DEPARTMENT OF HOMELAND SECURITY
Immigration and Customs Enforcement

REPORT OF INVESTIGATION
HB 4200-01 (37), Special Agent Handbook

1. CASE NUMBER
201307302

PREPARED BY
[redacted]

2. REPORT NUMBER
008

3. TITLE
Garcia-Mejia, Jorge/Unknown/0617 Detainee/Alien - Death (Suicide)/ELOY, PINAL, AZ

4. FINAL RESOLUTION

5. STATUS	6. TYPE OF REPORT	7. RELATED CASES
Addendum	Investigative Findings	

8. TOPIC
Investigative Findings for the Death of Detainee Jorge GARCIA-Maldonado, aka Jorge Garcia-Mejia.

9. SYNOPSIS
On April 30, 2013, the Joint Intake Center, Washington, D.C., was notified of the death of Immigration and Customs Enforcement Detainee Jorge GARCIA-Maldonado, aka Jorge Garcia Mejia. GARCIA-Maldonado was a citizen of Guatemala who was born on March 5, 1973, and died on April 30, 2013, at the Eloy Detention Center located at 4465 East Hanna Road, Eloy, Arizona. GARCIA-Maldonado was 40 years old when he died. The Pinal County Medical Examiner determined GARCIA-Maldonado's cause of death to be asphyxia due to hanging, and his manner of death to be suicide.

The ICE Office of Professional Responsibility, Office of Detention Oversight has completed a Detainee Death Review of Jorge GARCIA-Maldonado's death. This report documents the findings of the review.

10. CASE OFFICER (Print Name & Title)	11. COMPLETION DATE	14. ORIGIN OFFICE
[redacted] - ICE-OPR Special Agent	07-OCT-2013	ICE OPR Office of Detention Oversight (ODO)-Houston
12. APPROVED BY(Print Name & Title)	**13. APPROVED DATE**	**15. TELEPHONE NUMBER**
[redacted] - ICE-OPR Special Agent Supervisor	07-OCT-2013	No Phone Number

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On April 30, 2013, the Joint Intake Center (JIC), Washington, D.C., was notified of the death of Immigration and Customs Enforcement (ICE) Detainee Jorge GARCIA-Maldonado, aka Jorge Garcia-Mejia. GARCIA-Maldonado was a citizen of Guatemala, who was born on March 5, 1973, and died on April 30, 2013, at the Eloy Detention Center (EDC) located at 4465 East Hanna Road, Eloy, Arizona (AZ). GARCIA-Maldonado was 40 years old when he died. The Pinal County Medical Examiner determined GARCIA-Maldonado's cause of death to be asphyxia due to hanging, and his manner of death to be suicide.

At the time of his death, GARCIA-Maldonado was in ICE custody at EDC. EDC has been open since 1994, and is owned and operated by Corrections Corporation of America (CCA) for the City of Eloy, AZ. EDC is an Intergovernmental Service Agreement (IGSA) facility contracted for use by ICE from the City of Eloy. EDC houses ICE detainees of all classification levels for periods in excess of 72 hours. Medical care at EDC is provided by the ICE Health Service Corps (IHSC). IHSC contracts with InGenesis Arora to supplement their medical staffing at EDC. EDC is required to comply with the ICE Performance Based National Detention Standards (PBNDS) 2011.

From June 18 to 20, 2013, Management and Program Analyst [redacted] and Supervisory Inspections and Compliance Specialist [redacted] assigned to the ICE Office of Professional Responsibility (OPR), Office of Detention Oversight (ODO), visited EDC as part of the Detainee Death Review regarding the death of GARCIA-Maldonado. ODO was assisted by Special Agent (SA) [redacted] currently assigned to the ICE OPR Office of the Resident Agent in Charge (RAC), Denver, Colorado. ODO was also assisted by Registered Nurse (RN) [redacted] a subject matter expert in correctional health care, and [redacted] a subject matter expert (SME) in correctional security. 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, including health care and security. As part of the review, ODO interviewed individuals employed by CCA at EDC, as well as employees of IHSC, InGenesis, and the ICE Office of Enforcement and Removal Operations (ERO). ODO also interviewed relevant EDC detainees regarding knowledge they had of GARCIA-Maldonado. Additionally, ODO reviewed immigration, medical, and detention records pertaining to GARCIA-Maldonado.

ODO determined the following timeline of events regarding GARCIA-Maldonado, from the time of his apprehension, through his detention at EDC. (NOTE: This report identifies the date and time of various events as documented in logs, as well as the time stamped in video surveillance footage. An event may be logged at slightly different times in different logbooks, and logbook entries may not exactly match the time stamp of that event in the video surveillance footage. For

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consistency, ODO used video surveillance footage time stamps to calculate the amount of time elapsed between events.)

On March 16, 2013, at approximately 2:47 a.m., ICE ERO Immigration Enforcement Agent (IEA) [redacted] encountered GARCIA-Maldonado, aka Garcia-Mejia, at the Fourth Avenue Jail in Maricopa County, Phoenix, AZ, where GARCIA-Maldonado was booked on an assault charge after being arrested by the Phoenix Police Department (PD). As documented in GARCIA-Maldonado's Form I-213 (Exhibit 1), IEA [redacted] interviewed him in Spanish and questioned him about his nationality and citizenship. GARCIA-Maldonado admitted he was a citizen and national of Guatemala and had entered the United States illegally at Douglas, AZ, in 2003.

IEA [redacted] documented GARCIA-Maldonado was previously apprehended by ICE on November 6, 2012, and served a Notice to Appear (NTA) (Exhibit 2) charging inadmissibility pursuant to section 212(a)(6)(A)(i) of the Immigration and Nationality Act, as an alien present in the United States without being admitted or paroled. He was subsequently released the same day on an Order of Recognizance (OREC) (Exhibit 3), and enrolled in the Alternatives to Detention (ATD), Intensive Supervision Appearance Program (ISAP).

On the Form I-213 (Exhibit 1), IEA [redacted] documented that, since GARCIA-Maldonado was previously processed as an NTA/OREC, and his case was still active, he would be detained in the custody of the Department of Homeland Security. On March 22, 2013, ICE ERO terminated GARCIA-Maldonado from the ISAP, revoked his OREC, and issued him a Notice of Custody Determination (Exhibit 7), requiring a bond in the amount of $8,000. This is documented in the Significant Incident Report (SIR) (Exhibit 6) regarding GARCIA-Maldonado's death.

On March 22, 2013, GARCIA-Maldonado placed a phone call to his significant other, described as "[redacted] (Exhibit 4). "[redacted] was listed as GARCIA-Maldonado's emergency contact on his Inmate Information Sheet from EDC (see Exhibit 11), and notification of GARCIA-Maldonado's death was sent to "[redacted] who was described in the notification as GARCIA-Maldonado's wife.

On March 22, 2013, the Fourth Avenue Jail released GARCIA-Maldonado into the custody of ICE ERO Phoenix, and a Warrant for Arrest of Alien (Exhibit 5) was served on him.

On March 22, 2013, at 11:13 p.m., GARCIA-Maldonado was first transferred to the asset protection area of the ICE ERO Phoenix District Office, Phoenix, AZ, as documented in the comments section of his Enforcement Removal Module (EARM) record (Exhibit 8), in the

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ENFORCE system. GARCIA-Maldonado was then moved to the Florence Arizona Processing Center, Florence, AZ, as documented on a Form I-216, Record of Persons Transferred (Exhibit 9).

On March 23, 2013, at 5:20 a.m., GARCIA-Maldonado was transferred from the Florence Arizona Processing Center to EDC (Exhibit 8).

On March 23, 2013, at 7:30 a.m., GARCIA-Maldonado arrived at EDC, as documented at his intake medical screening (Exhibit 10).

On March 23, 2013, at 8:16 a.m., GARCIA-Maldonado was booked into EDC (Exhibit 11) under an Order to Detain or Release Alien (Exhibit 12).

GARCIA-Maldonado was classified (Exhibit 13) as a "Low Level Two" detainee, and assigned to Echo housing unit, pod 200, cell 208 (Exhibit 14), where he was housed for the duration of his stay at EDC.

According to the Allowable Personal Property Inventory/Receipt (Exhibit 15) prepared for GARCIA-Maldonado upon admission, he was permitted to take his shoes with him into the facility.

On March 23, 2013, at 11:00 a.m., GARCIA-Maldonado underwent an intake medical screening by InGenesis RN [redacted] which was reviewed by InGenesis RN [redacted] as documented on the ICE Health Service Corps (IHSC) Intake Screening form (IHSC Form 795 A) (Exhibit 10). RN [redacted] documented GARCIA-Maldonado complained of a sore throat, but otherwise felt "okay." RN [redacted] checked a box on the form indicating GARCIA-Maldonado spoke English, and she did not note an interpreter was needed or used.

ODO interviewed RN [redacted] on June 18, 2013. RN [redacted] confirmed she conducted GARCIA-Maldonado's intake medical screening. After reviewing GARCIA-Maldonado's medical chart, RN [redacted] stated GARCIA-Maldonado arrived at the facility with cold-like symptoms; she provided him medications to alleviate the symptoms; and he did not express any intent to harm himself. RN [redacted] stated that, during every intake medical screening, the detainee being screened is provided a pamphlet on managing stress and a pamphlet on access to medical care. Both pamphlets are available in English and Spanish. During the on-site review, ODO looked through GARCIA-Maldonado's property and did not find the pamphlet on managing stress. RN [redacted] stated she does not speak Spanish fluently, but readily uses Interpretalk, a telephonic interpretation service contracted by ICE, to communicate with non English speaking detainees. RN [redacted] did not remember whether she used Interpretalk during GARCIA-Maldonado's

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screening. RN [redacted] stated she accidentally checked the box indicating GARCIA-Maldonado spoke English on the Form 795-A (Exhibit 10).

