safety smock and blanket, floor mattress, sack lunches, and that he not have access to saran wrap or utensils.[56] The order required nursing checks every eight hours, mental health checks every 24 hours, and one-on-one observation by an officer. Dr. [redacted] also noted a request that facility physicians be prepared to order emergency psychiatric medications as needed. Dr. [redacted] stated during his interview that after ordering DENIZ-Sahagun's placement on suicide watch, he recommended to Dr. [redacted] that involuntary psychotropic medications be administered to the detainee. Dr. [redacted] stated during his interview that Dr. [redacted] informed him involuntary psychotropic medications may be necessary for DENIZ-Sahagun, but no decision was made during their first communication on the matter.

A segregation order placing DENIZ-Sahagun on constant watch was signed by Assistant Chief of Security [redacted] at 2:00 p.m.[57] A strip search was also authorized and documented on a Record of Search form.[58]

A five person cell extraction team was assembled at 12:11 p.m. to move DENIZ-Sahagun from Echo Unit to Bravo 600 Unit, EDC's special housing unit, for suicide watch. Bravo 600 is in a different building within the EDC compound and is a considerable distance from Echo Unit. Officers determined carrying DENIZ-Sahagun to Bravo 600 on a stretcher was the best way to ensure both staff and detainee safety.[59] During his interview with ODO, [redacted] stated he

[55] According to Creative Corrections, delusional disorder is characterized by "false beliefs based on incorrect inference about external reality that persist despite evidence to the contrary; can be beliefs of something occurring in a person's life which are not out of the realm of possibility and may be characterized as persecutory; must be for a duration of at least one month with no other psychotic symptoms."
[56] *See* EXHIBIT 13: Special Needs Form, May 19, 2015.
[57] Segregation Order, May 19, 2015.
[58] Record of Search Form, May 19, 2015.
[59] When carrying a detainee, staff may tire and lose their grip which could cause the detainee to fall. Additionally, carrying a detainee face down while being held by each limb places pressure on the shoulders and may cause a shoulder or arm injury.

discussed carrying the detainee by stretcher with HSA [redacted], and she agreed a gurney could be used, on the condition DENIZ-Sahagun not be strapped down and the sides of the gurney remain up. When the stretcher was brought to Echo Unit, DENIZ-Sahagun agreed to be placed on it and was successfully transported via that method[60]. However, once he arrived at Bravo 600, he refused to get off the stretcher, and staff had to carry him into cell 603. This was the fourth and final use-of-force incident.

Upon arrival to Bravo 600, officers removed DENIZ-Sahagun's clothing using a cut down tool and assisted him into a suicide gown. During interviews, officers stated the detainee was still too agitated to safely remove the handcuffs so that he could remove his clothing himself. They also stated he was aware his clothing was being removed so he could be placed in a suicide gown, and he did not resist removal of his clothing.[61] RN [redacted] examined DENIZ-Sahagun after he was changed and found minor red marks on his wrists from the restraints.[62]

ODO's review of the Bravo 600 surveillance video[63] found that at 12:33 p.m.,[64] five ERT officers dressed in uniforms and helmets, arrived at Bravo 600 carrying DENIZ-Sahagun. Each of the four officers was holding a limb and the detainee was carried face down into cell 603. At 12:35 p.m., restraints were handed out of the cell door to officers standing in the dayroom. The ERT members then exited the cell and each recorded an account of their role during the use-of-force on the handheld camera, per CCA's Use of Force policy.[65] During each recording, the subject officer removed his helmet and stated he had no injuries. RN [redacted]s also recorded her account on the handheld camera stating she medically examined the detainee and he had a minor injury on his left wrist caused by the handcuffs. As seen in the surveillance footage, at 12:38 p.m., a stool was placed outside the door to cell 603, and an officer positioned himself at the door for one-on-one observation. At approximately 12:40 p.m., after each account was recorded, the handheld camera was turned off.

EDC utilizes a use-of-force review team comprised of the Security Chief, the HSA, the Warden or designee, and ICE staff. Following DENIZ-Sahagun's death, the four use-of-force incidents were reviewed by [redacted], HSA [redacted], Acting Warden Easterling, and SIEA [redacted] The team watched all video related to the event and reviewed all staff statements. They concluded

[60] *But see* EXHIBIT 11. ODO notes an inconsistency in documentation of DENIZ-Sahagun's transport to Bravo 600: RN [redacted] documented DENIZ-Sahagun was extracted from his cell in Echo Unit by force, but the handheld video recording shows force was not required to remove the detainee from his cell.

[61] A 1:47 p.m. suicide watch entry to DENIZ-Sahagun's medical record by RN [redacted] documents because the detainee refused to remove his clothes, they were cut off with force. ODO notes the information that the detainee refused to take off his clothes and that they were cut off with force is inconsistent with the handheld video recording of the event.

[62] Progress note by RN [redacted], May 19, 2015.

[63] *See* EXHIBIT 14: Bravo 600 surveillance footage, May 19 to 20, 2015. ODO notes the camera is mounted in a location which provides a view of the dayroom and the cells on each side, including a clear view of the exterior of cell 603.

[64] Based on analysis of written statements, handheld video and available documentation, the time stamp on the camera in Bravo Unit appears to be two hours later than the actual time. Therefore, in this report, two hours have been deducted from the times shown on the video to reflect the actual time events occurred.

[65] CCA Policy 9-1, Use of Force & Restraints.

the force used on the detainee was "reasonable and appropriate." A Use of Force report was submitted to the ICE Field Office Director on May 21, 2015, by Chief Reed.[66]

Video surveillance footage from the stationary camera shows that at 1:21 p.m., the officer stationed at cell 603 motioned another officer over to the door, and the second officer uses his radio to make a call.[67] A medical emergency was called at 1:26 p.m. and at 1:28 p.m., the ERT and medical staff arrived on site. The surveillance footage shows RN [redacted] arrived carrying a backpack. She was accompanied by five officers, one of whom was carrying a shield. A wheelchair was brought into the unit as well. RN [redacted] spoke to DENIZ-Sahagun through the door. At 1:32 p.m., RN [redacted] and the responding officers departed the area.

RN [redacted] documented in DENIZ-Sahagun's medical record, and also stated during her interview that she was called to Bravo 600 after an officer reported DENIZ-Sahagun was hitting his head on the sink in his cell.[68] She conducted a quick visual assessment of the detainee's head through the cell door's food trap and did not see any injury.[69] She documented DENIZ-Sahagun agreed to remain calm and not hurt himself. During her interview, RN [redacted] stated the detainee claimed he was not hitting his head, but was instead leaning over the sink to drink some water. She documented she spoke to Dr. [redacted] and Dr [redacted] after evaluating the detainee concerning his "instability and "combative behavior." RN [redacted] also documented she spoke to Dr. [redacted] via telephone after the encounter to request an immediate mental health assessment, and informed Dr. [redacted] that force was required to move the detainee from Echo Unit because he had attacked officers. ODO notes there is no video evidence, written documentation, or verbal report supporting RN [redacted] statement that DENIZ-Sahagun attacked officers.

At approximately 1:55 p.m., Dr. [redacted] ordered one dose of haloperidol lactate solution 5 mg *(treats mental health, behavior problems, and agitation)* and lorazepam 2 mg *(treats anxiety)* for DENIZ-Sahagun, to be given at bedtime.[70] He also ordered the same medications to be administered by injection "now." During his interview with ODO, Dr. [redacted] stated when Dr [redacted] approached him a second time to request psychotropic medications to calm DENIZ-Sahagun, Dr. [redacted] did not articulate specific reasons justifying the medications, nor did Dr. [redacted] attempt to elicit them. However, Dr. [redacted] knew Dr [redacted] had seen the detainee and on that basis, he wrote the order. Dr. [redacted] also stated he did not personally attempt to evaluate DENIZ-Sahagun, although he emphasized he observed the detainee's behavior during the incident in the clinic. ODO notes Dr [redacted] order did not stipulate the medications were to be administered involuntarily, or that they even could be, if necessary. Dr. [redacted] stated during his interview that he assumed involuntary administration would be necessary, but acknowledged this was not clearly authorized in his order.

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[66] Use of Force report.
[67] *See* EXHIBIT 14.
[68] *See* EXHIBIT 11.
[69] RN [redacted] stated during her interview that DENIZ-Sahagun did not want to comply with application of handcuffs so that she could safely enter the cell. So, in the interest of safety and expediency, she visually inspected his head through the food trap.
[70] *See* EXHIBIT 15: Medication order by Dr [redacted] May 19, 2015.

