

# DETAINEE DEATH REVIEW of Peter George Carlysle ROCKWELL

## JICMS Number 201404529

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### SYNOPSIS

Forty-six year-old Immigration and Customs Enforcement detainee Peter George Carlysle ROCKWELL, a citizen and national of Canada, died on February 22, 2014, at Memorial Hermann Northeast Hospital in Humble, Texas. The Harris County Institute of Forensic Sciences determined ROCKWELL's cause of death to be hypertensive cardiovascular disease with hemorrhagic right basal ganglia infarct, and his manner of death to be natural.

### DETAILS OF REVIEW

ROCKWELL 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 2011 Performance Based National Detention Standards (PBNDS) at the time of ROCKWELL's death.

From April 22 to 24, 2014, Inspections and Compliance Specialist [REDACTED], Supervisory Inspections and Compliance Specialist [REDACTED], Management and Program Analyst [REDACTED], and Inspections and Compliance Specialist [REDACTED], all assigned to the ICE Office of Professional Responsibility (OPR), Office of Detention Oversight (ODO), visited HCDF to examine the circumstances of ROCKWELL's death. Registered Nurse (RN) [REDACTED], a subject matter expert (SME) in correctional health care, and [REDACTED], an SME in correctional security, assisted ODO with the death review. RN [REDACTED] and SME [REDACTED] are employed by Creative Corrections, a national management and consulting firm contracted by ICE to provide subject matter expertise in detention management and compliance with detention standards, including health care and security. ODO interviewed individuals employed by 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 ROCKWELL.

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

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

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JANUARY 30, 2014 to FEBRUARY 14, 2014

On July 21, 1993, ROCKWELL lawfully entered the United States near Houston, Texas, as a Lawful Permanent Resident on an E-34 immigrant visa valid until November 16, 1993.<sup>1</sup> On January 30, 2014, ICE's Houston area Fugitive Operations team arrested ROCKWELL at his place of residence in Beaumont, Texas, and issued him a Notice to Appear, charging removability pursuant to §237(a)(2)(A)(ii) of the Immigration Nationality Act, as an alien who has been convicted of two crimes involving moral turpitude. Prior to coming into ICE custody, Rockwell had two separate convictions in Jefferson County, Texas, for evading arrest with a motor vehicle (incidents on March 7, 2013, and April 5, 2013, respectively).<sup>2</sup>

On January 30, 2014, ROCKWELL was booked into HCDF. Upon admission, he received a timely medical intake screening performed by IHSC Lieutenant Commander (LCDR) [REDACTED], RN.<sup>3</sup> During the medical screening, ROCKWELL stated that he had high blood pressure for which he took medication, but stated he had not taken any medication that day. He further indicated he did not know the names of his medications, but referred to one of them as a "water pill."<sup>4</sup> LCDR [REDACTED] recorded that ROCKWELL stated he felt "fine," and documented ROCKWELL's vital signs were within normal limits with the exception of his blood pressure. ROCKWELL's blood pressure was documented as 172/109, which Creative Corrections notes is considered high.<sup>5</sup> A physical examination was scheduled for ROCKWELL, and a telephone order was given by a provider for two blood pressure medications, which were both obtained and administered to the detainee.<sup>6</sup> LCDR [REDACTED] medically cleared ROCKWELL for housing in general population.

Once ROCKWELL was medically cleared for housing, he was appropriately classified by security staff as a high level detainee based on his criminal history.<sup>7</sup>

On January 31, 2014, ROCKWELL was transferred to general population housing unit B-2, which is designated to hold high level detainees. Later the same day, ROCKWELL received a physical examination by IHSC Lieutenant Commander (LCDR) [REDACTED], Nurse

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<sup>1</sup> I-862 form (Notice to Appear) signed by Deportation Officer [REDACTED], January 30, 2014.

<sup>2</sup> I-213 form signed by Deportation Officer [REDACTED], January 30, 2014. In addition to ROCKWELL's 2013 convictions in Jefferson County, TX, he was wanted by the Ontario Provincial Police, Ontario, Canada, for impersonation with intent, forged documents, and fraud; and, by the Ottawa Police Service, Ottawa, Canada, for spousal assault, breach of recognizance, and failure to appear.

<sup>3</sup> Medical prescreen form signed by LCDR [REDACTED], January 30, 2014.

<sup>4</sup> Diuretics used for high blood pressure are commonly referred to as "water pills," as they help the body expel extra water and salt through urine.

<sup>5</sup> Exhibit 1, page 3: Creative Corrections Security and Health Care Compliance Analysis. Creative Corrections notes that a blood pressure reading of 120/80 is considered normal.

<sup>6</sup> Telephone Encounter form for prescription medications signed by LCDR [REDACTED], January 30, 2014.

