

DETAINEE DEATH REVIEW - Clemente MPONDA

JICMS #201312347

SYNOPSIS

Twenty-seven year-old ICE detainee Clemente Ntangola MPONDA, a citizen and national of the Republic of Mozambique, died on September 2, 2013, at Memorial Hermann Northeast Hospital, Humble, Texas. The Harris County Institute of Forensic Sciences determined MPONDA's cause of death to be combined toxicity of amitriptyline (brand name Elavil) and risperidone (brand name Risperdal), and his manner of death to be undetermined.

DETAILS OF REVIEW

MPONDA was in ICE custody at the Houston Contract Detention Facility (HCDF) at the time of his death. HCDF opened in April 1984, and is owned and operated by Corrections Corporation of America (CCA). HCDF houses ICE detainees of all classification levels for periods exceeding 72 hours. ICE Health Service Corps (IHSC) provides medical care at HCDF. IHSC contracts with InGenesis Aurora (InGenesis) to supplement their medical staffing at HCDF. HCDF was required to comply with the ICE Performance Based National Detention Standards (PBNDS) 2008 at the time of MPONDA's death.

From November 5 to 7, 2013, Management and Program Analyst [REDACTED] [REDACTED] Supervisory Inspections and Compliance Specialist [REDACTED] [REDACTED] and Inspections and Compliance Specialists [REDACTED] [REDACTED] and [REDACTED] [REDACTED] all assigned to the ICE Office of Professional Responsibility (OPR), Office of Detention Oversight (ODO), visited HCDF to examine the circumstances of MPONDA's death. Registered Nurse (RN) [REDACTED] [REDACTED] a subject matter expert (SME) in correctional health care, and [REDACTED] [REDACTED] an SME in correctional security, assisted ODO with the death review. RN [REDACTED] and SME [REDACTED] are employed by Creative Corrections, a national management and consulting firm contracted by ICE to provide subject matter expertise in detention management and compliance with detention standards, including health care and security. ODO interviewed individuals employed by CCA at HCDF, as well as employees of IHSC, InGenesis, and the ICE Office of Enforcement and Removal Operations (ERO). ODO also reviewed immigration, medical, and detention records pertaining to MPONDA.

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

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

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MAY 26, 2012, to SEPTEMBER 1, 2013

On May 26, 2012, a Harris County deputy sheriff¹ who is trained and certified by ICE to perform immigration work, encountered and interviewed MPONDA at the sheriff's office jail where he was serving a 20-day sentence for theft. MPONDA, who could speak English, admitted being a citizen and national of the Republic of Mozambique.² The deputy learned MPONDA lawfully entered the United States at Atlanta, Georgia, on August 20, 2007, on an F-1 student visa, valid until August 8, 2008.

Prior to being turned over to ICE, MPONDA had a history of being belligerent with Harris County Jail (HCJ) staff, and they found it necessary to take him for treatment to the Mental Health and Mental Retardation Authority of Harris County.³

MPONDA had also been placed in the HCJ's infirmary for alcohol detoxification, and, on May 26, 2012, he was placed on suicide precautions in HCJ's mental health unit because he stated he was depressed, and because he refused to sign a consent form for a psychotropic medication.⁴

On May 27, 2012, while in HCJ's mental health unit, MPONDA approached one of the staff in an assaultive manner and had to be restrained and placed in a padded room.⁵

On May 29, 2012, the HCJ turned MPONDA over to ICE, and he was transported to HCDF. MPONDA immediately continued his pattern of resistance towards authority by refusing to sign his HCDF booking form.⁶

At his medical screening the same day, MPONDA said he felt okay. He admitted being treated in the past for "some kind of mental health disorder," which he suspected was depression and schizophrenia. He also acknowledged having had hallucinations and feelings of paranoia.⁷

On May 29, 2012, MPONDA was initially assigned to B-segregation following intake processing, due to his assaultive history.⁸

B-Segregation is HCDF's administrative and disciplinary segregation unit, and consists of 32 single-occupancy cells. The cells are equipped with a bed, toilet, sink, and two small shelves. B-Segregation has television sets mounted outside the cells enabling detainees to watch television from their cell doors. The unit also has an indoor recreation pen in the dayroom which

¹ 287(g) Designated Immigration Officer ■■■■■

² Some documents reviewed by ODO erroneously listed his country of citizenship as Central African Republic.

³ I-213 prepared by IEA ■■■■■ May 29, 2012, p. 2.

⁴ HCJ Health Services, Mental Health Unit Note, 5/26/2012, 1715.

⁵ Id., 5/27/2012, 0125.

⁶ HCDF, Inmate/Detainee Commitment Summary, 5/29/2012, p. 2.

⁷ DIHS, Note and Event View Print, Intake Assessment, 5/29/2012, 3:58:12 PM.

⁸ HCDF, Inmate/Detainee Commitment Summary, p. 1.

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includes a table and chair, reading materials, and a computer station for legal research. An officer's desk is located at the end of the unit, to the right of the unit's entrance. Post orders require housing unit officers to conduct routine security checks of the segregation unit every 30 minutes on an irregular basis.

Two officers are assigned to B-Segregation during two 12-hour shifts; 6:00 a.m. to 6:00 p.m., and 6:00 p.m. to 6:00 a.m. Additionally, officers can manually open the cell doors in B-Segregation with keys, or the officer assigned to B-Control can open them electronically. An officer checks the keys in and out of B-Control at the start and end of each shift. B-Control is located adjacent to B-Segregation, and B-Control officers have a direct line of sight into B-Segregation. B-Control officers monitor a video surveillance camera located behind the housing unit officer's desk.

CCA Officer [REDACTED] [REDACTED] who booked MPONDA into HCDF and assigned him to segregation, did not specifically remember why MPONDA was first placed in segregation, but she said CCA generally places a detainee in segregation immediately upon admission if ICE recommends it. Officer [REDACTED] also stated any documentation of assaultive history in the detainee's I-213 or I-203, as in MPONDA's case, would prompt the booking officer to notify his or her shift supervisor for a recommendation on whether that detainee should initially be housed in segregation.⁹

CCA Assistant Warden (AW) [REDACTED] [REDACTED] said he was informed via email from ICE¹⁰ that MPONDA had been assaultive, refused staff orders, and had to be restrained while detained at HCJ; that he was believed to have mental health problems; and, that his criminal history included a sexual assault charge with an unknown disposition. AW [REDACTED] determined MPONDA should be placed in segregation upon admission to HCDF, based on the information from ICE, as well as knowledge that MPONDA "became belligerent with staff" at HCJ, as documented on his Form I-213.¹¹ SME [REDACTED] noted (**Exhibit 1, page 6**) that although the sexual assault charge was nolle prosequi, the information regarding MPONDA's behavior at HCJ constitutes valid grounds for segregation under the ICE PBNDS, Special Management Units standard.

On May 30, 2012, at 12:19 p.m., the IHSC nurse practitioner performing a physical examination of MPONDA had to discontinue her interview of him regarding his mental health when he became upset and did not want to continue. She immediately referred MPONDA to mental health.¹²

⁹ ODO interview of CCA Officer [REDACTED] [REDACTED] 11/6/2013.

¹⁰ EMAIL from [REDACTED] [REDACTED] 5/29/2012, 05:18 AM.

¹¹ ODO interview of CCA AW [REDACTED] [REDACTED] 11/7/2013.

¹² DIHS, Note and Event View Print, Physical Exam, 5/30/2012, 12:19:18 PM.

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Later that same day, contract psychiatrist [REDACTED] [REDACTED] MD, performed an initial psychiatric evaluation of MPONDA. Dr. [REDACTED] confirmed with MPONDA, his history of mental illness, but documented he was a poor historian. She noted he denied paranoia, depression, and intent to harm himself or others, that he was somewhat disorganized and could not recall his prior diagnosis and medications. Dr. [REDACTED] documented “Depression or Schizophrenia?” as her diagnosis, and noted that although he seemed motivated for treatment, she believed he had poor coping skills with questionable medication compliance. Her notes show she discussed the risks and benefits of two psychiatric medications with MPONDA, risperidone and Cogentin, and that MPONDA agreed to take them (**Exhibit 2**).

RN [REDACTED] noted that risperidone is used to treat schizophrenia and symptoms of bi-polar disorder, and Cogentin is used to treat the side effects of psychotropic drugs (**Exhibit 1, page 7**).

MPONDA signed IHSC psychiatric consent Form 844, which shows he consented to take all indicated medication types including mood stabilizers, antidepressants, and antipsychotics. RN [REDACTED] noted (**Exhibit 1, page 7**) that Risperdal was not identified on the Form 844. NOTE: though IHSC Form 844 was used by HCDF at the time of MPONDA’s admission, HCDF currently uses an updated version of the form: IHSC Form 880.

MPONDA refused his risperidone on June 5, June 7, June 8 and June 11 (**Exhibit 3**).

MPONDA had four encounters with HCDF mental health staff during June 2012. On June 11th staff documented that MPONDA said his medications caused sleeplessness.¹³ On June 13th, contract psychiatrist [REDACTED] [REDACTED] discontinued Risperdal and ordered Trazadone and Paxil.¹⁴ RN [REDACTED] noted Trazadone is used to treat depression and anxiety, and Paxil is used to treat major depression. RN [REDACTED] also noted (**Exhibit 1, page 8**) that staff did not obtain specific written consent from MPONDA for the two ordered medications.

On June 27th, MPONDA told mental health staff he was tired of being in segregation and that he wanted to die. When asked, MPONDA denied any ideas, plans or intentions he might have to end his life. Staff noted that MPONDA was adjusting adequately to being in segregation, that he appeared to be stable with no intent to harm himself or others, and that he agreed with staff to stay safe and to communicate to them any suicidal ideations or plans.¹⁵

On June 29, 2012, HCDF’s segregation committee reviewed MPONDA’s status and documented “due to his Assaultive History and for the safety and security of the facility,” he would remain in administrative segregation for another 30 days, at which time his status would be reviewed

¹³ Case Trakker, 2012-06-11, 13:08:58, Encounter: Mental Health, page 279.

¹⁴ Id., 2012-06-13, 11:14:14, Encounter: Mental Health, p. 273.

¹⁵ Id., 2012-06-27, 15:10:06, Encounter: Mental Health, pp. 260-261.

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again.¹⁶ However, specific justification for keeping MPONDA in administrative segregation was not documented. Additionally, MPONDA's detention records do not contain any reports of disciplinary incidents or behavioral issues between his arrival on May 29, 2012, and the segregation committee review on June 29, 2012. SME [REDACTED] noted (**Exhibit 1, page 9**):¹⁷ "if concerns regarding his mental health and medication non-compliance were factors, there is no documentation so indicating, and no documentation of communication between security and mental health staff."

MPONDA remained in segregation through December 2012, with the segregation committee conducting reviews in August¹⁷, October¹⁸, November¹⁹ and December.²⁰ No review form could be found for July or September. For the August review, the committee cited the same justification—the detainee's assaultive history, and the safety and security of the facility, without any supporting details. A different form was used for the reviews in October through December. Except for MPONDA's name, the date of the review, and a signature, no justification or supporting details were offered.

