

DETAINEE DEATH REVIEW – Welmer Alberto GARCIA-Huezo

JICMS #201410359

SYNOPSIS

Twenty-four year-old ICE detainee Welmer Alberto GARCIA-Huezo, a citizen and national of El Salvador, died on August 3, 2014, at Laredo Medical Center in Laredo, Texas. The Webb County Chief Medical Examiner documented GARCIA suffered a fever of unknown origin, and that his cause of death was undetermined.

DETAILS OF REVIEW

GARCIA was in ICE custody at the Rio Grande Detention Center (RGDC) at the time of his death. RGDC opened in September 2008, and is owned and operated by the GEO Group, Inc. (GEO). RGDC houses ICE detainees of all classification levels for periods exceeding 72 hours. RGDC is accredited by the American Correctional Association and the National Commission on Correctional Healthcare, and GEO medical staff provides medical care at RGDC. RGDC was required to comply with the ICE 2008 Performance Based National Detention Standards (PBNDS) at the time of GARCIA's death.

From August 19 to 21, 2014, Supervisory Inspections and Compliance Specialist [REDACTED] and Inspections and Compliance Specialists [REDACTED] and [REDACTED] all assigned to the ICE Office of Professional Responsibility (OPR), Office of Detention Oversight (ODO), visited RGDC to examine the circumstances of GARCIA's death. Registered Nurse (RN) [REDACTED] a subject matter expert (SME) in correctional healthcare, assisted ODO with the death review. RN [REDACTED] is 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. ODO interviewed individuals employed by GEO at RGDC. ODO also reviewed video surveillance, immigration, medical, and detention records pertaining to GARCIA.

During this review, ODO staff took note of any deficiencies observed in the detention standards, as they related to the care and custody of the deceased detainee, and documented those deficiencies herein for information purposes only. Their inclusion in the report should not be construed in any way as meaning the deficiency contributed to the death of the detainee.

ODO determined the following timeline of events, from the time of GARCIA's apprehension, through his detention at RGDC.

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JUNE 27, 2014 to JULY 6, 2014

On June 25, 2014, GARCIA unlawfully entered the United States near Harlingen, Texas, where he was encountered by the United States Border Patrol and served with a Notice and Order of Expedited Removal pursuant to § 212(a)(7)(A)(i)(I) of the Immigration and Nationality Act (INA) as an alien not in possession of a valid immigrant visa, reentry permit, border crossing card, or other valid entry.¹

On June 27, 2014, GARCIA was transferred to ICE custody and was booked into RGDC at 6:58 a.m.² Immediately after booking, he received a protein purified derivative (PPD) skin test (*a method used to diagnose latent tuberculosis infection which involves injection of tuberculin protein derivative into the inner surface of the forearm*).³ ODO notes that GARCIA did not sign a medical consent form prior to the administration of the PPD skin test. The consent form, which authorizes RGDC medical staff to perform general medical treatment, was not signed until the following day.⁴

After receiving his PPD skin test, GARCIA was transferred to RGDC security staff for classification. RGDC uses the ICE Custody Classification Worksheet to determine classification levels for incoming detainees.⁵ Because GARCIA had no prior criminal history, he was designated a low risk detainee.⁶ RGDC assigned GARCIA to general population housing unit 5-A, which houses low and medium risk detainees in a dormitory setting. Although 5-A does not have a housing unit officer permanently assigned inside the unit, two correctional officers are assigned as rovers to monitor housing unit 5-A and adjacent units. Housing unit 5-A is also overseen by a control officer who monitors surveillance cameras located within the unit.

On June 28, 2014, at 3:35 p.m., approximately 32.5 hours after GARCIA's arrival to RGDC, an initial medical, dental and mental health screening was completed by LVN [REDACTED].⁷ LVN [REDACTED] recorded GARCIA's vital signs as within normal limits, and documented that he did not claim to have any medical issues or take any medications. During the screening, GARCIA also signed the medical consent form referenced above.⁸ ODO notes GARCIA's record contains no documentation showing RGDC's clinical medical authority, Dr. [REDACTED] - [REDACTED].

¹ I-860 form, Notice and Order of Expedited Removal, signed by Acting Patrol Agent in Charge, [REDACTED] June 26, 2014.

² Exhibit 1: GARCIA's booking form.