<sup>7</sup> ICE Custody Classification Worksheet signed by HCDF Intake Supervisor [REDACTED], January 30, 2014.

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Practitioner (NP). LCDR ██████ findings were consistent with the medical intake screening results produced by LCDR ██████<sup>8</sup> She noted that ROCKWELL stated he was “doing fine,” that he had a 20-year history of hypertension, and his immediate family had a “strong” history of heart disease. With the exception of his blood pressure, which was recorded as 135/81, ROCKWELL’s vital signs were within normal limits. LCDR ██████ treatment plan for ROCKWELL included the following:

- continuation of high blood pressure medications and Aspirin, which were to be kept on ROCKWELL’s person;
- daily monitoring of blood pressure for seven days;
- lab work;
- an electrocardiogram (ECG) which was scheduled for February 14, 2014;
- assignment of a low fat, low salt, low cholesterol, high fiber diet; and,
- assignment to a low bunk.

IHSC Captain ██████, MD, HCDF’s Medical Director, reviewed and signed the physical examination the same day.<sup>9</sup>

On February 4, 2014, ROCKWELL was seen by InGenesis RN ██████, and complained that his vision had been blurry for approximately one week.<sup>10</sup> RN ██████ referred ROCKWELL to a mid-level provider to be seen within two days. ODO notes RN ██████ did not take ROCKWELL’s vital signs even though ROCKWELL had a documented history of hypertension, and LCDR ██████ previously ordered a daily blood pressure monitoring treatment plan for ROCKWELL.<sup>11</sup> ROCKWELL’s medical record does not contain any documentation that the blood pressure checks were completed from February 1 to 5, 2014. Documentation of completed blood pressure checks was present for February 6, 7, 8, and 10, 2014.<sup>12</sup> ROCKWELL refused his blood pressure check on February 9, 2014, and declined to sign a form acknowledging his refusal.<sup>13</sup>

On February 5, 2014, InGenesis Physician Assistant (PA) ██████ concurred with RN ██████ findings regarding ROCKWELL’s complaint of blurred vision, and referred

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<sup>8</sup> Exhibit 2: Physical examination medical progress note signed by LCDR ██████ January 31, 2014.

<sup>9</sup> Id.

<sup>10</sup> Medical progress note, signed by RN ██████, February 4, 2014. ODO notes ROCKWELL denied any vision issues during his medical intake screening. He also made no complaint of blurred vision during his physical examination by LCDR ██████ on January 31, 2014. In fact, LCDR ██████ medical notes recorded ROCKWELL’s vision as 20/20.

<sup>11</sup> See Exhibit 2.

<sup>12</sup> Medical progress notes signed by InGenesis RN ██████ and InGenesis RN ██████, February 6 to 10, 2014.

<sup>13</sup> Id.

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ROCKWELL to be seen by a provider within one day.<sup>14</sup> During her interview with ODO, PA [REDACTED] stated that she recommended an assessment be completed within one day so that ROCKWELL would be given priority and be seen the following morning.<sup>15</sup> ODO reviewed the list of detainees who were referred for provider assessment on February 6, 2014, and noted ROCKWELL's name was not listed. ROCKWELL's medical record contains no documentation to support he was seen by a provider on that date, or that he was even scheduled to be seen.<sup>16</sup>

On February 11, 2014, a progress note by IHSC Lieutenant [REDACTED] RN, documented that he saw ROCKWELL for additional complaints of blurred vision and a sore throat; he also noted the detainee's history of hypertension and current medication treatment plan. Lieutenant [REDACTED] told ROCKWELL to increase his fluid intake and also referred him to a provider for a follow-up evaluation.<sup>17</sup>

Later that same day, ROCKWELL was seen by PA [REDACTED]. She noted the detainee denied, having many symptoms including, fatigue, fever, chills, chest pain, headache and loss of appetite. PA [REDACTED] also documented that ROCKWELL tested negative for strep throat and that his heart rhythm was normal with no murmurs. PA [REDACTED] documented that ROCKWELL was experiencing throat pain, and instructed the detainee to take Ibuprofen up to three times per day and gargle warm salt water twice daily as needed.<sup>18</sup> Although ROCKWELL was seen and treated for issues related to his sore throat, he was not evaluated by PA [REDACTED] in regard to his complaint of blurred vision. In interviews with PA [REDACTED] she stated that the detainee was a "walk in" and because of that, she had not reviewed his entire medical record including the notation regarding his blurred vision. She also stated she was certain ROCKWELL did not mention blurry vision during their encounter because she would have documented it in her notes.<sup>19</sup>

### FEBRUARY 15, 2014

The following events were recorded in logs, incident statements, video surveillance footage, and footage from a handheld video camera; and, were discussed during ODO's interviews of facility employees.