On June 29, 2012, Dr. [REDACTED] ordered increased dosages of both Trazadone and Paxil for MPONDA and also ordered Geodon.²¹ RN [REDACTED] noted (**Exhibit 1, page 9**) Geodon is used to treat schizophrenia. She also noted mental health staff did not obtain specific consent from MPONDA to take Geodon.

Later in the evening after Dr. [REDACTED] ordered these medications, MPONDA used a dinner tray to break a light casing in his cell,²² because, "demons want the lights turned off."²³

In the evening of July 1, 2012, officers found MPONDA with a thermal shirt wrapped around his neck "as if in attempt to harm himself." He was taken to the medical clinic where staff noted he denied suicidal ideation or plan to harm himself; they noted their decision not to place him on suicide watch, and they returned him to his cell in segregation.²⁴ RN [REDACTED] noted (**Exhibit 10, page 9**) the medical record does not contain documentation of evaluation for suicide risk addressing the criteria in the ICE PBNDS 2008 Suicide Prevention and Intervention standard.

On July 2, 2012, an Institution Disciplinary Panel found MPONDA guilty of destroying CCA property by breaking the light casing in his cell, ordered him to pay \$744.22 in restitution, and

¹⁶ CCA Segregation Committee Review form, 6/28/2012.

¹⁷ CCA Segregation Committee Review form, 8/29/2012.

¹⁸ Id., 10/24/2012.

¹⁹ Id., 11/23/2012.

²⁰ Id., 12/22/2012.

²¹ Case Trakker, 2012-06-29, 15:18:22, Order Entry: Pharmacy Paxil Geodon, p. 254.

²² [REDACTED] Form No I-884, Incident of Prohibited Acts And Notice of Charges, 6/29/2012.

²³ [REDACTED] Form I-890, Investigation Report, 6/30/2012.

²⁴ Case Trakker, 2012-07-01, 21:10:23, Encounter: Nursing, pp. 250-251.

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sanctioned him with seven days in disciplinary segregation.²⁵ MPONDA was held in disciplinary segregation from July 2, 2012, to July 8, 2012.²⁶

On July 6, 2012, Dr. [REDACTED] and CDR [REDACTED] a licensed independent social worker (LISW) examined and evaluated MPONDA. Dr. [REDACTED] noted MPONDA felt the medications were helpful, but that he continued to be bizarre. MPONDA told them he wanted medical services to help him draw his blood to drink because he believed he was a vampire. MPONDA denied any suicidal or homicidal intentions, but admitted to audible hallucinations. Dr. [REDACTED] also documented that MPONDA's cell displayed a number of bizarre drawings mixing common satanic images with his own particular delusions. Dr. [REDACTED] increased MPONDA's Geodon medication (**Exhibit 4**).

On July 8, 2012, MPONDA was moved from disciplinary segregation, back to administrative segregation.²⁷ No explanation or supporting documentation to justify his placement back in administrative segregation was provided. Additionally, MPONDA's detention record did not contain an Administrative Segregation Order for July 8, 2012.

On July 11, 2012, Dr. Sauer evaluated MPONDA and documented he was "on a fast from showering, because his mother died a year ago;" that he was "Not manic or depressed, but delusional, although much improved;" and, that he was compliant with medications and gradually stabilizing (**Exhibit 5**).

On July 13, 2012, at approximately 9:10 p.m., MPONDA attempted to hang himself by using a torn strip of bed sheet tied to the inside of his cell door. Officers on duty in the unit at the time responded with a suicide knife and cut MPONDA down. After being cut down, MPONDA became combative with officers, to include biting a finger of one officer (**Exhibit 6**). After gaining control of MPONDA, officers escorted him to the medical unit where he was examined and placed on suicide watch.²⁸ IHSC notified ERO 11:17 p.m. that MPONDA would be admitted to West Oaks Hospital, a comprehensive psychiatric care facility in Houston.²⁹

On July 14, 2012, at 2:03 a.m., MPONDA was transferred³⁰ to West Oaks Hospital³¹ where he was held until July 30, 2012.

On July 16, 2012, an immigration judge administratively closed MPONDA's immigration case.³²

²⁵ Institution Disciplinary Panel Report, signed by OIC 7/3/2012.

²⁶ Form I-883, Disciplinary Segregation Order, 7/2/2012.

²⁷ Inmate Status Change Form, 7/8/2012.

²⁸ Case Trakker, 2012-07-13, 22:43:00, Encounter: Urgent Care, p. 231.

²⁹ MPONDA's EARM record, Comments, 7/16/2012, 7:48 a.m., entered by [REDACTED]

³⁰ Order to Detain or Release Alien, 7/13/2012.

³¹ Case Trakker, 2012-07-14, 02:03:45, Encounter: Nursing, p. 230.

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On July 30, 2012, at 2:29 p.m., MPONDA was admitted back into HCDF.³³

On July 30, 2012, at 3:29 p.m., CDR [REDACTED] evaluated MPONDA and documented he reported “feeling good,” and that he stated he was “just playing” when he wrapped the piece of bed sheet around his neck on July 13, 2012.³⁴ CDR [REDACTED] documented that Dr. [REDACTED] who is also on staff at West Oaks Hospital and who treated MPONDA while he was hospitalized, ordered medications per the hospital discharge instructions. RN [REDACTED] noted (**Exhibit 1, page 10**) mental health staff did not obtain specific consent from MPONDA for the medications given to him. CDR [REDACTED] also documented Dr. [REDACTED] directed that MPONDA should be housed in segregation upon his return to HCDF because of his potential for “behavioral issues” and negative interactions with his peers.

On July 30, 2012, an Administrative Segregation Order and an Inmate Status Change form were created for MPONDA, documenting that he was placed in segregation as a result of his “mental history.”³⁵ The Administrative Segregation Order also documents that MPONDA was “a security risk to self or the security of the facility.” The shift supervisor signed the Administrative Segregation Order, but the signature line for “Medical Officer” was left blank. The Administrative Segregation Order and the Inmate Status Change Form³⁶ lacked specific information regarding the safety and security risk posed by MPONDA, and did not contain supporting documentation concerning his mental history.

On July 30, 2012, at 5:27 p.m., RN [REDACTED] documented that MPONDA was cleared for placement in segregation, and noted that, “Security needs him in seg for safety reasons. Mental Health Team also approved patient should go to seg.”³⁷

On August 3,³⁸ 23,³⁹ 24,⁴⁰ and 30,⁴¹ 2012, an LISW evaluated MPONDA, and on August 15, 2012, Dr. [REDACTED] consulted with mental health staff regarding MPONDA’s medication.⁴² The medical notes from these visits document MPONDA refused all psychotropic medications after returning from West Oaks Hospital, and Dr. [REDACTED] discontinued his medications as a result. Contrary to the notations on the Administrative Review Forms, the medical notes reflect

³² ICE Significant Incident Report, 2013SIR0014485, 9/2/2013, p. 2.

³³ HCDF, Inmate/Detainee Commitment Summary, 7/30/2012.

³⁴ Case Trakker, 2012-07-30, 15:29:00, Encounter: Mental Health, p. 221.

³⁵ Administrative Segregation Order, 7/30/2012.

³⁶ Inmate Status Change Form, 7/30/2012.

³⁷ Case Trakker, 2012-07-30, 17:27:34, Encounter: Nursing, p. 220.

³⁸ Id., 2012-08-03, 12:50:52, Encounter: Mental Health, p. 210.

³⁹ Id., 2012-08-23, 15:24:29, Encounter: Mental Health, p. 192.

⁴⁰ Id., 2012-08-24, 12:38:38, Encounter: Mental Health, p. 189.

⁴¹ Id., 2012-08-30, 08:23:39, Encounter: Mental Health, p. 184.

⁴² Id., 2012-08-15, 11:41:06, Chart Review: -RevPos: Noted, p. 199.

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MPONDA was not exhibiting psychosis, and that staff did not report problems with disruptive behaviors (**Exhibit 7**).

On August 8, 2012, DHS filed a Motion to Reopen (MTR) on MPONDA's immigration case.⁴³

On August 29, 2012, Acting AW [REDACTED] signed an Extended Segregation Notification for DHS-ICE concerning MPONDA. The notification states MPONDA will "remain in B-Segregation on Administrative Segregation due to his disciplinary history and for the safety and security of the facility."⁴⁴ (NOTE: MPONDA is listed as the subject at the top of the form, but another detainee is incorrectly recorded in the comments section.) SME [REDACTED] noted (**Exhibit 1, page 12**) that at the time this notification was signed, MPONDA's disciplinary history at HCDF included one infraction for breaking the light casing in his cell on June 29, 2012. The July 13, 2012 incident where MPONDA bit the finger of an officer who intervened when MPONDA attempted suicide was not put through the disciplinary process.

On September 7, 2012, Dr. [REDACTED] documented MPONDA was refusing all medications, and threatened to, kill himself if the judge doesn't let him go. Dr. [REDACTED] documented MPONDA made numerous suicide threats if he doesn't get released or taken to the hospital, that he remains highly manipulative, and that he wanted to go to the hospital where he has more liberty. Dr. [REDACTED] noted there was no advantage to taking MPONDA to the hospital, and that he was at risk of acting out at the hospital. Dr. [REDACTED] also noted that MPONDA still had chronic delusions (**Exhibit 8**).

From September 7-10, 2012, Dr. [REDACTED] ordered that MPONDA be placed on constant suicide watch with 15-minute checks. Documentation shows officers conducted 15-minute checks,⁴⁵ and nursing staff evaluated MPONDA on September 8,⁴⁶ and September 9, 2012.⁴⁷ The medical records indicate mental health staff did not see MPONDA until September 10, 2012.⁴⁸ The medical record also documents that while on suicide watch, MPONDA refused to comply with orders to change his uniform, resulting in the application of chemical force to gain his compliance.⁴⁹

⁴³ ICE Significant Incident Report, 2013SIR0014485, 9/2/2013, p. 2.

⁴⁴ HCDF Extended Segregation Notification for ICE, 8/29/2012.

⁴⁵ "Monitoring Form," dated 9/7/2012 – 9/10/2012, 5 pp.

⁴⁶ Case Trakker, 2012-09-08, 16:52:46, Encounter: Other – Suicide Watch, page 174; 2012-09-08, 21:52:38, Encounter: Medical Admin, p. 174; 2012-09-08, 22:00:00, Encounter: Nursing, p. 173.

⁴⁷ Id., 2012-09-09, 02:02:19, Encounter: Other – Suicide Watch, p. 172; 2012-09-09, 06:49:00, Encounter: Other, pp. 170-172; 2012-09-09, 16:16:28, Encounter: Sick Call, p. 170; 2012-09-09, 16:17:47, Encounter: Other – Suicide Watch, p. 169.

⁴⁸ Id., 2012-09-10, 08:40:53, Encounter: Mental Health, pp. 164-165.

⁴⁹ Id., 2012-09-07, 11:43:01, Encounter: Medical, p. 178.

