DEPARTMENT OF HOMELAND SECURITY
Immigration and Customs Enforcement

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

1. CASE NUMBER
201307166

PREPARED BY
[redacted]

2. REPORT NUMBER
003

3. TITLE
Guadalupe-Gonzales, Elsa/Unknown/0617 Detainee/Alien - Death (Suicide)/PHOENIX, MARICOPA, AZ

4. FINAL RESOLUTION

5. STATUS	6. TYPE OF REPORT	7. RELATED CASES
Closing Report	Detainee Death Review	201309468

8. TOPIC
Death of ICE Detainee Elsa GUADALUPE-Gonzales, April 28, 2013, Eloy, AZ

9. SYNOPSIS
On April 28, 2013, the Joint Intake Center, Washington, D.C., was notified of the death of Immigration and Customs Enforcement Detainee Elsa GUADALUPE-Gonzales. GUADALUPE-Gonzales was a citizen of Guatemala who was born on December 15, 1988, and died on April 28, 2013, at the Eloy Detention Center located at 4465 East Hanna Road, Eloy, Arizona. GUADALUPE-Gonzales was 24 years old when she died. The Pinal County Medical Examiner reported GUADALUPE-Gonzales's cause of death as hanging, and the manner of death as suicide.

On May 28, 2013, following the completion of a preliminary investigation by the ICE Office of Professional Responsibility, Office of Investigations, the Office of Detention Oversight initiated a Detainee Death Review of Elsa GUADALUPE-Gonzales'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 Analyst Plus	25-SEP-2013	ICE OPR Office of Detention Oversight (ODO)
12. APPROVED BY(Print Name & Title)	**13. APPROVED DATE**	**15. TELEPHONE NUMBER**
[redacted] - ICE-OPR Special Agent Supervisor	25-SEP-2013	No Phone Number

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10. NARRATIVE

On April 28, 2013, the Joint Intake Center (JIC), Washington, D.C., was notified of the death of Immigration and Customs Enforcement (ICE) Detainee Elsa GUADALUPE-Gonzales, a citizen of Guatemala born on December 15, 1988. GUADALUPE-Gonzales died on April 28, 2013, at the Eloy Detention Center (EDC) located at 4465 East Hanna Road, Eloy, Arizona (AZ). GUADALUPE-Gonzales was 24 years old when she died.

At the time of her death, GUADALUPE-Gonzales 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 both male and female 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 provide most of the medical staff at EDC. Under the IGSA, EDC is required to comply with the ICE Performance Based National Detention Standards (PBNDS) 2011.

From June 4 to 6, 2013, Management and Program Analyst (MPA) [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 GUADALUPE-Gonzales. ODO was assisted by Special Agent (SA) [redacted] who is 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 in correctional security. RN [redacted] and Ms. [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 some detainees regarding knowledge they had of GUADALUPE-Gonzales. Additionally, ODO reviewed immigration, medical, and detention records pertaining to GUADALUPE-Gonzales.

ODO determined the following timeline of events regarding GUADALUPE-Gonzales, from the time of her apprehension, through her detention at EDC.

On March 18, 2013, at approximately 7:45 a.m., GUADALUPE-Gonzales was apprehended by Border Patrol Agents (BPA) assigned to the Tucson Sector Border Patrol Station in Tucson, AZ, near Choulic, AZ. The exact location of her apprehension was documented with GPS coordinates

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and described as "S. 14 Drag Cow Tank" (Exhibit 1).

On March 19, 2013, GUADALUPE-Gonzales was processed by BPA [redacted] at the Tucson Sector Centralized Processing Facility. BPA [redacted] completed a Form I-213, Record of Deportable/Inadmissible Alien (Exhibit 2) for GUADALUPE-Gonzales which documents she was interviewed in Spanish, and responded "no" when asked if she had any fear about being returned to her home country or of being removed from the United States. (NOTE: GUADALUPE-Gonzales later stated in her credible fear interview (Exhibit 25, Credible Fear Notes, Page 11) she had told the BPA who arrested her she was "scared.") BPA [redacted] also documented GUADALUPE-Gonzales told him she entered the United States on March 17, 2013, on foot, 14 miles west of Sasabe, AZ.

BPA [redacted] completed a Form I-867A, Record of Sworn Statement in Proceedings under Section 235(b)(1) (Exhibit 3) for GUADALUPE-Gonzales which also documents she was interviewed in Spanish and indicated no fear of return or removal.

BPA [redacted] served GUADALUPE-Gonzales with a Form I-860, Notice and Order of Expedited Removal (Exhibit 4), and a Form I-296, Notice to Alien Ordered Removed/Departure Verification (Exhibit 5).

BPA [redacted] also completed a "Medical Screening Form" (Exhibit 6) for GUADALUPE-Gonzales which was signed by GUADALUPE-Gonzales and documents she had no medical complaints at that time.

ODO was advised Tucson Sector Centralized Processing Facility's Florence Placement Log (Exhibit 7), documents they received notice on March 20, 2013, at 1:15 a.m., that GUADALUPE-Gonzales was assigned to EDC.

On March 20, 2013, ICE prepared Form I-203, Order to Detain or Release Alien (Exhibit 8), for GUADALUPE-Gonzales, designating EDC as the facility where she would be housed.

On March 20, 2013, at 2:00 a.m., GUADALUPE-Gonzales was transferred from Tucson Sector Centralized Processing Facility to EDC (Exhibit 9).

On March 20, 2013 at 9:19 a.m., GUADALUPE-Gonzales was booked into EDC (Exhibit 10), and classified as a level one detainee (Exhibit 11).

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GUADALUPE-Gonzales was assigned to Pod 200 of the Bravo housing unit (Bravo 200), which is referred to as "B2" in her Housing History Report, and cell 206 on the bottom tier of Bravo 200, which is referred to as "06 L" in GUADALUPE-Gonzales's Housing History Report (Exhibit 12).

According to the Allowable Personal Property Inventory/Receipt (Exhibit 13) prepared for GUADALUPE-Gonzales upon admission, she was permitted to take her shoes with her into the facility. During the review, ODO examined GUADALUPE-Gonzales's property, including her shoes, which were athletic shoes designed to be used with laces.

On March 20, 2013, at 10:50 a.m., GUADALUPE-Gonzales underwent an intake medical screening by InGenesis RN [redacted] which was reviewed by InGenesis RN [redacted] as documented on the IHSC Intake Screening form (IHSC Form 795-A) (Exhibit 14). RN Wellman documented GUADALUPE-Gonzales was in good health and denied any mental health problems, including suicide attempts or thoughts. RN [redacted] also checked a box on the form indicating GUADALUPE-Gonzales spoke English, and she did not note an interpreter was needed or used. RN [redacted] checked several boxes on the form documenting educational information was provided to GUADALUPE-Gonzales, including the box, "Patient given the Dealing with Stress and Medical Orientation and Health Information Brochure in patient's language." RN [redacted] also checked the box, "Patient verbalized understanding of any teaching or instruction."

RN [redacted] no longer works at EDC and was not available for an interview. Medical staff interviewed by ODO stated RN [redacted] is fluent in Spanish.

On March 22, 2013, GUADALUPE-Gonzales met with her assigned Deportation Officer (DO), [redacted] DO [redacted] documented on a Record of Action (Exhibit 15) that GUADALUPE-Gonzales had "no fear."

ODO interviewed DO [redacted] on June 5, 2013. DO [redacted] stated he does not specifically remember GUADALUPE-Gonzales, but that he made a notation in her file she did not express fear of returning to Guatemala. DO [redacted] is fluent in Spanish.

On March 26, 2013, [redacted] was assigned to GUADALUPE-Gonzales' cell (Exhibit 16). [redacted] was released from EDC on May 7, 2013 (Exhibit 17).

On April 1, 2013, at 8:00 a.m., GUADALUPE-Gonzales underwent a physical examination provided by InGenesis RN [redacted] as documented on IHSC Form 795-B, Physical Examination/Health Appraisal (Exhibit 18). RN [redacted] checked the box "No" on page 1 of the

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form next to "Interpreter Provided." RN [redacted] noted GUADALUPE-Gonzales did not display any medical conditions and denied any current or previous mental health issues. RN [redacted] checked the boxes on page 3 of the form next to, "Patient was given Staying Healthy and Clinic and Health Orientation brochure in patient's language," and next to, "Patient verbalized understanding of any teaching or instruction."

ODO interviewed RN [redacted] on June 5, 2013. RN [redacted] stated GUADALUPE-Gonzales's face is familiar to her, but she does not remember anything specific about their interaction. RN [redacted] is fluent in Spanish and stated when she converses with a Spanish speaking detainee, she asks the detainee open-ended questions to ensure the detainee is understanding her.

On April 1, 2013, GUADALUPE-Gonzales signed a Spanish-language Form M-444, Information about Credible Fear Interview (Exhibit 19). A note the same day in the EARM Case Comments (Exhibit 20) for GUADALUPE-Gonzales shows her Form M-444 would be referred to the USCIS Asylum Office for a credible fear interview. ODO was unable to determine how or when GUADALUPE-Gonzales obtained the Form M-444. A March 26, 2013, notation in the EARM Case Comments for GUADALUPE-Gonzales shows she was tentatively scheduled for removal via ICE Air on April 2, 2013.