On February 15, 2014, at 7:57 p.m., as seen in video surveillance footage,<sup>20</sup> ROCKWELL collapsed to the ground in housing unit B-2 while heating food in the microwave.<sup>21</sup> Detention

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<sup>14</sup> Medical progress note signed by RN [REDACTED], February 4, 2014.

<sup>15</sup> ODO interview with PA [REDACTED], April 23, 2014.

<sup>16</sup> See Exhibit 1, page 6.

<sup>17</sup> Medical progress note signed by Lieutenant [REDACTED], February 11, 2014.

<sup>18</sup> Medical progress note signed by PA [REDACTED], February 11, 2014.

<sup>19</sup> ODO interview with PA [REDACTED], April 23, 2014.

<sup>20</sup> February 15, 2014 video surveillance footage of B-2.

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Officer (DO) [REDACTED], who was on duty in B-2, stated that when he saw the detainee fall, he called a medical emergency on his radio and requested a wheelchair, and immediately approached ROCKWELL.<sup>22</sup> DO [REDACTED] stated ROCKWELL was conscious when he arrived at ROCKWELL's side. The B-Control logbook documents the medical emergency call made by DO [REDACTED] was received at 7:58 p.m. DO [REDACTED] stated that he and another detainee assisted ROCKWELL into a chair, and that ROCKWELL told DO [REDACTED] he felt sleepy. DO [REDACTED] stated that while they waited for medical personnel to arrive, ROCKWELL slumped down in the chair and began foaming at the mouth.

At 8:00 p.m., [REDACTED] and InGenesis RN [REDACTED] arrived at housing unit B-2 with a wheelchair in response to the medical emergency call.<sup>23</sup> Lieutenant [REDACTED] documented in his incident statement that he and RN [REDACTED] also brought an automated external device (AED), and an Ambu bag (*a manual ventilator used on patients who need assisted breathing*) to the scene.<sup>24</sup> The video surveillance footage shows that Lieutenant [REDACTED] brought an orange emergency bag to the scene, and ODO learned during the onsite review that HCDF's orange emergency bag does not contain either an AED or an Ambu bag.<sup>25</sup> ODO notes that HCDF's Emergency Service's Local Operating Procedures (LOP) also requires medical staff to grab an oxygen tank and stretcher when responding to any "man down" emergency;<sup>26</sup> however, as seen in the video surveillance footage and as stated during staff interviews, neither device was brought to B-2 in response to the medical emergency call concerning ROCKWELL.<sup>27</sup> Lieutenant [REDACTED] documented in his incident statement that when he arrived in B-2, ROCKWELL was sitting upright in a chair and taking shallow breaths, that his eyes were open, that he was non-responsive to verbal commands, and that his skin was red and flushed.<sup>28</sup>

At 8:01 p.m., ROCKWELL was placed on the floor where medical staff opened his airway, and checked his pulse.<sup>29</sup> Lieutenant [REDACTED] noted that ROCKWELL was taking shallow breaths, and

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<sup>21</sup> ODO notes the Significant Event Notification (SEN) concerning ROCKWELL's death states the detainee collapsed while on the telephone. During onsite interviews, ODO determined facility staff had misconceptions about the circumstances surrounding ROCKWELL's death, and some of these misconceptions were reported as facts. The inaccurate reporting of events without specific supporting information is addressed in the Areas of Concern portion of this report.

<sup>22</sup> ODO interview with DO [REDACTED], April 22, 2014.

<sup>23</sup> February 15, 2014 video surveillance footage of B-2.

<sup>24</sup> Exhibit 3: Incident Statement prepared by Lieutenant [REDACTED], February 15, 2014.

<sup>25</sup> The HCDF medical unit uses two emergency bags, an orange one and a red one. ODO examined the contents of both, and spoke with the HSA who confirmed that only the red bag contains an AED and Ambu bag.

<sup>26</sup> HCDF LOP 822, Emergency Services, Section I (1)(a).

<sup>27</sup> See Exhibit 1, page 8.

<sup>28</sup> See Exhibit 3.

<sup>29</sup> February 15, 2014 video surveillance footage of B-2.