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On September 10, 2012, CDR [REDACTED] evaluated MPONDA and removed him from suicide watch.⁵⁰ MPONDA was immediately placed in disciplinary segregation for “conduct that disrupts security refuse to obey orders.”⁵¹ The Disciplinary Segregation Order does not contain specific justification for placing MPONDA on disciplinary segregation, although the justification provided presumably refers to the September 7, 2012, incident when MPONDA refused to change his uniform.

From September 10, 2012, to September 24, 2012, MPONDA was housed in disciplinary segregation.⁵²

On September 17, 2012, CDR [REDACTED] evaluated MPONDA and documented he refused to take his medication.⁵³

On September 24, 2012, MPONDA was transferred from disciplinary segregation to administrative segregation.⁵⁴ The Administrative Segregation Order documents MPONDA was placed in administrative segregation for the “Safety & Security of facility.”⁵⁵

From September 24, 2012, to January 23, 2013, MPONDA remained in administrative segregation. His status in administrative segregation during this time was reviewed regularly.⁵⁶ The Administrative Segregation Review Forms created for MPONDA during this period, excluding those dated November 8, and November 22, 2012, are consistent with those created previously, in that the OIC signing off on the forms indicated his concurrence with the recommendation of the reviewing supervisor, even though no recommendation was made; and, the forms did not document any interviews with MPONDA.⁵⁷

On September 24, October 24, November 23, and December 23, 2012, the HCDF Warden’s Office notified ICE that MPONDA would continue to be held in administrative segregation.⁵⁸

RN Herges noted (**Exhibit 1, page 13**) MPONDA took his medications sporadically between September 24, and January 23, 2012, and mental health staff did not obtain specific consent from MPONDA for the medications ordered during this time.

⁵⁰ Case Trakker, 2012-09-10, 08:40:53, Encounter: Mental Health, pp. 164-165.

⁵¹ Disciplinary Segregation Order, 9/10/2012.

⁵² Special Management Review form, started 9/10/2012, ended 9/24/2012.

⁵³ Case Trakker, 2012-09-17, 08:54:26, Chart Review: -Standard – RevPos: Noted, p. 160.

⁵⁴ Inmate Status Change Form, 9/24/2012, two pp.

⁵⁵ Administrative Segregation Order, start 9/24/2012, end 1/23/2013.

⁵⁶ Special Management Review form, started 9/24/2012, ended 1/23/2013.

⁵⁷ Administrative Segregation Review forms dated 9/27/2012, 10/4/2012, 10/11/2012, 10/18/2012, 10/25/2012, 11/1/2012, and 11/15/2012.

⁵⁸ HCDF Extended Segregation Notification For DHS-ICE forms dated 9/24/2012, 10/24/2012, 11/23/2012, and 12/23/2012.

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On December 28, 2012, Dr. [REDACTED] documented that MPONDA remained very manipulative; that he was essentially off of medications, and he was likely to deteriorate. Dr. [REDACTED] also wrote that he does not advise moving MPONDA to a dorm.” (Exhibit 9).⁵⁹

On January 23, 2013, MPONDA was moved to a general population, “Level Three,” housing unit.⁶⁰ SME [REDACTED] noted (Exhibit 1, page 13) that although MPONDA was incorrectly classified as a “Level Three” detainee during his admission to the facility, his disciplinary incidents while housed at HCDF would have caused him to be appropriately reclassified as a “Level Three.”

CCA Officer [REDACTED] [REDACTED] one of the officers who worked in the general population dorm where MPONDA was housed, advised ODO that MPONDA had made a “remarkable change” from his erratic behavior in segregation and was very cooperative when he was moved to general population.⁶¹

During January and February 2013, MPONDA did not consistently comply with taking his psychotropic medications.⁶² RN Herges noted (Exhibit 1, pages 13-14) MPONDA refused 68 percent of all Risperdal doses and 55 percent of Elavil doses during the first half of January 2013. MPONDA started taking Elavil as ordered during the second half of January 2013, and through February 2013. MPONDA refused all Risperdal doses in February.

On March 1, 2013, LCDR [REDACTED]-[REDACTED] documented she saw MPONDA, and that he was doing well in general population.⁶³

On March 4, 2013, MPONDA was placed in administrative segregation pending a disciplinary hearing after engaging in a fist fight with another detainee.⁶⁴ MPONDA was medically cleared for administrative segregation,⁶⁵ however, RN [REDACTED] noted (Exhibit 1, page 14) mental health staff did not conduct an evaluation of MPONDA before he was moved to segregation.

On March 6, 2013, the Institution Disciplinary Panel held a hearing for MPONDA for the March 4, 2013 fight, and he was sanctioned to 30 days of disciplinary segregation.⁶⁶ On this same date, officers found MPONDA writing with a red pen on the wall of his segregation cell.⁶⁷

⁵⁹ Case Trakker, 2012-12-28, 13:57:57, Encounter: Mental Health, pp. 73-74.

⁶⁰ Inmate Status Change Form, 1/23/2013.

⁶¹ ODO interview of CCA Officer [REDACTED] [REDACTED] 11/6/2013.

⁶² HCDF Medication Administration Record for months 01/2013 and 02/2013.

⁶³ Case Trakker, 2013-03-01, 14:30:34, Encounter: Mental Health, pp. 40-41.

⁶⁴ Incident of Prohibited Acts And Notice of Charges, Form I-884, 3/4/2013.

⁶⁵ Case Trakker, 2013-03-04, 21:10:43, Encounter: Urgent Care, pp. 39-40.

⁶⁶ Institution Disciplinary Panel Report, signed by OIC on 3/7/2013.

⁶⁷ Incident of Prohibited Acts And Notice of Charges, Form I-884, 3/6/2013.

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On March 9, 2013, the Institution Disciplinary Panel held a hearing for MPONDA for writing on his wall. The panel sanctioned MPONDA with “restitution for damages,” requiring him to repaint the wall in his cell.⁶⁸

On March 19, 2013, HCDF released MPONDA from segregation to general population.⁶⁹

MPONDA was housed in general population unit B3 from March 19, 2013, to June 19, 2013, and was housed in general population unit B1 from June 19, 2013, to August 31, 2013.⁷⁰

On March 22, 2013, Dr. [REDACTED] evaluated MPONDA⁷¹ and documented he had antisocial features, he had highly manipulative behaviors, and that without medications, he had a significant risk of deteriorating (**Exhibit 10**).

MPONDA’s continued to refuse Risperdal during the month of March 2013, but he took Elavil as ordered until March 21, 2013, after which he also refused Elavil through the end of the month.⁷²

On March 27, 2013, an immigration judge denied MPONDA’s asylum claim and withholding of removal request because MPONDA did not complete an I-589 Application for Asylum or Withholding of Removal. The Immigration Judge ordered MPONDA removed to the Republic of Mozambique.⁷³

On May 29, 2013, MPONDA filed an appeal with the Board of Immigration Appeals (BIA).⁷⁴

On August 19, 2013, the BIA remanded MPONDA’s case to an immigration judge for further proceedings based on MPONDA’s asylum claim and withholding of removal request.⁷⁵

From March 19, 2013, to August 30, 2013, MPONDA was housed in general population without any disciplinary incidents. MPONDA’s demonstrated poor compliance in taking his medications as ordered during April, May, and early June 2013.⁷⁶

On June 7, 2013, Dr. [REDACTED] evaluated MPONDA and documented he was generally stable and managing in general population, but that he still had “residual psychosis and irritability”

⁶⁸ Institution Disciplinary Panel Report, signed by OIC on 3/13/2013.

⁶⁹ Inmate Status Change Form, 3/19/2013.

⁷⁰ Screen print from GTL Offender Management System.

⁷¹ Case Trakker, 2013-03-22, 10:58:56, Encounter: Mental Health, pp. 21-23.

⁷² HCDF Medication Administration Record for month 03/2013.

⁷³ ICE Significant Incident Report, 2013SIR0014485, 9/2/2013, p. 2.

⁷⁴ Id.

⁷⁵ Id.

⁷⁶ HCDF Medication Administration Record for months 04/2013, 05/2013 and 06/2013.

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(**Exhibit 11**). After seeing Dr. [REDACTED] MPONDA demonstrated a substantial improvement in medication compliance.⁷⁷

On July 19, 2013, Dr. [REDACTED] evaluated MPONDA and scheduled him for a follow-up appointment on August 30, 2013.⁷⁸ MPONDA's MARs showed substantial medication compliance for both Risperdal and Elavil during July and August, 2013.⁷⁹

On August 31, 2013, at approximately 1:00 a.m., MPONDA engaged in a physical fight with detainee [REDACTED] [REDACTED] and was consequently placed in administrative segregation.⁸⁰

Captain [REDACTED] [REDACTED] said that while conducting his rounds during the evening shift on August 30-31, 2013, he encountered MPONDA in the B1 housing unit. Captain [REDACTED] remembered MPONDA playing Scrabble with detainee [REDACTED] that night, and that he was acting "high strung." Captain [REDACTED] said he decided to move MPONDA to another dorm after MPONDA lost a game and got into a verbal argument with [REDACTED]. He said that while MPONDA was packing his belongings to move, MPONDA physically attacked [REDACTED]. Captain [REDACTED] said he placed an emergency call over his radio and separated the two detainees. Captain [REDACTED] said that per CCA policy, following the incident, MPONDA was first escorted to the medical unit for medical clearance to be placed in segregation, and then escorted to segregation.⁸¹ The incident report documents MPONDA struck detainee [REDACTED] on the head with an ink pen after they argued, and that staff first escorted both detainees to the medical unit and then placed them in B-Segregation.⁸² Medical staff examined MPONDA and found no injuries.⁸³

Security staff used handheld video cameras to record the aftermath of MPONDA's and [REDACTED] fight, including removal of the detainees from the B1 housing unit, escort to the medical unit, medical examinations, and placement into cells in B-Segregation (**Exhibit 12**). The video recording shows staff placing MPONDA in wrist restraints behind his back and walking him to the medical unit. While walking, MPONDA throws what appears to be a small white object into a trash receptacle. It is unknown whether the officers escorting MPONDA observed him throwing the object into the trash receptacle. The handheld video recording does not show officers conducting a pat search of MPONDA prior to his being escorted to the medical unit. SME [REDACTED] advised (**Exhibit 1, page 15**) that "prior to placing a detainee in restraints, a thorough pat search should be conducted to ensure no objects are secreted that could be used against staff or other detainees."

⁷⁷ HCDF Medication Administration Record for month 07/2013.

⁷⁸ Case Trakker, 2013-07-19, 12:05:18, Encounter: Mental Health, p. 2-3.

⁷⁹ HCDF Medication Administration Record for month 08/2013.

⁸⁰ HCDF Incident Report 2013-0201-046-III, author [REDACTED] [REDACTED] 8/31/2013.

⁸¹ ODO interview of CCA Captain [REDACTED] [REDACTED] 11/5/2013.

⁸² HCDF Incident Report 2013-0201-046-III, author [REDACTED] [REDACTED] 8/31/2013.

⁸³ eClinicalWorks Progress Notes: [REDACTED] [REDACTED] RN, 8/31/2013, pp. 5-6 of 16.