³ Exhibit 2: Nurses Incoming Screen Progress Note, dated June 28, 2014, and signed by LVN [REDACTED] documents GARCIA received the PPD on June 27, 2014. The note does not document the time of the PPD.

⁴ Exhibit 3: Consent Form, June 28, 2014.

⁵ The ICE Custody Classification Worksheet accompanies the detainee upon arrival to the facility.

⁶ ICE Custody Classification Worksheet, signed by Supervisory Immigration and Enforcement Agent [REDACTED]

[REDACTED]
⁷ Exhibit 4: Intake Medical and Mental Health Screening, June 28, 2014.

⁸ Exhibit 3

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reviewed GARCIA's medical intake screening forms within 24 hours, or one business day, as required under the ICE 2008 PBNDS.

On June 29, 2014, GARCIA's PPD skin test result was documented as negative.⁹ During interviews, RGDC nursing staff stated that it is common medical practice to read PPD skin test results after 48 hours.¹⁰ Because specific times were not documented for the time GARCIA's PPD test was administered or the time it was read, ODO was unable to verify the requisite 48 hours elapsed.

On July 4, 2014, GARCIA filled out a handwritten request for medical services noting that he had pain in his throat and body, and asking to be seen as soon as possible.¹¹ ICE detainee [REDACTED] who was housed with GARCIA, remembered GARCIA talking about not feeling well on July 4, 2014, and telling other detainees that he thought he had a fever. [REDACTED] also stated that GARCIA stayed in bed all day on that date, which was unusual for GARCIA.¹²

RGDC has a designated medical request box mounted outside of each housing unit. Health Services Administrator (HSA) [REDACTED] LVN [REDACTED] and LVN [REDACTED] all stated that the medical requests are retrieved daily from these boxes.¹³ However, as documented by LVN [REDACTED] GARCIA's July 4, 2014 medical request was not received by medical staff until July 9, 2014.¹⁴ LVN [REDACTED] noted on the medical request slip that she was unable to triage GARCIA's July 4, 2014 request because he was at the hospital at the time she reviewed it. During her interview, LVN [REDACTED] confirmed GARCIA's request was found in the medical request box on July 9, 2014, but was unable to explain why it was not retrieved prior to that date.¹⁵ ODO reviewed sick call logs from July 4 to 9, 2014, and observed that medical requests submitted by other detainees in GARCIA's housing unit between those dates were received and reviewed on the date submitted.

JULY 6, 2014

The following events were recorded in logs, incident statements, RGDC's video surveillance footage, and handheld video footage recording the response to GARCIA's medical emergency.

⁹ Medical progress note, June 29, 2014.

¹⁰ ODO interviews with various RGDC nursing staff from August 19 to 21, 2014. Additionally, the Centers for Disease Control and Prevention (CDC) recommends the PPD skin test be read between 48 and 72 hours after administration.

¹¹ Exhibit 5: Request for Health Services form signed by GARCIA, July 4, 2014.

¹² ODO interview with ICE detainee [REDACTED] August 21, 2014.

¹³ ODO interviews with LVN [REDACTED] HSA [REDACTED] and LVN [REDACTED] on August 19, 20, and 21, 2014, respectively.

¹⁴ Exhibit 5.

¹⁵ ODO interview with LVN [REDACTED] August 21, 2014.

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On July 6, 2014, at 3:27 a.m., GARCIA rolled off his lower bunk onto the floor while sleeping.¹⁶ At 3:28 a.m., Control Officer [REDACTED] [REDACTED] [REDACTED] who was monitoring RGDC's security cameras for housing unit 5-A, noticed GARCIA lying on the floor. Officer [REDACTED] immediately contacted the roving officers assigned to housing unit 5-A, Corrections Officer (CO) [REDACTED] [REDACTED] and CO [REDACTED] [REDACTED] via radio, to check on GARCIA.¹⁷

At 3:30 a.m., CO [REDACTED] and CO [REDACTED] entered housing unit 5-A and found GARCIA face down on the floor by his bunk covered with a sheet. Both officers attempted to wake GARCIA by tapping him to determine if he was sleeping or unconscious.¹⁸ Both CO [REDACTED] and CO [REDACTED] stated during their interviews that GARCIA was breathing and making a noise that sounded like snoring, so they tapped him again but received no response.¹⁹