At 2:18 p.m., Dr. [redacted] and RN [redacted] visited DENIZ-Sahagun in his cell. Bravo 600 surveillance footage shows they remained in his cell for approximately two minutes, and then conferred with officers outside the cell door. All parties, except the officer watching DENIZ-Sahagun on one-on-one observation, departed at 2:24 p.m. ODO notes DENIZ-Sahagun's medical record does not contain an entry clearly aligning with this encounter.

At approximately 2:20 p.m., HSA [redacted] encountered RN [redacted] in a hallway of the clinic, and RN [redacted] mentioned the Special Operations Response Team (SORT) was being assembled to physically restrain DENIZ-Sahagun so anti-psychotic medications could be administered.[71] HSA [redacted] stated during her interview that she asked RN [redacted] to describe DENIZ-Sahagun's state, and RN [redacted] indicated the detainee, though highly agitated earlier, had been calm for over an hour. HSA [redacted] was concerned whether DENIZ-Sahagun should be administered an involuntary anti-psychotic since he was now calm, and approached Dr. [redacted] to discuss the matter. As documented in a memorandum she wrote to memorialize the conversation, HSA [redacted] informed Dr. [redacted] and members of the clinic administration and management team that involuntary injectable anti-psychotics could only be administered when there was an immediate threat to self or others.[72] After Dr. [redacted] explained DENIZ-Sahagun's erratic behavior throughout the day, HSA [redacted] reluctantly agreed to have a nurse administer the medications. However, during her interview with ODO, HSA [redacted] stated she was uncomfortable with the decision, since it did not seem DENIZ-Sahagun was a threat to himself or others at that time.

Immediately thereafter, HSA [redacted] met with RN [redacted] on an unrelated matter, and during the meeting, RN [redacted] reiterated DENIZ-Sahagun had been calm for over an hour, whereupon HSA [redacted] decided it was not appropriate to administer the medications. She directed the Acting Assistant HSA (AHSA) Lieutenant Commander (LCDR) [redacted] to have the SORT stand down. HSA [redacted] stated during her interview that during shift change that afternoon, she instructed incoming staff to send the detainee to the emergency room for crisis intervention and stabilization in the event he became agitated again, since Dr. [redacted] and Dr. [redacted] would likely have left the facility for the day.

ODO notes HSA [redacted] did not confer with or notify Dr. [redacted] or Dr. [redacted] of her decision concerning administration of the ordered medications. Dr. [redacted] and Dr. [redacted] both stated during their interviews they were unaware the detainee was not given the medications until the following day. ODO notes the medical record contains no documentation showing the medications were not administered. ODO also notes that at no point did medical staff attempt to gain DENIZ-Sahagun's consent for voluntary psychotropic medications to calm him.

Throughout the evening, the Bravo 600 surveillance footage shows an officer remained posted outside the detainee's cell door maintaining one-on-one observation. At approximately 8:53

[71] HSA [redacted] Memorandum for Record. ODO notes that although the 2:20 p.m. time does not align with the timing of RN [redacted] 2:18 encounter with DENIZ-Sahagun, it was merely an approximated time by HSA [redacted]
[72] Local Operating Procedure 1501, Suicide Prevention and Intervention.

p.m., InGenesis RN [redacted] visited DENIZ-Sahagun and documented the detainee said he was fine and had no plan to harm himself.[73] RN [redacted] noted the officer posted to DENIZ-Sahagun's cell reported the detainee had been quiet during his shift and had no complaints other than being hungry, for which he was provided some finger food.

May 20, 2015, Day of Death

An officer maintained one-on-one observation of DENIZ-Sahagun without interruption or incident through the night of May 19-20, 2015.[74] At 4:51a.m., during a routine nursing round, InGenesis RN [redacted] documented DENIZ-Sahagun was observed sleeping, and the officer assigned to one-on-one observation reported the detainee slept through the night.[75]

At 8:06 a.m., five officers, one of whom was carrying a shield, arrive at the detainee's cell. At 8:08 a.m., DENIZ-Sahagun exited the cell wearing a one piece suicide gown and was escorted by an officer without force to an office on the unit to see Dr. [redacted].[76] The video shows neither the shield nor any other restraining device was used. The escorting officer remained outside the interview room with the door cracked open slightly. At 8:17 a.m., DENIZ-Sahagun was escorted back into his cell.

Dr. [redacted] entry to the medical record for this encounter is time stamped 8:20 a.m. The full text of the History of Present Illness Narrative is as follows:[77]

> "31 [year old] English-speaking male from Mexcio [*sic*], living in Las Vegas for the past 7 years. Presents today with a clear sensorium, oriented in all spheres, embarrassed about the events of yesterday. States that his mind suddenly started making connections between voices, people, sounds, and perceptions that convinced him that he was going to die here; he has no explanation for why he started thinking that way. Apparently has a very clear recollection of the events of yesterday. CCA personnel report that detainee has already written them an apology letter.[78] Detainee expresses understanding of the ICE adjudication process, expresses understanding why is being detained in this facility. He is completely agreeable to ongoing [mental health] services as indicated, and requests classes or groups on personal growth."

[73] Suicide watch progress note by RN [redacted] May 19, 2015.
[74] *See* EXHIBIT 14.
[75] Progress note by RN [redacted] May 20, 2015.
[76] *See* EXHIBIT 14.
[77] *See* EXHIBIT 16: Mental health note by Dr. [redacted] May 20, 2015.
[78] Dr. [redacted] stated during his interview he learned of the apology letter through CCA staff. ODO notes that because the detainee was on suicide watch, the implements necessary to write an apology letter were unavailable to the detainee; also, the video recording shows no evidence they were provided. It is further noted no apology letter was ever found.

The examination was documented as follows (emphasis as it appears in the text):

> "PSYCH: The patient looks his stated age. Presents in suicide watch attire but is careful with personal modesty. He was alert, attentive and cooperative and had good eye contact. There was no evidence of psychomotor abnormality. Speech was normal in rate, rhythm, volume, amount, accent, inflection, fluency and articulation. Mood was mildly anxious but stable; affect was expressive and congruent with content. Thought processes were logical, linear and goal oriented. Thought content was without suicidal/homicidal ideation, plan or intent. There were no aggressive or self-injurious thoughts, feelings or impulses. There was no evidence of perceptual disturbances. The patient was oriented in time, person place and situation; the patient is of normal intelligence. Short and long term memories were intact. Insight and judgment good."

Dr. [redacted] documented assessment of DENIZ-Sahagun was the detainee suffered from brief reactive psychosis (*occurs shortly after and often in response to a trauma or major stress, most often a brief psychotic disorder occurring as a reaction to a very disturbing event; and, it may be characterized by hallucinations, delusions, disorganized thinking, speech or language that doesn't make sense, unusual behavior, problems with memory, disorientation or confusion, changes in energy level, and inability to make decisions*), but the symptoms were resolving. Dr. [redacted] documented the detainee should be discontinued from suicide watch, but remain on mental health observation until further evaluation by a mental health provider. Dr. [redacted] documented a follow-up appointment was scheduled for the next day. During his interview, Dr. [redacted] stated he planned to see DENIZ-Sahagun the next day with EDC's psychiatrist, Dr. [redacted] MD, who works onsite at EDC two days per week.

During his interview, Dr. [redacted] stated when he saw DENIZ-Sahagun the morning of May 20, 2015, the detainee was not in restraints and behaved dramatically different from the previous day. He stated the detainee spoke fluently in English and articulated understanding of where he was and why he was there. Dr. [redacted] stated DENIZ-Sahagun was very apologetic, embarrassed, did not understand why he did what he did, and had no explanation for thinking he was going to die. Dr. [redacted] stated it was not clear to him what prompted DENIZ-Sahagun's change, but he assumed the detainee had been administered a sedative.

Dr. [redacted] also stated during his interview that he considered doing a thorough mental health psychosocial exam the morning of May 20, 2015, but instead decided to watch the detainee for the next 24 hours since he appeared stable. Dr. [redacted] stated he changed DENIZ-Sahagun's status from suicide watch to mental health observation because he believed the detainee was no longer a danger to himself.

Although Dr. [redacted] documented his assessment in DENIZ-Sahagun's medical record, he did not complete IHSC's suicide risk assessment form. During his interview, Dr. [redacted] stated the risk assessment is typically only completed to determine if placement on suicide watch is necessary, not to evaluate readiness for removal from suicide watch. Dr. [redacted] stated the form is only available in its entirety in an electronic format, and because Bravo 600 is not equipped with a computer from which the form can be accessed, he does not use the form while evaluating

patients in the unit. Dr. [redacted] also commented he finds the tool is not necessarily reliable in identifying intent or plan, hopelessness, lack of goal-directed thinking, and other critical items. He articulated his belief that use of the risk assessment tool would not have changed the outcome for DENIZ-Sahagun.

