DETAINEE DEATH REVIEW – Santiago SIERRA-Sanchez
JICMS #201409551

SYNOPSIS

Thirty-eight year old ICE detainee Santiago SIERRA-Sanchez, a citizen and national of Mexico, died on July 12, 2014, at the Utah Valley Regional Medical Center, Provo, Utah. The Utah Department of Health, Office of the Medical Examiner determined SIERRA-Sanchez's cause of death to be a disseminated Staphylococcus aureus infection resulting in severe pneumonia.

DETAILS OF THE REVIEW

SIERRA-Sanchez was in ICE custody at the Utah County Jail (UCJ) at the time of his death. UCJ opened in 1997, and is owned and operated by the Utah County Sheriff's Office (UCSO). UCJ houses both male and female Immigration and Customs Enforcement (ICE) detainees of all classification levels for periods exceeding 72 hours under an Intergovernmental Service Agreement (IGSA). Medical care is provided by employees of Utah County, and UCJ has 24-hour nursing care. UCJ is required to comply with the ICE National Detention Standards (NDS).

From August 18 to 20, 2014, Management and Program Analyst [redacted] and Supervisory Inspections and Compliance Specialist [redacted] both assigned to the ICE Office of Professional Responsibility (OPR), Office of Detention Oversight (ODO), visited UCJ to examine the circumstances of SIERRA-Sanchez'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 UCJ, as well as ICE Office of Enforcement and Removal Operation (ERO) staff. ODO also reviewed immigration, medical, and detention records pertaining to SIERRA-Sanchez.

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 SIERRA-Sanchez's apprehension, through his detention at UCJ.

NARRATIVE

On July 9, 2014, Immigration Enforcement Agent (IEA), [redacted], based out of the Salt Lake City (SLC) ERO Field Office, encountered SIERRA-Sanchez during a routine check at the

Salt Lake County Adult Detention Facility (SLCADF).[1] During the encounter, IEA [redacted] noticed SIERRA-Sanchez was walking slowly and asked him if he had any medical issues.[2] SIERRA-Sanchez told IEA [redacted] he injured his back approximately six months prior and that SLCADF treated him with Tylenol for the pain.

SIERRA-Sanchez was released into ICE custody on July 11, 2014, at approximately 6:15 a.m., and was picked up at the SLCADC by two IEAs from the SLC ERO Field Office.[3] Prior to getting on the ICE transport bus, SIERRA-Sanchez complained about having back pain to IEA [redacted], and IEA [redacted] noticed SIERRA-Sanchez had difficulty walking.[4] IEA [redacted] placed SIERRA-Sanchez in the front section of the bus, where he was separated by a cage from detainees in the back section, because SIERRA-Sanchez did not appear strong enough to defend himself if an altercation were to occur during transit. SIERRA-Sanchez was transferred only with his personal property, not with any discharge records from SLCADF.[5]

When the transport bus arrived at the SLC ERO Field Office at approximately 6:45 a.m., the IEAs helped SIERRA-Sanchez off the bus and placed him in a wheeled office chair which was used to move SIERRA-Sanchez into the processing area of the Field Office.[6] A supervisor, SDDO [redacted], was immediately notified by IEAs that a detainee with an apparent medical problem was in the processing area. SDDO [redacted] requested that the onsite IHSC Field Medical Coordinator (FMC), Lieutenant [redacted], RN, see SIERRA-Sanchez in the processing area. SDDO [redacted] then visited SIERRA-Sanchez in the processing area and asked if SIERRA-Sanchez needed Emergency Medical Services (EMS).[7] SIERRA-Sanchez replied he did not need EMS, but needed pain medication for his back. SDDO [redacted] informed SIERRA-Sanchez that he could not distribute any medication. Lieutenant [redacted] arrived in the processing area shortly thereafter.