On March 31, April 14, April 21, and April 28, 2013, GARCIA-Maldonado attended Christian religious services at EDC, as indicated on an EDC Religious Service Attendance logs (Exhibit 16).

ODO interviewed EDC Chaplain [redacted] on June 18, 2013. Chaplain [redacted] has worked at EDC for approximately one year. Chaplain [redacted] stated in addition to coordinating a variety of religious services and activities at the facility, she also provides guidance and support to detainees and staff. Chaplain [redacted] stated when a correctional officer (CO) notices a detainee behaving in an unusual manner (i.e., sad, anxious, depressed), the CO typically notifies her and mental health staff. Chaplain [redacted] stated she is not fluent in Spanish, but she often uses detainees to translate for her. Chaplain [redacted] stated although she found GARCIA-Maldonado's name on attendance sheets for Christian services at the facility, she does not specifically remember him. Chaplain [redacted] stated she was on duty at EDC when GARCIA-Maldonado died, and she counseled detainees in Echo 200 in the hours following his death.

On April 19, 2013, Detainee [redacted] was assigned to cell 208 with GARCIA-Maldonado (Exhibit 17). GARCIA-Maldonado and [redacted] remained cellmates until GARCIA-Maldonado's death.

ODO interviewed [redacted] on June 18, 2013. [redacted] stated while they were housed together, GARCIA-Maldonado often read the Bible and always cried while he read. [redacted] stated GARCIA-Maldonado was worried about his wife and daughters, and talked about wanting to kill himself. [redacted] stated while he informed several detainees whom he viewed as authority figures in Echo 200 of GARCIA-Maldonado's suicidal statements; he did not report those statements to facility staff (Exhibit 56). [redacted] handwrote an incident statement in Spanish on April 30, 2013, and, according to EDC Investigator [redacted] she typed and translated it into English (Exhibit 18).

On April 1, 2013, at 7:55 p.m., GARCIA-Maldonado received a physical examination by InGenesis RN [redacted] as documented in IHSC Form 795-B, Physical Examination/Health Appraisal (Exhibit 19). RN [redacted] documented GARCIA-Maldonado was a "40 year old male with no chronic medical problems," and he had no current or past mental health issues. RN [redacted] documented that GARCIA-Maldonado had some swelling around his dentures as well as fungus between his toes for which she provided him anti-fungal cream. RN [redacted] wrote that GARCIA-Maldonado's physical examination, "shows no significant medical/mental health issues

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currently," and she checked a box noting his mood was "appropriate." RN [redacted] also checked the box next to, "Patient was given Staying Healthy and Clinic and Health Orientation brochure in patient's language." ODO did not find this pamphlet when inspecting GARCIA-Maldonado's property. RN [redacted] checked the "No" box after "Interpreter Provided?" at the top of page 1 of the form.

On April 18, 2013, GARCIA-Maldonado's physical examination was reviewed and approved by IHSC Dr. [redacted] as indicated at the bottom of pages 1-3 of the IHSC Form 795-B, Physical Examination/Health Appraisal (Exhibit 19).

ODO interviewed RN [redacted] on June 18, 2013. RN [redacted] confirmed she completed GARCIA-Maldonado's physical examination. She stated she is fluent in Spanish and fully capable of performing a physical examination in Spanish. She stated she asks Spanish-speaking detainees open-ended questions to gauge their ability to understand her.

On March 26, 2013, GARCIA-Maldonado met with his assigned ICE ERO Deportation Officer (DO), [redacted] During their meeting, GARCIA-Maldonado signed a form (Exhibit 20) acknowledging he wished to have Guatemala consular officials notified of his detention at EDC. On that same day, DO [redacted] notified the Guatemalan Consulate in Phoenix, AZ via facsimile (Exhibit 21) that GARCIA-Maldonado was in the custody of ICE at EDC.

ODO interviewed DO [redacted] on June 19, 2013. DO [redacted] has worked as a DO at EDC for approximately six years. DO [redacted] stated he did not have any recollection of GARCIA-Maldonado or their meeting on March 26, 2013.

Between March 23, 2013, and April 29, 2013, GARCIA-Maldonado placed 12 telephone calls, as documented in an EDC Call Detail Report (Exhibit 22). The Call Detail Report reflects that all 12 telephone calls were placed to the same telephone number listed on the form documenting GARCIA-Maldonado's March 22, 2013 telephone call to "[redacted] (Exhibit 4).

On April 23, 2013, Detective [redacted] Crimes Against Children Unit, Phoenix Police Department (PD), Phoenix, AZ, contacted DO [redacted] by telephone to notify him Phoenix PD had probable cause to charge GARCIA-Maldonado with several counts of sexual conduct with a minor; he was in the process of getting a warrant for GARCIA-Maldonado's arrest; and he and his partner, Detective [redacted] planned to visit GARCIA-Maldonado at EDC for questioning on April 26, 2013. Detective [redacted] followed up the telephone call with an email (Exhibit 23) to DO [redacted] in which he reiterated his plan to charge GARCIA-Maldonado.

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During his interview with ODO, DO [redacted] stated after receiving Detective [redacted] call and email on April 23, 2013, he received a follow-up call notifying him the detectives would visit GARCIA-Maldonado on April 30, 2013, instead of April 26, 2013. DO [redacted] stated he sent Detective [redacted] email to his supervisor, ICE ERO Supervisory Deportation and Detention Officer (SDDO) [redacted] who instructed him to contact DO [redacted] to have GARCIA-Maldonado cleared before the meeting with the detectives. (See also Exhibit 23.) DO [redacted] is responsible for conducting third agency checks to ensure there are no active ongoing Homeland Security Investigations (HSI) investigations of a particular detainee before that detainee meets with another law enforcement agency. DO [redacted] stated once GARCIA-Maldonado was cleared by DO [redacted] he notified Detective [redacted] they were clear to meet with GARCIA-Maldonado on April 30, 2013.

On April 30, 2013, at 5:25 a.m., the Echo housing unit started breakfast as documented in the Echo Officer in Charge (OIC) logbook (Exhibit 24). During his interview, [redacted] stated he and GARCIA-Maldonado attended breakfast that morning.

On April 30, 2013, at 6:05 a.m., EDC CO [redacted] assumed his post as the pod officer in Echo 200 as documented in the Echo 200 logbook (Exhibit 25).

During his interview with ODO, [redacted] stated that, after breakfast, he found GARCIA-Maldonado in their cell reading his Bible and crying. [redacted] stated he napped while GARCIA-Maldonado continued to read his Bible. [redacted] stated when he awoke, Echo 200 was at recreation and GARCIA-Maldonado was not in their cell.

On April 30, 2013, at 9:10 a.m., Echo 200 went to recreation (Exhibit 25).

During his interview with ODO, [redacted] stated when he joined Echo 200 at recreation, he saw GARCIA-Maldonado walking alone on the recreation yard and looking upset. [redacted] stated he did not see GARCIA-Maldonado back in Echo 200 after recreation.

On April 30, 2013, at 10:45 a.m., CO [redacted] logged (Exhibit 25) a security check of Echo 200. The time of Echo 200's return from recreation was not logged.

On April 30, 2013, at 10:47 a.m. and 10:48 a.m. respectively, Detective [redacted] and Detective [redacted] entered EDC to meet with GARCIA-Maldonado, as documented in the facility's Entry Control Accountability Report (Exhibit 26).

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During his interview with ODO, DO [redacted] stated a CCA officer escorted GARCIA-Maldonado to visitation on April 30, 2013, to meet with the detectives. According to an Incident Investigation Report (Exhibit 27, page 5) prepared by Investigator [redacted] CO [redacted] stated to her that GARCIA-Maldonado was in the recreation yard when he was called to visitation. The exact time of GARCIA-Maldonado's movement to visitation is unknown. ODO learned EDC records individual detainee movements on a loose leaf sheet of paper labeled "Movement Log" which is only retained for a few days. The Echo 200 Movement Log from April 30, 2013, was unavailable at the time of ODO's review.

ODO interviewed EDC CO [redacted] on June 18, 2013. CO [redacted] was the Visitation Officer on April 30, 2013. CO [redacted] stated the Visitation Officer only logs security checks and does not log detainees in and out of the visitation area. CO [redacted] stated pod officers are required to log individual detainee movements, including those to visitation.

In an email (Exhibit 28) sent by DO [redacted] to Assistant Field Office Director, [redacted] at 4:34 p.m. on April 30, 2013, DO [redacted] documented he spoke with Detective [redacted] and Detective [redacted] after GARCIA-Maldonado's death regarding their meeting with the detainee earlier that day. According to the email, during the meeting, Detective [redacted] informed GARCIA-Maldonado the daughter of his domestic partner made allegations he sexually assaulted her on multiple occasions, and caused her to have an abortion on two occasions. Detective [redacted] noted GARCIA-Maldonado admitted to the allegations, and GARCIA-Maldonado was informed he would be charged with sexual conduct with a minor. Detective [redacted] also noted GARCIA-Maldonado was upset at times during the meeting, but did not mention hurting himself at any time.