ODO notes the electronic IHSC suicide risk assessment form includes a series of questions with drop-down boxes prompting specific follow up queries. The mental health assessment documented by Dr. [redacted] in his progress note was not as comprehensive as called for by the form, including identification of specified vulnerability risk factors, and asking the detainee to rate on a scale of one to ten current feelings of hopelessness and future hopefulness. Because the answers DENIZ-Sahagun may have given to questions on the form are unknown, had they been asked, it cannot be determined if its completion would have changed the outcome.

Dr. [redacted] electronically signed the order removing DENIZ-Sahagun from suicide watch at 8:47 a.m. The new order placing DENIZ-Sahagun on mental health observation status stated he was to receive normal clothes, hygiene supplies, bedding, and meals; security checks were to be completed every 15 minutes; nursing checks were to be completed every eight hours; and a mental health evaluation was to be done daily.[80] At 9:33 a.m., the officer posted to cell 603 left his post, marking the time the detainee was removed from one-on-one observation and stepped down to 15 minute checks.[81] At 9:41 a.m., a Division of Immigration Health Services[82] Medical/Suicide Observation Checklist form was placed on the clipboard outside the cell to record the checks. The form has times listed in 15 minute increments on the hour, quarter hour, half hour, and three-quarters hour; for example, 12:00 p.m., 12:15 p.m., 12:30 p.m., 12:45 p.m. There are also codes for location (bed, shower, hallway); behavior (crying, angry, sleeping, or walking); and status change (observation discontinued, placed in restraints or placed on one-on-one observation). The officer makes a notation such as 1/13 (which correlates to on bed and sleeping) and then initials the form.

Although the officers assigned to Bravo 600 on May 20, 2015, made entries to DENIZ-Sahagun's Medical/Suicide Observation Checklist at the pre-printed times, it is noted the video surveillance footage showed rounds were conducted at random intervals, rather than precisely every 15 minutes.[83] Officers are seen making rounds in intervals of six, seven, nine, and ten minutes, well within the requirement; however, on ten occasions, rounds exceeded the 15 minute requirement, though most were only by a minute or two. The longest gap between rounds occurred between 10:15 a.m. and 10:40 a.m., which exceeded the 15 minute requirement by ten minutes. In addition to the regular rounds documented on the form, the video shows additional rounds were made by officers, but not noted on the form. The surveillance footage shows officers taking various routes so rounds could not be predicted with any accuracy. The footage

[79] *See* EXHIBIT 16.
[80] *See* EXHIBIT 17: Special Needs Form, May 20, 2015, and May 20, 2015 email to IHSC Regional Clinical Director, [redacted] MD.
[81] *See* EXHIBIT 14.
[82] IHSC was formerly the Division of Immigration Health Services.
[83] IHSC Directive: 07-04, Significant Self-Harm and Suicide Prevention and Intervention, requires 15 minute staggered checks for detainees with a recent history of self-destructive behavior.

also shows officers looking carefully into DENIZ-Sahagun's cell during each round, stopping each time to verify he is breathing and alive.

An eight-hour nursing round was conducted by InGenesis RN [redacted] at an undetermined time.[84] RN [redacted] documented DENIZ-Sahagun denied any pain and was apologetic for his actions the previous day.[85] She documented the detainee stated he was feeling very calm, and denied anxiety or thoughts of harming himself or others. During her interview with ODO, RN [redacted] stated DENIZ-Sahagun was still in his green quilted suicide smock when she saw him for this encounter; however, she had been verbally informed by Dr. [redacted] he was no longer on suicide watch.[86] She stated the detainee was smiling, pleasant, calm, and was embarrassed about his actions the day before. When she asked him if he was depressed, anxious, or had thoughts of suicide, DENIZ-Sahagun replied no.

At 2:30 p.m., DENIZ-Sahagun was removed from his cell and escorted to the shower by Officer [redacted] and Sergeant [redacted].[87] The shower is enclosed with chain link fencing and has a locking gate. The video shows DENIZ-Sahagun initially stepping in and then out of the shower area when he is first brought over. After the officers speak to him, he again enters the shower, and the gate is locked. Sergeant [redacted] stated during his interview with ODO that DENIZ-Sahagun did not want the door to the shower locked and he had the feeling the detainee wanted to run.[88] At 2:33 p.m., Sergeant [redacted] handed DENIZ-Sahagun his clothing. At 2:52 p.m., the officers placed a bedroll containing two sets of clothing and a mattress inside cell 603. At 2:53 p.m., DENIZ-Sahagun exited the shower area dressed in green pants and a green shirt and was returned to cell 603.[89]

At 4:22 p.m., a food tray was delivered to DENIZ-Sahagun.[90] At 4:35 p.m., the detainee placed his food tray on his open trap for pick-up by an officer. At 4:40 p.m., Officer [redacted] picked up the tray and closed the trap. Between 4:49 p.m. and 4:57 p.m., DENIZ-Sahagun's silhouette can be seen at the cell door on four occasions.

At 5:00 p.m., during a round, Officer [redacted] opened the food trap and leaned down to listen.[91] He then closed the trap and walked away, but returned at 5:04 p.m. with a toothbrush and toothpaste tube which he passed to DENIZ-Sahagun through the trap. Officer [redacted]

[84] The time documented on the progress note, 2:44 p.m., does not correlate with subsequent events. During her interview with ODO, RN [redacted] stated she likely created the note that afternoon after completing her rounds, not necessarily immediately following her encounter with DENIZ-Sahagun. The electronic medical record system does not prompt the user to document the time of encounter but instead time-stamps the note at the time it was created.
[85] Medical progress note by RN [redacted] May 20, 2015.
[86] ODO interview with RN [redacted] July 2, 2015.
[87] *See* EXHIBIT 14.
[88] ODO interview with Sergeant [redacted] June 30, 2015.
[89] ODO was unable to determine why DENIZ-Sahagun was not showered and provided these items until 2:30 p.m., as Dr. [redacted] order for the detainee to be stepped down to mental health observation was made at 8:47 a.m., and one-on-one observation ceased at 9:33 a.m., approximately 5 hours earlier.
[90] *See* EXHIBIT 14.
[91] *Id.*

closed the trap again and walked away from cell 603. ODO notes this was the last time there was direct video surveillance evidence the detainee was up and at the cell door.

At 5:12 p.m., Officer [redacted] made a round and is seen in the surveillance footage leaning in close to observe through DENIZ-Sahagun's door. The code on the observation checklist for this round indicates the detainee was lying on his bed. During his interview with ODO, Officer [redacted] stated DENIZ-Sahagun was sitting on his bed during this check and replied "yes" when asked if he was fine.[92]

The next round took place 15 minutes later at 5:27 p.m. Six detainees were present in the dayroom at this time. As seen in the surveillance footage, Officer [redacted] looks into cell 603 and knocks on the door. He then opens the trap and appears to call out to DENIZ-Sahagun. At 5:28 p.m., he calls a medical emergency[93] using a handheld radio and then leaves the immediate area. As seen in the surveillance footage, several detainees in the dayroom walk over and look inside the cell.

At 5:29 p.m., Officer [redacted] returned to the cell and instructed those detainees to return to their cells. Officer [redacted] then remained outside cell 603 looking through the trap until 5:31 p.m., when he left to meet two responding officers. The three officers can be seen returning to cell 603 and waiting outside the door.

At 5:31 p.m., Officer [redacted] ran to the Bravo 600 entrance, and then returned to cell 603 with two officers.

At 5:32 p.m., a fourth officer and Sergeant [redacted] arrived at DENIZ-Sahagun's cell. Officer [redacted] unlocked the door and Sergeant [redacted] opened it slightly. Sergeant [redacted] stated during his interview that he could see DENIZ-Sahagun's back rising and he heard gurgling noises and labored breathing. As seen in the surveillance footage, he quickly shuts the cell door without entering. [redacted] and [redacted] arrived at the scene as the door was shut, bringing the total number of security staff present to seven.[94]

At 5:33 p.m. InGenesis Licensed Practical Nurse (LPN) [redacted] and InGenesis RN [redacted] arrived on the scene. RN [redacted] brought an emergency bag. IHSC Lieutenant Commander (LCDR) [redacted] Physician Assistant (PA), immediately followed. During their interviews, LPN [redacted] RN [redacted] and PA [redacted] all stated they observed DENIZ-Sahagun lying face down and unresponsive on his bed while they waited for officers to unlock and open his cell door.