Lieutenant [redacted] described to ODO that SIERRA-Sanchez complained he had severe back pain and asked for pain medication, but would not provide specific information regarding the source

[1] SIERRA-Sanchez was held at SLCADF after his arrest by the Unified Police Department of Greater Salt Lake on July 6, 2014, for possession or use of a controlled substance and possession or use of drug paraphernalia.
[2] ODO interview with IEA [redacted], August 20, 2014.
[3] Form G-391 completed by IEAs [redacted] shows SIERRA-Sanchez was one of two detainees picked up at the SLCADF on the morning of July 11, 2014.
[4] ODO interview with IEA [redacted], August 21, 2014.
[5] IEA [redacted] stated that when he picks detainees up from SLCADF, he signs release paperwork for the facility, but does not typically receive any paperwork to accompany the detainee. According to SLC ERO Field Office staff, Utah does not have a law requiring that medical information be transferred with an inmate or detainee. The SLC ERO Field Office has encouraged UCJ to establish a practice with SLCADF of transferring medical records when detainees are released into ICE custody.
[6] ODO visited the SLC ERO Field Office on August 21, 2014, and received confirmation from Assistant Field Office Director (AFOD) [redacted] that two wheelchairs were ordered for the Field Office that same day.
[7] ODO interview with SDDO [redacted], August 21, 2014.

of his pain.[8] Lieutenant [redacted] stated that he did not send SIERRA-Sanchez to the hospital because SIERRA-Sanchez did not appear to be in an unusual amount of pain, was "evasive" when answering questions about his medical condition,[9] and had only "non-specific" complaints.[10] Lieutenant [redacted] told ODO that he is not responsible for conducting any sort of intake or other medical screening of detainees at the Field Office, and that he does not have any diagnostic tools at his disposal.[11] Lieutenant [redacted] stated that in addition to his administrative responsibilities as the FMC, he assists the Field Office by informally meeting with detainees who appear to have medical conditions, recommending they be sent to the hospital when appropriate, and/or notifying a facility that an incoming detainee has medical concerns that need to be addressed.[12]

At approximately 7:00 a.m., after talking to Lieutenant [redacted] SIERRA-Sanchez was interviewed by his case agent, IEA [redacted].[13] IEA [redacted] interviewed SIERRA-Sanchez in Spanish. IEA [redacted] documented that SIERRA-Sanchez claimed to have back pain, but was cleared by Lieutenant [redacted] because he did not disclose "any mechanism of injury." IEA [redacted] stated to ODO that SIERRA-Sanchez appeared to be in "mid-level" pain the morning of July 11, 2014.[14] After his interview with IEA [redacted], SIERRA-Sanchez was placed in cell one where he remained until his transfer to UCJ except for short excursions out of the cell for fingerprints, photographs, and a second interview with Lieutenant [redacted] IEA [redacted] stated he saw SIERRA-Sanchez several times on July 11, 2014, and remembered that SIERRA-Sanchez required assistance with both standing up and sitting down throughout the day.

Later in the day, after SIERRA-Sanchez complained to ERO staff that he was "dying" from the pain in his back,[15] SDDO [redacted] asked Lieutenant [redacted] to see SIERRA-Sanchez again.[16] During their second encounter, SIERRA-Sanchez told Lieutenant [redacted] that his back pain was debilitating and proclaimed that he was dying.[17] SIERRA-Sanchez also told Lieutenant [redacted] that he previously used methamphetamine, but was no longer using it. While in the processing

[8] ODO interview with Lieutenant [redacted], August 20, 2014.
[9] Lieutenant [redacted] described that SIERRA-Sanchez could not articulate what initially caused the pain or exactly what the pain felt like, and that he did not observe any obvious signs of pain during his interview with SIERRA-Sanchez. Lieutenant [redacted] stated he did not conduct any sort of physical examination of SIERRA-Sanchez.
[10] Both Lieutenant [redacted] and SDDO [redacted] stated that detainees often make false complaints about non-specific pain to get out of being placed in detention.
[11] During ODO's visit to the SLC ERO Field Office, ERO staff indicated Lieutenant [redacted] has a complete medical kit including a stethoscope, blood pressure cuff, and other medical assessment tools.
[12] A June 2014 job announcement for the position of FMC with IHSC includes the following job responsibilities: provide medical consultation services and screening of individuals in ICE custody…; and, assist ICE officers with post intake screening of detainees who have significant health issues as needed.
[13] I-213 completed by IEA [redacted] on July 11, 2014.
[14] ODO interview with IEA [redacted] August 20, 2014.
[15] ODO interview with Lieutenant [redacted], August 20, 2014.
[16] ODO interview with SDDO [redacted] August 21, 2014.
[17] ODO interview with Lieutenant [redacted] August 20, 2014.