On April 30, 2013, at 12:04 p.m., Detective [redacted] and Detective [redacted] exited EDC (Exhibit 26).

During his interview with ODO, CO [redacted] stated he remembered GARCIA-Maldonado's meeting with Phoenix PD detectives on April 30, 2013. He stated that, after their meeting concluded, GARCIA-Maldonado waited in visitation for approximately one hour before he was escorted to the dining hall to have lunch with Echo 200. EDC did not require CO [redacted] to prepare an incident statement following GARCIA-Maldonado's death.

During his interview with ODO, DO [redacted] stated that, approximately one hour after GARCIA-Maldonado's meeting began with Detective [redacted] and Detective [redacted] he called visitation to determine the status of the meeting and was informed it had concluded. DO [redacted] stated he did not notify any correctional or medical staff that GARCIA-Maldonado met with the

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detectives.

ODO interviewed SDDO [redacted] on June 20, 2013. SDDO [redacted] stated he was notified by DO [redacted] that Phoenix PD detectives set up a meeting with GARCIA-Maldonado, but that he did not know the outcome of the meeting until after GARCIA-Maldonado's death. SDDO [redacted] stated if he had known the seriousness of the allegations raised against GARCIA-Maldonado, or that GARCIA-Maldonado was upset during the meeting, he would have notified IHSC medical staff at the facility. ODO provided to SDDO [redacted] for his review, a copy of the April 23, 2013, email (Exhibit 23) DO [redacted] had forwarded to him that date at 1:06 p.m., describing the potential charges facing GARCIA-Maldonado. SDDO [redacted] conceded to ODO he was made aware of the seriousness of the meeting. SDDO [redacted] stated many detainees are interviewed by police, but are never actually charged. SDDO [redacted] stated that, since GARCIA-Maldonado's death, ERO is more attuned to detainees who receive bad news.

On April 30, 2013, at 12:25 p.m., Echo's OIC, EDC CO [redacted] logged (Exhibit 24) Echo began lunch. At EDC, the OIC (also referred to as the desk officer) sits in a central "rotunda" area of the housing unit where he or she has limited visibility into each of the five pods comprising the housing unit. The OIC controls the slider doors to each pod.

On April 30, 2013, at 12:23 p.m., CO [redacted] logged (Exhibit 25) a security check of Echo 200.

On April 30, 2013, at 12:37 p.m., CO [redacted] logged (Exhibit 25) Echo 200 went to lunch. Video surveillance footage (Exhibit 29) of Echo 200 shows detainees leaving the pod for lunch at time stamp 12:38 p.m.

No documentation is available to confirm the time GARCIA-Maldonado left visitation, but during his interview, [redacted] stated he saw GARCIA-Maldonado in the dining hall at approximately 12:30 p.m.

During his interview, [redacted] stated after he finished lunch, he returned to Echo 200 to retrieve his identification card, and he then went to the library. EDC was unable to produce a movement log documenting [redacted] went to the library after lunch, and [redacted] name does not appear on EDC's April 30, 2013 library log (Exhibit 30). However, an outcount sheet (Exhibit 31) prepared for the 1:15 p.m. official count on April 30, 2013, documents Serrano-Leon was in the North Library during the count.

On April 30, 2013, at time stamp 1:09 p.m., video surveillance footage (Exhibit 29) shows the Echo

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200 detainees returning to the pod after lunch and returning to their cells to prepare for the 1:15 p.m. official count.

On April 30, 2013, at 1:15 p.m. CO [redacted] logged (Exhibit 25) he conducted an official count. Video surveillance footage (Exhibit 29) shows CO [redacted] conducted an official count with EDC CO [redacted] which started at time stamp 1:17 p.m. and concluded at time stamp 1:21 p.m.

In an incident statement (Exhibit 32) prepared on April 30, 2013, CO [redacted] stated he conducted the 1:15 p.m. count with CO [redacted] who was assigned to Echo 300. According to EDC Post Order #24, section IV(B)(4) (Exhibit 33), Direct Supervision Housing Unit, two staff members must conduct each formal pod count, independently count each tier in the pod, and then confirm their counts with one another. CO [redacted] stated that, during the count, he noticed GARCIA-Maldonado's feet moving inside cell 208, and marked there was one live body. CO [redacted] stated after he and CO [redacted] finished counting Echo 200 and Echo 300, they provided their count slips to CO [redacted] CO [redacted] stated while CO [redacted] counted the slips, he went into Echo 300 where CO [redacted] was sitting, and after a few minutes CO [redacted] asked him to take the count slips to Central Control. CO [redacted] stated he then returned to Echo 200 where he logged " standby for count, conduct official count, conducting security check, security check complete, and off post" (Exhibit 32). CO [redacted] wrote in his statement (Exhibit 32) that, after making this log entry, he took the count slips to Central Control.

ODO interviewed CO [redacted] on June 19, 2013. CO [redacted] stated he conducted the 1:15 p.m. count of Echo 200 with CO [redacted] on April 30, 2013. CO [redacted] stated he believes GARCIA-Maldonado was lying on his top bunk during count, and he believes he saw GARCIA-Maldonado's feet at the end of the bunk. CO [redacted] stated he does not remember seeing a towel covering the window of cell 208's door during count, and would have asked GARCIA-Maldonado to remove the towel if one had been covering the window. During the review, ODO noted each cell has a metal door with a window at eye level for the average person, the window being made of steel mesh, approximately two feet high and 18 inches wide. CO [redacted] stated that, during the day shift, a final security check typically occurs at approximately 1:45 p.m. CO [redacted] also stated that, prior to GARCIA-Maldonado's death, it was common practice for pod officers to leave their posts 15 to 20 minutes prior to the end of a shift in order to clock out on time.

On April 30, 2013, at 1:35 p.m., CO [redacted] logged (Exhibit 25) he was conducting a security check. This security check was not corroborated by the video surveillance footage. Review of the video surveillance footage (Exhibit 29) shows a CO is not visible inside Echo 200 from time stamp 1:21 p.m. until time stamp 2:14 p.m.

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At 1:39 p.m., CO [redacted] logged (Exhibit 25) Echo 200 was secure.

At 1:45 p.m., CO [redacted] logged (Exhibit 25) he was "off post."

During CCA's investigation of GARCIA-Maldonado's death, Investigator [redacted] reviewed video surveillance footage of Echo 200 and observed CO [redacted] did not conduct a security check corresponding to his logged security check at 1:35 p.m. Investigator [redacted] documented in her Incident Investigation Report (Exhibit 27, page 5) CO [redacted] considered the 1:15 p.m. count to be a security check, and said that it is not common for another check to be done prior to leaving shift. CO [redacted] told Investigator [redacted] this is common practice by many COs, but he acknowledged there is sufficient time prior to the end of shift to conduct another security check. During her interview with ODO, Investigator [redacted] stated her investigation reports ultimately end up with EDC Warden Charles DeRosa for review.

ODO interviewed EDC Captain [redacted] on June 18, 2013. Captain [redacted] has worked at Eloy for approximately two-and-a-half years and was assigned as the Shift Supervisor during the day shift on April 30, 2013. Captain [redacted] stated that, prior to GARCIA-Maldonado's death, it was common for COs to leave their posts prior to the end of a shift in order to clock out on time.

On a form titled "CCA Facility Employee Problem Solving Notice" (Exhibit 34) dated May 29, 2013, EDC Chief of Security (COS) [redacted], documented that, while reviewing GARCIA-Maldonado's death, Investigator [redacted] determined CO [redacted] falsely logged a security check at 1:35 p.m. that was not evident in video surveillance footage of Echo 200. COS [redacted] recommended CO [redacted] employment be terminated for failing to conduct a security check and for creating a false log entry. (NOTE: The matter of CO [redacted] falsifying the log and his subsequent termination from CCA were documented by SA [redacted] OPR RAC Tucson, in OPR File 201307302, Report of Investigation (ROI) 002 (Exhibit 57).) On May 30, 2013, Warden DeRosa signed the form indicating his agreement with COS [redacted] recommendation, and [redacted] signed the form acknowledging receipt of his notice of termination.

ODO interviewed CO [redacted] on June 19, 2013. CO [redacted] has worked at EDC for over 11 years. CO [redacted] stated that, on April 30, 2013, he was the Echo housing unit's OIC during the day shift. He stated the 1:15 p.m. count went well, and after the count CO [redacted] volunteered to take the Echo housing unit's count slips to Central Control. In an incident statement (Exhibit 35) prepared by CO [redacted] on April 30, 2013, he stated CO [redacted] took the count slips to Central Control at approximately 1:40 p.m. CO [redacted] also documented that, between the time CO [redacted] took the

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count slips to Central Control and the time CO [redacted] was relieved by EDC CO [redacted] at approximately 2:05 p.m., CO [redacted] looked into each pod from the rotunda area of the housing unit. During his interview with ODO, CO [redacted] stated that, because cell 208 is situated behind the pod's staircase, the OIC does not have any visibility into that cell from the rotunda. CO [redacted] also stated that, at the time of GARCIA-Maldonado's death, it was not standard practice for pod officers to conduct a security check between the 1:15 p.m. count and the 2:00 p.m. shift change.

On April 30, 2013, at 2:06 p.m., CO [redacted] logged (Exhibit 24) he assumed the Echo OIC post.