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[92] ODO interview with Officer [redacted] June 30, 2015.

[93] The time of the emergency call was taken from Bravo 600 surveillance footage and reflects the time Officer [redacted] is seen using his radio after the 5:27 p.m. round. ODO notes this conflicts with the time of 5:34 p.m. documented in the control log and incident statements.

[94] It is difficult to determine from the Bravo 600 video the order in which each officer arrived. However, the seven officers onsite at this time included Officer [redacted] Officer [redacted] Sergeant [redacted] Officer [redacted] Officer [redacted] Security Chief [redacted] and Captain [redacted]

At 5:34 p.m. a shield was brought to the cell per Captain [redacted] instruction.[95] During his interview, Captain [redacted] stated he directed use of the shield and handcuffs to ensure officer safety. He stated he was aware DENIZ-Sahagun had recently been removed from constant watch and had been combative, and therefore had an obligation to ensure the detainee was not faking a medical emergency. ODO notes Captain [redacted] did not document his order to use the shield for this event in his incident report.[96] Chief [redacted] stated during his interview that directing use of the shield was a discretionary call made by the ranking officer on the scene, and he believed it was justified in this case due to DENIZ-Sahagun's erratic and combative behavior the previous day. Chief [redacted] also stated it is not uncommon for a detainee to fake incapacitation to lure responders close and then attempt to attack them or run. ODO notes both PA [redacted] and RN [redacted] stated during their interviews that this was the first emergency they have responded to where a shield was used.

At 5:34:16 p.m., DENIZ-Sahagun's cell door was opened.[97] Officer [redacted] entered the cell first with the shield in front of him. The remaining officers followed, including Officer [redacted] with a handheld camera.[98] When officers entered the cell, DENIZ-Sahagun was lying on his stomach on the bed with his head directed toward the window. Officer [redacted] straddled DENIZ-Sahagun, and placed the shield on top of him. As seen in the handheld footage, Officer [redacted] does not appear to be applying pressure with the shield. The shield was removed at the six second (0:00:06) mark of the video, and Officer [redacted] backed away. The unit surveillance video shows the shield was removed from the cell at 5:34:52 p.m.

After the shield was removed, Sergeant [redacted] applied handcuffs and took hold of DENIZ-Sahagun's right arm. At the 11 second (0:00:11) mark of the handheld footage, DENIZ-Sahagun is turned on his right side by LPN [redacted] and Sergeant [redacted] As he was turned, the detainee opened his mouth and moaned. During his interview, Sergeant [redacted] stated he observed saliva and foam coming from DENIZ-Sahagun's mouth. RN [redacted] documented DENIZ-Sahagun's face was cyanotic *(blue)* and swollen;[99] during her interview, she stated it was obvious the detainee's airway was blocked.[100]

At the 19 second (0:00:19) mark, an unidentified individual announced "He's having a seizure," and at 31 second (0:00:31) mark a different unidentified individual stated "If he's seizing, just leave him there." Although the officers and medical staff interviewed were not certain who

[95] Incident Statement by Officer [redacted] completed May 21, 2015.
[96] Incident Statement by Captain [redacted] completed May 20, 2015.
[97] *See* EXHIBIT 14. ODO notes this occurred seven minutes after Officer [redacted] first discovered DENIZ-Sahagun unresponsive. ODO also notes that although Officer [redacted] acted in accordance with policy and sound correctional practice by not entering the cell while alone, a Sergeant and four additional officers were present within five minutes of the medical emergency call. When Sergeant [redacted] arrived and opened the cell door, not only did he have four additional officers to provide back up if needed, but DENIZ-Sahagun did not rise or rush the door, indicating he was legitimately incapacitated. Further, Sergeant [redacted] heard labored breathing and gurgling noises signifying medical distress and justifying immediate entry into the cell.
[98] *See* EXHIBIT 18: Handheld camera footage, May 20, 2015.
[99] *See* EXHIBIT 19: Progress note by RN [redacted] completed May 21, 2015.
[100] ODO interview with RN [redacted] July 2, 2015.

made these proclamations, LPN [redacted] stated during his interview that medical staff quickly realized the detainee was not having a seizure.[101]

PA [redacted] stated during his interview the detainee was having obvious difficulty breathing, was making gasping and gurgling sounds, and that he immediately recognized this type of breathing as agonal.[102] PA [redacted] stated he recognized DENIZ-Sahagun was going to die very soon if they could not clear his airway. The handheld video shows medical staff tilting DENIZ-Sahagun's head, and during his interview, PA [redacted] clarified this was done to help him check inside the detainee's mouth. PA [redacted] stated he checked the inside of the mouth and airway to the extent possible, but the detainee's jaw was tightly clenched which made it difficult.

At the 1 minute, 30 second (0:01:30) mark on the video, RN [redacted] attempted to take DENIZ-Sahagun's carotid pulse, could not find it, and then instructed officers to remove the handcuffs. Sergeant [redacted] struggled to remove the handcuffs for approximately 41 seconds before he got them off at approximately 5:37:03. During his interview, Sergeant [redacted] stated the position of DENIZ-Sahagun's body made it difficult to quickly unlock and remove the handcuffs. PA [redacted] stated during his interview that although the delay in removing the handcuffs was not ideal, it had no influence on the ultimate outcome for DENIZ-Sahagun. However, when considered in the context of the entire emergency response, the delay only added to the total elapsed time since Officer [redacted] emergency call, more than nine minutes earlier. Further, approximately four of those minutes were consumed taking and discontinuing security precautions.

At the two minute, 17 second (0:02:17) mark on the handheld video, the blood pressure cuff was attached. ODO notes the handheld video recording only continued for another 36 seconds during which time LPN [redacted] continued to try to get a response from DENIZ-Sahagun, and PA [redacted] checked for a heartbeat with a stethoscope. Officer [redacted] stated during her interview with ODO that after recording for a total of two minutes, 53 seconds (0:02:53), Chief [redacted] instructed her to turn off the handheld camera.[103] ODO notes her written incident report documents Captain [redacted] gave the order to stop recording.[104] Captain [redacted] stated during his interview the camera was turned on initially because the event was an ERT event, and once it became a medical procedure, the recording had to be stopped.[105]

PA [redacted] documented he heard a very faint heart beat upon listening to his heartbeat with a stethoscope and made the decision to initiate CPR and hook an Automated External Defibrillator (AED) up to DENIZ-Sahagun.[106] At 5:38 p.m., ten minutes after the medical emergency was called and four minutes after entry into the cell, PA [redacted] directed officers to call 911. Per

[101] ODO interview with LPN [redacted] July 2, 2015.
[102] ODO interview with PA [redacted] July 2, 2015. "Agonal" breathing is an "inadequate pattern of breathing associated with extreme physiological distress."
[103] ODO interview with Officer [redacted] July 1, 2015.
[104] Officer [redacted] Incident Statement.
[105] ODO interview with Captain [redacted] June 30, 2015.
[106] *See* EXHIBIT 20: Progress note by PA [redacted] May 20, 2015.

the Eloy Fire District Emergency Medical System (EMS) report, the ambulance was dispatched to EDC at 5:39 p.m.

RN [redacted] stated during her interview with ODO that she began CPR compressions after attempting to take DENIZ-Sahagun's blood pressure and placing the detainee on oxygen.[107] She documented the concentration of oxygen in DENIZ-Sahagun's blood as being only 48 percent[108]. She stated LPN [redacted] gave two rescue breaths after the first round of compressions and the AED was placed on the detainee. At no time during the approximately 15 minutes staff performed CPR did the AED advise a shock. Officer [redacted] whose duty as an ERT member that day was to bring a CPR mask, performed one round of CPR and assisted with the ambu-bag.[109] PA [redacted] documented sputum and chunks of paper came from the detainee's mouth and nose during CPR which was quickly suctioned with a manual suction device during compression cycles.[110] During interviews, all persons present in the cell observed some sort of paper, presumed to be tissue, coming from the detainee's mouth and nostrils. ODO notes the surveillance video shows a roll of toilet paper remained outside DENIZ-Sahagun's cell. During interviews, officers stated the detainee was never issued a roll of toilet paper to keep inside his cell, but was instead given sections of toilet paper upon request.