area, Lieutenant [redacted] stated he observed SIERRA-Sanchez walk slowly from his cell to the processing desk where he was fingerprinted. Because SIERRA-Sanchez's back pain was still non-specific, and because Lieutenant [redacted] saw SIERRA-Sanchez was able to walk, albeit with difficulty, Lieutenant [redacted] advised ERO staff that SIERRA-Sanchez was fit for transfer to UCJ.

Lieutenant [redacted] sent an email to UCJ's Health Services Administrator (HSA), [redacted] RN, at 2:04 p.m. on July 11, 2014, stating that UCJ would be receiving SIERRA-Sanchez who complained of "debilitating" back pain which started three days prior, and that SIERRA-Sanchez "was able to ambulate" when he got his fingerprints done at the Field Office, but otherwise "insisted that he was unable to ambulate and was pushed everywhere in a desk chair."[18] Also included in Lieutenant [redacted] email is a reference to SIERRA-Sanchez's past methamphetamine use, and speculation that SIERRA-Sanchez aggravated an old back injury while attempting to flee from police officers during his July 6, 2014 arrest.[19]

SIERRA-Sanchez was held at the Salt Lake City Field Office until approximately 1:34 p.m., when he was transported to UCJ by ICE van.[20] SIERRA-Sanchez was escorted to UCJ by three IEA's, including [redacted], who was not assigned to the transport but rode along to assist. IEA [redacted] stated SIERRA-Sanchez was in obvious pain during the drive to UCJ, and required assistance getting in and out of the transport van as well as walking into the facility.[21]

SIERRA-Sanchez was booked into UCJ at 2:29 p.m. by Deputy [redacted].[22] Deputy [redacted] stated SIERRA-Sanchez walked into the initial processing area of UCJ with the assistance of an ICE IEA and another ICE detainee.[23] Deputy [redacted] remembered SIERRA-Sanchez complained of being in a lot of pain. Video surveillance footage of SIERRA-Sanchez's entry into the booking area shows SIERRA-Sanchez walking slowly with assistance from another detainee, and also shows SIERRA-Sanchez having great difficulty getting from a standing to sitting position.[24] Deputy [redacted] stated that after SIERRA-Sanchez was searched, Deputies helped him into a wheelchair. Video surveillance footage shows SIERRA-Sanchez being pushed into another section of the booking area in a wheelchair.[25] Prior to having his photograph taken,

[18] Exhibit 1: July 11, 2014 email from Lieutenant [redacted] to UCJ's HAS, [redacted], RN.
[19] Lieutenant [redacted] stated he heard secondhand that SIERRA-Sanchez tried to flee from police during his arrest, but later learned it did not actually happen. Lieutenant [redacted] acknowledged that these statements in his email could have influenced how UCJ initially perceived SIERRA-Sanchez and his complaint of back pain.
[20] Form G-391 completed by IEAs [redacted] and [redacted] shows SIERRA-Sanchez left for UCJ at 1:34 p.m., and arrived at 2:28 p.m..
[21] ODO interview with IEA [redacted], August 21, 2014.
[22] Booking sheet, July 11, 2014.
[23] ODO interview with Deputy [redacted] August 19, 2014.
[24] Video surveillance footage of SIERRA-Sanchez's admission to UCJ, July 11, 2014.
[25] Id.