At 3:31 a.m., CO [REDACTED] called a medical emergency over his radio after he realized GARCIA had stopped breathing. While relaying details about the emergency to medical staff, CO [REDACTED] felt GARCIA's neck and detected a faint pulse. CO [REDACTED] determined that GARCIA was not breathing even though CO [REDACTED] detected a faint pulse, and relayed this information to medical staff over the radio.²⁰

At 3:32 a.m., CO [REDACTED] [REDACTED] and CO [REDACTED] [REDACTED] who is a cardiopulmonary resuscitation (CPR) instructor, entered the housing unit and assessed the detainee.²¹ CO [REDACTED] determined GARCIA did not have a pulse and was not breathing; he immediately rolled GARCIA onto his back and started CPR.²² As CO M. [REDACTED] was initiating CPR, CO [REDACTED] and Sergeant [REDACTED] [REDACTED] arrived at the housing unit. Sergeant [REDACTED] instructed CO [REDACTED] to retrieve the handheld camera to document the emergency response.²³

At 3:34 a.m., RN [REDACTED] [REDACTED] [REDACTED] LVN [REDACTED] [REDACTED] and CO [REDACTED] [REDACTED] arrived to the housing unit with a gurney, an emergency equipment bag, an automated external defibrillator (AED), and an Ambu bag (*registered trademark name for a manual ventilator used on patients that need assisted breathing*).²⁴ CO [REDACTED] continued to perform chest compressions while LVN [REDACTED] initiated rescue breathing with the Ambu bag. After two cycles of CPR, GARCIA was gasping, spitting, and breathing on his own. After he started breathing, GARCIA was rolled on his left side to prevent aspiration, placed on a backboard, and then lifted onto the gurney for transport to the medical unit.²⁵

¹⁶ Exhibit 6: Video Surveillance Footage.

¹⁷ RGDC's Control Logbook for Housing 5, July 6, 2014.

¹⁸ Exhibit 6.

¹⁹ ODO interviews with CO [REDACTED] and CO [REDACTED] August 19, 2014.

²⁰ Id.

²¹ Exhibit 6.

²² ODO interview with CO [REDACTED] August 19, 2014.

²³ ODO interviews with CO [REDACTED] and Sergeant [REDACTED] on August 19 and 20, 2014; respectively.

²⁴ Exhibit 6.

²⁵ Inter-Office Communications signed by CO [REDACTED] [REDACTED] and LVN [REDACTED] July 6, 2014.

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At 3:35 a.m., GARCIA was rolled out of housing unit 5-A on the gurney. While exiting the housing unit,²⁶ RN [REDACTED] instructed Lieutenant [REDACTED] to call 911.²⁷

At 3:38 a.m., medical and security staff arrived at the medical unit with GARCIA, and noticed the detainee no longer had a pulse.²⁸ CO [REDACTED] and CO [REDACTED] immediately initiated CPR on GARCIA, and LVN [REDACTED] performed rescue breathing with the Ambu bag. LVN [REDACTED] asked Officer [REDACTED] to retrieve the automated external defibrillator (AED) which was stored under the gurney. CO [REDACTED] found the AED and handed it to Lieutenant [REDACTED] who placed the AED pads on GARCIA.³⁰ The AED detected an abnormal cardiac rhythm and advised a shock, which was delivered. The AED then advised that CPR should be continued.³¹ CPR was continued for a short period until the AED detected a pulse.³² LVN [REDACTED] documented that while CPR was being performed, GARCIA started gasping, spitting up phlegm, and following simple commands to squeeze her hand.³³

After determining GARCIA was responsive and breathing on his own, medical staff rolled GARCIA onto his left side and LVN [REDACTED] placed a non-rebreather mask (*a special face mask used to deliver high concentrations of oxygen and prevent the victim's exhaled air from mixing with the oxygen*) on GARCIA.³⁴ As LVN [REDACTED] proceeded to connect the mask to an oxygen bottle, she noticed the oxygen level in the bottle was very low and needed to be refilled.³⁵ LVN [REDACTED] continued to use the oxygen bottle because it had approximately ten to 15 minutes of oxygen left in it, and the facility's alternate oxygen bottles were all empty. During her interview, LVN [REDACTED] stated RGDC has either five or six oxygen bottles onsite, and that nursing staff who work the first shift of the day are generally responsible for conducting an inventory of all emergency equipment, including oxygen bottles, daily.³⁶ ODO reviewed RGDC's daily emergency equipment log, and observed that the log does not include oxygen bottles as an itemized piece of equipment to be checked daily. ODO addressed this issue with HSA [REDACTED] while on-site, and HSA [REDACTED] promptly revised the log to include a daily inventory of oxygen bottles and their respective levels of oxygen.