MPA [redacted] interviewed Asylum Officer (AO) [redacted] on July 10, 2013. AO [redacted] works for the United States Citizenship and Immigration Services (USCIS) Asylum Office in Anaheim, CA, which has jurisdiction over asylum cases arising from illegal entries in Arizona. AO [redacted] explained that a detainee awaiting expedited removal may apply for asylum at any time before he or she is removed. If the detainee wishes to seek asylum because of fear of persecution in his or her home country, that detainee submits a Form M-444 to the USCIS Regional Asylum Office, which has jurisdiction over the location where he or she entered the country illegally. The Form M-444 is transmitted to USCIS through the detainee's DO. Once USCIS receives the Form M-444, an AO is assigned to conduct a credible fear interview of the detainee.

On April 3, 2013, IHSC Commander Rebecca Fox, Nurse Manager, medically cleared GUADALUPE-Gonzales for travel (Exhibit 21).

On April 4, 2013, DO [redacted] sent via email attachment (Exhibit 22), GUADALUPE-Gonzales's Form M-444, to the USCIS Asylum Office, Anaheim, California, group email address of ZLA APSO. Accordingly, a note in the EARM Case Comments (Exhibit 20) for GUADALUPE-Gonzales indicates her case was referred to the USCIS Asylum Office on this date.

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During his interview with ODO, DO [redacted] stated that, although he was responsible for submitting GUADALUPE-Gonzales's Form M-444 to USCIS, he did not speak with her about the form or about her credible fear interview.

Between April 9, 2013, and April 27, 2013, GUADALUPE-Gonzales placed 16 telephone calls, as indicated on an EDC Records Summary Report (Exhibit 23). Recordings of those telephone calls were preserved by EDC.

On April 9, April 16, and April 23, 2013, GUADALUPE-Gonzales attended Christian religious services at EDC, as indicated on an EDC Religious Service Attendance log (Exhibit 24).

ODO interviewed EDC Chaplain [redacted] on June 18, 2013. Chaplain [redacted] has worked at EDC for approximately one year. Chaplain [redacted] stated that, 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 that she often uses detainees to translate for her. Chaplain [redacted] stated that, although she found GUADALUPE-Gonzales's name on attendance sheets for Christian services at the facility, she does not specifically remember GUADALUPE-Gonzales.

On April 26, 2013, at 9:45 a.m., GUADALUPE-Gonzales underwent a credible fear interview conducted at EDC by AO [redacted] as documented in Form I-870, Record of Determination/Credible Fear Worksheet (Exhibit 25). The interview was conducted using a Spanish interpreter for 50 minutes (see Interpreter Services Log, last page of Exhibit 25).

During her July 10, 2103 interview with ODO, AO [redacted] stated she remembered interviewing GUADALUPE-Gonzales, and recalled GUADALUPE-Gonzales seemed tired and somewhat withdrawn during her interview. She stated that, because it is not unusual for detainees to seem quiet and bored during their interviews, GUADALUPE-Gonzales's behavior did not stand out to her. AO [redacted] stated she reviewed GUADALUPE-Gonzales's husband's credible fear application prior to interviewing GUADALUPE-Gonzales, and noticed it did not list GUADALUPE-Gonzales as his spouse. She asked GUADALUPE-Gonzales if she would like to be added to her husband's application, and GUADALUPE-Gonzales declined.

AO [redacted] stated GUADALUPE-Gonzales's credible fear claim, that her family was involved in a violent property dispute in Guatemala, which caused her to fear for her life, is a common claim

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among Guatemalan applicants. Based on the criteria required to establish "credible fear of persecution" in one's home country, AO [redacted] determined GUADALUPE-Gonzales to have credible fear.

AO [redacted] stated AOs are not permitted to tell applicants the outcome of their credible fear claim during the interview, so GUADALUPE-Gonzales was not made aware of the positive finding in her case. AO [redacted] stated that, after a credible fear interview, it generally takes two to three weeks for the applicant's case to be processed. Once processed, the applicant is served with a Notice to Appear (NTA), informing the applicant credible fear was found, and that the applicant must appear at an asylum hearing before an immigration judge. AO [redacted] stated it is typical for a detainee to undergo a parole hearing and be released on bond prior to seeing an immigration judge. ODO reviewed GUADALUPE-Gonzales's Alien File and found an NTA (Exhibit 26) stating, "This notice is being issued after an asylum officer has found that the respondent has demonstrated a credible fear of persecution or torture." The NTA, which is not signed or dated, documents GUADALUPE-Gonzales's hearing with an immigration judge was not yet scheduled at the time of her death. The NTA was not served on GUADALUPE-Gonzales prior to her death.

GUADALUPE-Gonzales's visitation records (Exhibit 27) reflect she did not have any visitors while detained at EDC, thus AO [redacted] visit for purposes of the credible fear interview was not recorded as visitation. ODO requested the Bravo 200 Movement Log from April 26, 2013, to verify in facility records the day and time GUADALUPE-Gonzales met with AO [redacted] 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 Movement Log from April 26, 2013, was unavailable at the time of ODO's review.

According to an incident statement (Exhibit 28) provided by Detainee [redacted] to EDC Investigator [redacted] on Friday, April 26, 2013, GUADALUPE-Gonzales had been happy, because she learned her husband, who was detained at the Florence Correctional Facility, Florence, AZ, had been released. [redacted] also stated to Investigator [redacted] that, after GUADALUPE-Gonzales's credible fear interview on April 26, 2013, GUADALUPE-Gonzales was "afraid."

ODO interviewed Detainee [redacted] on June 5, 2013. [redacted] stated during the time she was housed in Bravo 200 with GUADALUPE-Gonzales, she learned GUADALUPE-Gonzales was initially afraid of being deported to Guatemala. [redacted] stated that, after GUADALUPE-Gonzales had her credible fear interview, she told [redacted] she

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hoped to be deported to Guatemala soon. [redacted] stated she heard from other detainees in Bravo 200 that GUADALUPE-Gonzales was impatient about her immigration case.

ODO interviewed Detainee Martha [redacted] on June 5, 2013. [redacted] stated that, although they were not close friends, on April 27, 2013, GUADALUPE-Gonzales asked [redacted] how long she had been in detention, and she stated she was tired of being detained. During their conversation, GUADALUPE-Gonzales also mentioned to [redacted] she was worried her bond would be too high for her family to pay, and she stated she wished to go back to Guatemala to be with her son.

ODO interviewed IHSC psychiatrist [redacted] MD, and InGenesis psychologist [redacted] PhD, together on June 5, 2013. Both have been employed at EDC since March 2013, and both are full-time mental health staff at the facility. During their interview, Dr. [redacted] and Dr. [redacted] stated they did not interact with GUADALUPE-Gonzales while she was detained at EDC. Dr. [redacted] and Dr. [redacted] stated as a general matter, they encounter increased levels of anxiety among ICE detainees, which is often due to a high level of uncertainty surrounding the duration of their stay in detention. They stated many detainees do not understand the detention process, the role of their DO, or the amount of time they can expect to be held in detention by ICE. Further, Dr. [redacted] stated even when detainees do receive adequate information regarding their immigration and detention status, cultural and contextual barriers often hinder their understanding of that information.

ODO interviewed InGenesis Licensed Clinical Social Worker (LCSW) [redacted] on June 4, 2013. LCSW [redacted] is a full-time mental health staff member at the facility. LCSW [redacted] stated she did not have any interaction with GUADALUPE-Gonzales while she was detained at EDC. LCSW [redacted] supported Dr. [redacted] and Dr. [redacted] opinion regarding anxiety among the detainees, stating detainees often just need more information about what is happening to them in ICE detention to help them feel more at ease. LCSW [redacted] asserted that language barriers are not the primary problem with the detainees' understanding of their circumstances in detention; instead, they generally do not know the right questions to ask in order to gain an understanding of their situation.

ODO interviewed EDC Correctional Counselor [redacted] on June 6, 2013. As a Correctional Counselor, Ms. [redacted] is responsible for assisting detainees with any questions or needs they may have, and for referring detainees to medical or mental health when appropriate. Ms. [redacted] was the Correctional Counselor for Bravo during the time GUADALUPE-Gonzales was detained at EDC. Ms. [redacted] stated she remembers GUADALUPE-Gonzales being very quiet, but

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she never had a conversation with her. Ms. [redacted] stated after GUADALUPE-Gonzales's death, she overheard detainees in Bravo 200 "gossiping" that several detainees told GUADALUPE-Gonzales she could still be deported, even if she received a favorable credible fear finding.

During an interview with Eloy Police Department (PD) Detective [redacted] Detainee [redacted] stated GUADALUPE-Gonzales did not go to breakfast on April 28, 2013. Detective Huffman documented the interview in a narrative report (Exhibit 29).

On April 28, 2013, EDC CO [redacted] was the assigned pod officer for Bravo 200 during the day shift, from 6:00 a.m. to 2:00 p.m. (Exhibit 30).