SIERRA-Sanchez is seen being pulled out of his wheelchair and into a standing position by a Deputy and another detainee, and clearly has great difficulty standing.[26]

After he was booked into UCJ, SIERRA-Sanchez was assisted by Deputy [redacted] while changing into his facility-issued jumpsuit. Deputy [redacted] stated SIERRA-Sanchez required assistance because he could not stand on his own, and remembered SIERRA-Sanchez stating that he had severe and worsening back pain.[27] Deputy [redacted] stated that he had SIERRA-Sanchez change his clothes prior to receiving a shower because the shower stalls in the booking area are narrow and do not contain benches, and he thought SIERRA-Sanchez would be more comfortable showering in the medical unit where the showers are handicap accessible. ODO notes SIERRA-Sanchez never received a shower at UCJ.[28]

At 3:15 p.m., RN [redacted] conducted SIERRA-Sanchez's intake medical screening and noted SIERRA-Sanchez complained of having a hurt back for seven months which had worsened during the previous few days.[29] RN [redacted]r also documented SIERRA-Sanchez's vital signs which were within normal limits, but did not take SIERRA-Sanchez's temperature or body weight.[30] RN [redacted] also did not screen SIERRA-Sanchez for tuberculosis (TB) using either a purified protein derivative (PPD) skin test or a chest X-ray. RN [redacted] stated he did not screen SIERRA-Sanchez for TB upon intake because he thought SIERRA-Sanchez might have already been screened at the SLCADF.[31] RN [redacted] stated he contacted SLCADF to get SIERRA-Sanchez's medical records, but was informed they did not have a record for anyone matching his name.[32] SIERRA-Sanchez's medical record does not document RN [redacted] attempt to procure his medical record from SLCADF. RN [redacted] stated when he asked SIERRA-Sanchez about his back pain, SIERRA-Sanchez pointed to his lower back.[33] RN [redacted] stated he checked SIERRA-Sanchez's alignment while SIERRA-Sanchez was seated in the wheelchair, and did not find any issues. RN [redacted] documented SIERRA-Sanchez should be housed in the Aspen observation unit[34] which is UCJ's medical observation unit.[35] RN [redacted] stated he decided to

[26] Id.
[27] ODO interview with Deputy [redacted] August 20, 2014.
[28] Deputy [redacted] stated he informed Deputy [redacted], who was on duty in unit where SIERRA-Sanchez was housed, that SIERRA-Sanchez needed a shower. Deputy [redacted] stated during his interview on August 19, 2014, that he did not remember Deputy [redacted] telling him SIERRA-Sanchez needed a shower.
[29] Exhibit 2: Intake Medical Screening, July 11, 2014.
[30] Exhibit 3: Creative Corrections Report, page 3, provides detailed analysis of SIERRA-Sanchez's intake medical screening.
[31] ODO interview with RN [redacted], August 19, 2014.
[32] ERO determined SIERRA-Sanchez had used a false name when he was apprehended on July 6, 2014, and subsequently detained at SLCADF.
[33] ODO interview with RN [redacted], August 19, 2014.
[34] Exhibit 3, page 4, contains a detailed description of the layout of the Aspen unit.
[35] UCJ's Administrative Segregation Policy states that detainees in administrative segregation will be housed separately from the general population, and that administrative segregation may include medical isolation when

place SIERRA-Sanchez in Aspen because SIERRA-Sanchez was unable to walk without assistance.[36] ODO notes that a non-medical intake screening form completed by a Deputy during booking documents SIERRA-Sanchez was classified on July 11, 2014, but his detention record does not contain any classification forms. ERO completed a Risk Classification Assessment (RCA) when SIERRA-Sanchez was processed at the Field Office, but does not typically provide RCA's to UCJ, and did not provide SIERRA-Sanchez's.

When his booking and intake medical screening were complete, SIERRA-Sanchez was escorted to Aspen by Deputy [redacted] At 3:43 p.m., Deputy [redacted], who was on duty in Aspen, assigned SIERRA-Sanchez to cell 20.[37] Deputy [redacted] stated SIERRA-Sanchez appeared to be in a lot of pain when he entered Aspen and that he asked for pain medications.[38] Deputy [redacted] stated he wanted to watch SIERRA-Sanchez closely, so he placed SIERRA-Sanchez in cell 20, which was located between two cells that held inmates on suicide watch, to ensure SIERRA-Sanchez was checked every 15 minutes.[39] Deputy [redacted] stated that he did not converse with SIERRA-Sanchez during the remainder of his shift, but during security rounds, he noticed SIERRA-Sanchez fidgeting.