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At 1:25 a.m., medical staff cleared MPONDA to be moved to “Special Housing Unit (Segregation).”⁸⁴

At 1:30 a.m., Captain [REDACTED] ordered⁸⁵ MPONDA to be placed in administrative segregation, cell 109.⁸⁶

Captain [REDACTED] said that once a detainee is medically cleared for placement in segregation, he is escorted to the segregation unit where he is first pat searched and then placed in a cell. He said that once in the cell, the detainee’s wrist restraints are removed through the cell door’s tray slot, and then the detainee is ordered to remove his clothing in front of an officer who observes from the opposite side of the door. Once he has undressed, the detainee must pass his clothing to the officer through the tray slot, and then put on a green jumpsuit which is provided to him through the tray slot. Captain [REDACTED] said that during such a clothing exchange, detainees remove all clothing except boxer shorts, and officers look for any type of contraband that might be concealed in the clothing. Captain [REDACTED] said he was present on August 31, 2013, when MPONDA was escorted to B-Segregation, and he was there while his restraints were removed, but he did not recall whether he witnessed MPONDA’s clothing exchange. According to Captain [REDACTED] after MPONDA was placed in the cell, officers in B-Segregation retrieved his property from B1 and brought it to B-Segregation to be searched.⁸⁷

The handheld video recording shows MPONDA entering B-Segregation and staff ushering him into cell 109 and immediately closing the cell door. MPONDA then backs up to the cell door to have his wrist restraints removed through the tray slot. Staff removes MPONDA’s wrist restraints, closes the tray slot and walks away from the cell. The recording then stops. The handheld video recording does not show officers conducting a pat search of MPONDA at any time (**Exhibit 12**). The recording of detainee [REDACTED] escort from B1 to the medical unit, and then to B-Segregation, shows that [REDACTED] also did not receive a pat search prior to being placed in a cell (**Exhibit 12**). SME [REDACTED] noted (**Exhibit 1, page 15**) the “clothing exchange and search completed later would not have prevented the introduction of contraband into the segregation unit and directly into MPONDA’s cell.”

Captain [REDACTED] wrote in an incident statement that, “detainee MPONDA was searched before being placed in B-Segregation. All medication was confiscated and given to medical before being assigned to the cell.”⁸⁸

⁸⁴ Division of Immigration Health Services, Report of Detainee Incident/Segregation Review, signed by [REDACTED] [REDACTED] LVN, 8/31/2013, 1:25 a.m.

⁸⁵ Administrative Segregation Order, signed by [REDACTED] [REDACTED] 8/31/2013, 0130.

⁸⁶ Screen print from GTL Offender Management System.

⁸⁷ ODO interview of CCA Captain [REDACTED] [REDACTED] 11/5/2013.

⁸⁸ HCDF Incident Statement 2013-0201-047 1, author [REDACTED] [REDACTED] 9/2/2013.

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CCA Officer [REDACTED] [REDACTED] who was on duty in B-segregation at the time MPONDA was brought in, said that when MPONDA entered B-Segregation, he underwent a regular pat search prior to being placed in a cell. Officer [REDACTED] said he remembers MPONDA's property was brought to B-Segregation from B1, that he and another officer on duty that night went through the property and found an unmarked plastic bottle containing several pills, and that the pills appeared to be damp and partially dissolved. Officer [REDACTED] stated he noted on a scrap piece of paper that the bottle was found in MPONDA's property, and he left the bottle of pills and note on the desk in the unit for the day shift officers to handle.⁸⁹ Officer [REDACTED] wrote in a statement that when MPONDA was admitted to B-Segregation, he was "shaken down for contraband," his property was inventoried, and "All meds were taken and held for medical."⁹⁰ SME [REDACTED] noted (**Exhibit 1, page 16**) that if Officer [REDACTED] had notified a supervisor of the pills in MPONDA's property, a thorough search of MPONDA's cell, and a strip search of MPONDA would have been justified to ensure he had no additional medications hidden.

Officer [REDACTED] also advised ODO that he knew MPONDA well and had a good relationship with him. He said he was aware MPONDA had a history of erratic behavior and of refusing to take his medications. Officer [REDACTED] stated MPONDA seemed to be doing well after he was moved to general population in January 2013. He stated MPONDA was able to function and remain in general population until his fight with detainee [REDACTED] aside from a brief stay in segregation in March.⁹¹ ODO notes that multiple officers interviewed during the course of this review stated they had knowledge of MPONDA's history of refusing and/or hoarding medications.

Captain [REDACTED] said that after the officers in B-Segregation searched MPONDA's property and found the bottle of pills, they notified medical staff and then escorted the pills to the medical unit.⁹²

CCA Officer [REDACTED] [REDACTED] said that when he arrived for work on August 31, 2013, at his assigned day shift duty location in B-Segregation, the night shift officers told him they found a bottle of pills while searching MPONDA's property, and they left the bottle on the officer's desk. Officer [REDACTED] remembers seeing the bottle on the desk, but did not handle or dispose of it.⁹³

⁸⁹ ODO interview of CCA Officer [REDACTED] [REDACTED] 11/5/2013.

⁹⁰ HCDF Incident Statement 2013-0201-047-F, author [REDACTED] [REDACTED] 9/2/2013.

⁹¹ ODO interview of CCA Officer [REDACTED] [REDACTED] 11/5/2013.

⁹² ODO interview of CCA Captain [REDACTED] [REDACTED] 11/5/2013.

⁹³ ODO interview of CCA Officer [REDACTED] [REDACTED] 11/5/2013.

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CCA Chief of Security (COS) ██████ said that if unauthorized pills are found during the search of a segregated detainee's property, the officer finding the pills should notify his or her shift supervisor and deliver the pills to medical staff.⁹⁴

On August 31, 2013, at 9:40 a.m., InGenesis LVN ██████-█████ conducted pill call in B-Segregation.⁹⁵ LVN ██████-█████ stated to ODO that she conducted pill call in B-Segregation on August 31, 2013, at approximately 9:00 a.m., and that MPONDA refused his medications. (The actual log sheet records the time of refusal at 8:45 a.m.⁹⁶) She stated that during pill call, an officer in B-Segregation gave her the bottle of pills found earlier in MPONDA's property when he was brought into the unit. LVN ██████-█████ stated officers typically call medical immediately when pills are found on a detainee. She said she remembers the pills looking damp and partially dissolved. LVN ██████-█████ stated she took the bottle of pills to the medical unit and placed them in the B-Segregation pill cart with a note indicating MPONDA's mouth should be double-checked during pill call to prevent him from hiding any pills in his mouth. LVN ██████-█████ stated that when pills are found on a detainee, protocol for medical staff is to notify a supervisor who in turn notifies medical administration, mental health, and the pharmacy. LVN ██████-█████ said everyone working the shift with her on August 31, 2013, was aware of the bottle of pills, including the charge nurse. LVN ██████ ██████ said the pills were not analyzed until the next regular work day because August 31, 2013, was a Saturday, and the pharmacy is not staffed on weekends.⁹⁷ The next regular work day was Tuesday, September 3, 2013, as Monday, September 2, 2013, was a federal holiday.

InGenesis RN ██████ ██████ said she was the charge nurse on duty at August 31, 2013, but that she was not informed about the bottle of pills found with MPONDA's property. RN ██████ said she would have notified the next shift during her shift report if she had been informed about the bottle of pills. RN ██████ stated it is protocol for medical staff to immediately report an incident like the pills found in MPONDA's property to medical administration, mental health, and the pharmacy.⁹⁸

HCDF's Health Services Administrator (HSA) IHSC Commander (CDR) ██████ ██████ stated that in the event a medical staff member receives a bottle of pills such as the one found in MPONDA's property, it is his expectation and the medical unit's protocol that the supervisor on duty is notified, who in turn immediately notifies the HSA or on-call provider. CDR ██████

⁹⁴ ODO interview of CCA Chief of Security ██████ ██████ 11/5/2013.

⁹⁵ EMAIL from Vicky Walter to ██████ ██████ 9/26/2013, 07:33 AM.

⁹⁶ Segregation Confinement Record for Clemente Mponda, Seg Cell 109, 8/31/2013, entry at 0845.

⁹⁷ ODO telephonic interview of InGenesis LVN ██████ ██████-█████ 11/19/2013.

⁹⁸ ODO telephonic interview of InGenesis RN ██████ ██████ 11/26/2013.

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stated he also expects the supervisor on duty to notify a CCA supervisor so proper monitoring of the detainee can take place.⁹⁹

According to CDR [REDACTED] after MPONDA's death, the HCDF's pharmacist analyzed the pills found in MPONDA's property and determined they included 21 units of amitriptyline, and 12 units of risperidone. The pharmacist documented his findings on a Post-it note, a copy of which (**Exhibit 13**) was provided to ODO.

CCA Officer [REDACTED] [REDACTED] who was assigned to B-Segregation during the day shift on August 31, and on September 1, 2013, said he remembers MPONDA primarily sleeping during the day on both August 31, and September 1, 2013. Officer [REDACTED] said that during the afternoon of September 1, 2013, MPONDA became more active, moved around his cell, asked for the television channel to be changed, and ate his dinner.¹⁰⁰ MPONDA was noted to have been awake on September 1, 2013, from when he accepted his food tray at 4:40 p.m., until he was found to be sleeping at 11:43 p.m.¹⁰¹

LVN [REDACTED] - [REDACTED] stated that when she conducted pill call on the morning of September 1, 2013, MPONDA took his Elavil, but refused his Risperdal.¹⁰²

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The following events were recorded in logs, incident statements, and video surveillance footage. The documented times of specific events in these records do not exactly match, as security cameras, clocks, and watches are not calibrated with each other. Specifically, the video surveillance footage is approximately ten minutes behind logged times.

On September 1, 2013, at 6:00 p.m., Officers [REDACTED] [REDACTED] and [REDACTED] [REDACTED] logged that they assumed the B-Segregation post, and that Captain [REDACTED] was the Shift Supervisor.¹⁰³

Officers [REDACTED] and [REDACTED] conducted regular 30-minute security checks in B-Segregation at 6:07 p.m., 6:35 p.m., 7:03 p.m., 7:31 p.m., 7:59 p.m., 8:35 p.m., 8:55 p.m., 9:23 p.m., 9:51 p.m., 10:20 p.m., 10:48 p.m., 11:12 p.m., 11:40 p.m., 12:00 a.m. (September 2), 12:28 a.m., and 12:56 a.m.¹⁰⁴ Video surveillance footage of B-Segregation confirms the occurrence of those 30-minute checks (**Exhibit 14**).

⁹⁹ ODO interview of IHSC CDR [REDACTED] [REDACTED] 11/6/2013.

¹⁰⁰ ODO interview of CCA Officer [REDACTED] [REDACTED] 11/5/2013.

¹⁰¹ Segregation Confinement Record, Clemente Mponda, Seg Cell: 109, 9/1/2013.

¹⁰² ODO telephonic interview of InGenesis LVN [REDACTED] [REDACTED] - [REDACTED] 11/19/2013.

¹⁰³ HCDF B-Segregation Housing Log, 9/1/2013, p. 18.

¹⁰⁴ Id.