On April 28, 2013, at 9:16 a.m., Bravo 200 went to recreation (Exhibit 31). [redacted] told Detective [redacted] (Exhibit 29) GUADALUPE-Gonzales did not go to recreation on April 28, 2013. Bravo 200 returned from recreation at 10:59 a.m. (Exhibit 31).

At 11:22 a.m., cell 206 was searched (Exhibit 31).

At 12:21 p.m., Bravo 200 went to lunch and returned at 1:03 p.m. (Exhibit 31).

[redacted] told Detective [redacted] (Exhibit 29) GUADALUPE-Gonzales went to lunch on April 28, 2013, but did not eat very much. [redacted] stated that, later in the day on April 28, 2013, she observed GUADALUPE-Gonzales washing her shoelaces. When she questioned GUADALUPE-Gonzales, GUADALUPE-Gonzales told [redacted] the shoelaces were dirty.

During their interviews with ODO, Detainees [redacted] and [redacted] stated that, on April 28, 2013, GUADALUPE-Gonzales told [redacted] t lunch that day would be her last meal.

On April 28, 2013, at 1:15 p.m., CO [redacted] conducted a count during which detainees were locked in their rooms (Exhibit 31).

As seen in the April 28, 2013 surveillance footage (Exhibit 32) of Bravo 200, CO [redacted] left the unit at video time 1:43 p.m., without being relieved by the oncoming swing shift officer. (Note: the time stamps on the surveillance footage do not exactly match with the times of events logged by Central Control, the housing unit officer, and the OIC. When referencing video surveillance footage, this report uses the term "video time" to distinguish times referenced in the video surveillance footage, from logged times).

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During interviews with CCA staff, ODO learned that, at the time of GUADALUPE-Gonzales's detention at EDC, it was common practice for housing unit officers to leave their posts several minutes prior to the end of their shift to avoid incurring overtime associated with shift change.

On April 28, 2013, at 2:10 p.m., EDC CO [redacted] assumed her duties as desk officer in Bravo 200 (Exhibit 31), where she was scheduled to work the swing shift, from 2:00 p.m. to 10:00 p.m. (Exhibit 30). The Officer in Charge (OIC) for Bravo during swing shift on April 28, 2013, was EDC CO [redacted] (Exhibit 30). 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.

ODO interviewed CO [redacted] on June 4, 2013. CO [redacted] has worked in a correctional environment for more than 15 years, and at EDC since January 2013. CO [redacted] stated that, in the months leading up to April 28, 2013, she was often assigned as the pod officer in Bravo 200. On April 28, 2013, she was also Bravo's designated Emergency Response Team (ERT) member (Exhibit 30). 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 Senior Correctional Officers.

During her interview with ODO, CO [redacted] stated she knew the detainees in Bravo 200, and their habits, well. CO [redacted] stated she remembers GUADALUPE-Gonzales as being very quiet, not socializing much, and primarily talking only to her cellmate. CO [redacted] stated she does not speak Spanish, but uses other COs or detainees to help her communicate with non-English speaking detainees.

On April 28, 2013, at 2:12 p.m. (video time 2:13), CO [redacted] conducted a security check during which she unlocked all the cell doors (Exhibits 31 and 32). CO [redacted] logged (Exhibit 31) a second security check at 2:41 p.m., and a third at 3:03 p.m. ODO's review of the video surveillance footage (Exhibit 32) revealed CO [redacted] did not conduct a security check corresponding with the logged security check at 2:41 p.m. The video surveillance footage shows CO [redacted] second security check occurred at video time 2:59 p.m., which presumably corresponds with the logged security check at 3:03 p.m.

On April 28, 2013, CO [redacted] logged (Exhibit 31) additional security checks at 3:22 p.m., 4:06 p.m., 4:17 p.m., and 4:21 p.m., all corroborated by the video surveillance footage (Exhibit 32).

During her interview with ODO, CO [redacted] stated prior to dinner on April 28, 2013, she asked

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CO [redacted] if Bravo 200 could be the first pod in Bravo to go to the dining hall. Dinner typically begins around 4:45 p.m. at EDC. CO [redacted] stated when CO [redacted] told her Bravo 200 could go to dinner first, she checked each cell in Bravo 200 to determine whether any detainees were staying behind during the meal.

On April 28, 2013, at 4:40 p.m., CO [redacted] logged (Exhibit 31) a security check of Bravo 200. Review of surveillance footage (Exhibit 32) shows CO [redacted] walking from cell to cell in the pod at time stamp 4:44 p.m.

According to an incident statement prepared by CO [redacted] on April 28, 2013 (Exhibit 33), during her check, she went to every cell, opened the door to see if there were any detainees inside, and told them to get ready for dinner. After she checked each cell, she heard the "standby for chow" announcement over the facility loudspeaker. After the announcement, at approximately 4:47 p.m., CO [redacted] began locking Bravo 200 down for dinner. During lockdown, she pushed each cell door to make sure it was latched, and looked inside the cell through a mesh window in the cell door to see if any detainees had stayed inside. 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. In both her incident statement and during her interview with ODO, CO [redacted] stated she did not see any detainees, including GUADALUPE-Gonzales, inside any of the cells.

During her interview with ODO, CO [redacted] stated occasionally detainees will try to hide from her by crouching beneath the mesh window. CO [redacted] stated some detainees crouch low enough that she is unable to see them when she looks in the window. During the review, ODO observed cell 206 in Bravo, where GUADALUPE-Gonzales was housed, and determined even a very small person crouched behind the cell door can be seen through the window.

Detainee [redacted] statement to Detective [redacted] (Exhibit 29) documents that, when dinner time arrived on April 28, 2013, she told GUADALUPE-Gonzales to put her shoes on and go to dinner, and that GUADALUPE-Gonzales responded by saying she did not want to go to dinner. [redacted] stated when Bravo 200 went to dinner, GUADALUPE-Gonzales was locked in her cell.

During her interview with ODO, Detainee [redacted] stated that, on April 28, 2013, CO [redacted] did a routine check before lining detainees up to leave for dinner. [redacted] stated as they were lining up, GUADALUPE-Gonzales shut her cell door while still inside, and smiled through the window in her cell, at the detainees in the dayroom.

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During her interview with ODO, CO [redacted] stated after conducting lockdown, she asked the detainees who were waiting to leave for dinner, "es todo?," which she understood to mean "total?," to determine whether everyone in the pod was going to dinner, and that they indicated back to her the entire pod was going to dinner.

On April 28, 2013, at 4:51 p.m. (video time 4:52 p.m.), Bravo 200 left the housing unit for dinner (Exhibits 31 and 32). (Note: the Bravo OIC logbook (Exhibit 34) documents Bravo went to dinner at 4:50 p.m.).

ODO interviewed CO [redacted] on June 6, 2013. CO [redacted] has worked as a CO at EDC since August 2012. On April 28, 2012, CO [redacted] was working as the OIC in Bravo (Exhibit 30). CO [redacted] stated that, on April 28, 2012, dinner started around 4:50 p.m., and Bravo 200 went to dinner first, followed by 500, 300, 100, and 400, in that order. CO [redacted] stated Bravo 500, which holds level three female detainees, receives satellite feeding; all of the other pods walk to a central dining hall. CO [redacted] stated in addition to the detainees in Bravo 500, he was informed by the Bravo 100 pod officer that three detainees were staying behind in Bravo 100 during dinner. CO [redacted] stated prior to GUADALUPE-Gonzales's death, pod officers were not required to notify the OIC if detainees were staying behind during dinner, and it was not common practice to document the detainees who stayed behind. CO [redacted] specifically remembers CO [redacted] telling him she had a full pod going to dinner on April 28, 2013. CO [redacted] stated that, at 5:10 p.m., he approached the open slider door to Bravo 100, and asked the three detainees in the pod to show their faces at the window in their cell door so he could verify their presence and well-being.

The OIC's logbook (Exhibit 34) from April 28, 2013, reflects CO [redacted] completed a security check at 5:15 p.m.

ODO interviewed EDC Unit Manager [redacted] on June 5, 2013. Ms. [redacted] role as Unit Manager is to oversee staff and detainees to make sure all detainee needs are met by the facility. Ms. [redacted] stated that, prior to GUADALUPE-Gonzales's death, a detainee who wanted to skip a meal was permitted to remain in the housing unit, locked in his or her cell. Ms. [redacted] stated COs were not required to make note of a detainee who chose not to attend a meal, nor to notify the desk officer of any detainee remaining in his or her cell, nor to check on their well-being while they remained in the housing unit, nor were they required to take a head count of detainees attending dinner. Ms. [redacted] also stated she is unaware of any written CCA policy regarding meal procedures.

During his interview, CO [redacted] stated that, at approximately 5:20 p.m., Bravo 200 returned from

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dinner, followed by Bravo 300. In an incident statement (Exhibit 35) prepared by CO [redacted] on April 28, 2013, CO [redacted] documented Bravo 300 returned from dinner at approximately 5:25 p.m.

On April 28, 2013, at 5:22 p.m., CO [redacted] documented (Exhibit 31) Bravo 200 returned from dinner, all doors were open, and a security check was completed. Video surveillance footage (Exhibit 32) shows Bravo 200 returning at video time 5:20 p.m., 27 minutes after the pod left for dinner.