At approximately 4:00 p.m., Deputy [redacted] entered Aspen to have SIERRA-Sanchez sign an administrative segregation order.[40] Deputy [redacted] stated when he entered SIERRA-Sanchez's cell, SIERRA-Sanchez was lying in his cot[41] with his knees up in the air and his jumpsuit only halfway on.[42] SIERRA-Sanchez asked for assistance getting into a sitting position on the cot and putting on his jumpsuit,[43] and then signed his order. Deputy [redacted] stated SIERRA-Sanchez asked him for narcotic pain medication, and that they discussed SIERRA-Sanchez's history of drug abuse, including heroin, as well as his back pain. Deputy [redacted] stated that although he initially thought SIERRA-Sanchez might be drug-seeking, he quickly

---

medical staff deems it necessary to isolate a detainee for medical reasons. Aspen is only used only for medical and mental health observation, and is considered an administrative segregation unit per the UCJ policy.

[36] ODO interview with RN [redacted], August 19, 2014.

[37] Housing record, July 11-12, 2014.

[38] ODO interview with Deputy [redacted], August 19, 2014.

[39] Both Deputy [redacted] and Deputy [redacted] stated during their interviews with ODO that there were "two or three" inmates on suicide watch the night of July 11, 2014. They also repeated this statement during their interviews with the Utah County Attorney's Office, as documented in the Utah County Attorney's Office Summary Report. Further, Deputy [redacted] documented in his incident statement that cell 20 was between two cells requiring 15 minute rounds. These statements were not supported by housing unit records, the electronic rounds system records, or available surveillance footage from the unit. ODO went through individual housing records for Aspen from July 11, 2014, with HSA [redacted] while onsite, and only confirmed that one inmate was on suicide watch the night of July 11, 2014, and he was housed in cell 13, which is located on the opposite side of Aspen from cell 20.

[40] Administrative segregation order, July 11, 2014.

[41] SIERRA-Sanchez had a plastic cot, referred to as a "canoe," which is very low to the ground.

[42] ODO interview with Deputy [redacted] August 20, 2014.

[43] Deputy [redacted] stated SIERRA-Sanchez was in too much pain to put his jumpsuit back on by himself after he used the bathroom.

realized the detainee was in legitimate pain.[44] Deputy [redacted] remembered stating to Deputy [redacted] before leaving the unit that he expected SIERRA-Sanchez would end up in the hospital that night.

At approximately 7:41 p.m., SIERRA-Sanchez was seen in his cell by RN [redacted] during med-pass.[45] RN [redacted] stated he asked SIERRA-Sanchez about his back pain, and SIERRA-Sanchez reported that the pain started after an accident several months prior, but refused to answer any additional questions.[46] SIERRA-Sanchez asked for pain medication, and RN [redacted] provided Tylenol and ibuprofen. RN [redacted] described SIERRA-Sanchez as uncooperative when questioned about his back pain, and stated that at the time he thought SIERRA-Sanchez "might be playing games" to get narcotic pain medication.[47] RN [redacted] took SIERRA-Sanchez's vital signs which showed an elevated pulse and borderline high blood pressure, but did not take SEIRRA's temperature.[48] RN [redacted] stated that he assumed SIERRA-Sanchez's temperature was taken during his intake screening. Creative Corrections notes that if RN [redacted] had reviewed SIERRA-Sanchez's intake screening, he not only would have realized SIERRA-Sanchez's temperature was never taken, but also would have observed a notable change in SIERRA-Sanchez's pulse and blood pressure, signifying the need for further evaluation.[49] RN [redacted] did not conduct a hands-on examination of SIERRA-Sanchez, and did not document SIERRA-Sanchez's pain level or any additional information concerning the intensity, location, or aggravating or relieving factors.[50] RN [redacted] stated that when he questioned SIERRA about his back pain, SIERRA-Sanchez's answers did not indicate that a more extensive examination was needed.[51] RN [redacted] also stated that he could not assess SIERRA-Sanchez because SIERRA-Sanchez did not want to be touched. SIERRA-Sanchez's medical record does not contain documentation that he refused to undergo a physical assessment of his back pain by RN [redacted].[52] Creative Corrections notes that UCJ's nursing protocol regarding back pain[53] requires an extensive assessment as well contacting the medical provider for orders, as needed.[54]