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During the 12:56 a.m. security check, Officer [REDACTED] found MPONDA on the bunk in his cell, bleeding, and noted the time as 12:59 a.m.¹⁰⁵

Officer [REDACTED] advised ODO that after he assumed his post on September 1, 2013, he talked to MPONDA and remembers him being in a good mood.¹⁰⁶ Officer [REDACTED] wrote in his incident statement that on the night of September 1, 2013, MPONDA interacted normally, asked for the television channel to be changed, and took his medication during pill call.¹⁰⁷ Officer [REDACTED] said he and Officer [REDACTED] took turns conducting 30-minute security checks. He stated he personally conducted 3 or 4 checks during which he remembers seeing MPONDA in his bed and breathing. Officer [REDACTED] said he specifically remembers MPONDA snoring unusually loud that night, but did not recall if or when the snoring ceased. Officer [REDACTED] said Officer [REDACTED] conducted the 12:56 a.m. security check, and that when Officer [REDACTED] checked MPONDA's cell, he yelled to Officer [REDACTED] that MPONDA did not look good. Officer [REDACTED] said he joined Officer [REDACTED] at MPONDA's cell, and they beat on the mesh window of the cell door to get MPONDA's attention. When MPONDA did not respond, Officer [REDACTED] called a medical emergency over the radio.¹⁰⁸

The video surveillance footage shows Officer [REDACTED] at MPONDA's cell at 12:59 a.m. (1:09 a.m. video time). Officer [REDACTED] is seen joining Officer [REDACTED] at MPONDA's cell door, and then walking to the officer's desk to retrieve his radio (**Exhibit 14**).

Officer [REDACTED] wrote in his incident statement that at 12:59 a.m., he saw MPONDA lying on his side with blood coming from his mouth, that he tried to wake MPONDA, and when MPONDA did not respond, he notified Captain [REDACTED] over his radio.¹⁰⁹

Officer [REDACTED] stated to ODO that after he observed the blood near MPONDA's mouth, he tried to get MPONDA to respond by yelling to him through the cell door. Officer [REDACTED] said he called Captain [REDACTED] and placed a medical emergency call over his radio when MPONDA did not respond. Officer [REDACTED] said he then tapped on the window of MPONDA's cell door and continued to try to wake him.¹¹⁰

When asked about their ability to enter MPONDA's cell, the officers provided differing responses. Officer [REDACTED] said he received keys to the cells in B-Segregation at the start of his shift, and that the cell keys are checked in and out of B-Control at the beginning and end of each shift. He said that although he is not required to wait for a supervisor before unlocking and

¹⁰⁵ HCDF B-Segregation Housing Log, 9/1/2013, p. 18.

¹⁰⁶ ODO interview of CCA Officer [REDACTED] 11/5/2013.

¹⁰⁷ HCDF Incident Statement 2013-0201-047-F, author [REDACTED] 9/2/2013.

¹⁰⁸ ODO interview of CCA Officer [REDACTED] 11/5/2013.

¹⁰⁹ HCDF Incident Statement 2013-0201-047-I, author [REDACTED] 9/2/2013.

¹¹⁰ ODO interview of CCA Officer [REDACTED] 11/5/2013.

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entering a cell, he did not enter MPONDA's cell that evening because he knew MPONDA had a history of being aggressive with detention staff.¹¹¹ Officer ██████ said he never unlocks a cell door without at least one other officer present, and he typically places a detainee in wrist restraints through the cell door's tray slot before unlocking the door. He said that once the detainee is in restraints, a supervisor does not need to be present when the officer unlocks the door.¹¹² Captain ██████ advised ODO it is policy to wait for a shift supervisor to be present before entering a cell in B-Segregation, that officers do not have keys to the cells, and B-Control must open the cell doors remotely.¹¹³ Facility policy states detainees must be placed in wrist restraints prior to a cell door being opened except in emergency situations, including medical emergencies.¹¹⁴

Captain ██████ wrote in his incident statement that RN ██████ ██████ and LVN ██████ ██████ arrived at B-Segregation just after him at 1:03 a.m.¹¹⁵ Captain ██████ said that when he arrived in B-Segregation, he approached MPONDA's cell and observed MPONDA "draped" on his bed with a small amount of blood near his mouth. Captain ██████ said he called out to MPONDA a few times and then asked CCA Officer ██████ ██████ to open the cell door. He said Officer ██████ unlocked the cell door, and he and one of the nurses moved MPONDA to the floor. Captain ██████ said medical staff immediately began performing CPR and he instructed Officer ██████ to call 911. Captain ██████ said he did not assist medical staff with CPR, but that all officers are trained in CPR.¹¹⁶

B-Control called 911 at 1:04 a.m.¹¹⁷

RN ██████ stated that around 1:00 a.m., CCA Officer ██████ ██████ informed her that a medical emergency call was made from B-Segregation concerning a detainee who was down and unresponsive. She said she and LVN ██████ accompanied by Officer ██████ immediately responded to B-Segregation with an Automated External Defibrillator (AED), arriving at MPONDA's cell in about four minutes. RN ██████ said MPONDA's cell was already unlocked and open, and MPONDA was lying on his side, facing the door, with blood on his chin and bed. She said officers were standing in front of the cell waiting for medical to arrive. RN ██████ said she helped one of the officers move MPONDA to the floor, checked MPONDA for a pulse, told LVN ██████ to bring the AED, and asked Captain ██████ to call 911. She said the four minutes that elapsed between the medical emergency call and medical's arrival on the scene was sufficient time for officers to move MPONDA to the floor and initiate CPR. RN ██████

¹¹¹ ODO interview of CCA Officer ██████ ██████ 11/5/2013.

¹¹² ODO interview of CCA Officer ██████ ██████ 11/5/2013.

¹¹³ ODO interview of CCA Captain ██████ ██████ 11/5/2013.

¹¹⁴ CCA Post Orders, Post Segregation, P.O. Number CCA-PO-23, 12/30/2010.

¹¹⁵ HCDF Incident Statement 2013-0201-047 1, author ██████ ██████ 9/2/2013.

¹¹⁶ ODO interview of CCA Captain ██████ ██████ 11/5/2013.

¹¹⁷ HCDF B-Control Log, 9/2/2013, p. 247.

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said she and LVN [REDACTED] administered CPR for about 15 minutes, at which point emergency medical services (EMS) workers arrived. She said no officer offered to assist during the 15 minutes she and LVN [REDACTED] were administering CPR.¹¹⁸ RN [REDACTED] did not complete an incident statement.

LVN [REDACTED] provided essentially the same information as RN [REDACTED] and added that the AED advised two shocks to MPONDA, indicating it picked up a heartbeat twice.¹¹⁹ LVN [REDACTED] did not complete an incident statement.

COS Forges advised ODO that, during a medical emergency in segregation, officers typically wait for medical staff and a handheld video camera to be present before opening a cell door and initiating CPR.¹²⁰

CCA Officer [REDACTED] [REDACTED] advised ODO that she responded to the medical emergency call regarding MPONDA and immediately retrieved a handheld camera when she arrived on scene and saw medical staff performing CPR. Officer [REDACTED] said she gave the camera to Officer [REDACTED] and instructed Officer [REDACTED] to record the incident. Officer [REDACTED] said she then went to the facility's back gate to escort emergency workers into the facility.¹²¹

Officer [REDACTED] confirmed that Officer [REDACTED] gave her a handheld camera and instructed her to record everything happening regarding MPONDA.¹²² She also completed an incident statement in which she documented her use of the camera.¹²³ The handheld video recording (**Exhibit 15**) shows RN [REDACTED] and LVN [REDACTED] conducting CPR for approximately 15 minutes without assistance from officers and becoming visibly fatigued. RN [REDACTED] noted the video shows that as the nurses became fatigued, they were unable to maintain proper arm position while administering CPR, which diminished the CPR's effectiveness (**Exhibit 1, page 18**). The recording shows resuscitation efforts until the moment EMS transported MPONDA to MHNH.

At 1:14 a.m., Captain [REDACTED] notified ICE Deportation Officer [REDACTED] [REDACTED] of what had occurred.¹²⁴

At 1:16 a.m., EMS workers arrived at B-Segregation.¹²⁵ Video surveillance footage shows EMS entering at 1:23 a.m., video time (**Exhibit 14**).

¹¹⁸ ODO interview of InGenesis RN [REDACTED] [REDACTED] [REDACTED] 11/5/2013.

¹¹⁹ ODO interview of InGenesis LVN [REDACTED] [REDACTED] 11/5/2013.

¹²⁰ ODO interview of CCA Chief of Security [REDACTED] [REDACTED] 11/5/2013.

¹²¹ ODO interview of CCA Officer [REDACTED] [REDACTED] 11/5/2013.

¹²² ODO interview of CCA Officer [REDACTED] [REDACTED] 11/5/2013.

¹²³ HCDF Incident Statement 2013-0201-047 I, author [REDACTED] [REDACTED] 9/2/2013.

¹²⁴ EMAIL from Christopher Toral to [REDACTED] [REDACTED] 9/2/2013, 03:43 AM.

¹²⁵ HCDF B-Control Log, 9/2/2013, p. 247.

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From approximately 1:18 a.m. to 1:55 a.m., EMS workers administered CPR to MPONDA in B-Segregation using a CPR compression sleeve (**Exhibit 15**).

CDR [REDACTED] stated LVN [REDACTED] called him at about 1:30 a.m. to notify him MPONDA was down and EMS workers were administering CPR. CDR [REDACTED] said he told LVN [REDACTED] to gather all medical documentation regarding MPONDA and to notify the on-call provider. CDR [REDACTED] said he then called and notified HCDF's Clinical Director, IHSC [REDACTED] MD. CDR [REDACTED] said he was informed about the bottle of pills found in MPONDA's property when he arrived at HCDF the morning of September 2, 2013. He said he sealed, labeled, and stored the bottle of pills until they could be analyzed by a pharmacist.¹²⁶

At 1:55 a.m., Captain [REDACTED] Officer [REDACTED] and six EMS workers exited B-Segregation with MPONDA, and at 2:00 a.m., the ambulance carrying MPONDA left HCDF for MHNH.¹²⁷

At 2:08 a.m., the ambulance carrying MPONDA arrived at MHNH (**Exhibit 16**).

At 2:19 a.m., Dr. [REDACTED] of MHNH declared MPONDA dead.¹²⁸

At 2:53 a.m., AFOD [REDACTED] notified the JIC of MPONDA's death.¹²⁹

At 4:19 a.m., B-Control called Houston Police Department (HPD) per Captain [REDACTED] direction.¹³⁰

At 4:40 a.m., DHS Office of the Inspector General (OIG) Special Agent (SA) [REDACTED] arrived at HCDF, and he departed at 5:20 a.m., advising he did not find evidence of any civil rights violations.¹³¹

At 5:25 a.m., HPD officers arrived at MHNH to begin their investigation of MPONDA's death.¹³² The police report documents that HPD officers examined MPONDA's body and did not observe any clear or visible signs of trauma or violence, and that the cause of death was unknown at the time of the investigation (**Exhibit 16**).