At 2:16 p.m., EDC CO [redacted] logged (Exhibit 25) he assumed the Echo 200 post.

ODO interviewed CO [redacted] on June 18, 2013. CO [redacted] has worked at EDC since February 2013. CO [redacted] stated that, on April 30, 2013, he was assigned to the Echo 200 pod during the swing shift, from 2:00 p.m. to 10 p.m. CO [redacted] stated all of the COs working the swing shift on April 30, 2013, were required to attend a briefing at the start of their shift. After the briefing, he immediately went to Echo 200, arriving at 2:16 p.m. CO [redacted] stated that, prior to GARCIA-Maldonado's death, COs were required to clock in and out exactly at their shift's start and end time, and frequently left their posts early to ensure they clocked out on time. CO [redacted] stated that, although COs left their posts early, the pod's OIC and Emergency Response Team (ERT) member always stayed in the housing unit until relief arrived. EDC has two ERTs assigned to each shift. Each housing unit has one designated ERT member during each shift who is responsible for responding to an incident in their area of the facility. Each shift also has two ERT leaders who are termed "Senior Correctional Officers." CO [redacted] stated that all COs are now required to remain at their posts until relieved.

During his interview, CO [redacted] stated when he arrived at Echo 200, he logged he was assuming the post, and immediately initiated a security check starting with the bottom tier of the pod, checking each cell from left to right. Video surveillance footage (Exhibit 29) shows CO [redacted] entering Echo 200 at time stamp 2:14 p.m., unlocking room 211 for a detainee worker who was identified as [redacted] sitting down at the pod officer's desk and making log entries, and then beginning his security check at time stamp 2:19 p.m. CO [redacted] stated when he approached cell 208 during the security check, a towel was covering the cell door's window, completely obstructing his view into the cell. CO [redacted] stated he asked the detainee inside the cell to remove the towel, that he did not receive an answer, and that he then unlocked the cell door. CO [redacted] stated when he unlocked and opened the door, he observed GARCIA-Maldonado hanging from his bunk bed. In an incident statement (Exhibit 36) prepared by

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CO [redacted] on April 30, 2013, he stated GARCIA-Maldonado, "was hanging from the top bunk with what appeared to be a shoestring around his neck," and "was hanging with his back facing the cell door with his chest against the front of the bunk."

During his interview, CO [redacted] stated after finding GARCIA-Maldonado, he immediately placed a medical emergency call over his radio and requested a cut-down tool. CO [redacted] stated he then entered the cell, lifted GARCIA-Maldonado to relieve the pressure on his neck, and yelled for help approximately five times. CO [redacted] stated a detainee eventually entered the cell and helped him untie the shoestring. CO [redacted] stated he laid GARCIA-Maldonado on the floor, immediately began administering CPR, and attempted to put a breathing device in GARCIA-Maldonado's mouth, but his tongue was too swollen for it to fit. In her report (Exhibit 37, pages 4-5), RN [redacted] notes "absent breathing and a pulse, the American Heart Association and Mayo Clinic advise calling 911 before beginning CPR." During his interview, CO [redacted] stated he has been instructed only medical staff can make the determination to call 911.

ODO interviewed Detainee [redacted] on June 20, 2013. [redacted] stated on the afternoon of April 30, 2013, during shift change, he was working in Echo 200 on outcount. [redacted] stated when CO [redacted] arrived, he unlocked [redacted] door first and then began unlocking the rest of the pod. When CO [redacted] reached cell 208, [redacted] heard him yell "get in here!" [redacted] stated he approached cell 208, saw CO [redacted] holding GARCIA-Maldonado, and saw a string around GARCIA-Maldonado's neck. [redacted] stated CO [redacted] asked him to help him remove the string, so [redacted] untied the string from GARCIA-Maldonado's neck and helped CO [redacted] place GARCIA-Maldonado on the floor. [redacted] stated he then saw CO [redacted] initiate CPR on GARCIA-Maldonado. [redacted] wrote an incident statement (Exhibit 38) on April 30, 2013. (NOTE: CO [redacted] incident statement identifies the detainee who helped him as [redacted] but review of video surveillance footage, incident statements, and interviews revealed [redacted] was the detainee who actually assisted CO [redacted]

On April 30, 2013, at 2:18 p.m., Medical Officer [redacted] logged (Exhibit 39) a medical emergency call from Echo 200, and noted medical staff responded.

At 2:19 p.m., CO [redacted] logged (Exhibit 24) from his OIC post, that a medical emergency had been reported in Echo 200 and CO [redacted] was the first responder.

At 2:19 p.m., Central Control logged (Exhibit 40) a medical emergency was called in Echo 200 for a suicide attempt.

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At 2:20 p.m., CO [redacted] logged 911 was called from the Echo housing unit, the detainee was unresponsive, and CPR was initiated (Exhibit 39).

At 2:21 p.m., CO [redacted] logged an ambulance called (Exhibit 24).

At 2:21 p.m., Central Control logged an ambulance was called (Exhibit 40).

ODO interviewed CO [redacted] on June 19, 2013. CO [redacted] has worked at EDC since February 2013, and was assigned to the OIC post in Echo during the swing shift on April 30, 2013. CO [redacted] stated that on that date, as COs arrived at Echo for their shift, they immediately started conducting security checks in their pods. CO [redacted] stated that at approximately 2:18 p.m., he heard CO [redacted] emergency call over the radio and then heard CO [redacted] yelling from Echo 200. CO [redacted] stated he immediately locked down all detainees in Echo and let Echo's ERT member, EDC CO [redacted] into Echo 200. CO [redacted] stated neither he nor CO [redacted] brought the cut-down tool into Echo 200, but that it was his responsibility as the OIC to give Echo's ERT member the cut-down tool. CO [redacted] also stated he did not call 911 and would not feel comfortable initiating a call to 911 without instruction from medical staff. CO [redacted] was not required to prepare an incident statement regarding GARCIA-Maldonado's death.

ODO interviewed CO [redacted] on June 19, 2013. CO [redacted] worked the swing shift on April 30, 2013, and was Echo's assigned ERT member as well as the pod officer in Echo 400. CO [redacted] stated that, at approximately 2:20 p.m., he heard an emergency call from Echo 200 over his radio. He stated CO [redacted] let him out of Echo 400 and into Echo 200, and that he took a handheld video camera with him into Echo 200 as part of his ERT responsibilities. Video surveillance footage (Exhibit 29) shows CO [redacted] entering Echo 200 at time stamp 2:21 p.m. CO [redacted] stated when he entered Echo 200, he observed CO [redacted] administering CPR to GARCIA-Maldonado in cell 208. CO [redacted] stated he asked CO [redacted] if he needed assistance with CPR and then began filming the scene. The recording (Exhibit 41) made by CO [redacted] is approximately three minutes and 31 seconds long, and shows the rescue efforts of CO [redacted] and medical staff. RN [redacted] notes (Exhibit 37, page 5, 2nd paragraph) the recording shows CO [redacted] performing CPR on GARCIA-Maldonado with bent elbows, and that, "Proper technique is to keep arms and elbow straight, pushing straight down with full upper body weight." The recording also shows a towel covering the window of cell 208's door. CO [redacted] stated when his supervisors, Captain [redacted] and EDC Lieutenant (LT) [redacted] arrived on the scene they told him to stop filming. CO [redacted] stated he was not required to complete an incident statement regarding GARCIA-Maldonado's death.

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During ODO's interview with Captain [redacted] he stated after his shift ended on April 30, 2013, he was conducting a supervisor's shift briefing when an emergency in Echo 200 was called over the radio. In an incident statement (Exhibit 42) prepared by Captain [redacted] on April 30, 2013, he stated that, after receiving the emergency call, he attempted to make radio contact with Echo to determine the nature of the emergency, and instructed Central Control to activate an ERT when he did not receive a response from Echo. Captain [redacted] stated he assembled a second small team with CO [redacted] and CO [redacted] and they all responded to the scene.

ODO interviewed LT [redacted] who currently serves as an Assistant Shift Supervisor, on June 19, 2013. LT [redacted] stated that, during shift change on April 30, 2013, he was posted in a hallway near Central Control providing instructions to the oncoming shift when he heard a medical emergency call from Echo 200 over his radio. He stated he specifically remembers hearing " medical emergency" and "cut-down tool" during the radio transmission. LT [redacted] stated he responded to Echo 200, and that medical staff were on-site when he arrived. He stated when he observed CO [redacted] recording the resuscitation efforts, he instructed him to stop recording because the event was medical in nature. LT [redacted] was not required to complete an incident statement regarding GARCIA-Maldonado's death.

ODO interviewed EDC LT [redacted] on June 20, 2013. LT [redacted] currently serves as an Assistant Shift Supervisor. LT [redacted] stated that, on April 30, 2013, he was posted near Central Control with LT [redacted] to process-in the swing shift. LT [redacted] stated a briefing was held for the officers at the beginning of their shift. Shortly after shift change, LT [redacted] and LT [redacted] heard CO [redacted] emergency call, and then received a call from COS [redacted] who stated medical was needed in Echo. LT [redacted] stated he first went to medical and then responded to Echo where medical staff were already working on GARCIA-Maldonado. LT [redacted] prepared an incident statement (Exhibit 43) on April 30, 2013, but it documents only his providing a camera to Eloy PD detectives, not the other facts discussed in his interview with ODO.