During her interview with ODO, CO [redacted] stated when Bravo 200 returned from dinner, she unlocked all of the cell doors, starting from the left side of the pod and moving to the right, before sitting down at her desk to log the pod's return. Video surveillance footage shows CO [redacted] unlocking cell doors at video time 5:21 p.m. In the footage (Exhibit 32), CO [redacted] is seen first unlocking the top tier of the pod, from left to right, and then unlocking the bottom tier of the pod, from left to right. CO [redacted] is seen returning to her desk at video time 5:24 p.m.

According to an incident statement (Exhibit 36) prepared by Detainee [redacted] on April 29, 2013, when Bravo 200 returned from chow, she started "walking." The video surveillance footage (Exhibit 32) of Bravo 200 shows two detainees walking around the pod while other detainees sit around the six metal tables in the pod's dayroom. [redacted] incident statement documents that after she started walking, her cellmate, [redacted] got up from the tables to check on GUADALUPE-Gonzales who had not yet come out of her cell. When Maldonado reached cell 206, she observed GUADALUPE-Gonzales hanging from her bed.

According to an incident statement (Exhibit 37) prepared by Detainee [redacted] on April 28, 2013, while sitting at a table in the common area of the pod, she thought it was strange GUADALUPE-Gonzales had not come out of her cell when the pod returned from chow, and she got up to check on her. When she approached the cell, [redacted] saw GUADALUPE-Gonzales was hanging.

As seen in the video surveillance footage (Exhibit 32) of Bravo 200, at video time 5:26 p.m., a detainee is observed rising from a dayroom table and walking to cell 206.

During her interview with ODO, CO [redacted] stated a couple of minutes after sitting down at her desk, she heard screaming from cell 206 and ran to the cell. The video surveillance footage (Exhibit 32) of Bravo 200 shows CO [redacted] responding to cell 206 at video time 5:26 p.m. CO [redacted] stated that, upon entering cell 206, she observed GUADALUPE-Gonzales facing her bunk with her body positioned in a way that made her look like she was "kneeling" or "praying."

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CO [redacted] stated she quickly saw GUADALUPE-Gonzales was hanging by her neck from the top bunk, ran to her, and lifted her body up to relieve the pressure on her neck. Immediately after lifting GUADALUPE-Gonzales, CO [redacted] used her radio to call in a medical emergency. CO [redacted] stated another detainee came into the cell to assist her.

According to CO [redacted] incident statement (Exhibit 33), GUADALUPE-Gonzales was hanging by what appeared to be a white cord. Once she lifted GUADALUPE-Gonzales and called for a medical response, CO [redacted] untied the cord from the top rung of the bunk bed. The cord was later determined to be GUADALUPE-Gonzales's shoelaces which she tied together to fashion a noose around her neck.

According to [redacted] incident statement (Exhibit 36), as well as one prepared by Detainee [redacted] (Exhibit 38) on April 28, 2013, both detainees helped CO [redacted] support GUADALUPE-Gonzales's weight by holding GUADALUPE-Gonzales's legs.

According to an incident statement (Exhibit 39) prepared by Detainee [redacted] on April 29, 2013, she tried to help CO [redacted] remove the "string" from the bunk bed. She stated she also tried to remove the "string" from around GUADALUPE-Gonzales's neck, but it was too tight.

According to CO [redacted] incident statement (Exhibit 33), once GUADALUPE-Gonzales was untied from the bed, CO [redacted] lowered her to the floor with assistance from the detainees. One of the detainees, who is not identified in the statement, removed the string from GUADALUPE-Gonzales's neck. CO [redacted] stated GUADALUPE-Gonzales was cold and her eyes were fixed in an upward stare. CO [redacted] told the detainees to leave the cell, and then checked GUADALUPE-Gonzales for a pulse. When CO [redacted] did not find a pulse, she initiated cardiopulmonary resuscitation (CPR) with the assistance of EDC Sergeant [redacted]

In her report (Exhibit 61, section 2, page 4, 4th paragraph), RN [redacted] points out that when a subject is not breathing and does not have a pulse, the American Heart Association and the Mayo Clinic both advise calling 911 before beginning CPR. During her interview with ODO, CO [redacted] stated it was her understanding only medical staff could make the determination to call 911. During interviews with EDC staff, ODO learned the majority of the COs interviewed believe they are not permitted to initiate a call to 911, via Central Control, without first being instructed to do so by a medical staff member.

ODO interviewed EDC's Senior Learning and Development Officer, [redacted] on June 5, 2013.

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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 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.

ODO interviewed IHSC Lieutenant (LT) [redacted] on June 5, 2013. LT [redacted] is an RN by training and has held the Health Services Administrator (HSA) position at EDC since February 24, 2012. LT [redacted] stated anyone certified in Basic Life Support (BLS) is permitted to initiate a call to 911. 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. However, LT [redacted] agreed 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.

During an interview with Detective [redacted] on April 28, 2013, (Exhibit 40) CO [redacted] stated she did not notice GUADALUPE-Gonzales when she unlocked the cell doors after dinner, because GUADALUPE-Gonzales's body was in a "kneeling position" behind the cell's sink, which obscured her view into the cell. CO [redacted] also stated when she entered cell 206 after hearing the screams, she didn't see anything at first, but then looked to her left and saw GUADALUPE-Gonzales hanging from the bed.

During the review, ODO observed the doors to cells 206 and 207 open outwards by pulling on a handle located on the left side of the door, whereas the doors to all the other cells in the pod are opened by pushing in. The lock on every cell door is also located on the left side of the door. Inside the cell, a toilet, sink and bunk bed are located against the left wall; a desk is located against the right wall. ODO noted that, because the door to cell 206 opens from the left to the outside of the cell, and CO [redacted] approached the cell from the left, she could have easily missed seeing GUADALUPE-Gonzales positioned next to the left wall of the cell when she unlocked the door after dinner.

During his interview with ODO, CO [redacted] stated that, as Bravo 300 was returning from chow, he heard a scream from inside Bravo 200. He opened the slider door to Bravo 300, instructed the detainees to go inside and stand by their doors, and he let the Bravo 300 pod officer, EDC CO [redacted] out of Bravo 300 and into Bravo 200. CO [redacted] stated he heard CO [redacted] call a medical emergency over her radio, and that he also called Central Control to clarify CO

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[redacted] message, which was difficult to understand. CO [redacted] stated Sergeant [redacted] arrived at Bravo about two minutes after CO [redacted] call went out.

ODO interviewed CO [redacted] on June 4, 2013. CO [redacted] stated that, on April 28, 2013, she was the pod officer for Bravo 300 (Exhibit 30). On April 28, 2013, when she returned to Bravo with the Bravo 300 detainees after dinner, she heard detainees screaming from Bravo 200 and heard someone say the word "hanging." CO [redacted] immediately told the Bravo 300 detainees to lockdown, and asked CO [redacted] to open the slider door to Bravo 200. The surveillance footage (Exhibit 32) of Bravo 200 shows CO [redacted] entering Bravo 200 at video time 5:27 p.m. When CO [redacted] entered Bravo 200, she witnessed CO [redacted] lift GUADALUPE-Gonzales with the assistance of two detainees, place her on the floor, and begin CPR. CO [redacted] instructed all of the Bravo 200 detainees to lock down, and she checked on those who seemed particularly affected. CO [redacted] stated once medical staff arrived on scene, she took over administering CPR from CO [redacted] CO [redacted] completed an incident statement (Exhibit 41) on April 28, 2013, which corroborates her interview.

During her interview with ODO, CO [redacted] stated Sergeant [redacted] arrived on scene quickly and helped her by administering ventilations to GUADALUPE-Gonzales while she administered chest compressions. CO [redacted] stated EDC CO [redacted] also arrived on scene quickly and assisted Sergeant [redacted] and CO [redacted] with CPR.

On April 28, 2013, at 5:25 p.m., EDC's Central Control logged (Exhibit 42) a medical emergency in Bravo 200. Notations in the log include "possible hanging," and "South ERT begin CPR." EDC's Medical Officer logbook (Exhibit 43) also reflects a medical emergency was called at 5:25 p.m.

On April 28, 2013, at approximately 5:25 p.m., Sergeant [redacted] responded to Bravo after receiving a medical emergency call over his radio, as documented in his incident statement (Exhibit 44). The video surveillance footage (Exhibit 32) shows Sergeant [redacted] arriving at the scene at video time 5:28 p.m.

ODO interviewed Sergeant [redacted] on June 5, 2013. Sergeant [redacted] stated during the swing shift on April 28, 2013, he was posted to the South yard and was the ERT lead (Exhibit 30). During dinner, he heard an emergency call over his radio from Bravo. He stated he remembered hearing "need help" and "suicide" during the radio transmission. After hearing the emergency call, Sergeant [redacted] immediately ran to Bravo where he encountered several detainees in the rotunda area pointing toward Bravo 200. When Sergeant [redacted] entered Bravo 200, he saw CO [redacted] administering CPR to GUADALUPE-Gonzales in cell 206. In his incident statement (Exhibit 44),

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Sergeant [redacted] stated CO [redacted] told him she found GUADALUPE-Gonzales hanging from the bunk bed by her shoelaces. Sergeant Garcia stated he immediately called Central Control to provide a description of the situation, and then assisted CO [redacted] with CPR by administering ventilations to GUADALUPE-Gonzales. Sergeant [redacted] stated CO [redacted] also assisted with CPR.