At 5:47 p.m., the ambulance arrived on site.[111] Both the Emergency Medical Services (EMS) report and the Bravo 600 video surveillance footage reflect the paramedics arrived at DENIZ-Sahagun's cell at 5:52 p.m. ODO notes the EMS report documents paramedics found the staff at Eloy performing "quality CPR" and had an AED in place. PA [redacted] stated during his interview that he informed the lead paramedic of the paper coming from the DENIZ-Sahagun's mouth and nose. The paramedics quickly determined DENIZ-Sahagun did not have a heartbeat, and exchanged the manual suction being used by Eloy staff with a more powerful suction device.[112] PA [redacted] stated during his interview that the paramedics did not suction any paper out of the detainee's mouth because his jaw was fully locked by then.

At 5:58 p.m., Captain [redacted] notified ICE Supervisory Detention and Deportation Officer (SDDO) [redacted] that EMS was called for DENIZ-Sahagun and was performing CPR.[113]

The paramedics took over CPR, performing four rounds over 15 minutes, and epinephrine *(the hormone adrenalin which is commonly used to treat cardiac arrest)* was administered intravenously three times during the CPR rounds. PA [redacted] documented the lead paramedic telephoned Banner Casa Grande Medical Center after the third round of CPR and epinephrine to report that DENIZ-Sahagun was unresponsive.[114] According to the EMS report, Dr. [redacted] of

[107] ODO interview with RN [redacted] This information was also documented in her May 20, 2015 progress note.
[108] *See* EXHIBIT 19. For purposes of oxygen saturation readings, according to Creative Corrections, anything under 90 percent is considered low; a reading of 48 indicates acute respiratory distress or a blocked airway.
[109] Incident Statement by Officer [redacted] completed May 20, 2015.
[110] *See* EXHIBIT 20.
[111] EMS report.
[112] *See* EXHIBIT 19.
[113] *See* EXHIBIT 21: Notification sheet from incident packet pertaining to DENIZ-Sahagun's death.
[114] *See* EXHIBIT 20.

Banner Casa Grande Medical Center advised the paramedics to terminate efforts. Detainee DENIZ-Sahagun was pronounced dead at 6:09 p.m.[115]

As seen in the Bravo 600 surveillance footage, the clipboard with the forms used to record rounds and security checks of the detainee was taken down for evidentiary safekeeping at 6:02 p.m., after the paramedics arrived and before death was pronounced. At 6:14 p.m. paramedics and all EDC staff exited the cell and the door was secured, and at 6:17 p.m., paramedics left the unit.[116]

At 6:17 p.m., Chief [redacted] notified Assistant Field Office Director (AFOD) [redacted] via telephone that DENIZ-Sahagun had expired.[117]

As seen in the Bravo 600 surveillance footage, at 6:39 p.m. two Eloy Police Department (EPD) officers, Detective [redacted] and Detective [redacted] enter Bravo 600 Unit. Sergeant [redacted] who was posted to sit outside the secured door of cell 603, opens the door for the two detectives. At 6:49 p.m., the officers exit the cell and the door is secured. At 7:14 p.m., the cell door is re-opened and the detectives take photos from outside the cell, looking inward. At 7:19 p.m. EDC Inspector [redacted] enters the unit with Chief [redacted]

The control center logged that the Pinal County Medical Examiner entered the rear gate of EDC at 8:04 p.m.[118] At 8:10 p.m., a gurney was wheeled onto the unit by Medical Examiner [redacted].[119] He took photos outside the cell and entered the cell at 8:18 p.m. At 8:38 p.m., a gurney was pulled into the cell, and at 8:40 p.m., the gurney was wheeled back out with the detainee's body enclosed in a body bag. The medical examiner unzipped the bag for Officer [redacted] who took fingerprints of the deceased for verification of identity.[120] At 8:47 p.m., the body bag was zipped back up, and at 8:50 p.m., the cell was secured. At 8:54 p.m., the gurney was wheeled off the unit by Mr. [redacted] and at 9:08 p.m., he departed EDC with DENIZ-Sahagun's body.[121]

Post-Death Events

On May 22, 2015, an autopsy was conducted by [redacted] MD, Forensic Pathologist, Pima County Office of the Medical Examiner.[122] The autopsy report documents an orange sock was impacted within DENIZ-Sahagun's esophagus which caused him to asphyxiate. Additionally, a nine centimeter toothbrush handle was found in his stomach, and injuries to his

[115] *See* EXHIBIT 22: Certificate of Death.
[116] *See* EXHIBIT 14.
[117] *See* EXHIBIT 20. Chief [redacted] stated during his interview he made this notification telephonically.
[118] Control Log
[119] *See* EXHIBIT 14.
[120] Officer [redacted] Incident Statement, completed May 20, 2015.
[121] Control log
[122] EXHIBIT 23: Autopsy Report.

head were noted.[123] The cause of death was documented as asphyxia due to choking, and the manner of death as suicide.

Detective [redacted] documented in his report that the Office of Medical Examiner advised him DENIZ-Sahagun's cause of death was asphyxiation, and that a sock was found in his throat and what appeared to be a nine centimeter toothbrush with the word "China" inscribed on it was found inside the detainee's stomach.[124] After receiving this report, Detective [redacted] returned to EDC and took photographs inside cell 603 including images of single sock in the cell and a wrapper from a toothbrush. He also obtained a new toothbrush from EDC staff and observed it had the word "China" inscribed on it. At the time of ODO's onsite review, EPD's investigation was still active and pending.

EDC's internal investigation into DENIZ-Sahagun's death was handled by EDC Investigator [redacted].[125] During her interview with ODO, Investigator [redacted] stated she collected statements and video, and reviewed documentation of rounds made by Officer [redacted].[126] ODO notes incident statements were not timely collected from all staff involved in the emergency response. Investigator [redacted] report did not make note of the late filings, nor did it mention the fact that the time stamp for the video surveillance system was off by two hours. Additionally, Investigator [redacted] report did not appear to include any findings or any indication EDC or CCA management reviewed her report. When asked if her review included identification of any policy violations on the part of security staff, Investigator [redacted] stated that level of review is outside the scope of her duties.

HSA [redacted] stated during her interview that to her knowledge, no formal, multi-disciplinary debriefing of ERO, facility, and medical staff was held following DENIZ-Sahagun's death. ODO notes IHSC policy requires a formal debriefing with the AFOD, [redacted] HSA, and other multidisciplinary team members be held the next business day.[127] HSA [redacted] also stated she did not conduct a debriefing with medical staff because she wanted to first see the results of the mortality review conducted by IHSC headquarters staff as well as ODO's review. She indicated she plans to perform a root cause analysis in the near future when she receives formatting instructions from IHSC.

During his interview, PA [redacted] confirmed no after-action review was conducted with medical staff, but shared that he informally submitted his after-action comments to HSA [redacted] He stated those comments included his observation that during the emergency response the nurses seemed preoccupied with taking the detainee's blood pressure instead of initiating the

[123] Although it cannot be concluded by ODO, the blunt force injuries to the head referenced in the autopsy findings may have been the result of the detainee having jumped from a concrete bench while in CBP custody, landing on his head. As discussed previously, the detainee reported he was trying to kill himself by breaking his neck. Unless the detainee attempted to harm himself by banging his head once removed from suicide watch, the EDC video evidence shows no apparent point at which the detainee may have sustained blunt force head injuries.
[124] Detective [redacted] Report of Investigation.
[125] Incident Report Packet concerning DENIZ-Sahagun's death.
[126] ODO interview with Investigator [redacted] June 30, 2015.
[127] EDC Local Operating Procedure 1501, Suicide Prevention and Intervention.

"ABCs" of CPR: Airway, Breathing, and Circulation; that the nurses did not recognize DENIZ-Sahagun's agonal breathing as quickly as he believed they should have; and, that the nurses seemed to have limited awareness of the contents of the emergency bag.

Chief [redacted] stated during his interview that the services of a community crisis intervention resource was offered to affected security staff, and HSA [redacted] stated the Employee Assistance Program (EAP) was made available to medical staff. ODO notes LPN [redacted] reported during his interview that he and other contract medical staff believed EAP was only available to IHSC employees. He stated InGenesis offered emotional support services approximately six weeks after the detainee's death.

In an undated letter from the [redacted] [redacted] Acting Field Office Director, Phoenix Field Office, sent "care of" the Consulate General of Mexico, DENIZ-Sahagun's sister, [redacted], was informed of her brother's death.

SECURITY AND HEALTHCARE REVIEW

Creative Corrections, a national management and consultant firm contracted by ICE to provide subject matter expertise in detention management including security and healthcare, reviewed the safety and security of DENIZ-Sahagun while he was detained at EDC, as well as the medical care he was provided while housed there. Creative Corrections found EDC did not fully comply with the following ICE PBNDS 2011standards: Medical Care, Significant Self-harm and Suicide Prevention and Intervention, Special Management Units, and Use of Force and Restraints. The Creative Corrections Security and Medical Compliance Analysis is included as an Exhibit to this report.[128]

IMMIGRATION AND DETENTION HISTORY

On September 27, 2011, DENIZ-Sahagun unlawfully entered the United States and was arrested by Border Patrol in Pine Valley, California (CA). He was processed as a Voluntary Return, and was returned to Mexico via the Alien Transfer and Exit Program (ATEP).