On April 30, 2013, at 2:20 p.m., CO [redacted] logged (Exhibit 24) the ERT had been activated, and Central Control logged (Exhibit 40) medical staff and the ERT were on-site, and CPR was started. The swing shift roster (Exhibit 44) from April 30, 2013, documents the North yard ERT consisted of EDC COs [redacted] and [redacted]

ODO interviewed CO [redacted] on June 18, 2013. CO [redacted] was the assigned ERT leader and North yard monitor on April 30, 2013. CO [redacted] stated that on April 30, 2013, at approximately 2:19 p.m., he heard an emergency call from Echo over his radio during, and the caller stated the phrases "detainee down" and "bring cutting tool." CO [redacted] stated he and the

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other members of the ERT arrived at Echo at the same time as medical staff. CO [redacted] stated once on-site, the ERT was responsible for isolating and containing all detainees in Echo 200. In an incident statement (Exhibit 45) prepared by CO [redacted] on April 30, 2013, he stated that, as the ERT leader, he kept in radio contact with Central Control.

In his incident statement (Exhibit 42), Captain [redacted] stated when he arrived at Echo 200 with CO [redacted] and CO [redacted] he instructed CO [redacted] to lock down the Echo housing unit, and he instructed CO [redacted] to keep a record of every person who entered Echo 200 as well as persons already present. During his interview with ODO, Captain [redacted] stated when he arrived at Echo 200, approximately eight medical personnel were on-site, and he recorded a timeline (Exhibit 46) of all events for the medical staff. Captain [redacted] also stated when he arrived at Echo 200, CO [redacted] was filming the scene, and he ordered CO [redacted] to stop filming because the incident was medical in nature.

ODO interviewed InGenesis RN [redacted] on June 19, 2013. RN [redacted] has worked at Eloy since October 2011, and was working the day shift on April 30, 2013. RN [redacted] stated that at approximately 2:20 p.m. on April 30, 2013, she was in sick call with InGenesis RN [redacted] when a medical emergency was called over the radio. RN [redacted] stated she and RN [redacted] grabbed an emergency bag and a wheelchair and responded to Echo. RN [redacted] stated they were closely followed by Health Services Administrator (HSA), IHSC LT [redacted] InGenesis RN [redacted] and InGenesis LPN [redacted] Video surveillance footage (Exhibit 29) shows RN [redacted] RN [redacted] and LT [redacted] arriving in Echo 200 at time stamp 2:22 p.m., followed by RN [redacted] and LPN [redacted] RN [redacted] stated when they arrived at Echo 200, CO [redacted] was performing CPR on GARCIA-Maldonado. Video footage (Exhibit 41) from the handheld camera used by CO [redacted] shows medical staff taking over CPR and applying an Automated External Defibrillator (AED) to GARCIA-Maldonado. RN [redacted] stated RN [redacted] and Physician Assistant (PA) IHSC LT Commander (LCDR) [redacted] also responded to the scene a few minutes later. RN [redacted] stated medical staff took turns administering CPR to GARCIA-Maldonado, and the AED advised one shock. RN [redacted] stated 911 was not called until medical staff were on-site, and that during emergencies, COs typically wait for medical to determine whether 911 should be called. RN [redacted] prepared an incident statement (Exhibit 47) at the request of LT [redacted]

ODO interviewed LT [redacted] on June 18, 2013. LT [redacted] is an RN by training and has held the HSA position at EDC since February 24, 2012. LT [redacted] stated that, at approximately 2:20 p.m. on April 30, 2013, he was in the clinic when a medical emergency in Echo 200 was called over the radio, and he responded to Echo 200 with RN [redacted] RN [redacted] RN [redacted] and LPN [redacted] LT [redacted] stated when they arrived on the scene, CO [redacted] was administering CPR to an

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unresponsive GARCIA-Maldonado, and LT [redacted] yelled out "call 911 now!" ODO was unable to determine which individual then notified Central Control that 911 should be called.

During his interview with ODO, LT [redacted] stated anyone certified in Basic Life Support (BLS) is permitted to initiate a call to 911, and all COs at EDC are required to have BLS certification. LT [redacted] stated whenever a CO encounters a situation where he or she must perform CPR, initiating a call to 911 should be "automatic." LT [redacted] agreed that many COs at EDC do not feel authorized to initiate a call to 911 without being directed to do so by medical staff. LT [redacted] expressed there is a "huge disconnect" between security and medical staff regarding the understanding of who should initiate a call to 911.

ODO interviewed EDC Senior Learning and Development Officer [redacted] on June 5, 2013. Mr. [redacted] has held this position since 2000, and has worked at EDC for approximately 17 years. Mr. [redacted] stated all COs are trained as first responders, and all are trained to call 911 whenever CPR is administered. To call for 911, COs must call Central Control on their radios since they generally do not have access to an outside telephone line in facility areas where detainees are housed or have access.

During his interview with ODO, CO [redacted] stated COs should not wait for instruction from medical staff to call 911 if the circumstances warrant an emergency medical response. He stated some COs are unfamiliar with the protocol for initiating a call to 911, because EDC does not experience a lot of incidents where a 911 response is necessary.

LT [redacted] stated that, after yelling out his order to call 911, he took over CPR for CO [redacted] while RN [redacted] attached the AED to GARCIA-Maldonado. LT [redacted] stated the AED advised one shock to GARCIA-Maldonado. LT [redacted] prepared a medical note (Exhibit 48) regarding GARCIA-Maldonado's death at 3:00 p.m. on April 30, 2013. LT [redacted] completed an incident statement (Exhibit 49) on May 1, 2013.

ODO interviewed Physician Assistant (PA) LCDR [redacted] on June 18, 2013. PA LCDR [redacted] has worked at EDC for approximately one year. PA LCDR Clairmont stated that at approximately 2:20 p.m. on April 30, 2013, he was in the clinic with a patient when a medical emergency in Echo 200 was called over the radio. Approximately five minutes later, when he finished with his patient, he responded to Echo 200. PA LCDR [redacted] stated when he arrived at Echo 200, he assisted with one round of CPR rotations and then assumed a leadership role over CPR rotations.

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On April 30, 2013, at 2:23 p.m., Central Control logged (Exhibit 40) CPR was still being administered and the ERT was on standby.

At 2:24 p.m., Central Control logged the North side of the facility was locked down (Exhibit 40), and CO [redacted] logged (Exhibit 24) from his OIC post that Echo was locked down. Central Control also logged CPR was administered from 2:24 p.m. to 2:34 p.m. (Exhibit 40).
On April 30, 2013, Captain [redacted] recorded that continuous rounds of CPR were administered to GARCIA-Maldonado from 2:25 p.m. to 2:38 p.m. (Exhibit 46).

At 2:35 p.m., Central Control logged an ambulance had entered the facility (Exhibit 40), and CO [redacted] logged an ambulance was on-site (Exhibit 24). During his interview with ODO, CO [redacted] stated he met the ambulance at the rear gate and escorted it to Echo.

At 2:37 p.m., Central Control logged Emergency Medical Technicians (EMTs) were on-site in Echo 200 (Exhibit 40). Video surveillance footage (Exhibit 29) shows EMTs arriving in Echo 200 at time stamp 2:39 p.m.

During his interview with ODO, LT [redacted] stated EMTs arrived on the scene approximately 15 minutes after he ordered that 911 be called, and after their arrival, EDC medical staff continued to administer the AED and CPR to GARCIA-Maldonado.

During his interview with ODO, PA LCDR [redacted] stated once EMTs arrived at Echo 200, they instructed EDC medical staff to move GARCIA-Maldonado out of cell 208 and into the dayroom area outside the cell door so medical staff would have more room to work on him.

At 2:39 p.m., Captain [redacted] recorded that EMTs removed GARCIA-Maldonado from his cell (Exhibit 46).

On April 30, 2013, Central Control logged (Exhibit 40) EMTs continued administering CPR from 2:38 p.m. to 2:43 p.m.

During his interview with ODO, PA LCDR [redacted] stated once the EMTs learned how long EDC medical staff had been administering CPR to GARCIA-Maldonado, they called their provider, Dr. [redacted] at Casa Grande Regional Medical Center so Dr. [redacted] could declare GARCIA-Maldonado dead. On May 28, 2013, PA LCDR [redacted] wrote a statement (Exhibit 50) concerning his involvement in the GARCIA-Maldonado emergency, in the notes section of GARCIA-Maldonado's medical chart.

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On April 30, 2013, at 2:45 p.m., Central Control and CO Alvarado logged (Exhibits 40 and 24) GARCIA-Maldonado's time of death as 2:45 p.m.

In his medical note (Exhibit 48), LT [redacted] documented GARCIA-Maldonado was declared dead at 2:45 p.m. after 22 rounds of CPR were administered. During his interview with ODO, LT [redacted] stated he immediately notified SDDO [redacted] and IHSC headquarters of GARCIA-Maldonado's passing.

On April 30, 2013, Warden DeRosa notified ICE ERO Phoenix that GARCIA-Maldonado committed suicide by hanging, as documented in the SIR concerning GARCIA-Maldonado's death (Exhibit 6). The SIR does not document the time of this notification.

On April 30, 2013, at 2:53 p.m., Central Control logged (Exhibit 40) Eloy PD officers in Echo 200 (Note: notification to the Eloy PD was not logged by Central Control), and CO [redacted] logged (Exhibit 24) EMTs left the Echo housing unit.