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that the medical staff called for a stretcher to be retrieved.<sup>30</sup> The video surveillance footage shows DO ██████ left B-2 at 8:01 p.m. to retrieve the stretcher.<sup>31</sup>

At 8:03 p.m., DO ██████ returned to the housing unit with the stretcher, and ROCKWELL was placed on the stretcher at 8:05 p.m.<sup>32</sup> Lieutenant ██████ documented that he also instructed CCA staff to call emergency medical services (EMS) at this time. The B-Control log documents that 911 was called at 8:05 p.m. ODO notes this call was made eight minutes after the medical emergency was first called for ROCKWELL, and approximately five minutes after the detainee was determined unresponsive.<sup>33</sup> During his interview, Dr. ██████ stated it only takes four minutes of oxygen deprivation to cause permanent brain damage.<sup>34</sup>

During their interviews with ODO, DO ██████ and Lieutenant ██████ stated they observed ROCKWELL losing color while the detainee and medical team were still in B-2; Lieutenant ██████ specifically stated he observed ROCKWELL becoming cyanotic (*bluish color to skin due to lack of oxygen*). InGenesis LVN ██████ stated she observed that ROCKWELL was already cyanotic at 8:05 p.m., when she arrived at B-2.<sup>35</sup> Upon review of the handheld video footage, ODO also observed ROCKWELL's skin color change dramatically while he was in the housing unit.<sup>36</sup>

The handheld video recording shows that once ROCKWELL was placed on the stretcher, medical and facility staff made multiple unsuccessful attempts to raise the stretcher into an upright position.<sup>37</sup> While onsite, ODO learned the two red levers which allow the stretcher to rise from a lowered position were not working properly on February 5, 2014. While staff attempted to raise the stretcher, RN ██████ checked the pulse oximeter (*a device used to measure the amount of oxygen in the blood*) attached to ROCKWELL's finger. During interviews, she stated the oximeter did not register, indicating there was little or no oxygen in the detainee's blood stream.<sup>38</sup>

At 8:06 p.m., as ROCKWELL was being loaded onto the stretcher, RN ██████ stated "we have got to get some oxygen on this guy."<sup>39</sup> During her interview, she stated she then ran to the medical unit to retrieve the oxygen tank, but by the time she returned, the detainee was

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<sup>30</sup> See Exhibit 3.

<sup>31</sup> February 15, 2014 video surveillance footage of B-2.

<sup>32</sup> February 15, 2014 video surveillance footage of B-2.

<sup>33</sup> See Exhibit 1, page 3.

<sup>34</sup> ODO interview with Dr. ██████, April 22, 2014.

<sup>35</sup> ODO interview with LVN ██████, April 23, 2014.

<sup>36</sup> See Exhibit 5.

<sup>37</sup> Id.

<sup>38</sup> ODO interview with RN ██████, April 24, 2014.

<sup>39</sup> See Exhibit 5.

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already being wheeled to the medical unit on the unraised stretcher.<sup>40</sup> ODO notes the video surveillance footage of B-2 ends at 8:06 p.m. while ROCKWELL and the medical staff were still in the housing unit. Video surveillance footage after 8:06 p.m. was unavailable as the facility did not extract the footage before the video surveillance system recorded over it.<sup>41</sup> ODO notes that CCA's Retention of Records Policy requires records that are or could be relevant to any pending or future litigation, investigative audit, or investigation, be retained.<sup>42</sup>

Based on the handheld video footage, ROCKWELL was wheeled out of the housing unit on the unraised stretcher at 8:07 p.m.;<sup>43</sup> two minutes after HCDF staff initiated their attempts to lift the stretcher. Because the stretcher could not be raised properly, maneuvering it from the housing unit to the medical unit was difficult. As observed in the handheld video recording, ROCKWELL's arms were not secured while he was being wheeled to the medical unit, and LVN [REDACTED] held onto them to keep them from dragging on the ground. The handheld video recording also shows staff were awkwardly positioned around the stretcher, and that LVN [REDACTED] lost her balance and fell while en route to the medical unit.<sup>44</sup> Between 8:07 p.m. and 8:09 p.m., the stretcher was stopped in the hallway four times because the detainee's hand was dragging on the ground or because a strap from the stretcher got caught under the wheels.

At approximately 8:09 p.m., ROCKWELL arrived on the stretcher at the medical unit's urgent care room.<sup>45</sup> Once in the urgent care room, staff tried to lift ROCKWELL onto a backboard,<sup>46</sup> but because he was too heavy, they slid the board underneath him.<sup>47</sup>

At 8:11 p.m., CPR was initiated, approximately 14 minutes after the initial medical emergency call was placed, and 11 minutes after the detainee was determined unresponsive. The handheld video recording shows LVN [REDACTED] performing chest compressions and RN [REDACTED] using a non-rebreather bag (*a device used for patients who can breathe on their own unassisted,*

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<sup>40</sup> ODO interview with RN [REDACTED], April 24, 2014.

<sup>41</sup> HCDF's PELCO video surveillance system tapes over existing footage after 21 days.

<sup>42</sup> CCA Retention of Records Policy, Policy Number 1-15.

<sup>43</sup> See Exhibit 5.