At 3:41 a.m., RN [REDACTED] left the treatment room to obtain GARCIA's medical record to review the detainee's history.³⁷ She returned at 3:44 a.m. and placed a pulse oximeter (*a non-*

²⁶ Exhibit 6.

²⁷ ODO interview with RN [REDACTED] August 19, 2014.

²⁸ Id.

²⁹ Exhibit 7: Handheld Camera Video Footage.

³⁰ ODO interview with Lieutenant [REDACTED] August 19, 2014.

³¹ Inter-Office Communication signed by CO [REDACTED] July 6, 2014.

³² Documentation of the incident does not record the number of CPR cycles that occurred before GARCIA's pulse was detected.

³³ Inter-Office Communication signed by LVN [REDACTED] July 6, 2014. Also, ODO interview with LVN [REDACTED] on August 20, 2014.

³⁴ Exhibit 7. See also, Inter-Office Communication signed by LVN [REDACTED] July 6, 2014.

³⁵ Exhibit 8, page 3: Creative Corrections Medical Compliance Analysis. Also, ODO interview with LVN [REDACTED] August 19, 2014.

³⁶ ODO interview with LVN [REDACTED] August 20, 2014.

³⁷ Exhibit 6.

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invasive method for monitoring a patient's oxygen saturation) on GARCIA's finger.³⁸ GARCIA's oxygen saturation level was 56 percent (*normal is between 96 percent and 100 percent*); LVN [REDACTED] continued to administer oxygen via the non-rebreather mask.³⁹ Creative Corrections notes GARCIA's record does not contain documentation his vital signs were taken by RGDC medical staff at any time during the emergency response.⁴⁰

At approximately 3:48 a.m., RGDC staff transported GARCIA via gurney from the medical care unit to the facility's rear entrance.⁴¹ At 3:50 a.m., the Laredo Fire Department Emergency Medical Services (EMS) arrived at the facility and assumed medical responsibility.⁴² As the detainee was loaded into the ambulance, RN [REDACTED] and Lieutenant [REDACTED] verbally briefed the paramedics on the emergency response.⁴³ The paramedics started an intravenous line (IV) on GARCIA, checked the detainee's vital signs, and noted he was breathing on his own.⁴⁴

At 3:55 a.m., the ambulance left the facility en route to Laredo Medical Center, Laredo, Texas.⁴⁵ CO [REDACTED] accompanied GARCIA in the back of the ambulance, and CO [REDACTED] rode in the front of the ambulance. CO [REDACTED] followed in a chase vehicle consistent with RGDC's Emergency Medical Transport of Detainees policy.⁴⁶ Documentation from Laredo Medical Center records GARCIA's time of arrival at 4:23 a.m.⁴⁷

At 6:48 a.m., CO [REDACTED] (first name unavailable) called his supervisor at RGDC, Lieutenant [REDACTED] (first name unavailable), for permission to remove GARCIA's restraints. Lieutenant [REDACTED] instructed CO [REDACTED] to remove GARCIA's wrist restraints, but maintain GARCIA's leg restraints.⁴⁸

At 8:00 a.m., Laredo Medical Center telephonically notified LVN [REDACTED] that GARCIA was intubated and would be admitted to the hospital.

At 10:35 a.m., RGDC's Lieutenant [REDACTED] and Sergeant [REDACTED] (first name unavailable) arrived at the Laredo Medical Center and were informed GARCIA was in critical condition, had swelling in his brain, and was not likely to survive.⁴⁹ Lieutenant [REDACTED] informed LVN [REDACTED] of GARCIA's prognosis at 10:55 a.m. via telephone. LT [REDACTED] also informed LVN [REDACTED] that she should obtain a list of the detainees who had contact with GARCIA, including those he was

³⁸ ODO interview with RN [REDACTED] August 19, 2014.

³⁹ Emergency On-Site Record form signed by LVN [REDACTED] July 6, 2014.

⁴⁰ Exhibit 8, page 4.

⁴¹ Id.

⁴² RGDC Rear Sally Port Logbook, July 6, 2014.

⁴³ RGDC Policy: Emergency Medical Transport of Detainees, 1300.03.

⁴⁴ ODO interview with CO [REDACTED] August 21, 2014.