At 2:55 p.m., Central Control logged the ambulance exited the facility, and CO [redacted] logged Eloy PD entered Echo 200.

At 2:56 p.m., according to a timeline of events (Exhibit 51) prepared by ERO, SDDO [redacted] notified the JIC of GARCIA-Maldonado's death.

During his interview with ODO, SDDO [redacted] stated he was the duty supervisor at the time of GARCIA-Maldonado's death. He stated when LT [redacted] called to notify him of GARCIA-Maldonado's death, he immediately called the JIC to report the death, and he then responded to the scene. SDDO [redacted] stated when he arrived at the scene, Eloy PD detectives were already on-site, taking photographs of the scene.

Eloy PD Report Number 00-201300001058-000 (Exhibit 52) documents Eloy PD Officer [redacted] was dispatched to EDC at approximately 2:28 p.m. in response to an attempted suicide. Officer [redacted] stated when he arrived at EDC and learned GARCIA-Maldonado was dead, he referred the case to Eloy PD detectives, and it was assigned to Detective [redacted] and Crime Scene Investigator/ID Tech [redacted] Officer [redacted] stated he entered the facility at approximately 2:55, and Detective [redacted] and Crime Scene ID Tech [redacted] arrived at Echo 200 at approximately 3:45 p.m.

On April 30, 2013, at 3:10 p.m., Central Control logged (Exhibit 40) Eloy PD Detective [redacted] was

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in EDC's front lobby.

In the Eloy PD report (Exhibit 52), Detective [redacted] stated he arrived at EDC at approximately 3:10 p.m. He stated after he questioned CO [redacted] and examined cell 208, he contacted the Pinal County Medical Examiner's Office and requested they pick up GARCIA-Maldonado's body.

On April 30, 2013, at 3:30 p.m., Central Control logged (Exhibit 40) the Eloy PD crime scene truck was on-site.

At 4:24 p.m., Central Control logged the medical examiner's vehicle was on-site (Exhibit 40).

In the Eloy PD Report (Exhibit 52), Detective [redacted] stated when [redacted] Stewart of the Pinal County Medical Examiner's Office arrived at Echo 200, he and Ms. [redacted] checked GARCIA-Maldonado's body for signs of assault and did not find any. Detective [redacted] also documented he checked cell 208 for a suicide note and found a sealed letter underneath several legal documents on the top bunk bed. Detective [redacted] documented that the letter was addressed to an individual named [redacted] and was written in Spanish. Detective [redacted] documented that he had the letter translated by an Eloy Justice Peace Court clerk, and that the letter included the following statement: "Do not trust [redacted] because she is the reason my children will not have a father. All [redacted] wanted was sex. Do not let [redacted] get custody of my children. God will forgive me and I leave this world with happiness in my heart" (Exhibit 52).

On April 30, 2013, at 5:17 p.m., Central Control logged (Exhibit 40) Eloy PD was offsite.

At 5:35 p.m., Central Control logged the medical examiner was offsite (Exhibit 40). Video surveillance footage (Exhibit 29) shows the medical examiner leaving Echo 200 with GARCIA-Maldonado's body on a gurney at time stamp 5:24 p.m.

At 5:47 p.m., Central Control logged (Exhibit 40) the Eloy PD crime scene vehicle was offsite.

At 7:38 p.m., SDDO [redacted] submitted a SIR (Exhibit 6) regarding GARCIA-Maldonado's death via the ICE Significant Event Notification System.

On May 1, 2013, Acting Field Office Director for the ICE ERO Phoenix Field Office, [redacted] notified GARCIA-Maldonado's wife, [redacted] of his death in a condolence letter sent via U.S. mail in care of the Guatemalan consulate (Exhibit 53).

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On May 2, 2013, the Pinal County Medical Examiner, [redacted] MD, completed an autopsy for GARCIA-Maldonado and determined his cause of death to be asphyxia due to hanging, and his manner of death to be suicide. Dr. [redacted] findings are documented in an autopsy report (Exhibit 54) dated July 3, 2013.

On May 6, 2013, Investigator [redacted] completed an Incident Investigation Report (Exhibit 27) concerning GARCIA-Maldonado's death. Investigator [redacted] report consists of incident statements and interviews of correctional staff, medical staff, and detainees. Investigator [redacted] also reviewed surveillance video footage of Echo 200 from April 30, 2013, and reviewed several of GARCIA-Maldonado's recorded telephone conversations. Investigator [redacted] concluded GARCIA-Maldonado committed suicide at some point after the 1:15 p.m. count on April 30, 2013, while his cellmate was in the library; Officer [redacted] did not conduct the security check that he logged at 1:35 p.m.; and additional monitoring of GARCIA-Maldonado could have been done if CCA had been notified of GARCIA-Maldonado's visit with Phoenix PD.

On May 10, 2013, all staff at EDC received an email "re-cap" (Exhibit 55) from COS [redacted] EDC Chief of Unit Management [redacted] and EDC Assistant Chief of Security [redacted] listing the following bullets:

- Effective immediately: all shoelaces have been taken from all detainees and are now considered contraband. All detainees, one unit at a time, will be issued facility shoes. As of now, Detainees in E-100, B-600, Echo unit and Delta units have all been issued new shoes.
- Effective immediately, NO CLOTHESLINES ARE ALLOWED at any time, during any shift.
- Effective immediately, a final security check will be conducted FIFTEEN minutes prior to the end of your shift and will be announced by Central Control.
- All detainees that do no [sic] wish to report to the dining hall for lunch or dinner will be required to report to 300 pod and remain under the supervision of the ERT officer. The Desk Officer will log the name, number and housing assignment of detainees that remain behind. Detainees will not be allowed to use phones, microwaves, TV's or engage in any activities. They are to remain seated at the dayroom tables.
- All officers are required to remain in their assigned pod with slider doors secured at the completion of the 0615, 1315, and 1815 count times.

On May 15, 2013, [redacted] Psy.D., a psychologist for IHSC, completed a psychological autopsy (Exhibit 56) of GARCIA-Maldonado. According to his report, Dr. [redacted] interviewed LCSW [redacted] LT [redacted] Chaplain [redacted]

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[redacted] and DO [redacted] reviewed GARCIA-Maldonado's medical record and EARM report; and reviewed GARCIA-Maldonado's telephone calls from March 24, 2013, April 2, 2013, and April 29, 2013. Dr. [redacted] determined GARCIA-Maldonado's suicide was influenced by several recent and severe stressors in his life, and it is possible his death could have been prevented if he had attempted to receive help from mental health staff, medical staff, the chaplain, or custodial staff.

On June 6, 2013, SA [redacted] determined that, although a CO falsified an entry into the Echo 200 Unit logbook, it is unknown if the CO's failure to actually conduct the security check would have prevented the death of detainee GARCIA-Maldonado. SA [redacted] documented his findings in OPR File 201307302, ROI 006 (Exhibit 57).

On July 2, 2013, the State of Arizona, Department of Health Services, Office of Vital Records issued a death certificate for GARCIA-Maldonado listing his immediate cause of death as asphyxia due to hanging (Exhibit 58).

MEDICAL COMPLIANCE REVIEW

Creative Corrections, a national management and consultant firm contracted by ICE to provide subject matter expertise in detention management including health care, reviewed the medical care of GARCIA-Maldonado while he was housed at EDC. Creative Corrections found EDC was not fully compliant with the Medical Care, and Suicide Prevention and Intervention ICE Performance Based National Detention Standards (PBNDS). The Creative Corrections Medical Record and Compliance Review report (Exhibit 37) is attached to this report.

SECURITY COMPLIANCE REVIEW

Creative Corrections also reviewed the safety and security of GARCIA-Maldonado while he was housed at EDC. Creative Corrections found EDC was not fully compliant with the Population Counts, and Emergency Plans PBNDS. The Creative Corrections Security Analysis and Compliance Review report (Exhibit 59) is attached to this report.

IMMIGRATION AND DETENTION HISTORY

GARCIA-Maldonado claimed he entered the United States in 2003, at or near Douglas, Arizona, without admission or parole after inspection by an Immigration Officer.

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On November 6, 2012, GARCIA-Maldonado was arrested at his residence by the ICE ERO Secure Communities Arrest Unit pursuant to Section 236 of the Immigration and Nationality Act.

On November 6, 2012, GARCIA-Maldonado was served with a Notice to Appear by ICE ERO Phoenix charging him with inadmissibility pursuant to 212(a)(6)(A)(i) of the Immigration and Nationality Act, as an alien present in the United States without being admitted or paroled.

On November 6, 2012, ICE ERO Phoenix released GARCIA-Maldonado on his own recognizance, and enrolled him in ISAP.

On March 22, 2013, the Phoenix Police Department released GARCIA-Maldonado into the custody of ICE ERO. ICE ERO Phoenix arrested GARCIA-Maldonado pursuant to section 236 of the Immigration and Nationality Act. ICE ERO Phoenix terminated GARCIA-Maldonado's enrollment in ISAP and issued him a Notice of Custody Determination requiring a bond in the amount of $8,000.

On March 23, 2013, GARCIA-Maldonado was transferred to EDC while his removal proceedings continued on a detained docket. There were no further actions in his immigration case before his death.

CRIMINAL HISTORY

According to the National Crime Information Center (NCIC), GARCIA-Maldonado was assigned an FBI number and an Arizona state identification (SID) number, and he had a conviction for driving while under the influence. GARCIA-Maldonado did not have a conviction for any offense deemed an "aggravated felony" under immigration law (Exhibit 1).