<sup>44</sup> Id.

<sup>45</sup> See Exhibit 3, which notes that the medical team and ROCKWELL arrived at the urgent care room at 8:06 p.m., though the surveillance video clearly shows they were still on housing unit B-2 at that time. During interview, Lieutenant [REDACTED] acknowledged he used times manually entered in the control logbook instead of referencing the timestamps on video recordings to document actions.

<sup>46</sup> Backboards are placed under the back of a patient during CPR when the patient is lying on a soft surface, like a mattress. The backboard provides a hard surface which helps to displace the absorption of the force of chest compressions by the soft surface, thereby directing that force into the patient's chest.

<sup>47</sup> See Exhibit 5.

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*but need high-flow oxygen*).<sup>48</sup> Lieutenant ██████ is then seen retrieving an Ambu bag and taking over simulated breathing efforts for RN ██████.<sup>49</sup>

At 8:12 p.m., the Houston Fire Department's (HFD) EMS unit arrived at the facility.<sup>50</sup> At the same time, HCDF medical staff opened the automated external defibrillator (AED) and applied the pads to ROCKWELL.<sup>51</sup> A shock was delivered at both 8:12 p.m. and 8:13 p.m., indicating the AED found a shockable heart rhythm.

At 8:16 p.m., the AED advised no shock. Medical staff continued to perform CPR. Medical staff did not request that corrections staff assist with CPR, and no corrections staff assisted. Corrections staff interviewed by ODO stated that they typically wait for direction from medical staff before assisting with CPR.<sup>52</sup>

At 8:17 p.m., EMS personnel arrived at ROCKWELL's side. Upon their arrival, facility medical staff informed EMS personnel that ROCKWELL had been shocked three times.<sup>53</sup> A second EMS unit arrived at 8:19 p.m.<sup>54</sup>

At 8:24 p.m., ROCKWELL was moved to a backboard on the floor, and Auto Pulse (*a mechanical device that automatically performs CPR*) was initiated.<sup>55</sup> Per the EMS Patient Care Report, a third EMS unit arrived at 8:25 p.m. An ECG was performed and resulted in a reading of pulseless electrical activity (*unresponsiveness and lack of palpable pulse; though a heart rhythm is present, there is insufficient cardiac output to generate a pulse and supply blood to the organs*).

At 8:28 p.m. a shock was advised and delivered. The EMS Patient Care Report documented ROCKWELL was also given epinephrine (*heart stimulant*) at 8:28 p.m., vasopressin (*diuretic that constricts blood vessels*) at 8:31 p.m., and more epinephrine at 8:35 p.m. Another shock was advised by the AED and delivered by EMS at 8:37. At 8:39 p.m., a pulse was detected and ROCKWELL's blood pressure was 180/100.<sup>56</sup>

At 8:43 p.m., ROCKWELL was placed onto an EMS stretcher and wheeled out of the medical unit. At 8:45 p.m., he was loaded into an ambulance which departed HCDF at 8:53 p.m., en

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<sup>48</sup> Id.

<sup>49</sup> Id.

<sup>50</sup> HFD EMS Patient Care Report Unit A064, February 15, 2014.

<sup>51</sup> See Exhibit 5.

<sup>52</sup> Id.

<sup>53</sup> ODO notes Lieutenant ██████ documented in his incident statement that HCDF medical staff shocked ROCKWELL three times prior to EMS arrival on the scene. This assertion is not corroborated by the handheld video recording which shows ROCKWELL was only shocked twice prior to EMS arrival.

<sup>54</sup> HFD EMS Patient Care Report, Unit E064 on February 14, 2014.

<sup>55</sup> HFD EMS Patient Care Report, Unit A064 on February 14, 2014.

<sup>56</sup> HFD EMS Patient Care Report, Unit M063 on February 14, 2014.



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route to Memorial Herman Northeast Hospital.<sup>57</sup> The ambulance arrived at the hospital at 9:04 p.m.<sup>58</sup>

DO [REDACTED] was assigned to ride in the ambulance with ROCKWELL and DO [REDACTED] was assigned to follow the ambulance in a chase vehicle. Although DO [REDACTED] took a supply bag specifically prepared for hospital transports, he did not check the contents of the bag before leaving HCDF, and did not notice the hospital logbook was missing from the bag. As a result, there is no log of events from the time ROCKWELL arrived at the hospital until DO [REDACTED] was relieved at 6:00 a.m. on February 16, 2014.