⁴⁵ RGDC Rear Sally Port Logbook, July 6, 2014.

⁴⁶ GEO Serious Incident Report prepared by LT [REDACTED] July 6, 2014

⁴⁷ Laredo Medical Center medical record for GARCIA.

⁴⁸ RGDC Hospital Detail Activity Log, July 6, 2014. Per the Hospital Detail Activity Log, GARCIA's leg restraints were removed at 10:44 p.m. on July 6, 2014.

⁴⁹ Id. See also, GEO Memorandum, Synopsis of GARCIA, prepared July 11, 2014.

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transported and housed with, due to a possible meningitis diagnosis for GARCIA.⁵⁰ At approximately 11:00 a.m., HSA [REDACTED] was notified by Laredo Medical Center that GARCIA would receive a computerized tomography (CT) scan to screen for possible meningitis.⁵¹ HSA [REDACTED] immediately notified GEO supervisors who placed detainees housed with GARCIA on “cohort status” (*a term for isolation/quarantine*), which resulted in detainees housed in 5-A being confined to the housing unit until the results of GARCIA’s tests were known.⁵²

On July 9, 2014, GARCIA’s spinal tap result was negative for meningitis, and the cohort status for housing unit 5-A was removed.⁵³

EVENTS NOTED POST-JULY 6, 2014

GARCIA remained at the Laredo Medical Center in the intensive care unit (ICU) on mechanical ventilation/life support until the time of his death on August 3, 2014. HSA [REDACTED] documented at least daily status updates on GARCIA during that time.⁵⁴ HSA [REDACTED] updates included documentation of numerous diagnostic procedures conducted on GARCIA including CT scans of the brain and chest, blood tests, a cerebral spinal fluid test which was negative for meningitis, sputum tests which were negative for bacterial or fungal infections, and urine tests which were positive for bacterial growth. GARCIA also required periodic kidney dialysis throughout his hospitalization because his kidneys were not functioning normally.

On July 9, 2014, a preliminary diagnosis was made of sepsis (*infection of the blood*), secondary to aspiration pneumonia (*an inflammation of the lungs due to taking food particles or fluid into the lungs*) with possible anoxic encephalopathy (*brain damage due to lack of oxygen*).⁵⁵

A magnetic resonance imaging (MRI) performed on GARCIA on July 15, 2014, revealed generalized swelling of his brain, and multiple areas of minimal or nonexistent blood flow in his brain indicating the presence of dead tissue in those areas.⁵⁶

On August 3, 2014, at approximately 2:43 p.m.,⁵⁷ GARCIA went into cardiac arrest as nurses were preparing to bathe him. CO [REDACTED] [REDACTED] who was assigned to GARCIA’s hospital detail with CO [REDACTED] [REDACTED] documented the nurses called a “code blue” (*common hospital code for a patient in need of immediate medical attention or resuscitation*) and initiated CPR.⁵⁸

⁵⁰ Medical progress note prepared by LVN [REDACTED] July 6, 2014.

⁵¹ ODO notes the CT Report for GARCIA from Laredo Medical Center documents the time of his CT scan as 11:14 a.m., July 6, 2014.

⁵² ODO interview with HSA [REDACTED] August 20, 2014; ODO interview with RGDC Chief of Security, [REDACTED] [REDACTED] August 20, 2014. See also, HSA [REDACTED] emails re GARCIA’s status, July 7 to 9, 2014.

[REDACTED] HSA [REDACTED] email re GARCIA’s status, July 9, 2014.

⁵⁴ GEO Memorandum, Synopsis of GARCIA, prepared July 11, 2014.

⁵⁵ Id.

⁵⁶ Id.

⁵⁷ RGDC Hospital Detail Activity Log, August 3, 2014. ODO notes a discrepancy between the timing of events documented in officer statements and the timing of events documented in the hospital log. This report documents the timing of events as they were documented in the Hospital Detail Activity Log.

⁵⁸ RGDC Inter-Office Communication signed by CO [REDACTED] August 3, 2014.