ODO interviewed CO [redacted] on June 4, 2013, who was the assigned ERT member in the Charlie housing unit on April 28, 2013. When CO [redacted] received the emergency transmission over her radio, she ordered her pod to lockdown, and responded to Bravo. When she entered Bravo, she took the Automated External Defibrillator (AED) from behind the OIC desk, and proceeded into Bravo 200. The video surveillance footage (Exhibit 32) shows CO [redacted] entering Bravo 200 with the AED at video time 5:29 p.m. CO [redacted] stated she gave the AED to Sergeant [redacted] CO [redacted] completed an incident statement (Exhibit 45) on April 28, 2013, which corroborates her interview with ODO.

In his incident statement (Exhibit 44), Sergeant [redacted] stated the AED arrived after he and CO [redacted] completed two cycles of CPR, and that he started to take out the AED pads and turn the AED on when medical staff arrived. During his interview with ODO, Sergeant [redacted] stated medical personnel, including RN [redacted] and InGenesis LPN [redacted] [redacted] arrived on the scene shortly after CO [redacted] gave him the AED. After medical personnel were on the scene, Sergeant [redacted] moved out of cell 206 to give the medical personnel room to work. Sergeant [redacted] stated that, upon her arrival, RN [redacted] instructed him to call 911. In his incident statement (Exhibit 44), Sergeant [redacted] documented when medical staff told him to call 911, he relayed the message to Central Control. Sergeant [redacted] stated once medical personnel arrived, his role was to keep Central Control informed of everything happening on the scene.

ODO interviewed RN [redacted] [redacted] on June 4, 2013. RN [redacted] has worked at EDC since July 2012. RN [redacted] stated she was on shift with LPN [redacted] the evening of April 28, 2013. She stated that, at 5:25 p.m., she overheard a "medical emergency" transmission on the Medical Officer's radio. RN [redacted] described the transmission as a female "screeching," and stated the Medical Officer, EDC CO [redacted] notified her there was a hanging in Bravo 200. RN [redacted] stated she and LPN [redacted] immediately grabbed a wheelchair and an emergency bag and walked from the medical unit to Bravo.

On April 28, 2013, at 5:28 p.m. (video time 5:31), EDC medical personnel arrived at Bravo 200 (Exhibits 42 and 32).

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According to EDC's Local Operating Procedure on Emergency Medical Services (LOP 811) (Exhibit 46), medical personnel must respond to all health related emergencies within a four-minute response time in teams of two. The teams are assigned at the beginning of each shift. The policy also provides, "If emergency medical services [are] needed, request an ambulance by either dialing 911 via CCA phone, or by using a facility radio, or by making the request verbally to a security staff member."

During his interview with ODO, LT [redacted] stated when a medical emergency is called, an RN must always respond to the scene with another medical staff member. LT [redacted] confirmed the medical team must arrive on the scene within four minutes of the emergency call, a standard time frame prescribed by the American Correctional Association. LT [redacted] also stated he instructs his staff to walk briskly, not run, to the scene of a medical emergency, to reduce the risk of a medical staff member falling and getting injured or arriving at the scene out of breath.

During her interview with ODO, RN [redacted] stated when she and LPN [redacted] arrived at GUADALUPE-Gonzales's cell, she remembers seeing two officers inside the cell, administering CPR, and Sergeant [redacted] standing outside the cell. RN [redacted] stated GUADALUPE-Gonzales was lying on the floor of the cell with her head near the entrance to the cell, and her feet pointing toward the bunk bed. RN [redacted] stated that, upon entering the cell, she checked GUADALUPE-Gonzales for a pulse and then instructed Sergeant [redacted] to call 911. RN [redacted] stated when she entered the cell, she found the AED, which had not yet been applied, on the floor next to GUADALUPE-Gonzales's right arm. RN [redacted] applied the AED pads to GUADALUPE-Gonzales, but did not get an instruction from the AED to administer a shock, indicating the AED did not detect any heart activity.

A note made by RN [redacted] in GUADALUPE-Gonzales's Chronological Record of Medical Care (Exhibit 47), documents that after she instructed Sergeant [redacted] to call 911, she continued CPR and use of the AED with assistance from LPN [redacted] CO [redacted] and CO [redacted]

On April 28, 2013, at 5:30 p.m., EDC's Central Control logged (Exhibit 42) 911 was called, medical staff were still administering CPR and AED, and GUADALUPE-Gonzales was still unresponsive.

During the review, ODO determined that confusion, as to who has authority to initiate a call to 911, resulted in a five minute delay between CO [redacted] emergency call at 5:25 p.m., and Central Control's logged call to 911 at 5:30 p.m.

On April 28, 2013, at 5:35 p.m. and 5:38 p.m., EDC's Central Control logged (Exhibit 42) medical

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staff were still administering CPR and AED, and GUADALUPE-Gonzales was still unresponsive.

At 5:40 p.m., an ambulance entered EDC through the facility's rear gate going to Bravo, according to the rear gate logbook (Exhibit 48). Central Control logged (Exhibit 42) the ambulance on-site at 5:41 p.m.

At 5:42 p.m., EDC's Central Control logged (Exhibit 42) medical staff were still administering CPR and AED, and GUADALUPE-Gonzales was still unresponsive.

At 5:44 p.m., EDC's Central Control logged (Exhibit 42) the ambulance was on-site at the South yard in front of Bravo, and paramedics had entered the unit.

RN [redacted] documented (Exhibit 47) two paramedics arrived at GUADALUPE-Gonzales's cell at 5:45 p.m. (video time 5:46 p.m.), and they advised her and LPN [redacted] to continue administering CPR.

CO [redacted] incident statement (Exhibit 41) documents she was also asked by medical staff to participate in the CPR rotation when the paramedics arrived.

RN [redacted] wrote (Exhibit 47) the paramedics administered four separate rounds of epinephrine to GUADALUPE-Gonzales, using an electrocardiogram (EKG) after each round to check for a heart rhythm. RN [redacted] notes (Exhibit 61, section 2, page 6, 2nd paragraph) epinephrine is commonly known as the hormone adrenalin, and is primarily used to reverse cardiac arrest by concentrating blood around vital organs, which stimulates cardiac contractions and strengthens the cardiac muscle.

RN [redacted] wrote (Exhibit 47) that, after the paramedics were unsuccessful in reviving GUADALUPE-Gonzales, one of them telephoned Dr. [redacted] at Casa Grande Regional Medical Center, Casa Grande, AZ, who declared GUADALUPE-Gonzales dead at 6:06 p.m.

Central Control also logged (Exhibit 42) GUADALUPE-Gonzales was pronounced dead at 6:06 p.m.

On April 28, 2013, at 6:10 p.m., Central Control called Investigator [redacted] (Exhibit 42).

ODO interviewed Investigator [redacted] on June 6, 2013. Investigator [redacted] has worked as the facility's investigator for two years, and is responsible for investigating and reporting on a variety of

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incidents at EDC including detainee deaths, sexual assaults, and employee misconduct. Investigator [redacted] stated she was called at home on April 28, 2013, around 6:00 p.m., and asked to come to EDC to investigate GUADALUPE-Gonzales's death. Investigator [redacted] stated when she arrived at the facility, personnel from Eloy PD were already on-site, and EDC Warden Charles DeRosa briefed her on the circumstances of GUADALUPE-Gonzales's death. Investigator [redacted] stated she interviewed COs and detainees, and listened to GUADALUPE-Gonzales's recorded telephone calls. Investigator [redacted] recalled detainees stating GUADALUPE-Gonzales did not want to go to dinner, and that she had recently been sad because she missed her son. Investigator [redacted] stated she did not go inside cell 206, and that she did not look through GUADALUPE-Gonzales's property. Investigator [redacted] report package (Exhibit 49) includes an Incident Report, Incident Statements, an Incident Investigation Report, an Incident Packet Checklist and Administrative Review, and photographs taken by Sergeant [redacted]

On April 28, 2013, at 6:15 p.m., Central Control called Eloy PD (Exhibit 42).

At 6:15 p.m., Warden DeRosa notified ICE ERO Detention Operations Supervisor (DOS) [redacted] of GUADALUPE-Gonzales's death (Exhibit 50).

At 6:27 p.m., RN [redacted] called LT [redacted] to notify him of GUADALUPE-Gonzales's death (Exhibit 47).

During his interview with ODO, LT [redacted] stated he immediately left for EDC after receiving RN [redacted] call. While en route to the facility, LT [redacted] notified IHSC Headquarters of the death. LT [redacted] also called Dr. [redacted] Dr. [redacted] and LCSW [redacted] who comprise EDC's mental health staff, to determine whether any of them was available to provide mental health support to detainees that evening. LT [redacted] stated LCSW [redacted] agreed to come to EDC that evening.