INVESTIGATIVE FINDINGS

1. Medical

GARCIA-Maldonado's medical record demonstrates no mental health concerns or indicators of suicide risk were identified at intake, and GARCIA-Maldonado did not display any indication he was at risk for suicide until April 30, 2013.

During the course of the review, ODO determined EDC failed to fully comply with the Medical Care, and Suicide Prevention and Intervention PBNDS. Deficiencies were identified in the

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following components of these PBNDS:

1. ICE PBNDS, Medical Care, section (II)(10), states, "Detainees will have access to specified 24-hour emergency medical, dental, and mental health services."

Confusion as to who has the authority to call for local emergency medical assistance led to a three-minute delay in calling 911 after GARCIA-Maldonado was found hanging in his cell, thereby delaying the required access to emergency medical services. ODO determined there was a delay of three minutes based on review of video surveillance footage, which shows CO [redacted] conducting the security check when he found GARCIA-Maldonado at time stamp 2:19 p.m., and on the arrival of medical staff when LT [redacted] instructed that 911 be called at time stamp 2:22 p.m.

The majority of security staff interviewed by ODO stated they had no authority to call 911 or to direct Central Control to do so, and indicated it was necessary to wait for medical staff to assess the emergency and direct that 911 be called if determined necessary. Though LT [redacted] and Training Director [redacted] stated otherwise (specifically, if a detainee is not breathing and without pulse, security staff are trained to call 911), security staff did not consistently understand they had the authority to request a 911 call.

According to CCA Policy 8-1A, Medical Emergency (Exhibit 60), in the event of a medical emergency, the Shift Supervisor or Assistant Shift Supervisor is to deploy the ERT to verify the emergency exists and notify the Shift Supervisor or Assistant Shift Supervisor. That supervisor is then instructed to assess all information and determine whether the situation can be resolved using staff and resources immediately available. The policy goes on to state in the event the emergency cannot be resolved in-house, the facility will be locked down and the notification process will be initiated. The first item on the notification list is to call 911.

2. ICE PBNDS, Medical Care, section (V)(J), states "The clinical medical authority shall be responsible for review of all health appraisals to assess the priority for treatment."

GARCIA-Maldonado's intake medical screening was reviewed by RN [redacted] without written designation of authority to perform the function. Designation of RNs to review intake medical screenings is allowed under IHSC Operations Memorandum 11 002 (May 10, 2011) (Exhibit 61, page 1), provided the clinical medical authority has so authorized, in writing. Upon request, the designation memorandum by the Western Regional Clinical Director (Exhibit 61, page 2) was provided to ODO; however, it was dated June 5, 2013, the date of the on-site review, and was not in place at the time of GARCIA-Maldonado's intake medical screening.

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3. ICE PBNDS, Suicide Prevention and Intervention, section (V), states, "Each detention facility shall have a written suicide prevention and intervention program (the "Program") that is reviewed and approved by the clinical health authority, approved and signed by the administrative health authority and facility administrator, and reviewed annually." The PBNDS requires the Program include the following key components: Staff training, Identification, Referral, Evaluation, Treatment, Housing, Monitoring, Communication, Intervention, Notification and reporting, Review, and Debriefing.

CCA Policy 9-19, Suicide Prevention/Risk Reduction (October 12, 2009) (Exhibit 62) addresses all of the mandatory components listed above with the exception of the final two: Review and Debriefing. Although a mortality review is conducted by IHSC, a local critical incident debriefing is not required by CCA Policy 9-19 and was not conducted in the aftermath of GARCIA-Maldonado's suicide.

ODO also determined EDC does not have a local Suicide Prevention Plan, in contravention of the PBNDS and CCA Policy 9-19 (Exhibit 62) which require the facility to develop a local Suicide Prevention Plan, reviewed annually, addressing "specific facility initiatives and the facility's plan for compliance" with the policy. HSA LT [redacted] stated EDC is currently in the process of developing a Suicide Prevention Plan.

4. ICE PBNDS, Suicide Prevention and Intervention, section (V)(K), states, "A critical incident debriefing shall be offered to all affected staff and detainees."

All EDC staff members interviewed by ODO stated EDC did not hold a multidisciplinary debriefing to review critical elements surrounding GARCIA-Maldonado's suicide. In her report (Exhibit 37, page 7, last paragraph), RN [redacted] advises debriefing is an important tool for identifying concerns, areas needing improvement, and future training needs. Interviewed staff reported they were referred to the Employee Assistance Program for personal support, and detainees received debriefing and follow-up support by mental health staff.

2. Safety and Security

On April 30, 2013, GARCIA-Maldonado met with two detectives from the Phoenix PD concerning

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potential charges of sexual conduct with a minor. During the meeting, GARCIA-Maldonado confessed to the alleged acts and was described by the detectives as upset at times. Prior to the meeting, ERO staff on-site at EDC received notice of the potential criminal charges against GARCIA-Maldonado and also received notice that Phoenix PD had probable cause to charge him. After the meeting, GARCIA-Maldonado went to the dining hall for lunch and then returned to his cell in Echo. ERO failed to notify correctional and medical staff that GARCIA-Maldonado met with the Phoenix PD, and that he was told serious charges against him were likely. This resulted in GARCIA-Maldonado being permitted to return to general population without undergoing a mental health evaluation for potential suicide risk. After returning to his cell, GARCIA-Maldonado had an unsupervised 53-minute period during which he committed suicide. During this period, a security check that did NOT occur was falsely documented.

ODO learned that, at the time of GARCIA-Maldonado's detention at EDC, it was common practice for COs to leave their posts prior to being properly relieved.

ODO determined GARCIA-Maldonado was permitted to take his personal athletic shoes into the facility per CCA Policy 17-100 Reception and Orientation, Section G, Part 3 (Exhibit 63), which states, "Inmates/detainees will only be allowed to retain personal property as authorized by CCA Policy 14-6AA Allowable Personal Property Inventory List." CCA Policy 14-6AA Allowable Personal Property Inventory List (Exhibit 64) lists shoes, including athletic shoes, among the allowable personal property items. GARCIA-Maldonado ultimately used the shoelaces from his shoes to hang himself. On May 10, 2013, EDC issued the following guidance via email (Exhibit 55) to all facility staff; "Effective immediately: all shoelaces have been taken from all detainees and are now considered contraband. All detainees, one unit at a time, will be issued facility shoes. "

During the course of the review, ODO determined EDC failed to fully comply with the Population Counts, and Emergency Plans. Deficiencies were identified in the following components:
1. ICE PBNDS, Population Counts, section (V)(C), Informal Counts, states, "Each officer shall make irregular but frequent checks to verify the presence of all detainees in his or her charge."

As seen in the video surveillance footage (Exhibit 29) of Echo 200 on April 30, 2013, CO [redacted] left Echo 200 after the 1:15 p.m. count ended at time stamp 1:21 p.m., and falsely documented a security check at 1:35 p.m. SME [redacted] states (Exhibit 59, page 8, 3rd paragraph) that, "Given the critical nature of security checks, falsely recording completion of a round is egregious and demonstrated lax adherence to post orders and facility policy." Once [redacted] left Echo 200, the pod remained without supervision for 53 minutes until CO [redacted] assumed the post at time

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stamp 2:14 p.m.

CO [redacted] violated EDC Policy and Procedure 9-13, Count Principles and Procedures (Exhibit 65), which states, "The physical accountability of inmates is a primary mission of all facility staff." He also violated two facility post orders. EDC Post Order #24, Housing Officer (Exhibit 33), requires officers to make informal counts of all detainees in the pod, conduct routine security checks at random times every 30 minutes, and maintain their post until properly relieved by either the oncoming correctional officer or supervisor. EDC General Post Orders CCA-PO-00, section (E)(2), Counts (Exhibit 66), requires informal counts to be conducted throughout the day and night at frequent but irregular intervals to verify all inmates/residents are present and accounted for. As noted earlier, CO [redacted] was terminated from his position after CCA discovered the false log entry (Exhibit 34).

CO [redacted] missed security round was compounded by his vacating his post prior to being properly relieved, and leaving Echo 200 unsupervised for 53 minutes during which GARCIA-Maldonado committed suicide. During interviews with COs and supervisory correctional staff at EDC, ODO learned that prior to GARCIA-Maldonado's death it was common for pod officers to leave their posts prior to being relieved in order to clock out at the end of their shift. Additionally, review of video surveillance footage of Echo 200 for the four days preceding GARCIA-Maldonado's death (Exhibit 67) shows several COs, in addition to CO [redacted] consistently leaving the post several minutes prior to shift change. SME [redacted] advises (Exhibit 59, page 8, 3rd paragraph), "the practice violates fundamental security principles and risks detainee safety." She points out that, "Leaving detainees unsupervised for extended periods of time, particularly when they are aware no officer is present, provides opportunity for not only suicide, but also physical and sexual assault. In addition, medical emergencies could go undetected."

The practice of vacating a post early also violates two post orders. Addendum to EDC Post Orders, Direct Supervision Guidelines (Exhibit 68), states, "Staff assigned to a direct supervision pod may not leave their post unless properly relieved." EDC General Post Orders CCA-PO-00, section (A)(2), Assignment (Exhibit 66), states "Once assigned to a post, you must remain at that post until properly relieved, or reassigned, by your supervisor or the on-duty Shift Supervisor. If, at the conclusion of your shift, required relief has not arrived, contact the Shift Supervisor for further instructions. Never leave a post unattended." (Emphasis in original document.) ODO notes that following GARCIA-Maldonado's death, COs are no longer permitted to leave their posts until properly relieved.