### EVENTS NOTED POST-FEBRUARY 15, 2014

During the time ROCKWELL was admitted into Memorial Hermann Northeast Hospital, IHSC Lieutenant Commander (LCDR) [REDACTED], Assistant HSA, documented at least daily status updates in emails to IHSC administrative staff and ERO. On February 16, 2014, ROCKWELL was placed in the Intensive Care Unit (ICU), where he remained on a ventilator until his death on February 22, 2014. Throughout the course of his stay at the hospital, ROCKWELL's status was bleak, and on many occasions his status updates were reported as "poor, unresponsive" or "very poor, grave."<sup>59</sup>

On February 19, 2014, the hospital requested to speak to ROCKWELL's family to determine life support measures. On February 21, 2014, ROCKWELL's father granted Memorial Herman Northeast Hospital permission to remove life support measures. Life support measures were removed at 5:55 p.m.<sup>60</sup>

At 2:00 a.m. on February 22, 2014, ROCKWELL was moved from the ICU to the medical unit and provided comfort measures. At 1:30 p.m. ROCKWELL's condition was deteriorating and hospital status updates document that although the detainee's breathing was slowing, only comfort measures were ordered. At 4:17 p.m., ROCKWELL was pronounced dead by Dr. [REDACTED]<sup>61</sup>

At approximately 4:17 p.m. on February 22, 2014, DO [REDACTED], who was on duty at the hospital, notified Shift Supervisor [REDACTED] of ROCKWELL's death.<sup>62</sup> At approximately 4:19 p.m., Shift Supervisor [REDACTED] notified HCDF's Duty Warden, [REDACTED], Chief of

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<sup>57</sup> See Exhibit 5.

<sup>58</sup> HFD EMS Patient Care Report, Unit M063 on February 14, 2014.

<sup>59</sup> IHSC's LCDR [REDACTED] Hospital Status Updates.

<sup>60</sup> Id.

<sup>61</sup> Id.

<sup>62</sup> Incident Statement prepared by DO [REDACTED], February 22, 2014.

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Security. ERO Detention and Deportation Officer [REDACTED] was notified of ROCKWELL's death at 4:20 p.m.<sup>63</sup>

ERO Houston notified the Canadian Consulate of ROCKWELL's death at 5:41 p.m.<sup>64</sup> Consistent with ICE policy, the Canadian Consulate made all notifications to next of kin. At 8:53 p.m., DO [REDACTED] and DO [REDACTED], who were on duty at the hospital, received a Report of Death from the hospital.<sup>65</sup> They then returned to HCDF to complete incident reports.<sup>66</sup>

On February 23, 2014, ERO Houston provided formal notice of ROCKWELL's death to the Joint Intake Center (JIC).<sup>67</sup>

A Certificate of Death, issued on March 10, 2014, listed hypertensive cardiovascular disease with hemorrhagic right basal as the immediate cause of death, and ganglia infarct as the underlying cause of death.<sup>68</sup>

### **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 ROCKWELL while he was detained at HCDF, as well as the medical care he was provided while housed there. Creative Corrections found HCDF did not fully comply with the following ICE 2011 PBNDS: Emergency Plans and Medical Care. The Creative Corrections Security and Healthcare Compliance Analysis is included as an Exhibit to this report.

### **IMMIGRATION AND DETENTION HISTORY**

On July 21, 1993, ROCKWELL lawfully entered the United States near Houston, Texas, as a Lawful Permanent Resident on an E-34 immigrant visa valid until November 16, 1993.

On July 10, 2013, the District Court of Jefferson County, Texas, convicted ROCKWELL on two counts of evading arrest with a motor vehicle, and sentenced him to three years of community supervision for each offense.

On January 30, 2014, ICE's Houston area Fugitive Operations Team arrested ROCKWELL at his place of residence in Beaumont, Texas and issued him a Notice to Appear, charging

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<sup>63</sup> Incident Statement prepared by HCDF Shift Supervisor [REDACTED], February 22, 2014.

<sup>64</sup> ERO email correspondence to Canadian Consulate General, February 22, 2014.

<sup>65</sup> Exhibit 7: Report of Death from Memorial Herman Northeast Hospital, February 22, 2014.

<sup>66</sup> Incident Statement prepared by DO [REDACTED] February 22, 2014.

<sup>67</sup> Exhibit 6: Significant Event Notification prepared by ERO Houston, February 22, 2014.

<sup>68</sup> Exhibit 9: Certificate of Death.

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removability pursuant to §237(a)(2)(A)(ii) of the Immigration Nationality Act, as an alien who has been convicted of two crimes involving moral turpitude.