During her interview with ODO, LCSW [redacted] stated that, on April 28, 2013, at approximately 7:30 p.m., LT [redacted] called her at home to find out whether she could come to EDC that evening to provide mental health support to detainees in the wake of a suicide. LCSW [redacted] stated she responded immediately and assisted detainees by talking with them about the suicide. LCSW [redacted] stated Warden DeRosa was present in the housing unit while she spoke with detainees, and that he also talked to detainees about GUADALUPE-Gonzales's death. LCSW [redacted] stated that, in the weeks following GUADALUPE-Gonzales's death, Dr. [redacted] and Dr. [redacted] held support group sessions with detainees.

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On April 28, 2013, at 6:30 p.m., Eloy PD officers arrived at EDC (Exhibit 42). Officer [redacted] responded first, and was briefed by Sergeant [redacted] on the circumstances of GUADALUPE-Gonzales's death. Officer [redacted] determined the case should be turned over to Eloy PD detectives, and Eloy PD Detectives [redacted] and [redacted] were assigned to the GUADALUPE-Gonzales case. Officer [redacted] secured cell 206 once medical staff cleared the area. When Detectives [redacted] and [redacted] arrived at the facility, they observed the Bravo 200 housing unit, cell 206, and GUADALUPE-Gonzales's body. The detectives also interviewed CO [redacted] Detainee [redacted] and Sergeant [redacted] The Eloy PD Investigative Report on the death of GUADALUPE-Gonzales is Report # 00-201300001040-000 (Exhibit 51).

On April 28, 2012, at 6:39 p.m., IHSC Headquarters was notified of GUADALUPE-Gonzales's death by LT [redacted] (Exhibit 52).

At 6:40 p.m., according to a draft Significant Incident Report (SIR) (Exhibit 53) prepared by the ERO Phoenix Field Office, the Pinal County Medical Examiner's Office was notified of GUADALUPE-Gonzales's death.

ODO interviewed Supervisory Deportation and Detention Officer (SDDO) [redacted] on June 5, 2013. SDDO [redacted] was the Duty Supervisor on the evening of GUADALUPE-Gonzales's death. SDDO [redacted] stated he notified the JIC of GUADALUPE-Gonzales's death at approximately 7:11 p.m., and immediately came to EDC. SDDO [redacted] stated when he arrived at the facility, Eloy PD was already on-site, and he helped facilitate their investigation. SDDO [redacted] prepared a SIR (Exhibit 54) documenting GUADALUPE-Gonzales's death.

During his interview with ODO, LT [redacted] stated he arrived at EDC at 7:12 p.m. on April 28, 2013, and met Warden DeRosa and Assistant Field Office Director (AFOD) [redacted] outside of Bravo. The three entered the unit together to wait for the medical examiner to arrive.

On April 28, 2013, at 9:25 p.m., as documented in the SIR (Exhibit 54) prepared by SDDO [redacted] Vice Consul [redacted] of the Guatemalan Consular Office in Phoenix, AZ, was notified of GUADALUPE-Gonzales's death.

At 9:39 p.m., EDC's Central Control logged (Exhibit 42) the arrival of the medical examiner. According to the Eloy PD report (Exhibit 51), the person responding from the Pinal County Medical Examiner's Office was Ms. [redacted]

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At 10:48 p.m. ., EDC's Central Control logged (Exhibit 42) the departure of Ms. [redacted]

On May 1, 2013, Acting Field Office Director for the ERO Phoenix Field Office, notified GUADALUPE-Gonzales's husband, [redacted] of her death in a condolence letter sent via U.S. mail (Exhibit 55).

On May 1, 2013, [redacted] MD, of the Pinal County, Arizona, Eloy PD, completed an autopsy of GUADALUPE-Gonzales (Exhibit 56). His opinion is recorded as "Death of this woman is due to hanging. The manner of death is certified as suicide."

On May 10, 2013, all staff at EDC received an email "re-cap" (Exhibit 57) from EDC Chief of Security [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 of GUADALUPE-Gonzales. According to his report (Exhibit 58), Dr. [redacted] interviewed detainees [redacted] and [redacted] Unit Manager [redacted], and Vice Consul [redacted] reviewed GUADALUPE-Gonzales's medical record and CCA incident reports prepared after her death; and reviewed several of GUADALUPE-Gonzales's telephone calls with assistance from Investigator [redacted] Dr. [redacted] determined GUADALUPE-Gonzales had minimal risk factors for suicidal behavior. Dr. [redacted] stated in the summary section of his report, "The available information provides essentially no guidance as to what may have contributed to her

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suicide."

On May 28, 2013, SA [redacted] ICE OPR RAC Tucson, determined no employee misconduct contributed to the death of GUADALUPE-Gonzales. SA [redacted] findings are documented in OPR File 201307166, Report of Investigation 002 (Exhibit 59).

On July 2, 2013, the State of Arizona, Department of Health Services, Office of Vital Records, issued a Death Certificate for GUADALUPE-Gonzales (Exhibit 60).

SECURITY COMPLIANCE REVIEW

Creative Corrections, a national management and consultant firm, contracted by ICE to provide subject matter expertise in detention management including facility safety and security, reviewed the safety and security of GUADALUPE-Gonzales while she was housed at EDC. Creative Corrections found EDC was not fully compliant with the ICE PBNDS on Population Counts, Facility Security and Control, Emergency Plans, and Food Service. The Creative Corrections report is attached to this report (Exhibit 61, Section 1).

MEDICAL COMPLIANCE REVIEW

Creative Corrections also reviewed the medical care of GUADALUPE-Gonzales while she was housed at EDC. Creative Corrections found EDC was not fully compliant with the ICE PBNDS on Medical Care, Suicide Prevention and Intervention, and Hunger Strikes. The Creative Corrections report is attached to this report (Exhibit 61, Section 2).

IMMIGRATION AND DETENTION HISTORY

On March 18, 2013, Elsa GUADALUPE-Gonzales, a native and citizen of Guatemala, was arrested by the United States Border Patrol near Choulic, AZ, after unlawfully entering the United States of America from Mexico.

On March 19, 2013, GUADALUPE-Gonzales was served a Form I-860, Notice and Order of Expedited Removal, charging GUADALUPE-Gonzales with violation of Section 212a(7)(A)(i)(II) of the Immigration and Nationality Act, as an alien who is not in possession of a valid unexpired immigrant visa, re-entry permit, border crossing card, or other valid entry document. GUADALUPE-Gonzales did not claim fear of persecution or torture if she were to be returned to Guatemala.

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On March 20, 2013, GUADALUPE-Gonzales was transferred to the custody of ICE and was placed in EDC.

On April 1, 2013, GUADALUPE-Gonzales submitted to the DO assigned to her case, a Form M-444, Information about Credible Fear Interview.

On April 4, 2013, the ERO Phoenix Field Office filed GUADALUPE-Gonzales's Form M-444 with the USCIS Asylum Office for adjudication.

On April 26, 2013, GUADALUPE-Gonzales was interviewed by an Asylum Officer, and was found to have credible fear of persecution if she were to be returned to Guatemala.

At the time of GUADALUPE-Gonzales's death, her credible fear hearing was pending, but not scheduled, and a Notice to Appear for a credible fear hearing was prepared, but not yet served on her.

CRIMINAL HISTORY

GUADALUPE-Gonzales had no criminal history.

INVESTIGATIVE FINDINGS

1. Safety and Security

GUADALUPE-Gonzales committed suicide using a noose made out of her shoelaces, tied to the bedframe of the top bunk in her cell. As demonstrated in video surveillance footage of Bravo 200, GUADALUPE-Gonzales had approximately 27 minutes to attempt suicide when she stayed behind in her cell while the other detainees in her pod went to dinner. Because CO [redacted] did not account for the detainees in her charge immediately prior to, during, or after dinner, she was unaware GUADALUPE-Gonzales stayed behind during the meal. The configuration of the door to GUADALUPE-Gonzales's cell, as well as the layout of the cell, impeded CO [redacted] from seeing GUADALUPE-Gonzales hanging from her bunk when she unlocked the cell after Bravo 200 returned from dinner. An additional six minutes lapsed before GUADALUPE-Gonzales was discovered by another detainee. Further, confusion as to whether COs have the authority to initiate a call to 911 absent instruction from medical staff resulted in a delay of an additional five minutes between the time CO [redacted] discovered GUADALUPE-Gonzales and when Central Control called 911.

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ODO determined GUADALUPE-Gonzales was permitted to take her personal athletic shoes into the facility per CCA Policy 17-100 Reception and Orientation, Section G, Part 3 (Exhibit 62), 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 List (Exhibit 63), lists shoes, including athletic shoes, among the allowable personal property items. GUADALUPE-Gonzales ultimately used the shoelaces from her shoes to hang herself. On May 10, 2013, EDC issued the following guidance via email (Exhibit 57) 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."

A CCA memorandum dated October 10, 2012, with the subject "Direct Supervision Guidelines (Addendum to Post Orders)," (Exhibit 64) provides procedures COs must follow during mass movements, including recreation and meal times. Procedure number 1 in the "Direct Supervision Movement Procedures" section of the memorandum states, "If the majority of the pod's population participates in a mass movement, the officer must secure the remainder of the detainees in their assigned cells (securing the door)." Procedure number 2 states, "Once this is complete, the officer will escort the majority of their assigned pod to the activity. During this mass movement the officer must maintain direct supervision of their assigned detainees." Procedure number 3 states, "Upon departure of a mass movement from the unit, the OIC (officer in charge) will leave the slider to the vacated pod open and conduct 30 minute checks on each detainee that stayed behind in their secured cell. The security check must be documented in the OIC's log."