On April 17, 2013, DENIZ-Sahagun unlawfully entered the United States. He was arrested by Border Patrol near Calexico, California, on April 18, 2013, and served with a Form I-860, Notice of Expedited Removal, charging him with inadmissibility pursuant to §212(a)(6)(A)(i) of the Immigration and Nationality Act (INA). On that same day, DENIZ-Sahagun was removed to Mexico through the San Ysidro, CA Port of Entry (POE) via ATEP.

On May 15, 2015, DENIZ-Sahagun applied for admission to the United States at the Douglas, Arizona POE. According to documentation by Border Patrol, DENIZ-Sahagun ran into the pedestrian lane at the POE visibly emotional and hysterical. When BPAs asked DENIZ-Sahagun what he needed, DENIZ-Sahagun reportedly stated "they are going to kill me."

[128] *See* EXHIBIT 24: Creative Corrections Security and Medical Compliance Analysis.

On May 16, 2015, Border Patrol served DENIZ-Sahagun with a Notice to Appear charging inadmissibility pursuant to §212(a)(7)(A)(i)(I) of the INA.

On May 18, 2015, DENIZ-Sahagun was transported by BPAs to the EDC where he was transferred to ICE custody.

CRIMINAL HISTORY

None.

CONCLUSIONS

Medical Compliance Findings

The following deficiencies in the ICE PBNDS 2011 were identified:

1. **ICE PBNDS 2011, Medical Care, section (V)(G)(12)**, which states, "Each facility shall have and comply with written policy and procedures for the management of pharmaceuticals, to include: 12. Documentation of accountability for administering or distributing medications in a timely manner according to licensed provider orders."

   DENIZ-Sahagun's medical record contains a May 19, 2015 order by Dr. [redacted] for the administration of haloperidol and lorazepam. HSA [redacted] decided to override that order when she learned DENIZ-Sahagun had calmed; however, she did not document the decision to not administer the medications or the rationale behind that decision.

2. **ICE PBNDS 2011, Significant Self-harm and Suicide Prevention and Intervention, section (V)(D)**, which states, "This evaluation[129] shall be conducted by a qualified mental health professional which will determine the level of suicide risk, level of supervision needed, and need for transfer to an inpatient mental health facility. This evaluation shall be documented in the medical record and must include the following information:

   1. relevant history;
   2. environmental factors;
   3. lethality of suicide plan;
   4. psychological factors;
   5. a determination of level of suicide risk;
   6. level of supervision needed;
   7. referral/transfer for inpatient care (if needed);
   8. instructions to medical staff for care; and

[129] "This evaluation" refers to a mental health evaluation that must be done by a mental health provider for any detainee who is identified for being "at risk" for significant self-harm or suicide. *See* ICE PBNDS 2011, Significant Self-harm and Suicide Prevention and Intervention, section (V)(C).

9. reassessment time frames.

Detainees placed on suicide watch shall be re-evaluated by appropriately trained and qualified medical staff on a daily basis, with this re-evaluation documented in the detainee's medical record. Only the mental health professional, CMA, or designee may terminate a suicide watch after a current suicide risk assessment is completed. A detainee may not be returned to the general population until this assessment has been completed."

Before discontinuing DENIZ-Sahagun's suicide watch on May 20, 2015, Dr. [redacted] did not perform a suicide risk assessment addressing all required factors. His assessment, documented in a progress note, did not address relevant history, environmental factors, and specific determination of level of suicide risk.

3. **ICE PBNDS 2011, Significant Self-harm and Suicide Prevention and Intervention, section (V)(K)**, which states, "A critical incident debriefing shall be offered to all affected staff and detainees within 24 to 72 hours after the critical incident."

   No critical incident debriefing was conducted with staff or detainees following DENIZ-Sahagun's death. ODO was informed security staff involved in the emergency response were offered supportive counseling by a local community crisis intervention source, and medical staff were referred to the Employee Assistance Program. ODO was not provided with information indicating detainees were offered such services.

   Additionally, EDC did not convene a multi-disciplinary debriefing in contravention of IHSC Local Operating Procedure 1501, Suicide Prevention and Intervention which requires, "A formal debriefing with the AFOD, Warden, HSA, and other multidisciplinary team members to convene the next business day for a formal debriefing to review critical elements that contributed to the death and measures to prevent future deaths."

In addition to the deficiencies, ODO notes the following **ICE PBNDS 2011 Expected Outcomes** were not met:

1. **Significant Self-harm and Suicide Prevention and Intervention, section (II)(1)**, which states, "All staff responsible for supervising detainees shall receive a minimum of eight hours of training initially during orientation, on effective methods of identifying significant self-harm, as well as suicide prevention and intervention with detainees."

   The CCA Suicide Prevention Orientation Lesson Plan lists the required credit hours as three rather than eight. However, ODO notes all staff who had contact with DENIZ-Sahagun received training in suicide prevention during orientation and annually. The requirement for eight hours of training during orientation training appears for the first time in the PBNDS 2011, which were implemented at EDC following hire of most involved staff.

2. **Medical Care, section (II)(2)**, which states, "The facility shall have a mental health staffing component on call to respond to the needs of the detainee population 24 hours a day, seven days a week."

   ODO learned during the review that midlevel providers address mental health needs after hours; mental health providers are not on call.

Safety and Security Compliance Findings

The following deficiencies in the ICE PBNDS 2011 were identified:

1. **ICE PBNDS 2011, Special Management Units, section (V)(A)(2)(b)**,[130] which states, "A written order shall be completed and approved by the facility administrator or designee before a detainee is placed in administrative segregation, except when exigent circumstances make such documentation impracticable. In such cases, an order shall be prepared as soon as possible.
   b. Prior to a detainee's actual placement in administrative segregation, the facility administrator or designee shall complete the administrative segregation order (Form I-885 or equivalent), detailing the reasons for placing the detainee in administrative segregation."

   EDC generates a "Confinement Watch Log" when a detainee is placed on segregation status. ODO learned during interviews that if segregation placement is for protective custody purposes, an investigation is conducted the day after placement to determine if segregation is warranted. Although a Confinement Watch Log was created for DENIZ-Sahagun, the detainee's detention records did not include a May 18, 2015 administrative segregation order pending a protective custody investigation, and ODO was unable to confirm one was created for him. ODO notes the Confinement Watch Log fails to meet the requirements of an administrative segregation order because it does not include a section to specify why placement in protective custody is necessary, does not show whether the detainee requested protective custody, and does not indicate whether the detainee was provided a copy of the form.

2. **ICE PBNDS 2011, Use of Force and Restraints, section (V)(I)(2)(e)**[131], which states, "Calculated use of force incidents shall be audio-visually recorded in the following order:
   e. Take close-ups of the detainee's body during a medical exam, focusing on the presence/absence of injuries. Staff injuries, if any, are to be described but not shown."

   During the May 19, 2015, post-use-of-force medical exam, RN [redacted] erroneously directed Officer [redacted] to turn the camera away and not visually record the detainee's exam.

[130] ICE has designated this particular portion of the standard as a Priority Component.
[131] ICE has designated this particular portion of the standard as a Priority Component.

In addition to the deficiencies, the reviewers note the following **ICE PBNDS 2011 Expected Outcome** was not met:

1. **Special Management Units, section (II)(7)**, which states, "Health care staff shall be immediately informed when a detainee is admitted to an SMU and shall conduct an assessment and review of the detainee's medical and mental health status and care needs. Health care personnel shall at a minimum conduct a daily assessment of detainees in an SMU. Where reason for concern exists, a qualified medical, or mental health professional shall conduct a complete evaluation."

   Health care staff were not informed DENIZ-Sahagun was transferred to segregation until the morning following his placement on protective custody status. RN [redacted] who happened to be in the unit to see another detainee, was asked to perform a medical clearance for DENIZ-Sahagun by an officer who noticed one had not yet been completed. RN [redacted] cleared DENIZ-Sahagun based on his interview with the detainee, but did not review the medical record before or after the assessment was done.

   ODO notes failure to medically evaluate DENIZ-Sahagun prior to his placement in Echo Unit on protective custody status also violates CCA Policy 10-100, Special Management Resident: Segregation/Restrictive Housing Unit Management, which requires all detainees to be screened by a qualified health care professional prior to placement in segregation.