At 7:55 a.m., HPD officers arrived at HCDF¹³³ and were met by CCA Investigator [REDACTED] and COS [REDACTED].¹³⁴ The HPD officers departed the facility at 12:20 p.m. Their police report documents the only remarkable item found in MPONDA's cell was a handwritten note

¹²⁶ ODO interview of IHSC CDR [REDACTED] 11/6/2013.

¹²⁷ HCDF B-Control Log, 9/2/2013, p. 247.

¹²⁸ CCA hospital log book, 9/2/2013, p. 127, entry at 0219.

¹²⁹ ERO Notification & Reporting of Detainee Deaths, Individual Incident Checklist, for Clemente MPONDA.

¹³⁰ HCDF B-Control Log, 9/2/2013, p. 248.

¹³¹ EMAIL from [REDACTED] to David Jennings, 9/2/2013, 05:26 AM.

¹³² CCA hospital log book, 9/2/2013, p. 127, entry at 0525.

¹³³ HCDF B-Control Log, 9/2/2013, p. 248.

¹³⁴ CCA Investigation Report Form, Facility: 201-007-13, author [REDACTED] 9/9/2013.

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which read, “For dust you are and to dust you will return! JAHOPE! Life after death!” HPD officers interviewed detainee [REDACTED] who stated to them that he and MPONDA were friends, and that MPONDA had expressed that he did not want to go back to Mozambique, because something terrible had happened to him there. Detainee [REDACTED] said MPONDA had recently learned an immigration judge agreed to re-hear his case, which made MPONDA happy. Detainee [REDACTED] said MPONDA was very religious and had referred to God as “Jahope.” He said MPONDA did not talk about killing himself, but that he told [REDACTED] “Jahope” would take care of him (**Exhibit 16**). (NOTE: ODO also learned from various HCDF staff that MPONDA referred to his God as Jahope).

Investigator [REDACTED] advised ODO that she was informed of MPONDA’s death at approximately 3:00 a.m. on September 2, 2013, and that she arrived at the facility at approximately 4:00 a.m. She said that when she arrived at the facility, she took statements from the officers who responded to the medical emergency call and who were present during the resuscitation efforts; that she searched MPONDA’s cell; and, that she reviewed the handheld footage of the resuscitation efforts, as well as the surveillance tapes from MPONDA’s fight in B1 on August 31, 2013. Investigator [REDACTED] said she did not notice while reviewing the handheld footage from August 31, 2013, that MPONDA had not received a pat search before being placed in segregation. She said she learned about the bottle of pills found in MPONDA’s property when she took Officer [REDACTED] statement following the death, but that she did not investigate it any further, as she believed the medical unit handled it. Investigator [REDACTED] acknowledged that CCA officers did not assist RN [REDACTED] and LVN [REDACTED] with CPR, but she stated she did not think it was unusual for medical personnel to administer CPR without assistance from security staff. Investigator [REDACTED] said that when the HPD officers arrived, she briefed them on the events surrounding MPONDA’s death, reviewed surveillance tapes with them, and provided them with the officer statements.¹³⁵

On September 2, 2013, at 1:40 p.m., the Harris County Institute of Forensic Sciences performed an autopsy of MPONDA’s body. An HPD officer present noted the only preliminary finding from the autopsy was that MPONDA’s stomach contained a large amount of whitish granular material, “raising the possibility that there was a large amount of partially digested pills in his stomach.” The officer noted an official ruling on MPONDA’s cause of death would not be made until toxicology and other lab results were received (**Exhibit 16**).

¹³⁵ ODO interview of CCA Investigator [REDACTED] [REDACTED] 11/7/2013.

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EVENTS NOTED POST-SEPTEMBER 2, 2013

On September 3, 2013, AFOD [REDACTED] notified [REDACTED] [REDACTED] of the Embassy of the Republic of Mozambique of MPONDA's death.¹³⁶

COS [REDACTED] advised ODO that he held a debriefing regarding MPONDA for supervisory security staff on September 3, 2013. COS [REDACTED] stated he addressed the failure of security staff to assist with CPR and advised them they should have offered assistance.¹³⁷

On September 4, 2013, detainee [REDACTED] [REDACTED] [REDACTED] told medical staff that on August 30, 2013, he witnessed MPONDA place medication in one of his socks prior to his altercation with detainee [REDACTED]. CDR [REDACTED] advised ODO that he immediately notified AW [REDACTED] and AFOD [REDACTED] of [REDACTED] [REDACTED] claim.¹³⁸ AFOD [REDACTED] notified HPD of this information that same day. HPD officers documented in the police report that they met with detainee [REDACTED] [REDACTED] on September 5, 2013, regarding the allegation MPONDA placed medication in his socks on August 30, 2013, but that detainee [REDACTED] [REDACTED] refused to answer any questions or provide a written statement regarding the allegation (**Exhibit 16**).

CDR [REDACTED] stated he conducted a debriefing of HCDF supervisors from both security and medical staffs on September 4, 2013, to identify issues raised by MPONDA's death, including operational areas needing improvement and future training needs. CDR [REDACTED] stated the following specific resolutions were identified during the debriefing: several types of medications will be routinely crushed in the future before being administered to detainees, medications will not continue to be automatically refilled, medical staff will participate in shakedowns, and the requirement that both security and medical staff conduct mouth checks will be enforced. CDR [REDACTED] stated he also addressed concerns regarding the failure of officers to initiate or assist with MPONDA's CPR.¹³⁹

On February 10, 2014, the Harris County Institute of Forensic Sciences released the autopsy report. The cause of death was determined to be the combined toxicity of amitriptyline and risperidone, and the manner of death was ruled to be undetermined (**Exhibit 17**).

SECURITY AND HEALTHCARE REVIEW

Creative Corrections, a national management and consultant firm contracted by ICE to provide subject matter expertise in detention management including security and healthcare, reviewed the safety and security of MPONDA while he was detained at HCDF, as well as the medical care he

¹³⁶ Letter from [REDACTED] [REDACTED] to [REDACTED] [REDACTED] transmitted by fax on 9/3/2013, 10:35 a.m.

¹³⁷ ODO interview of CCA Chief of Security [REDACTED] [REDACTED] 11/5/2013.

¹³⁸ ODO interview of IHSC CDR [REDACTED] [REDACTED] 11/6/2013.

¹³⁹ ODO interview of IHSC CDR [REDACTED] [REDACTED] 11/6/2013.

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was provided while housed there. Creative Corrections found HCDF did not fully comply with the following ICE PBNDS: Classification System, Special Management Units, Contraband, Facility Security and Control, Emergency Plans, Medical Care, and Suicide Prevention and Intervention. The Creative Corrections Security and Healthcare Compliance Analysis is included as an Exhibit to this report (**Exhibit 1**).

IMMIGRATION AND DETENTION HISTORY

On August 20, 2007, MPONDA entered the United States at Atlanta, Georgia, on an F-1 student visa, valid from August 9, 2007, to August 8, 2008.

On May 26, 2012, ICE Designated Immigration Officer (287(g)), [REDACTED] encountered MPONDA at the Harris County Jail in Houston, TX. Officer [REDACTED] interviewed MPONDA who admitted to being a citizen and national of the Republic of Mozambique, and who claimed to have no fear of returning to his home country.

On May 29, 2012, ICE ERO served MPONDA with an NTA, charging Section 237(a)(1)(B) of the Immigration and Nationality Act, for remaining in the United States for a time longer than permitted.

On May 29, 2012, the Harris County Jail released MPONDA into ICE custody. ICE ERO placed MPONDA at the HCDF.

On July 16, 2012, an immigration judge administratively closed MPONDA's immigration case.

On August 8, 2012, the Department of Homeland Security filed a motion to reopen MPONDA's immigration case.

On March 27, 2013, an immigration judge denied MPONDA's asylum claim and withholding of removal request because MPONDA did not complete an I-589 Application for Asylum or Withholding of Removal. The immigration judge ordered MPONDA removed to the Republic of Mozambique.

On May 29, 2013, MPONDA filed an appeal with the Board of Immigration Appeals.

On August 19, 2013, the Board of Immigration Appeals remanded MPONDA's immigration case back to the immigration judge for further proceedings based on MPONDA's asylum claim and withholding of removal request.

CRIMINAL HISTORY

According to the National Crime Information Center (NCIC), MPONDA was assigned an FBI number, a Connecticut state identification (SID) number, and a Texas SID. On June 26, 2011,

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MPONDA was charged with sexual assault, unlawful restraint, and resisting arrest in New Haven, Connecticut. These charges were not prosecuted. MPONDA had one conviction for "Theft \$50-\$500," in Harris County, TX, on May 21, 2012.

INVESTIGATIVE FINDINGS

Safety and Security

MPONDA had been detained at HCDF for one year and three months at the time of his death. MPONDA was assigned to administrative segregation immediately upon admission to HCDF on May 29, 2013, due to his history of assaultive behavior, and to preserve the safety and security of the facility. He was housed in both administrative and disciplinary segregation for approximately eight of the fifteen months at HCDF, including three days spent on suicide watch. Regular segregation status reviews were conducted throughout the time MPONDA was housed in segregation. However, these reviews did not document specific justification for keeping MPONDA on a segregation status, and did not show participation or input from the mental health professionals who worked with MPONDA regarding his segregation status.

After being transferred to general population on January 23, 2013, MPONDA functioned well. He was involved in one fight on March 4, 2013, which resulted in a sanction of disciplinary segregation. When MPONDA returned to general population on March 19, 2013, he spent over five months there without incident.

MPONDA physically attacked another detainee during the early morning hours on August 31, 2013. After undergoing a medical examination, he was immediately placed in administrative segregation pending a disciplinary hearing. Handheld video recording from August 31, 2013, shows MPONDA was not searched for contraband before or after being placed in a segregation cell. Additionally, when MPONDA's property was searched on August 31, 2013, discovery of a bottle of partially dissolved pills did not prompt officers to search MPONDA for contraband. Through interviews with security staff at HCDF, ODO learned officers are unclear about the protocol for searching detainees admitted to segregation.

On September 2, 2013, at 12:59 a.m., an officer found MPONDA unresponsive in his cell during a routine security check. Records show officers properly completed routine 30-minute security checks of the segregation unit. The officer who found MPONDA immediately placed a medical emergency call over his radio. ODO learned during the review that officers did not enter MPONDA's cell until medical staff arrived on the scene. Their wait to enter the cell delayed the initiation of CPR, and did not comply with CCA Post Order 23, Segregation, which permits officers to open a cell door during a medical emergency without needing to first restrain the

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detainee inside.¹⁴⁰ Additionally, as observed in the handheld video recording of MPONDA's resuscitation efforts, officers did not assist medical staff members with CPR.

ODO determined HCDF did not fully comply with the ICE PBNDS 2008 on Classification System, Special Management Units, Contraband, Facility Security and Control, and Emergency Plans.

1. ICE PBNDS 2008, Classification System, section (V)(C), Intake/Processing Officer Duties (Initial Classification), states, "The classification officer assigned to intake processing will review the detainee's A-file, work-folder and information provided by ICE/DRO to identify and classify each new arrival according to the Detention Classification System (DCS)."