The October 10, 2012, memorandum (Exhibit 64) and EDC's Post Order #24, Housing Officer (Direct Supervision) (Exhibit 65), are silent regarding the counting of detainees who participate in a mass movement and regarding the documentation of detainees who stay behind during a mass movement, and they are silent as to whether the OIC must be notified of any detainees who stay behind.

CO [redacted] did not count the detainees going to dinner on April 28, 2013, and did not know GUADALUPE-Gonzales remained in her cell. Had CO [redacted] known and informed CO [redacted] that GUADALUPE-Gonzales had stayed behind during dinner, a reasonable person would likely conclude that CO [redacted] would have probably checked on her while Bravo 200 was at dinner. Instead, GUADALUPE-Gonzales had an unsupervised 27-minute window of opportunity to take her own life.

In the "Conclusions" section of her report (Exhibit 61, Section 1, page 6), Ms. [redacted] states, "From a broader perspective, it is noted leaving detainees unsupervised for this length of time

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presents opportunities for other emergencies to go undetected. OIC presence in the rotunda would not assure [sic] awareness of a medical or other emergency, including a physical or sexual assault in cases where two detainees remained in one room."

On June 3, 2013, the EDC Chiefs' Office issued a revised "Feeding Procedures" memorandum (Exhibit 66) to all EDC staff and detainees. The memorandum lists the following bulleted instructions regarding detainees who choose to remain in their housing unit during lunch and dinner:

• "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 be allowed to take the following items to 300 pod: 1. Cup/bottle of water, 2. T.V. headphones, 3. (1) Book, 4. (1) Deck of Playing cards."

• "If a detainee needs to return to their cell during this time to use the restroom, the Desk officer will escort the detainee to their cell and back to 300 pod."

ODO determined EDC failed to fully comply with the following PBNDS with respect to GUADALUPE-Gonzales's detention and subsequent suicide: Population Counts, Facility Security and Control, Emergency Plans, and Food Service. 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."

On April 28, 2013, at 2:41 p.m., prior to detainee GUADALUPE-Gonzales's suicide, CO [redacted] falsely logged a security round she did not conduct. (This matter was reported to the JIC and was documented in OPR File 201309468.) As a result, a period of 46 minutes elapsed between rounds. Failing to conduct a 30-minute round also contravenes EDC Policy and Procedure 9-13, Count Principles and Procedures (Exhibit 67), which states, "The physical accountability of inmates is a primary mission of all facility staff;" EDC Post Order #24, Housing Officer (Exhibit 65), which states, "Routine security checks should be conducted at random times every thirty (30)

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minutes;" EDC General Post Orders CCA-PO-00, section (E)(2), Counts (Exhibit 68), which states, "Informal counts will be conducted throughout the day and night at frequent but irregular intervals . . .;" and EDC General Post Orders, sections (P)(1) and (P)(6), Logbook Maintenance (Exhibit 68), which states, "Maintain logbooks with the highest degree of care." This section also requires the logging of counts.

On April 28, 2013, day shift officer, CO [redacted] left her post as the Bravo 200 housing unit officer prior to being properly relieved, leaving the post unattended for 27 minutes. Several COs interviewed by ODO stated that, at the time of GUADALUPE-Gonzales's death, leaving a post prior to being relieved was a practice sanctioned by facility administration. This practice violates not only the PBNDS, but also EDC General Post Orders, section A2, Assignment (Exhibit 68), which 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.) CO [redacted] also violated EDC Post Order #24 (Exhibit 65), which states, "Maintain post until properly relieved by either the on-coming correctional officer or a Supervisor."

During the review, ODO learned COs are no longer permitted to leave their posts until properly relieved.

2. ICE PBNDS, Facility Security and Control, section (V)(D)(2), Supervision and Communication, states, "As prescribed by Post orders, staff shall observe, supervise, and control movement of detainees from one area to another."

During her interview with ODO, CO [redacted] stated she did not count the detainees who went to dinner on April 28, 2013; she did not require the Bravo 200 detainees to sit together at dinner; and, she did not count the detainees prior to leaving the dining room. Further, she acknowledged it was common practice for detainees to return from meals with other pods. As a result, CO [redacted] failed to properly account for detainees under her supervision from the time they left Bravo 200 until they returned, approximately 27 minutes later. The majority of COs interviewed by ODO also stated they are not required to count detainees prior to, during, and after meals; that detainees are permitted to sit with other pods during meals; and, that detainees sometimes return to their housing unit with other pods after meals.

3. ICE PBNDS, Emergency Plans, section (V)(D)(18)(c), Post-Emergency Procedures, states, "The post-emergency part of the plan shall include the following action items: seizing,

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documenting and preserving evidence."

In her incident statement (Exhibit 33), CO [redacted] stated she saw a Spanish Bible in GUADALUPE-Gonzales's cell which was open and had piece of paper under a scripture. In the Eloy PD report (Exhibit 51), Detective [redacted] also documented he observed a Spanish Bible in GUADALUPE's cell opened to the book of Genesis. This Bible was not secured or properly inventoried and retained by EDC, and was unaccounted for at the time of ODO's review.

4. ICE PBNDS, Emergency Plans, section (V)(D)(18)(h), Post-Emergency Procedures, states, "The post-emergency part of the plan shall include the following action items: debriefing of staff involved and follow-up for additional analysis and implications for changes in policy or procedures."

During interviews with security and medical staff, ODO learned EDC failed to bring together security and medical staff to conduct an after-action debriefing to discuss GUADALUPE-Gonzales's suicide and possible improvements to prevent future incidents.

5. ICE PBNDS, Food Service, section (V)(B)(6), Counts, states, "The FSA shall establish procedures for informing staff of the local counting procedures and for ensuring that the procedures are followed. Staff must be able to account for detainees at all times. The counting officer must have a staff observer/backup during each count. Detainees should be assembled in one section of the dining room and be required to remain seated until their names are called and then move to another section of the dining room."

As discussed above, ODO learned it was not common practice to count detainees prior to, during, or after a meal at EDC. Also, detainees were permitted to mingle with detainees from other pods during meals. Once detainees finish eating, they form a line outside of the dining hall, are subject to random pat searches, and are escorted back to their housing units. ODO learned it was not uncommon for detainees to return to their housing unit with a different pod depending on when they finished eating. The lack of policy and procedure requiring detainees to be counted when traveling to and from the dining hall, and allowing detainees to mingle with detainees from other pods during meals, does not allow accurate accounting of detainees at all times.

2. Medical

During the review of GUADALUPE-Gonzales's death, ODO determined GUADALUPE-Gonzales's medical record demonstrates no mental health concerns or indicators of suicide risk were

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identified at intake; further, based on available information, she did not communicate or display signs of suicidal ideation to staff or other detainees prior to her suicide. When GUADALUPE-Gonzales was found hanging in her room, CO [redacted] acted promptly to free GUADALUPE-Gonzales from her makeshift noose, transmit an emergency medical call via radio, and initiate CPR.

ODO determined EDC failed to fully comply with the following three PBNDS with respect to GUADALUPE-Gonzales's detention and subsequent suicide: Medical Care, Suicide Prevention and Intervention, and Hunger Strikes. Deficiencies were identified in the following components:

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 five minute delay in calling 911 after GUADALUPE-Gonzales was found hanging in her cell. This delay failed to provide the required access to emergency medical services.

LT [redacted] and Mr. [redacted] stated if a detainee is not breathing and without pulse, security staff may and should call 911. However, ODO found the majority of security staff interviewed did not understand their authority to call 911, with most stating it was necessary to wait for medical staff to assess the emergency and direct that 911 be called if determined necessary.

According to CCA Policy 8-1A, Medical Emergency (Exhibit 69), 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. This person is then to assess all information and determine whether the situation can be resolved using staff and resources immediately available. The policy goes on to state that, 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."

GUADALUPE-Gonzales's intake medical screening was reviewed by RN [redacted] without written designation of authority for an RN to perform this function. Designation of RNs to review intake medical screenings is allowed under IHSC Operations Memorandum dated May 10, 2011, (Exhibit 70, page 1), provided the clinical medical authority has so authorized, in writing. Upon

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request, the designation memorandum by the Western Regional Clinical Director (Exhibit 70, page 2) was provided to ODO; however, it was dated June 5, 2013, the date of ODO's on-site review, and was not in place at the time of GUADALUPE-Gonzales's intake medical screening.

3. ICE PBNDS, Suicide Prevention and Intervention, section (V), requires, "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, dated October 12, 2009, does not include the final mandatory component listed above: Debriefing. Although a mortality review is conducted by IHSC, a local critical incident debriefing is not required by CCA Policy 9-19 (Exhibit 71) and was not conducted in the aftermath of GUADALUPE-Gonzales'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 71), which require the facility to develop a local Suicide Prevention Plan, to be reviewed annually, addressing "specific facility initiatives and the facility's plan for compliance" with the policy. HSA [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 GUADALUPE-Gonzales's suicide. In her report (Exhibit 61, section 2, page 8, 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.