[44] ODO interview with Deputy [redacted], August 20, 2014.
[45] Exhibit 4: Medical notes, July 11-12, 2014.
[46] ODO interview with RN [redacted], August 19, 2014.
[47] Id.
[48] Exhibit 3, page 5.
[49] Id.
[50] Id.
[51] ODO interview with RN [redacted], August 19, 2014.
[52] Exhibit 3, page 5. Creative Corrections also notes that RN [redacted] failed to document SIERRA-Sanchez's refusal to sign a release form to obtain previous medical records and X-rays. During his interview, RN [redacted] acknowledged his poor documentation in SIERRA-Sanchez's chart, but stated that he did not document "every little thing" because he did not realize there was a need to do so.
[53] Exhibit 5: UCJ's RN Back Pain Protocol.
[54] Id. Specifically, nursing protocol requires an assessment of the affected area, and if the pain is a result of trauma, a head-to-toe assessment must be done. The assessment should include obtaining a history of the complaint, noting

Deputy [redacted] was present during RN [redacted] visit with SIERRA-Sanchez, and remembered SIERRA-Sanchez became frustrated when RN [redacted] did not give him stronger pain medication.[55] Deputy [redacted] in his interview with the Utah County Attorney's Office that SIERRA-Sanchez described that his pain was on the right side of his body, and that he was also spitting blood.[56] When Deputy [redacted] and RN [redacted] looked for evidence of SIERRA-Sanchez spitting blood, they did not find anything. Creative Corrections notes that coughing up blood is a possible symptom of TB.[57] Deputy [redacted] also stated that he told RN [redacted] about SIERRA-Sanchez's history of heroin abuse, as reported by Deputy [redacted] as well as the fact that he saw SIERRA-Sanchez fidgeting in his cell throughout the evening. RN [redacted] told ODO that he had no recollection of Deputy [redacted] mentioning SIERRA-Sanchez's history of drug abuse during the visit. Creative Corrections notes that SIERRA-Sanchez's fidgeting behavior coupled with a history of recent drug abuse warranted a medical assessment to rule out possible drug withdrawal.[58]

RN [redacted] stated during his interview that he contacted Deputy [redacted] later during the night of July 11, 2014, to find out if SIERRA-Sanchez's condition had changed or worsened, and Deputy [redacted] did not indicate any worsening of SIERRA-Sanchez's symptoms.[59] SIERRA-Sanchez's medical record does not contain documentation of this conversation.

At approximately 10:00 p.m., Deputy [redacted] assumed the Aspen unit post from Deputy [redacted] Deputy [redacted] stated that Deputy [redacted] briefed him on SIERRA-Sanchez's condition during shift change and mentioned SIERRA-Sanchez was uncooperative with RN [redacted] during med-pass.[60] Deputy [redacted] also documented in his incident statement that he told Deputy [redacted] he thought SIERRA-Sanchez might be trying to obtain unauthorized pain medication.[61]

Deputy [redacted] electronically logged 13 rounds between 10:00 p.m. and 4:00 a.m., July 12, 2014.[62] During his interview, Deputy [redacted] stated he conducted rounds every 15 minutes; however, the log shows only three 15 minute rounds were done. The remaining ten rounds were done approximately every 30 minutes. Review of video surveillance footage[63] shows Deputy

---

location, nature and duration, radiation of pain if not focalized, loss of bowel/bladder control, and any factors that make the pain better or worse.

[55] ODO interview with Deputy [redacted], August 19, 2014.

[56] Exhibit 6: Deputy [redacted] statement to Utah County Attorney's Office, July 12, 2014.

[57] Exhibit 3, page 6. Creative Corrections notes SIERRA-Sanchez's medical record does not contain documentation showing any action was taken at any time to evaluate SIERRA-Sanchez for TB.

[58] Id.

[59] ODO interview with RN [redacted] August 19, 2014.

[60] ODO interview with Deputy [redacted], August 19, 2014.