### **CRIMINAL HISTORY**

According to the National Crime Information Center (NCIC), ROCKWELL was assigned an FBI number, a Florida state identification (SID) number, a Washington SID, and a Texas SID. On March 12, 1999, ROCKWELL was arrested for driving under the influence in Sarasota County, Florida. He was also arrested for assault on January 12, 2006, in Seattle, Washington. The dispositions of these events are unknown. On both March 7, 2013, and April 5, 2013, ROCKWELL was arrested for evading arrest with a motor vehicle in Jefferson County, Texas. He was charged and convicted for both offenses and sentenced to three years of community supervision on July 10, 2013. On January 30, 2014, ROCKWELL was arrested at his place of residence, without incident, by ERO Houston's Fugitive Operations Unit and deemed removable under Section 237 (a)(2)(A)(ii) of the Immigration and Nationality Act.

### **INVESTIGATIVE FINDINGS**

#### SECURITY

ROCKWELL was housed at HCDF from January 30 to February 15, 2014. During that time, he was assigned to a general population housing unit and was not involved in any disciplinary incidents. He filed no grievances. On February 15, 2014, ROCKWELL collapsed while using the microwave oven in the housing unit. A medical emergency was called and medical staff responded and initiated rescue efforts. No deficiencies in the ICE 2011 Performance Based-National Detention Standards were identified with respect to security staff's response to the medical emergency; however, deficiencies related to security practices following ROCKWELL's death were identified. As specified below, no de-briefing with staff was conducted, and reports were not collected from all staff members who had contact with ROCKWELL during and following the medical emergency. De-briefing of staff supports the post-incident investigation process, allowing determination of the appropriateness of actions taken and identification of training needs. Obtaining written reports in a timely manner ensures all persons involved document events, activities, interactions, and observations which may have relevance in fact finding and post-incident review. It is noted one of the deficiencies also violated a facility policy. Under the Areas of Concern portion of this report, ODO identifies additional violations of facility post orders.

ODO determined HCDF did not fully comply with the ICE 2011 PBNDS concerning Emergency Plans.

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1. ICE 2011 PBNDS Emergency Plans, section (V)(D)(18)(f), Post Emergency Procedures, states, “The post-emergency part of the plan shall include the following action items: collecting written reports....”

Written reports related to this incident were not collected from all involved staff. Two nurses who responded and participated in rescue efforts did not complete incident reports. In addition, the officer who rode in the ambulance with the detainee and the officer in the chase vehicle, both of whom were with the detainee until relieved at 6:00 a.m. on February 15, 2014, did not complete incident reports.

Failure to complete incident reports also violates CCA Policy 5-1, Incident Reporting, which requires all employees involved in or witnessing an incident to independently complete an incident statement.

2. ICE 2011 PBNDS, Emergency Plans, section (V)(D)(18)(h), Post Emergency Procedures states, “The post-emergency part of the plan shall include the following action items: h. debriefing involved staff, and following up for additional analysis and/or implicated changes in policy or procedures...”

No debriefing with corrections staff was conducted following ROCKWELL’s medical emergency.

### HEALTHCARE

ROCKWELL was admitted to HCDF with a history of hypertension for which he took medications. Medications were ordered and given upon intake, and continued throughout his detention period. A physical examination was performed by a midlevel provider within 24 hours of admission and reviewed by the clinical director. ODO only found one deficiency with regard to the medical care ROCKWELL received at HCDF, which is described below; however, numerous additional concerns regarding his medical care are described in the Areas of Concern portion of this report.

ODO determined HCDF did not fully comply with the ICE 2011 PBNDS on Medical Care.

1. ICE 2011 PBNDS, Medical Care, section (V)(R)(4), states, “Medical and safety equipment shall be available and maintained and staff shall be trained in proper use of the equipment.”

The oxygen tank for use in emergencies was not in its designated location in the medical unit’s urgent care room at the time of ROCKWELL’s medical emergency, and the regulator on the alternate oxygen tank was faulty. Also, as a result of either mechanical or staff error, the stretcher could not be raised to its optimum level while transporting ROCKWELL from the

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housing unit to the medical unit's urgent care room. Finally, nursing staff initially used an improper oxygen mask for treatment before switching to an Ambu bag.