Areas of Note

1. CCA Policy 9-19, Suicide Prevention/Risk Reduction requires development of a "Suicide Prevention Plan," which is reviewed annually and addresses specific facility initiatives for suicide prevention. The plan should also address facility compliance with the policy, the areas of focus needing improvement, and monitoring and quality improvement activities. During review of DENIZ-Sahagun's death, ODO found no evidence EDC has developed such a plan, despite DENIZ-Sahagun's suicide being the third at EDC since April 2013, and the fifth since 2005. ODO notes a plan should be collaboratively developed by CCA and IHSC and include all elements required in CCA Policy 9-19, and which considers any findings resulting from internal reviews and/or investigations by outside sources of all suicides at the facility.

2. CCA Policy 5-1.4, Incident Reporting, section (c)(2)(b)(iv) states, "Employees must complete a 5-1C prior to the end of their shift and departing the facility, when practical completion will take place immediately following the incident. In the event circumstances (e.g. at the hospital, etc.) prevent an employee from completing necessary paperwork prior to departing the facility, a verbal statement shall be taken from the employee (by the Unit Manager, Shift Supervisor, or designee) and paperwork will be obtained as soon as practical. The individual obtaining the verbal statement must document the reason that the employee was not able to complete a 5-1C." ODO notes incident statements were not timely collected from all staff involved in both the use of

force incidents on May 19, 2015, and the emergency response on May 20, 2015. Specifically, Delta Unit Manager [redacted] did not file an incident report until May 21, 2015 for his minor involvement in the use-of-force incident on May 19, 2015; also, Chief [redacted] and Officer [redacted] did not file incident statements until the day after the death of the detainee, although they were present for parts of the emergency response on May 20, 2015. In addition, medical staff who responded to the emergency did not file incident statements on the day of the event. PA [redacted] and LPN [redacted] filed their statements two days later, on May 22, 2015, and RN [redacted] filed her report six days later on May 26, 2015.

3. The BPAs who transported DENIZ-Sahagun to EDC notified RN [redacted] he attempted suicide the day prior by jumping from a bench at the Border Patrol Station, and behaved erratically during transport to EDC including banging his head. These reported behaviors were never documented in DENIZ-Sahagun's medical record. During intake, DENIZ-Sahagun acknowledged he attempted to kill himself while in USBP custody, stating he feared he would otherwise be killed by the cartel; however, because DENIZ-Sahagun reported he had no mental health history and appeared stable to the intake nurse, RN [redacted] a routine referral for mental health evaluation was made. Although the referral was classified as routine, RN [redacted] still discussed DENIZ-Sahagun with LCSW [redacted] and reported the detainee's suicide attempt the day before, as well as her observation that he appeared stable at that time. Based on RN [redacted] observations, LCSW [redacted] determined it was not necessary for DENIZ-Sahagun to receive a mental health evaluation until the following day, May 19, 2015. ODO notes that although LCSW [redacted] was informed DENIZ-Sahagun attempted suicide the day before, she relied on the judgment of RN [redacted] and deferred evaluation or consideration of mental health observation to the following day.

4. As discussed in the narrative summary, on May 19, 2015, force was used to control DENIZ-Sahagun on four occasions over the course of more than three hours. All actions and events during this time were audio-visually recorded by stationary and/or handheld cameras. Review of the video recordings found no evidence staff used excessive force on DENIZ-Sahagun at any time. The officers handling DENIZ-Sahagun used verbal de-escalation techniques, spoke to the detainee in both English and Spanish, and called upon medical and ICE staff to assist. No incapacitating agents were used on DENIZ-Sahagun. Although officers took detainee DENIZ-Sahagun to the ground on two occasions, ODO determined reasonable force was used on both occasions. Pressure point control techniques were used and represented the least amount of force necessary to gain compliance. DENIZ-Sahagun twice had to be carried from one location to another due to his refusal to walk or be moved by wheelchair. When he refused to move a third time, officers requested and received authorization to use a gurney. Based on a review of available documentation, including handheld video recording, ODO determined the amount of force used on DENIZ-Sahagun on May 19, 2015, was reasonable and appropriate.

5. Footage from EDC's surveillance camera is time stamped to the hundredths of a second and no gaps in the recordings were identified. However, the time stamp is incorrect by two hours. ODO notes video surveillance recordings provide potentially critical evidence of facility compliance or non-compliance with policies and standards, and video surveillance equipment should be checked routinely to ensure the times recorded are accurate.

6. Dr. [redacted] and Dr. [redacted] both witnessed DENIZ-Sahagun's behavior in the clinic on May 19, 2015, after the post-use-of-force medical examination. During the 14 minute event in which the detainee cried and screamed he was in fear of being killed, Dr. [redacted] attempted to assist in efforts to calm him; Dr. [redacted] determined psychological intervention was impossible at that point and returned to his office. Neither Dr. [redacted] nor Dr. [redacted] inquired as to the detainee's status, including any known mental health history, or considered whether placement on mental health observation would be more appropriate than returning him to segregation.

7. After DENIZ-Sahagun was returned to segregation and continued to behave in a highly agitated state, Dr. [redacted] ultimately decided to place him on suicide watch. Later that day, following a report from an officer that DENIZ-Sahagun was banging his head on the sink in his cell, Dr. [redacted] recommended to Dr. [redacted] that the detainee be administered involuntary psychotropic medications to calm him. Dr. [redacted] later ordered the medications per Dr. [redacted] recommendation but without evaluating the detainee himself or discussing the order with HSA [redacted] ODO notes that because the psychotropic medications were never administered to DENIZ-Sahagun, no deficiency is cited regarding the PBNDS 2011 requirements for involuntary administration of psychotropic medications. However, as noted in the narrative of this report, steps to administer the involuntary psychotropic medications were well underway, and only ceased upon intervention of HSA [redacted] when she learned the detainee was no longer agitated. ODO also notes, when HSA [redacted] decided to stop administration of the medication to DENIZ-Sahagun, she did not confer with Dr. [redacted] before doing so, and did not document her decision to countermand the order in the detainee's medical record. At no time was the detainee offered medications, even when reportedly calm, and as cited above, the medical record does not reflect that the ordered medications were not given.

8. Per HSA [redacted] DENIZ-Sahagun's concerning behavior was perceived to be developing at the time Dr. [redacted] wrote the order for injectable anti-psychotics. The PBNDS 2011, Medical Care, section (V)(N)(6), requires that absent a declared emergency, before psychotropic medication is involuntarily administered, the HSA must contact ERO management, and the authorizing physician must take the specific steps listed in the standard, including specifying the reasons for and duration of therapy and whether the detainee has been asked if he would consent to such medications. Dr. [redacted] did not characterize DENIZ-Sahagun's state as an emergency in the medical record, nor did he indicate the situation rose to the level of an emergency during his interview with ODO. However, the only medical record documentation offering justification for the order was

a note entered by Dr. [redacted] at 2:41 p.m., which states, "Detainee moved to Suicide Watch housing/protocol – continues to reject all MH intervention, escalates at the slightest questioning which he interprets as provocation. Continues to threaten self-harm if not allowed to immediately talk to his lawyer – has no lawyer on file in ICE records. Coordination with M.D. and HSA to administer a 1-time involuntary psychiatric medication." The record does not document DENIZ-Sahagun was ever asked to voluntarily consent to psychotropic medications, and interviews with medical staff indicate he was not asked for such consent.

9. DENIZ-Sahagun's placement on suicide watch occurred within two days of a self-professed suicide attempt and within one day of transfer to protective custody due to his fear his cellmate would kill him. His placement on suicide watch also followed his agitated, fearful, hysterical, and inconsolable state which lasted for more than three hours on May 19, 2015. Approximately 20 hours after DENIZ-Sahagun was placed on suicide watch, Dr. [redacted] decided DENIZ-Sahagun should be discontinued from suicide watch based on the detainee's apparent dramatic improvement overnight. Dr. [redacted] ordered DENIZ-Sahagun be placed on mental health observation status with no restrictions on property. As described in the narrative, DENIZ-Sahagun ultimately used items from his property to end his own life.

10. Although Dr. [redacted] documented his mental health assessment of DENIZ-Sahagun in the detainee's medical record, he did not complete the IHSC suicide risk assessment form. During his interview with ODO, Dr. [redacted] stated he was unable to complete the form for DENIZ-Sahagun because it is only available in its entirety in electronic format, and a computer was unavailable in Echo Unit's medical room where he evaluated DENIZ-Sahagun. Dr. [redacted] also stated the form is typically used to determine placement on suicide watch versus removal from the status, and indicated he was unaware it should be used for removal purposes.