[61] Exhibit 7: Deputy [redacted] incident statement, July 12, 2014.

[62] Electronic record of rounds conducted in Aspen during the time of SIERRA-Sanchez's detention, July 11-12, 2014. Rounds are logged electronically by swiping a key card on electronic key card readers which are affixed to the wall. There is one key card reader on each wall which logs rounds for every cell along that wall.

[63] Video surveillance footage of Aspen, 10:00 p.m. to 4:00 a.m., July 11-12, 2014.

[redacted] conducting additional rounds which he did not electronically log.[64] The video also shows Deputy [redacted] passing by cell 20 during several of his rounds without looking in, or making only a cursory glance toward the cell as he walks by. Deputy [redacted] documented in his incident statement, that he checked SIERRA-Sanchez every 15 minutes while conducting 15 minute rounds of the three inmates on suicide watch in Aspen.[65] ODO notes again that there was only one confirmed inmate on suicide watch that night, and that inmate was housed on the opposite side of the unit. Deputy [redacted] stated during his interview that he did not converse with SIERRA-Sanchez, but noticed SIERRA-Sanchez sitting on his cot throughout the night fidgeting with his jumpsuit and hands, and his position and behavior did not change until the 3:30 a.m. round.

Deputy [redacted] conducted a round of SIERRA-Sanchez at approximately 3:15 a.m.,[66] and stated that SIERRA-Sanchez was sitting on his cot as he had been doing throughout the night.[67] The video surveillance footage shows Deputy [redacted] standing at the door of cell 20, looking in the window, at time stamp 3:07 a.m.[68] ODO notes that the time stamps on the surveillance footage are approximately seven minutes slower than times recorded in electronic rounds and written statements. Deputy [redacted] next rounds occurred at 3:29 a.m.[69] Deputy [redacted] documented in his incident statement and stated during his interview that during this round, he observed SIERRA-Sanchez lying face-down on his cot with his head hanging off the side. Deputy [redacted] stated SIERRA-Sanchez's head was turned away from the cell door and his face was not visible. Deputy [redacted] thought SIERRA-Sanchez's positioning was strange since he had been sitting on his cot in the same position throughout the night, but did not think anything was immediately wrong, and decided to finish his round of Aspen before taking a closer look at SIERRA-Sanchez. Approximately two minutes later,[70] Deputy [redacted] returned to SIERRA-Sanchez's cell and knocked on the window to get his attention, but did not get a response.[71] Deputy [redacted] stated he then returned to the deputy's station where he attempted to call SIERRA-Sanchez over the intercom system. When he again got no response from SIERRA-Sanchez, Deputy [redacted] walked back to cell 20, looked in the window and saw that SIERRA-Sanchez had not moved from his face-down position on the cot, and then decided to call medical staff to look at SIERRA-Sanchez. Deputy [redacted] stated that although SIERRA-Sanchez was not responding, he did not

[64] Review of the surveillance footage indicates that the camera, which is designed to be motion-activated, does not appear to be functioning as designed. The footage shows that recording continued in areas where there was no movement, and stopped during periods of activity.
[65] Exhibit 8: Deputy [redacted] Incident Statement, July 12, 2014.
[66] This round was not electronically logged, but is corroborated by video surveillance footage.
[67] Exhibit 8.
[68] Video surveillance footage of Aspen, 10:00 p.m. to 4:00 a.m., July 11-12, 2014.
[69] Electronic record of rounds documents this round. Surveillance video shows this round occurring at 3:23 a.m.
[70] Surveillance footage skips ahead two minutes and shows Deputy [redacted] already at cell 20, knocking on the window.
[71] Exhibit 8.

think anything was critically wrong, which is why he did not call for medical back-up.[72] The video surveillance footage cuts out until approximately four minutes later, or approximately 3:36 a.m., when the door to cell 20 is open and a person can be seen entering the cell.