ODO determined MPONDA was incorrectly classified as a "Level Three" detainee instead of a "Level One" detainee.¹⁴¹ HCDF's classification officer acknowledged she gave MPONDA incorrect high rating scores for his prior charges and convictions, and that the inaccurate ratings were carried through to all of his classification reassessments thereafter.¹⁴²

2. ICE PBNDS 2008, Classification System, section (V)(D), Classification Review, states, "The designated classification supervisor (if the facility has one) or first-line supervisor shall review the intake processing officer's classification files for accuracy and completeness."

HCDF's classification supervisor acknowledged she reviewed and approved MPONDA's initial and subsequent classification assessments which contained incorrect ratings.¹⁴³

3. ICE PBNDS 2008, Classification System, section (V)(B), First Reassessment, states, "A Classification Reassessment shall be completed 60 to 90 days after the date of the initial assessment."

MPONDA's first classification reassessment took place on September 28, 2012, 119 days after his initial assessment, and the form was marked "60 days."¹⁴⁴ Failure to conduct a classification reassessment within 60 to 90 days also violates CCA Policy 18-1, Internal Classification Assessment System, section 4(E)(1), which requires compliance with the

¹⁴⁰ CCA Post Orders, Post Segregation, P.O. Number CCA-PO-23, 12/30/2010.

¹⁴¹ USINS Detainee Classification System – Primary Assessment Form, Clemente Mponda, Classified by [REDACTED] 5/29/2012.

¹⁴² ODO interview of CCA Classification Officer [REDACTED] 11/6/2013.

¹⁴³ ODO interview of CCA Classification Supervisor [REDACTED] 11/7/2013.

¹⁴⁴ USINS Detainee Classification System – Secondary Assessment Form, Clemente Mponda, Classified by [REDACTED] 9/28/2012.

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ICE PBNDS in completing the first classification reassessment 60 to 90 days after the initial assessment.¹⁴⁵

4. ICE PBNDS 2008, Classification System, section (V)(B), Special Reassessment, states, “A special reassessment is to be completed within 24 hours before a detainee leaves disciplinary segregation, and at any other time when additional, relevant information becomes known. Reclassification may occur as a result of an assault, a criminal act, or victimization.”

MPONDA was released from disciplinary segregation on three separate occasions: July 8, 2012; September 24, 2012; and, March 19, 2013. MPONDA’s detention records do not contain documentation that classification reassessments were completed on any of those dates.

5. ICE PBNDS 2008, Special Management Units, section (V)(C)(1)(b), Reasons for Placement in Administrative Segregation, states, “A detainee may be placed in Administrative Segregation when the detainee’s continued presence in the general population poses a threat to life, property, self, staff, or other detainees, for the secure and orderly operation of the facility, for medical reasons, or other circumstances set forth below. Some examples of incidents warranting a detainee’s assignment to Administrative Segregation include, but are not limited to, the following: A detainee is a threat to the security of the facility. The facility administrator may determine that a detainee’s criminal record, past behavior at other institutions, behavior while in ICE/DRO detention, or other evidence is sufficient to warrant placement of the detainee in Administrative Segregation. Copies of records supporting this action shall be attached to the Administrative Segregation Order.”

MPONDA’s Administrative Segregation Orders and Inmate Status Change forms from May 29, 2012, July 30, 2012, and September 24, 2012, list “threat to facility security” as one of the reasons for assigning MPONDA to administrative segregation. Those orders do not contain additional attached records or documentation supporting the decision to assign MPONDA to administrative segregation.

6. ICE PBNDS 2008, Special Management Units, section (V)(C)(2), Administrative Segregation Order, states, “A written order shall be completed and approved by a security supervisor before a detainee is placed in Administrative Segregation, except when exigent circumstances make this impracticable. In such cases, an order shall be prepared

¹⁴⁵ CCA Policy 18-1: Internal Classification Assessment System (ICAS), Facility Effective Date 2/1/2010.

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as soon as possible. A copy of the order shall be given to the detainee within 24 hours, unless delivery would jeopardize the safety, security, or orderly operation of the facility.”

MPONDA’s detention record does not contain documentation showing he received any of his Administrative Segregation Orders.

7. ICE PBNDS 2008, Special Management Units, section (V)(C)(2)(a), Administrative Segregation Order, states, “The facility administrator or designee shall complete the Administrative Segregation Order (Form I-885 or equivalent), detailing the reasons for placing a detainee in Administrative Segregation, before his or her actual placement.”

MPONDA’s detention record did not contain an Administration Segregation Order for his July 8, 2012 assignment to Administrative Segregation after he completed a term in disciplinary segregation. ODO notes the record does contain an Inmate Status Change form for MPONDA’s assignment to administrative segregation on July 8, 2012, but this form does not provide current, detailed reasons for the assignment, and it is not a substitute for an Administrative Segregation Order.

8. ICE PBNDS 2008, Special Management Units, section (V)(C)(1)(e), Reasons for Placement in Administrative Segregation, states, “A medical professional who ordered a detainee removed from the general population shall complete and sign an Administrative Segregation Order (see below), unless the detainee is to stay in the medical department’s isolation ward.”

MPONDA’s medical documentation indicates Dr. [REDACTED] ordered MPONDA be placed in administrative segregation upon his return from West Oaks Hospital on July 30, 2012. MPONDA’s July 30, 2012 Administrative Segregation Order notes both “mental history” and “Security risk to self or security of the facility,” but is not signed by Dr. [REDACTED] and does not include any supporting documentation, leaving ambiguity as to the specific rationale for assigning MPONDA to administrative segregation.

9. ICE PBNDS 2008, Special Management Units, section (V)(C)(3)(a), Review of Detainee Status in Administrative Segregation, states, “A security supervisor shall conduct a review within 72 hours of the detainee’s placement in Administrative Segregation to determine whether separation is still warranted. The review shall include an interview with the detainee. A written record shall be made of the decision and the justification.”

MPONDA’s Administrative Segregation reviews consistently omitted documentation that he was interviewed during his reviews. AW [REDACTED] explained he regularly interviewed

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detainee MPONDA, but the interviews were not documented. Additionally, justification for keeping MPONDA in administrative segregation was only documented on the Administrative Segregation Review forms through a pre-printed checklist. Supporting documentation of the specific reasons for maintaining MPONDA's segregation status was not included.

Although the Administrative Segregation Review form dictates a detainee who meets any checklist criteria must remain on administrative segregation, it also requires a reviewing supervisor to make a recommendation as to whether the detainee should remain in administrative segregation. Nine of the 11 Administrative Segregation Review forms for MPONDA that ODO reviewed show the reviewing supervisor did not make a recommendation regarding continuation of his segregation status.

Finally, although documentation shows HCDF regularly conducted an initial 72-hour review of MPONDA's placement in segregation, CCA Policy 10-100, Segregation Management, only requires the segregation committee to provide a review of a detainee's placement in administrative segregation every seven days for the first two months, which does not comply with the ICE PBNDS 2008, Special Management Units, described above.

10. ICE PBNDS 2008, Special Management Units, section (V)(C)(3)(b), Review of Detainee Status in Administrative Segregation, states, "A security supervisor shall conduct the same type of review after the detainee has spent seven days in Administrative Segregation and every week thereafter, for the first 60 days and (at least) every 30 days thereafter."

Although seven-day reviews were faithfully conducted throughout MPONDA's time in administrative segregation, the Administrative Segregation Review forms do not document that MPONDA was interviewed during the reviews as required under section (V)(C)(3)(a) of the standard. Additionally, reviewing supervisors consistently neglected to make a recommendation regarding the continuation of MPONDA's segregation status on the Administrative Segregation Review forms, and the forms do not include documentation supporting the specific rationale for maintaining MPONDA's segregation status.

11. ICE PBNDS 2008, Special Management Units, section (V)(C)(3)(h), Review of Detainee Status in Administrative Segregation, states, "When a detainee has been held in Administrative Segregation for more than 30 days, the facility administrator shall notify

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the Field Office Director (FOD), who shall notify the ICE/DRO Assistant Director, Detention Management Division in writing.”

Since MPONDA was admitted to HCDF on May 29, 2012, and immediately placed and maintained in administrative segregation, HCDF was required to notify the FOD of MPONDA’s status on June 29, 2012. Notice to the FOD was not made until July 10, 2012.

12. ICE PBNDS 2008, Contraband, section (I), Purpose and Scope, states, “This Detention Standard protects detainees and staff and enhances facility security and good order by identifying, detecting, controlling, and properly disposing of contraband. Narcotics and other controlled substances not dispensed or approved by the medical department, not used as prescribed, or in the possession of a detainee other than the person for whom it was prescribed are considered “hard” contraband.” Section (V)(B), Procedures for Handling Contraband, states, “All facilities shall have written policy and procedures for the handling of contraband.”

After MPONDA was placed in administrative segregation on August 31, 2012, his property was searched and a bottle of partially dissolved pills was discovered. Those pills constituted hard contraband. CCA Policy 9-6, Contraband Control, section 9-6.5(B), states, “When any CCA employee discovers a Contraband item, that employee will: Confiscate the item; Notify his/her supervisor of the discovery; Document in report form who the Contraband item was taken from, the location and time of the discovery, and the immediate action taken” The officers in B-Segregation on the morning of August 31, 2012, did not notify a supervisor that a bottle of pills was discovered, and did not create a report concerning the pills.

13. ICE PBNDS 2008, Facility Security and Control, section (V)(D)(5)(E)(1), Special Management Units, states, “Because Special Management Units are inherently among the most secure areas of any detention facility, special security and control measures are required. Every facility administrator shall establish written policy and procedures to secure the SMU from contraband.”

CCA Policy 9-5, Searches of Inmates/Residents and Various Locations, does not address searching detainees upon admission to segregation. However, CCA Policy 10-100, Segregation Management, directs, “Any item allowed into the unit will be thoroughly inspected and searched to prevent the introduction of contraband, including...personal property.” Furthermore, the policy states, “No property will be taken into the segregation area until it has been searched by the segregation officer.”

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During interviews with officers regularly assigned to work in B-Segregation, ODO learned that officers have varying ideas on how detainees are searched upon admission to B-Segregation. One officer stated that during clothing exchange, a detainee strips down to his boxer shorts and socks, and passes the rest of his clothing to an officer through the tray slot for inspection and storage; a second officer stated detainees are permitted to keep their T-shirt, boxer shorts, and socks on; a third officer stated detainees must remove all clothing except for boxer shorts. SME ██████ advised allowing detainees to retain personal clothing items without being searched when placed in the cell, circumvents the policy.

Additionally, according to HCDF Post Order 23, Segregation, every detainee must be frisk searched upon assignment to segregation, unless reasonable suspicion that the detainee is in possession of contraband exists, which would warrant a strip search with supervisory approval. Handheld video footage of MPONDA's escort to and placement in B-Segregation does not show he was subject to a frisk search at any time. Further, when the bottle of partially dissolved pills was discovered in MPONDA's property, officers had sufficient justification to notify a supervisor for approval to conduct a strip search under both Post Order 23, and ICE PBNDS 2008, Searches of Detainees, section (V)(D)(2)(c), Reasonable Suspicion.

14. 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."