5. ICE PBNDS, Hunger Strikes, section (II)(1), states, "Any detainee who does not eat for 72 hours will be referred to the medical department for evaluation and possible treatment."

During the review, ODO learned EDC only tracks and reports skipped meals for detainees who are

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housed in segregation. Consequently, there is no system in place to determine when a detainee housed in general population has not eaten for more than 72 hours so hunger strike protocols may be implemented. The facility did not track GUADALUPE-Gonzales's failure to attend dinner on April 28, 2013.

AREAS OF CONCERN

According to CCA's guidance on emergency procedures at EDC (Exhibit 72), any employee who becomes aware of any emergency must immediately notify Central Control. If the emergency involves a suicide attempt by hanging, 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." Additionally, the employee should, "Begin standard first aid and/or CPR as necessary." CCA Suicide Prevention/Risk Reduction Policy 9-19 (Exhibit 71) also requires staff to immediately "alert other staff to retrieve the cut down tool and make every effort to relieve the pressure off the victim's neck." CO [redacted] did not request the cut down tool, which is located behind the OIC's desk, when she made her emergency call after finding GUADALUPE-Gonzales hanging, and neither CO [redacted] nor Sergeant [redacted] brought the cut down tool with them when they responded to CO [redacted] call. Though the tool was not necessary, because Officer [redacted] had succeeded in untying the shoelaces, Officer [redacted] and Sergeant [redacted] did not know this when they responded to the call.

After the Medical Officer received a radio call indicating a medical emergency in Bravo, nursing personnel acted immediately to gather emergency equipment and respond. Video surveillance footage shows the nurses walked into Bravo at an unhurried pace. Although, LT [redacted] stated the nurses' pace was consistent with standing direction not to run to emergencies to avoid injury, or to avoid arriving at the scene out of breath, RN [redacted] advised in her report (Exhibit 61, section 2, page 5, 3rd paragraph), that, in medical emergencies, every effort should be made to respond as quickly as possible. For example, an Evaluation Log (Exhibit 73) for a CPR drill conducted on October 31, 2012, documents as a discussion point, "Medical responses are always being watched by ICE, CCA, detainees--always respond professionally with a sense of urgency."

CCA Policy 9-19, Suicide Prevention/Risk Reduction (Exhibit 71), requires CPR drills, "to assist in suicide prevention. At least one (1) CPR drill per calendar year will simulate a suicide attempt by hanging." ODO determined the CCA safety officer conducts these drills, and correctional and medical staff participate, as verified by review of the CPR drill and evaluation logs (Exhibit 73). In addition, IHSC conducts CPR drills which include suicide attempt by hanging; however, during interviews with EDC medical staff, ODO learned the IHSC-led drills are typically for medical staff

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only. It is recommended all drills involve both correctional and medical staff.

ODO determined EDC did not thoroughly and properly investigate GUADALUPE-Gonzales's death, which diminished the facility's ability to identify and correct deficiencies. Not only did Investigator [redacted] fail to preserve and maintain the Bible seen in GUADALUPE-Gonzales's cell, but during her interview with ODO, she stated she did not inspect GUADALUPE-Gonzales's property, and never actually visited cell 206. Investigator [redacted] stated the cell was initially sealed, and after it was reopened, she "just didn't get a chance to go down there."

Additionally, although Investigator [redacted] documented she reviewed video surveillance footage of Bravo 200 on April 28, 2013, she failed to identify that CO [redacted] falsified a security check at 2:41 p.m. In her report, Investigator [redacted] states, "EDC's preliminary investigation did not reveal any established CCA policy was violated," and, "staff acted in concert with policy with no noted concerns." Both statements are inaccurate given Bravo 200 was left unattended during shift change, CO [redacted] falsified a security check, and CO [redacted] failed to properly account for all of the detainees in her charge before, during and after dinner.

ODO determined there is a lack of understanding among facility staff concerning language used in radio transmissions during emergency situations. Several COs interviewed by ODO stated they were instructed to be discreet when using the radio to transmit an emergency call in order to avoid alarming the detainees, and to avoid using words like "hanging" and "suicide;" other COs stated they were instructed to speak clearly and plainly when making an emergency call over the radio. EDC General Post Orders, section (I)(f)(ii) (Exhibit 68) states, "Always use proper language and clear text in all radio transmissions (no "ten"-codes or jargon)." Additionally, EDC Post Order #24 (Exhibit 65), Section IV., "Definitions," under "Clear Spoken English:" states, "When transmitting an incident on the radio, do not use code language. Briefly describe what is happening…Repeat the transmission a second time." ODO confirmed EDC does not use "10 codes," which are commonly used by law enforcement and corrections personnel nationwide to identify various frequently encountered situations. Ms. [redacted] advised (Exhibit 61, section 1, page 7, 2nd paragraph), "Further guidance, clarification, and training for staff regarding these issues are necessary to eliminate confusion during future emergency situations."

EDC Post Order #24 (IV)(B)(7) (Exhibit 65) states, "During individual movements such as library, court, medical, or visitation, you will be responsible for issuing a colored pass and documenting the movement on the movement log sheet. You must be able to verify the whereabouts of all detainees that [sic] have left the pod." ODO was unable to obtain Bravo 200's movement log for April 26, 2013, to determine whether GUADALUPE-Gonzales was logged out of the pod when she

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met with AO [redacted] EDC staff stated individual movements are logged on a loose leaf sheet of paper during day and swing shifts, and the logs are not retained by the facility for more than a few days. A movement log should be kept during all three shifts in order to account for individual detainee movements 24 hours per day. Additionally, by not retaining the movement logs, EDC makes it impossible to determine a particular detainee's whereabouts and whether his or her movements were properly logged during a review such as ODO's.

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1. USBP Field Processing Form.

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

3. Record of Sworn Statement in Proceedings, Form I-867A.

4. Notice and Order of Expedited Removal, Form I-860.

5. Notice to Alien Ordered Removed/Departure Verification, Form I-296.

6. Medical Screening Form.

7. Florence Placement Log.

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

9. Manifest of Persons/Property Transferred.

10. GUADALUPE-Gonzales Booking Screen Shot.

11. GUADALUPE-Gonzales Classification.

12. GUADALUPE-Gonzales Housing Assignment.

13. GUADALUPE-Gonzales Allowable Personal Property Inventory/Receipt.

14. Intake Screening, form 795-A.

15. Record of Action.

16. [redacted] housing history report.

17. [redacted] release documentation.

18. Physical Examination/Health Appraisal, form 795-B.

19. Information about Credible Fear Interview form M-444.

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20. EARM notes.

21. Medical clearance for travel.

22. Confirmation M-444 sent.

23. GUDADALUPE-Gonzales Call log.

24. Religious attendance sheets.

25. Record of Determination/Credible Fear Worksheet, Form I-870.

26. Notice to Appear.

27. GUADALUPE-Gonzales Visitation record.

28. [redacted] Incident Statement.

29. [redacted] Eloy PD Statement.

30. April 28, 2013 Swing Shift Roster.

31. April 28, 2013 Bravo 200 Log.

32. April 28, 2013 Bravo 200 Video Surveillance Footage.

33. CO [redacted] Incident Statement.

34. April 28, 2013 Bravo OIC Logbook.

35. [redacted] Incident Statement.

36. [redacted] Incident Statement.

37. [redacted] Incident Statement.

38. [redacted] Incident Statement.

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39. [redacted] Incident Statement.

40. CO [redacted] Eloy PD Statement.

41. CO [redacted] Incident Statement.

42. April 28, 2013 Central Control Logbook.

43. April 28, 2013 Medical Officer Logbook.

44. Sergeant [redacted] Incident Statement.

45. CO [redacted] Incident Statement.

46. Local Operating Procedure (LOP) on Emergency Medical Services 811.

47. RN [redacted] Note in Medical Chart.

48. April 28, 2013 Rear Gate Logbook.

49. CCA Investigation Report.

50. [redacted] Email.

51. Eloy Police Department Report.

52. Lieutenant [redacted] Note in Medical Chart.

53. Draft Significant Incident Report.

54. Significant Incident Report.

55. [redacted] Condolence Letter.

56. GUADALUPE-Gonzales Autopsy Report.

57. May 10, 2013 Email.

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	201307166
	PREPARED BY
	[redacted]
REPORT OF INVESTIGATION Exhibit List HB 4200-01 (37), Special Agent Handbook	2. REPORT NUMBER 003

58. GUADALUPE-Gonzalez Psychological Autopsy.

59. OPR File 201307166, ROI 002.

60. GUADALUPE-Gonzales Death Certificate.

61. Creative Corrections Report.

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

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

64. Direct Supervision Guidelines (Addendum to Post Orders) memorandum.

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

66. June 3, 2013, Feeding Procedures memorandum.

67. CCA Policy 9-13, Count Principles and Procedures.

68. EDC General Post Orders.

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

70. May 10, 2011, IHSC Operations memorandum.

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

72. General Emergency Procedures.

73. CPR Drill Evaluation Log.