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Resuscitation efforts were successful and GARCIA was stabilized at 2:51 p.m. At 2:53 p.m., CO [REDACTED] telephonically notified both RN [REDACTED] and Lieutenant [REDACTED] at RGDC of the code blue.⁵⁹ CO [REDACTED] and CO [REDACTED] were relieved by CO [REDACTED] and CO [REDACTED] at 2:55 p.m.⁶⁰

At 3:46 p.m., GARCIA went into cardiac arrest again. Hospital staff called a code blue and initiated CPR. CPR was continued for three minutes with no response from GARCIA, and at 3:49 p.m., Dr. [REDACTED] pronounced GARCIA dead.⁶¹ Documentation by CO [REDACTED] stated he telephonically notified [REDACTED] of GARCIA's death (exact time undocumented).⁶²

At approximately 3:50 p.m., RN [REDACTED] at RGDC was notified of GARCIA's expiration by Laredo Medical Center.⁶³ RN [REDACTED] then notified HSA [REDACTED] via email at 4:06 p.m. HSA [REDACTED] notified RGDC's Warden, George "Butch" Head, and ERO's Supervisory Detention and Deportation Officer (SDDO) [REDACTED] at 4:10 p.m.⁶⁴

ERO San Antonio notified the El Salvadoran Consulate of GARCIA's death at 4:10 p.m.⁶⁵ Consistent with ICE policy, the El Salvadoran Consulate made all notifications to next of kin.

ERO San Antonio provided formal notice of GARCIA's death to the Joint Intake Center (JIC) at 11:34 p.m.⁶⁶

On August 6, 2014, the Webb County Chief Medical Examiner, Dr. Corinne E. Stern, conducted an autopsy of GARCIA and documented that he suffered a fever of unknown origin, and died of undetermined causes.⁶⁷

A Certificate of Death, issued on September 4, 2014, records GARCIA's cause of death as pending.⁶⁸

⁵⁹ Id. Also, ODO interview with CO [REDACTED] August 21, 2014.

⁶⁰ Hospital Detail Activity Log, August 3, 2014.

⁶¹ Id.

⁶² RGDC Inter-Office Communications signed by CO [REDACTED] and CO [REDACTED] August 3, 2014.

⁶³ Medical progress note by RN [REDACTED] August 3, 2014.

⁶⁴ RGDC email correspondence contained in GARCIA's electronic medical record, electronically signed by HSA [REDACTED] on August 3, 2014.

ERO email correspondence regarding notice to El Salvadoran Consulate, August 03, 2014.

⁶⁶ Exhibit 9: ERO San Antonio Email correspondence to JIC, August 3, 2014.

⁶⁷ Exhibit 10: Medical Examiner's Autopsy. ODO notes that the Medical Examiner's Autopsy was issued to ERO San Antonio on December 5, 2014. ODO also notes the Medical Examiner's Autopsy documents GARCIA did not complain of being ill and did not exhibit any symptoms prior to being admitted to the hospital; GARCIA's medical record does not indicate RGDC medical staff notified Laredo Medical Center of GARCIA's July 4, 2014 medical request slip.

⁶⁸ Exhibit 11: Certificate of Death. As of the date of this report's publication, the Certificate of Death was not yet updated to reflect the Chief Medical Examiner's finding that GARCIA died of undetermined causes.

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MEDICAL CARE AND SECURITY REVIEW

Creative Corrections, a national management and consultant firm contracted by ICE to provide subject matter expertise in correctional healthcare, reviewed the medical care GARCIA received while housed at RGDC. Creative Corrections found RGDC did not fully comply with the ICE 2008 PBNDS for Medical Care. The Creative Corrections Medical Compliance Analysis is included as an Exhibit to this report.⁶⁹

Additionally, ODO reviewed the safety and security of GARCIA while he was detained at RGDC, and found that RGDC did not fully comply with the ICE 2008 PBNDS for Emergency Plans.

IMMIGRATION AND DETENTION HISTORY

On July 25, 2014, GARCIA unlawfully entered the United States near Harlingen, Texas. He was apprehended by the United States Border Patrol and served with a Notice and Order of Expedited Removal pursuant to § 212(a)(7)(A)(i)(I) of the Immigration and Nationality Act (INA) as an alien not in possession of a valid immigrant visa, reentry permit, border crossing card, or other valid entry.⁷⁰

On June 27, 2014 GARCIA was transferred to ICE custody and booked into RGDC.⁷¹

CRIMINAL HISTORY

GARCIA had no prior criminal history.⁷²

INVESTIGATIVE FINDINGS

MEDICAL CARE

GARCIA was admitted to RGDC with no known medical conditions or history of taking medications. He appeared to be a healthy adult male. The July 6, 2014 emergency response by RGDC correctional and medical staff was appropriate and timely. Both correctional and medical staff provided emergency resuscitative care until paramedics arrived and assumed medical responsibility for GARCIA.