Investigator Johnson, during her investigation of MPONDA's death, did not collect written incident reports from any of the medical staff who responded to the scene. Not collecting incident reports also violates CCA Policy 5-1, Incident Reporting, which requires all employees who are involved with or witness an incident to independently complete a 5-1C Incident Statement.

Medical

Medical and mental health professionals promptly evaluated MPONDA upon admission to HCDF, and mental health professionals regularly evaluated him throughout the fifteen months he was detained at the facility. Because MPONDA regularly refused his psychotropic medications, providers were largely unsuccessful at treating his mental health issues through medications. However, MPONDA was educated about the benefits of his prescribed medications on multiple occasions and was offered alternative medications and dosages. All medication refusals were dutifully recorded in MPONDA's MARs, and providers were notified of those refusals. ODO

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learned consent for the specific psychotropic medications ordered for MPONDA was never obtained, and that providers did not document a mental health treatment plan for MPONDA.

1. ICE PBNDS Medical Care, section (V)(T), Informed Consent and Involuntary Treatment, states, “Upon admission at the facility, documented informed consent will be obtained for the provision of health care services. For any additional procedure, a separate documented informed consent will be obtained.”

MPONDA did not sign specific consent forms for the psychotropic medications ordered for him by providers throughout the time he was detained at HCDF. The May 30, 2012 IHSC Form 844 was the only psychiatric consent form MPONDA signed, and it did not specify any particular medications. Not obtaining patient consent for psychotropic medications also violates IHSC/ERO Directive, Mental Health Services (4)(4-5)(a), which requires separate informed consent using the “Consent for Psychotropic Medications for Adults” IHSC Form 880.

2. ICE PBNDS Medical Care, section (V)(K)(4), Mental Health Program Referrals and Treatment, states, “The provider shall develop an overall treatment/management plan that may include transfer to a mental health facility if the detainee’s mental illness or developmental disability needs exceed the treatment capability of the facility.”

MPONDA received a timely initial mental health evaluation, and he received routine and timely mental health follow-ups. However, MPONDA’s medical record does not contain any documentation of a mental health treatment or management plan containing measureable goals and objectives guiding overall mental health care.

Additionally, IHSC/ERO Directive, Suicide Prevention and Intervention, section (4)(4-2)(b) requires the development of an overall mental health treatment/management plan following a suicide attempt. MPONDA’s medical record does not contain documentation that an overall treatment/management plan was developed after his July 13, 2012 suicide attempt.

3. ICE PBNDS Special Management Units, section (II)(4), states, “Health care personnel will be immediately informed when a detainee is admitted to an SMU to provide assessment and review as indicated by health care authority protocols.”

MPONDA’s medical and detention records do not contain any documentation he was cleared for placement in disciplinary segregation on September 10, 2012, after he was removed from suicide watch. Not medically clearing MPONDA for placement in disciplinary segregation also violates IHSC Policy, Medical, section 8.7, which requires

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that after a detainee is assigned to segregation, a qualified healthcare professional review the detainee's health record to determine whether existing mental health needs contraindicate placement in segregation.

4. ICE PBNDS, Suicide Prevention and Intervention, section (V)(D), Evaluation, states, "Appropriately trained and qualified medical staff shall evaluate the detainee within 24 hours of the referral. This evaluation will be documented in the medical record and include: relevant history, environmental factors, lethality of suicide plan, psychological factors, a determination of level of suicide risk, level of supervision needed, referral/transfer for inpatient care (if needed), instructions to medical staff for care, and reassessment time frames."

After MPONDA was found with a shirt wrapped around his neck on July 1, 2012, he was immediately evaluated by nursing staff. However, Dr. [REDACTED] did not evaluate him until July 6, 2012, five days later.

5. ICE PBNDS, Suicide Prevention and Intervention, section (V)(D), Evaluation, states, "Detainees who are placed on suicide watch are to be re-evaluated by appropriately trained and qualified medical staff on a daily basis and this re-evaluation is documented in the medical record."

On Friday, September 7, 2012, MPONDA was placed on suicide watch. He remained on suicide watch until Monday, September 10, 2012, when he was transferred to disciplinary segregation. MPONDA's medical record shows nursing staff saw him on September 8, and on September 9, 2012. However, the record does not contain documentation that qualified medical staff reevaluated MPONDA at any time while he was on suicide watch. The absence of reevaluations of MPONDA by qualified medical staff between September 7-10, 2012, also violates IHSC/ERO Directive, Suicide Prevention and Intervention, section (4)(4-2)(a) which requires documentation of daily reevaluation by a mental health provider, physician, or mid-level provider; and, section (4)(4-6) which requires a follow up appointment within a week of discharge from suicide watch. On September 28, 2012, 18 days after he was removed from suicide watch, a mental health provider evaluated MPONDA.

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

ODO learned through interviews with the security and medical staff who responded to MPONDA on September 2, 2012, that the chaplain came to the facility following the

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incident and met with the responding officers; CDR ██████ convened an informal debriefing for supervisory correctional and medical staff; and the responding officers were encouraged to use the Employee Assistance Program, if needed. HCDF did not conduct a formal incident debriefing open to all affected staff.

AREAS OF CONCERN

1. During the review, ODO learned HCDF has a 16-bed Short Stay Unit (SSU) which includes 12 beds in dormitory-style housing and four single cells primarily used for medical isolation. HCDF did not provide ODO with specific written admission and discharge criteria for the SSU; however, RN ██████ noted that IHSC policy 8.18.2, Medical Care Admission Criteria, describes the criteria detainees must meet for admission to the SSU, including the following:
 - In need of supervised medical, surgical or psychotropic therapy (to include all modes of therapy);
 - Have suicidal ideation or gestures that do not require hospitalization, but need observation in a controlled environment; and,
 - At risk of clinical deterioration by remaining in the general population in the opinion of the medical staff.

ODO learned detainees with mental health issues who cannot be managed in the general population may be housed in the SSU. When there is not sufficient space in the SSU, those detainees may also be housed in B-Segregation. Additionally, when the SSU's four single cells are occupied, "Level Three" detainees may be placed in B-Segregation instead of the dormitory area of the SSU to prevent comingling of "Level One" and "Level Three" detainees. ODO was informed that when detainees with mental health issues are housed in B-Segregation instead of the SSU, they are considered to be under "therapeutic seclusion," they are treated as though they are in the SSU, and their mental health protocols are the same including daily rounds by a provider.

CDR ██████ said detainees are only placed in B-Segregation under a therapeutic seclusion status when there is no bed space available in the SSU. He stated the detainees under therapeutic seclusion in B-Segregation receive a daily reassessment by a provider, and are transferred to the SSU when space becomes available.¹⁴⁶ RN ██████ noted Dr. ██████ July 30, 2013 recommendation specifies MPONDA be placed in segregation upon his return from West Oaks Hospital, and does not discuss therapeutic seclusion for ultimate placement in SSU.

¹⁴⁶ ODO interview of IHSC CDR ██████ ██████ 11/6/2013.

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Dr. ██████ stated he recommended MPONDA be placed in segregation on July 30, 2012, because MPONDA was “manipulative” and “refused to bathe.” Dr. ██████ stated he ordinarily does not recommend segregation because it is often a “destabilizing environment.” Dr. ██████ said that when he does recommend segregation, he does so for “behavioral symptoms,” not mental health issues.¹⁴⁷ RN ██████ noted MPONDA’s discharge summary from West Oaks Hospital, written by Dr. ██████ documents MPONDA was “ultimately compliant with med” and “no longer combative or agitated and has been cooperative” (**Exhibit 1**).

LISW ██████ advised ODO stated that because MPONDA was no longer “psychotic,” he was not eligible for placement in the SSU.¹⁴⁸

The July 30, 2012 Administrative Segregation Order created for MPONDA documents that he was placed in segregation as a result of his “mental history.” COS ██████ acknowledged during his interview that if mental health was a factor in the decision to place MPONDA in administrative segregation on July 30, 2012, the Administrative Segregation Order should have included supporting documentation from mental health staff, but none was provided.

Creative Corrections noted the conflict between Dr. ██████ order that MPONDA be placed in administrative segregation for behavior reasons, and the Administrative Segregation Order’s notation of “mental history” creates ambiguity as to why MPONDA was actually placed in segregation on July 30, 2012. If MPONDA’s mental health was a deciding factor, therapeutic seclusion protocols should have applied; however, MPONDA’s detention record does not contain documentation those protocols were implemented.

2. During interviews with officers, ODO learned officers have conflicting ideas on their role in medication administration and in ensuring medications are not hidden or hoarded.

Officer ██████ stated that during pill call, medical staff are responsible for ensuring detainees actually swallow their pills, and officers are only present to provide security.¹⁴⁹ In contrast, Officer ██████ stated he accompanies medical staff during pill call, both to provide security and to ensure detainees swallow their medications. Officer ██████ said that after a detainee places a pill in his mouth, he requires the detainee to drink water and open his mouth to show the pill has been swallowed.¹⁵⁰

¹⁴⁷ ODO interview of Dr. ██████ ██████ M.D., 11/5/2013.

¹⁴⁸ ODO telephonic interview of CDR ██████ ██████ LISW, 11/19/2013.

¹⁴⁹ ODO interview of CCA Officer ██████ ██████ 11/5/2013.

¹⁵⁰ ODO interview of CCA Officer ██████ ██████ 11/5/2013.

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CCA Officer ██████ said she often accompanies nurses during pill call and conducts a secondary “mouth check” to ensure detainees are not hiding pills in their mouths. She said she remembered MPONDA trying to hide pills on more than one occasion while he was housed in general population prior to August 31, 2013, and specifically remembered MPONDA dropping his pills on the floor and putting them in his pockets.¹⁵¹

CCA’s Post Order 23, Segregation, requires officers to, “Escort health services staff to each cell when medications are being delivered. Ensure that the inmate/resident has swallowed the medications by visually checking the inmate/resident’s hands and mouth.” ODO notes that per CDR ██████ September 4, 2013 debriefing, HCDF is committed to ensuring both security and medical staff members conduct a mouth check of every detainee during pill call.

¹⁵¹ ODO interview of CCA Officer ██████ ██████ 11/5/2013.

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EXHIBIT LIST

- 1. Creative Corrections Report**
- 2. May 30, 2012 Psychiatric Evaluation**
- 3. June 2012 MAR**
- 4. July 6, 2012 Mental Health Note by Dr. [REDACTED]**
- 5. July 11, 2012 Mental Health Note by Dr. [REDACTED]**
- 6. July 13, 2012 Incident**
- 7. August 15, 2012 Mental Health Note by Dr. [REDACTED]**
- 8. September 7, 2012 Mental Health Note by Dr. [REDACTED]**
- 9. December 28, 2012 Mental Health Note by Dr. [REDACTED]**
- 10. March 22, 2013 Mental Health Note by Dr. [REDACTED]**
- 11. June 7, 2013 Mental Health Note by Dr. [REDACTED]**
- 12. August 31, 2013 Handheld Video Footage**
- 13. Note re Medications Found in MPONDA's Property**
- 14. Surveillance Video Footage**
- 15. September 2, 2013 Handheld Video Recording**
- 16. Houston Police Department Report No. 110217513**
- 17. Autopsy Report**