### AREAS OF CONCERN

1. ODO observed inaccuracies in information provided by facility staff in both their written reports and during their interviews. These inaccuracies included the following:  
ROCKWELL was on the telephone when he collapsed, medical staff performed CPR in the housing unit, ROCKWELL was shocked with the AED three times before EMS arrived, and medical staff brought both an AED and an Ambu bag to the scene. ODO notes that accuracy in both written and oral reports is critical to post-incident review of an emergency event including those actions taken in response to the event.
2. Review of surveillance footage and interviews with staff demonstrated that five minutes elapsed between the time ROCKWELL collapsed and when other detainees in the housing unit were instructed to go to their bunks. During that time, detainees crowded around ROCKWELL and the responding staff, unnecessarily adding to the commotion at the scene. ODO notes that during an emergency, the area should be cleared immediately.
3. When the medical emergency call was made for ROCKWELL, medical staff responded with only a wheelchair and an emergency bag which did not contain an AED or Ambu bag. The HCDF medical unit's Local Operating Procedure for Medical Emergencies requires that essential medical supplies needed for emergency health care be maintained in an emergency medical bag and be ready for an emergency situation. Additionally, as noted in the narrative of this report, medical staff did not bring an oxygen tank or stretcher to the scene. As a result of not having the necessary medical equipment immediately available, medical staff were unable to perform CPR until they transported ROCKWELL to the medical unit, 11 minutes after medical staff first arrived on the scene in the housing unit. Once CPR was initiated, it was performed solely by medical staff without assistance from security staff. ODO learned during interviews that security staff are trained in CPR and in their responsibility to perform CPR during an emergency, but that these duties are not fulfilled in practice. Additionally, according to the American Heart Association's Adult Basic Life Support guidelines, as soon as ROCKWELL was determined to have ineffective or agonal breathing (*abnormal breathing characterized by gasping, labored breaths*), 911 should have been called, an AED should have been used, and CPR should have been initiated.
4. Video documentation of the emergency response for ROCKWELL was available through both the video surveillance footage, and the handheld video recording, which ODO identifies as a best practice. However, during his interview with ODO, HCDF's HSA stated that the medical response should not have been recorded. The Security Chief confirmed this position, stating that facility policy prohibits the video recording of a medical emergency

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response with a handheld camera, and that footage from stationary surveillance cameras is sufficient. Although the stationary surveillance footage is helpful, it is of limited value on its own because the cameras are placed high which results in grainy and indistinct images. Additionally, it is contradictory of the facility to allow one form of video documentation, but not another. ODO notes that video recording of all actions related to an emergency provides potentially critical documentation of events, which supports after action review, staff accountability, and implementation of corrective action.

5. According to the individuals ODO interviewed, HCDF staff were not offered supportive counseling following ROCKWELL's death. Referring the staff who responded to a critical incident to an employee assistance program or other source of professional counseling demonstrates sensitivity, and ensures those responders are offered assistance in emotionally processing the event.
6. DO [REDACTED] and DO [REDACTED] did not bring the hospital logbook when they accompanied ROCKWELL to the hospital. As a result, there was no record of activities and events for a period of approximately 9 hours, between 9:00 p.m. on February 15, 2014, and 6:00 a.m. on February 16, 2014. HCDF's General Post Orders, Log Book Maintenance, requires documentation of the post name, time post was assumed, and all activities occurring while on post, to include late entries if something is not logged at the time of occurrence. Additionally, HCDF's Transportation Post Orders require that a post logbook be maintained.
7. Review of ROCKWELL's medical record shows that daily blood pressure checks were not performed for six days after they were ordered by a provider. Also, an ECG ordered to be performed two weeks after ROCKWELL's physical examination was not completed. ODO notes that it should have been completed on February 14, 2014, the day before ROCKWELL's medical emergency.
8. ROCKWELL first complained of blurry vision five days after his admission to HCDF. RN [REDACTED] referred ROCKWELL to a provider as a result of the complaint, and PA [REDACTED] concurred that the detainee should be seen by a provider for his vision problems within one day. Medical records staff did not schedule the vision appointment, and ROCKWELL was never seen by a provider for the blurry vision. One week later, ROCKWELL complained of acute vision problems and a sore throat. ROCKWELL was first assessed by Lieutenant [REDACTED], and later seen by PA [REDACTED] however, PA [REDACTED] only evaluated the sore throat. During her interview with ODO, PA [REDACTED] stated she did not evaluate ROCKWELL's vision problems because they were not communicated to her by Lieutenant [REDACTED] and because she did not review ROCKWELL's medical record during the evaluation.
9. ROCKWELL's medical record shows that his vital signs were not taken during the emergency response.

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10. During medical staff interviews, ODO observed that no medical staff member assumed a leadership role during the emergency response to ROCKWELL, including delegation of duties or assigning a recorder to document events.

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**EXHIBIT LIST**

1. Creative Corrections Report
2. January 31, 2014 Physical Examination Medical Progress Note
3. February 15, 2014 Incident Statement prepared by Lieutenant [REDACTED]
4. February 15, 2014 PELCO Video Surveillance Footage
5. February 15, 2014 Video Footage from Handheld Camera
6. February 22, 2014 ERO Houston Significant Event Notice
7. February 22, 2014 Report of Death from Memorial Herman Northeast Hospital
8. April 7, 2014 Harris County Institute of Forensic Sciences Autopsy Report signed by Deputy Chief Medical Examiner Dr. [REDACTED]
9. March 10, 2014 Certificate of Death