⁶⁹ Exhibit 8.

⁷⁰ I-860 form, Notice and Order of Expedited Removal signed by (A) Patrol Agent in Charge, [REDACTED] June 26, 2014.

⁷¹ I-213 form signed by Border Patrol Agent [REDACTED] June 26, 2014.

⁷² Id.

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

1. ICE 2008 PBNDS, Medical Care, section (V)(I)(1), states the initial medical, dental, and mental health screening shall be done within 12 hours of arrival by a health care provider; further, the clinical medical authority is responsible for review of all health screening forms within 24 hours or the next business day to assess the priority for treatment.
 - Documentation in GARCIA's medical record indicates the medical, dental, and mental health screening was done approximately 32.5 hours after the detainee's arrival.
 - GARCIA's medical record contains no documentation indicating the clinical medical authority reviewed the health screening forms within 24 hours or the next business day.
2. ICE 2008 PBNDS, Medical Care, section (V)(N), states all facilities must have an established procedure in place to ensure that all sick call requests are received and triaged by appropriate medical personnel within 48 hours after the detainee submits the request.
 - GARCIA's July 4, 2014 medical request slip was not received by medical staff until July 9, 2014, and could not be triaged at that time because GARCIA was already admitted to the Laredo Medical Center.
3. ICE 2008 PBNDS, Medical Care, section (V)(O), states medical and emergency equipment shall be available and maintained, and staff shall be trained in proper use of the equipment.
 - During the emergency response, RGDC's oxygen canisters were empty except for one canister which had only a low level of oxygen. After reviewing the daily emergency equipment log, ODO found the oxygen canisters were not specifically itemized on the daily inventory.
4. ICE 2008 PBNDS, Medical Care, section (V)(T), states upon admission to the facility, documented informed consent will be obtained for the provision of health care services.
 - GARCIA did not sign the Consent to Medical Treatment form before nursing staff administered his PPD on June 27, 2014, at 6:58 a.m. The Consent to Medical Treatment form was signed as part of GARCIA's medical intake screening

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process on June 28, 2014, at 3:35 p.m, more than a day after the PPD administration.

SAFETY AND SECURITY

Upon review of documentation and interviews with correctional staff, ODO notes that staff responded appropriately, and no deficiencies were identified with respect to actions taken during the emergency response. However, ODO found that RGDC did not collect incident reports from all correctional staff members who participated in the emergency response, nor were all incident reports filled out in a timely manner.

ODO determined RGDC did not fully comply with the ICE 2008 PBNDS, Emergency Plans.

1. ICE 2008 PBNDS, Emergency Plans, section (V)(d)(18)(b), Post Emergency Procedures states, “The post-emergency part of the plan shall include the following action items: b. collecting written reports...”
 - The following staff members performed an active role in fulfilling a duty or responsibility in response to GARCIA’s medical emergency on July 6, 2014, and did not file incident reports: Lieutenant [REDACTED] [REDACTED] and Sergeant [REDACTED] [REDACTED] who were responders to the medical emergency and helped coordinate response activities; Correctional Officer [REDACTED] [REDACTED] who accompanied GARCIA in the ambulance en route to the hospital; and Correctional Officer [REDACTED] [REDACTED] who was assigned to hospital duty when GARCIA was pronounced dead on August 3, 2014. Additionally, ODO determined four incident reports filed by correctional officers following the medical emergency were filed in an untimely manner. These reports were filled out by correctional staff between three and six days after GARCIA’s medical emergency on July 6, 2014. ODO notes that obtaining written reports in a timely manner (immediately following an incident) ensures all persons involved document events, activities, interactions, and observations accurately, which may have relevance in fact finding and after-action efforts.

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EXHIBIT LIST

1. June 27, 2014, Booking Information
2. June 28, 2014, Medical Progress Note
3. Consent to Medical Treatment
4. Intake Medical and Mental Health Screening
5. July 4, 2014 Medical Request
6. July 6, 2014 Video Surveillance Footage
7. July 6, 2014 Handheld Camera Video Footage
8. Creative Corrections Medical Compliance Analysis
9. August 3, 2014 ERO San Antonio Email correspondence to JIC
10. Autopsy Report
11. Certificate of Death