11. When DENIZ-Sahagun was first found unresponsive in his cell, Officer [redacted] immediately called a medical emergency and appropriately did not enter the cell. ODO notes entering a secured cell without back-up is an unsafe practice because it makes an officer vulnerable to physical attack, and to having their keys, radio and other equipment taken, including OC spray, if carried. However, as reflected in the narrative of this report, four additional security staff arrived within four minutes of Officer [redacted] medical emergency call. Despite opening the cell door and observing DENIZ-Sahagun was unresponsive and exhibited abnormal breathing, Sergeant [redacted] re-shut the door and waited an additional two minutes until Captain [redacted] arrived and directed officers to the enter the cell with a shield.

    ODO recognizes during emergency situations, officers must make quick decisions that consider both staff safety and detainee welfare. On this occasion, officers determined DENIZ-Sahagun's behavior the previous day warranted the need for maximum caution and Sergeant [redacted] decided to wait for the full ERT to assemble, and for Captain [redacted] to arrive, before entering the cell; likewise, Captain [redacted] determined use of the shield

and handcuffs was necessary. Upon review of the incident, ODO observed that initiating rescue efforts when Sergeant [redacted] first opened the cell door would not have placed staff at risk. Additionally, although Captain [redacted] exercised his discretionary judgment, use of the shield and handcuffs was not clearly indicated for DENIZ-Sahagun. ODO notes having an ERT for medical emergencies is an efficient method of assuring an adequate number of staff with assigned duties respond; however, it should not be a substitute for exercise of sound judgment by the first responders, and rendering of emergency care should not be delayed pending the arrival of the full team.

12. Medical staff entered DENIZ-Sahagun's cell within five minutes of Officer [redacted] medical emergency call. ODO notes this exceeds the four-minute timeframe called for in emergency response training by one minute. According to the medical staff interviewed, they departed the clinic immediately upon receiving Officer [redacted] medical emergency call and arrived at Echo Unit shortly thereafter, and within four minutes. Due to the security precautions discussed in this report, medical staff were required to wait an additional minute to enter the cell, and then did not have unfettered access to DENIZ-Sahagun until approximately nine minutes after the detainee was first found unresponsive. ODO notes, as observed by PA [redacted] the delay was excessive from a medical perspective, even if it had no bearing on the eventual outcome. If Sergeant [redacted] had allowed medical staff to enter DENIZ-Sahagun's cell immediately upon their arrival, minutes may have been saved before EMS was called.

13. PA [redacted] directed EMS be called approximately four minutes after he entered DENIZ-Sahagun's cell. According to the American Heart Association,[132] 911 should be called immediately after a patient is found unresponsive and before resuscitative efforts commence. Adherence to this guideline would have resulted in calling EMS upon medical staff's determination the detainee was unresponsive when they entered the cell, approximately four minutes prior to PA [redacted] direction to make the call.

14. ODO recognizes that events surrounding DENIZ-Sahagun's detention and death at EDC transpired quickly, and several entries to his medical record were consequently made after-the-fact and in summary fashion. However, ODO notes the following pertinent information, though conveyed verbally to ODO during interviews, was not documented in the record.

    - The BPAs report of DENIZ-Sahagun's erratic behavior while in Border Patrol custody to RN [redacted]
    - RN [redacted] conversation with DENIZ-Sahagun in the intake area when he expressed fear the cartel was after him and had difficulty answering RN [redacted] questions coherently.
    - LCSW [redacted] and RN [redacted] telephone discussion regarding DENIZ-Sahagun's self-reported suicide attempt and his current psychological state as observed by RN

[132] 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care.

Sandoval, which led to LCSW [redacted] determination the detainee should have a non-urgent mental health referral and be scheduled for a mental health evaluation the following day.

- A documented justification for Dr. [redacted] order of involuntary psychotropic medications for DENIZ-Sahagun on May 19, 2015, as well as documented authorization by Dr. [redacted] that the medications should be administered involuntarily.
- RN [redacted] and Dr. [redacted] encounter with DENIZ-Sahagun at 2:18 p.m. on May 19, 2015, after he was allegedly observed banging his head on the sink while on suicide watch.
- RN [redacted] observation, which was provided verbally to HSA [redacted] that DENIZ-Sahagun was calm when she visited him at 2:18 p.m. and had remained calm for approximately one hour, which led to HSA [redacted] decision to intervene in the administration of involuntary medications to the detainee.

ODO also identified the following inaccurate accounts of events in DENIZ-Sahagun's medical record.

- Dr. [redacted] documented that upon arrival in the clinic for medical services on May 19, 2015, DENIZ-Sahagun "immediately threw himself on the floor and began to scream about being killed." During the review, ODO found no information showing Dr. [redacted] witnessed the detainee's arrival in the clinic; furthermore, his account is not supported by the video recording or staff reports.
- Dr. [redacted] documentation of DENIZ-Sahagun's May 19, 2015 assessment states DENIZ-Sahagun arrived at EDC with a neck brace as a result of his repeated attempts to bang his head against walls. ODO notes this information was apparently relayed verbally, but was never documented in the detainee's records, yet Dr. [redacted] presents it as fact.
- RN [redacted] documented force was used to extract the detainee from his cell in Echo Unit for placement on suicide watch. ODO notes force was not used during this movement.
- RN [redacted] documented a telephone encounter with Dr. [redacted] wherein she requested an immediate assessment due to DENIZ-Sahaugn's combative and uncooperative behavior, and because he "attacked" CCA staff. As described in the narrative of this report, neither video footage, written documentation or verbal reports show DENIZ-Sahagun ever attacked any staff member at EDC.
- In a suicide watch entry, RN [redacted] documented officers reported DENIZ-Sahagun refused to take off his clothes, so his clothes were cut off with force. This information is inconsistent with the handheld video recording of the event.

15. Although an after action review of the four uses-of-force on DENIZ-Sahagun was conducted, no multi-disciplinary debriefing on the detainee's death was convened by the HSA or CCA, nor was there evidence of a documented internal review or investigation of DENIZ-Sahagun's detention and death. Likewise, no debriefing or review of actions

taken by medical staff during the emergency response was conducted by HSA [redacted]. Based on information provided to ODO, the investigation completed by EDC's investigator, [redacted] consisted of collecting video recordings, documentation of 15-minute rounds in Echo Unit, and incident statements from staff, some of which were collected several days after the event. ODO did not find documentation that an investigation or critical analysis of all events transpiring during DENIZ-Sahagun's detention period was conducted and reviewed by facility and CCA management.

Conducting a comprehensive internal after action review and investigation serves the critical purpose of identifying any policy violations during an event and areas needing improvement, thereby facilitating prompt implementation of appropriate corrective action. ODO also notes that internal review supports the suicide prevention plan called for in CCA policy. As noted above, the policy on suicide prevention and risk reduction requires a plan that addresses "specific facility initiatives and the facility's plan for compliance," "areas of focus needing improvement," and "monitoring and quality improvement activities." There is no evidence of such a plan, despite detainee DENIZ-Sahagun's suicide is the third at EDC since April 2013 and the fifth since 2005. A plan should be collaboratively developed by CCA and IHSC which includes all required elements and factors the findings resulting from internal review, if any, and investigation by outside sources for all detainee suicides.

EXHIBITS

1. Medical Record from Banner University Medical Center
2. Pre-Screening
3. Medical Intake Screening
4. Encounter Note by LCSW [redacted]
5. Housing Record
6. May 18, 2015 Email Regarding Protective Custody Placement
7. Progress Note by RN [redacted]
8. Handheld Video Camera Recording, May 19, 2015
9. Progress Note by RN [redacted]
10. April 20, 2015 Email Regarding Post-Use of Force Medical Examinations
11. Progress Note by RN [redacted] May 19, 2015
12. Progress Note by Dr. [redacted] May 19, 2015
13. Special Needs Form, May 19, 2015
14. Bravo 600 Surveillance Footage, May 19 to 20, 2015
15. Medication Order by Dr. [redacted]
16. Progress Note by Dr. [redacted] May 20, 2015
17. Special Needs Form, May 20, 2015; May 20, 2015 email to Dr. [redacted]
18. Handheld Video Camera Footage, May 20, 2015
19. Progress Note by RN [redacted]
20. Progress Note by PA [redacted]
21. Notification Sheet from CCA Incident Packet
22. Certificate of Death
23. Autopsy Report
24. Creative Corrections Security and Medical Compliance Analysis