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2. ICE 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: collecting written reports."

In reviewing CCA's investigation report on GARCIA-Maldonado's death, ODO determined written reports were not required of several staff members who responded to the emergency, as well as from staff with knowledge of the events leading up to GARCIA-Maldonado's suicide. Interviews with correctional staff at EDC demonstrated confusion exists as to who is required to complete an incident statement following an emergency at the facility. During his interview, LT [redacted] stated the Shift Supervisor is responsible for determining all individuals who are required to write an incident statement, and his understanding is everyone who responds to an emergency and everyone on the scene of an emergency is required to write an incident statement. LT [redacted] acknowledged it was unusual that CO [redacted] who was first to arrive on the scene after CO [redacted] was not required to write an incident statement. During his interview, LT [redacted] stated he was not required to an write incident statement, because he did not have "hands on" GARCIA-Maldonado. ODO also determined medical staff were not asked to write incident statements by CCA, and only did so at the request of LT [redacted] several days after the incident.

Failure to collect incident statements from all individuals who responded to, or who were on the scene of GARCIA-Maldonado's death also violates CCA and EDC policies and procedures. CCA Policy 5-1, Incident Reporting (Exhibit 69), requires all employees involved in or witnessing the incident to independently complete a 5-1C Incident Statement. CCA Policy 9-16, Emergency Response Team, section E(1)(h) (Exhibit 70), requires the employee assigned as the ERT leader to be responsible for assisting the Shift Supervisor with gathering all reports and documentation pertaining to the incident, including incident statements. EDC Post Orders CCA-PO-00, section (R)(4), Reports (Exhibit 66), states, "You must complete a 5-1C Incident Statement following any incident." EDC Post Orders CCA-PO-01, section III(H)(1), Reports/Paperwork (Exhibit 71), requires the Shift Supervisor to, "Ensure that all incident reports are completed in accordance with CCA Policy Incident Reporting prior to the end of your shift." EDC Post Orders CCA-PO-02, section III(H)(1), Reports/Paperwork (Exhibit 72), states, "At the direction of the Shift Supervisor, ensure that all incident reports are completed in accordance with CCA Policy Incident Reporting prior to the end of your shift."

AREAS OF CONCERN

ICE ERO received notice of the potential criminal charges against GARCIA-Maldonado, prior to his interview with Phoenix PD detectives on April 30, 2013, but ICE ERO did not make

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arrangements to check on GARCIA-Maldonado after the interview, nor to notify correctional and mental health staff that GARCIA-Maldonado should be monitored. RN [redacted] advises GARCIA-Maldonado should have met with a mental health or medical professional following the meeting with police detectives for assessment of suicide risk. RN [redacted] states (Exhibit 37, page 7, 1st paragraph) that failure to assess GARCIA-Maldonado for suicide risk, "was critical and resulted in his return to general population without evaluation for possible placement on suicide watch."

After CO [redacted] found GARCIA-Maldonado hanging in his cell, he immediately called a medical emergency over his radio and asked for a cut-down tool. At EDC, the cut-down tool is stored in a glass box behind the OIC desk. According to CCA's General Emergency Information, section I(A) (Exhibit 73), any employee who becomes aware of any emergency will immediately notify Central Control. Section II(A)(3) provides that if the emergency involves a suicide attempt by hanging by the neck, "the employee should alert other staff to retrieve the cut-down tool and make every effort to relieve the pressure on the victim's neck." CCA Suicide Prevention/Risk Reduction Policy 9-19, Procedures section (F)(1)(c) (Exhibit 62) also requires staff to immediately request the cut-down tool. Shortly after the emergency call, CO [redacted] and CO [redacted] responded to Echo 200, but neither brought the cut-down tool with him. Although CO [redacted] and Detainee [redacted] were successful in untying the shoelaces from GARCIA-Maldonado's neck, CO [redacted] and CO [redacted] did not know this until they entered the cell. RN [redacted] notes (Exhibit 37, page 7, 2nd paragraph) "In all suicide attempts by hanging, it is critical that a cut down tool be brought to the scene."

As described in this report, based on interviews with correctional staff at EDC, many COs believe they are not permitted to initiate a call to 911 without direction from medical staff. Although medical staff responded to Echo 200 within three minutes of CO [redacted] emergency call and directed that 911 be called, RN [redacted] advises (Exhibit 37, page 7, 3rd paragraph) "such a rapid response may not always be possible," and, "The lapse between correctional staff discovering a medical emergency and health care staff arrival may delay critical life saving measures."

During interviews with correctional staff at EDC, ODO learned it is not uncommon for detainees to place towels over the windows in their cell doors while using the toilet, and that this practice is not consistently prohibited. SME [redacted] advises (Exhibit 59, page 9, 3rd paragraph) this prohibition should be strictly enforced by the facility for the safety and security of detainees.

ODO was unable to verify the movements of GARCIA-Maldonado and [redacted] on April 30, 2013. EDC Post Order #24, Housing Officer, Direct Supervision, section IV(B)(7) (Exhibit 33),

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requires the housing officer issue a pass to any detainee leaving the pod for visitation, recreation, or medical and that the movement is documented on a movement log sheet. A movement log showing [redacted]-[redacted] movement to the library and GARCIA-Maldonado's movement to visitation was unavailable at the time of ODO's review. SME [redacted] states (Exhibit 59, page 9, 3rd paragraph) this "call[s] into question the degree to which EDC adheres to sound security practice and requires detainees be accounted for at all times." She further advises, "When a death occurs at a detention facility, determining the detainee's activities and whereabouts in the hours leading up to the death is an important part of the investigation. Likewise, in cases where there is a roommate, it is critical to rule out his or her presence in the room where the death occurred based on documented evidence."

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1. Record of Deportable/Inadmissible Alien, Form I-213.

2. Notice to Appear (NTA), Form I-862.

3. Order of Release on Recognizance.

4. Call sheet March 22, 2013.

5. Warrant for Arrest of Alien, Form I-200.

6. Significant Incident Report (SIR).

7. Notice of Custody Determination, Form I-286.

8. EARM Case Comments.

9. Record of Persons Transferred, I-216.

10. Intake Screening, Form IHSC 795-A.

11. EDC Inmate Information Sheet.

12. Order to Detain or Release Alien, Form I-203.

13. Classification form.

14. EDC Inmate Housing History Report.

15. Allowable Personal Property Inventory/Receipt.

16. EDC Religious Service Attendance log sheets.

17. [redacted] housing history report.

18. Incident Statement of [redacted]

19. Physical Examination/Health Appraisal, IHSC Form 795-B.

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20. Consular notification form.

21. Facsimile of consular notification.

22. EDC Telephone Call Detail Report.

23. Email from Detective [redacted] dated April 23, 2013.

24. Echo housing unit OIC log.

25. Echo 200 housing pod log.

26. Entry Control Accountability Report.

27. CO [redacted] incident statement.

28. Email from DO [redacted] dated April 30, 2013.

29. Video surveillance footage of Echo 200 from April 30, 2013.

30. EDC North Library Sign In/Out Sheet from April 30, 2013.

31. EDC Outcount Sheet from April 30, 2013 1:15 p.m.

32. Incident Statement of CO [redacted]

33. EDC Post Order #24, Housing Officer (Direct Supervision).

34. CCA Facility Employee Problem Solving Notice.

35. Incident Statement of CO [redacted]

36. Incident Statement of CO [redacted]

37. Creative Corrections Medical Review.

38. Incident Statement of [redacted]

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39. Medical Officer log.

40. Central Control log.

41. Handheld Camera Recording.

42. Incident Statement of Captain [redacted]

43. Incident Statement of LT [redacted]

44. Swing shift roster from April 30, 2013.

45. Incident Statement of CO [redacted]

46. Timeline prepared by Captain [redacted]

47. Statement of RN [redacted]

48. Medical note prepared by LT [redacted]

49. Statement of LT [redacted]

50. Medical note prepared by PA LCDR [redacted]

51. Timeline prepared by ERO.

52. Eloy Police Department report.

53. Condolence letter from ICE ERO.

54. Autopsy Report.

55. Email from EDC chiefs regarding new policies.

56. Psychological Autopsy.

57. OPR File 201307302, ROI 006.

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58. Death Certificate.

59. Creative Corrections Safety and Security Report.

60. CCA Policy 8-1A, Medical Emergency.

61. IHSC Policy on Review of Intake Screening, and Memorandum of June 5, 2013.

62. CCA Policy 9-19, Suicide Prevention/Risk Reduction.

63. CCA Policy 17-100, Reception and Orientation.

64. CCA Policy 14-6AA, Allowable Personal Property Inventory List.

65. EDC Policy and Procedure 9-13, Count Principles and Procedures.

66. EDC General Post Orders CCA-PO-00.

67. Video Surveillance Footage of Echo 200 April 24-27, 2013

68. Addendum to EDC Post Orders, Direct Supervision Guidelines.

69. CCA Policy 5-1, Incident Reporting.

70. CCA Policy 9-16, Emergency Response Team.

71. Post Orders 1, Shift Supervisor.

72. Post Orders 2, Assistant Shift Supervisor.

73. General Emergency Information.