RN [redacted] documented he received a call at approximately 3:35 a.m. from Deputy [redacted] who asked him to check on SIERRA-Sanchez.[73] When RN [redacted] arrived in Aspen, Deputy [redacted] unlocked SIERRA-Sanchez's cell door, and the two entered the cell together.[74] The video surveillance footage shows that six minutes elapsed between the security round when Deputy [redacted] first observed SIERRA-Sanchez lying partially off of his cot, and when SIERRA-Sanchez's cell was entered by Deputy [redacted] and RN [redacted] RN [redacted] stated SIERRA-Sanchez was lying face down in a pool of bloody vomit, and looked as though he had leaned over the side of the cot to vomit and then fell in it. RN [redacted] stated that as soon as he saw the vomit, he told Deputy [redacted] to call for medical back-up. RN [redacted] checked SIERRA-Sanchez for a pulse, did not find one, and then rolled SIERRA-Sanchez back on to the cot and initiated cardiopulmonary resuscitation (CPR). RN [redacted] stated that he immediately sensed SIERRA-[redacted] was already dead, but because his body was still warm, he did not think SIERRA-[redacted] had been dead for very long.

Deputy [redacted] stated he called for medical back-up as RN [redacted] initiated CPR.[75] A timeline of events compiled by Sergeant [redacted] logs Deputy [redacted] call at 3:34 a.m.;[76] incident reports by other deputies document receiving the medical back-up call at 3:38 a.m. and 3:40 a.m. ODO notes that the variance in documented times of events is likely due to personal watches not being calibrated to one another, and Deputy [redacted] medical back-up call was placed sometime between 3:36 a.m. and 3:40 a.m.

The video surveillance footage shows both medical and correctional staff responded to Deputy [redacted] call for medical back-up within four minutes of Deputy [redacted] and RN [redacted] entering SIERRA-Sanchez's cell.[77] Responding staff included RNs [redacted] and [redacted] and Deputies [redacted] and [redacted] who all assisted with the CPR.[78] The video surveillance footage also shows that a Deputy brought an automated external defibrillator (AED) to the scene. RN [redacted] stated a Deputy was instructed to retrieve an AED

[72] UCJ uses the term "medical back-up call" when referencing a call for a medical emergency, and "back-up call" for general emergency situations.
[73] Exhibit 4.
[74] ODO interview with RN [redacted] August 19, 2014.
[75] ODO interview with Deputy [redacted] August 19, 2014.
[76] Exhibit 9: Sergeant [redacted] timeline of events. ODO notes that the times documented by Sergeant [redacted] do not exactly match times documented by officers in incident statements, and should only be considered as approximate.
[77] Video surveillance footage of Aspen, 10:00 p.m. to 4:00 a.m., July 11-12, 2014.
[78] A handheld camera was not used to document the resuscitation efforts.

after CPR was initiated, but Emergency Medical Technicians (EMTs) arrived before the AED was applied to SIERRA-Sanchez.

Sergeant [redacted] one of the officers who responded to Deputy [redacted] medical back-up call, stated that Deputy [redacted] specified he needed medical back-up for an unresponsive inmate when he made the call.[79] Sergeant [redacted] stated that when he arrived in Aspen and saw medical personnel performing CPR on SIERRA-Sanchez, he immediately called dispatch to send an ambulance for the detainee. The Spanish Fork City Ambulance report documents that the call for an ambulance was received at 3:39 a.m., the ambulance arrived at the facility at 3:51 a.m., and EMTs arrived at SIERRA-Sanchez's side at 3:52 a.m.[80]

After Sergeant [redacted] called for an ambulance, Sergeant [redacted] who also responded to the scene, notified both his supervisor, Lieutenant [redacted] and the ICE agent on-call, [redacted] that SIERRA-Sanchez was found unresponsive in his cell and was being sent to the hospital.[81] Lieutenant [redacted] then notified Chief [redacted] who in turn notified the Utah County Protocol Team.[82]

The ambulance carrying SIERRA-Sanchez departed UCJ at 3:59 a.m., and arrived at the Utah Valley Regional Medical Center at 4:08 a.m.[83] Deputy [redacted] escorted SIERRA-Sanchez in the ambulance, and Deputy [redacted] followed the ambulance in a UCJ van. Deputy [redacted] stated EMTs used an automated chest compression machine on SIERRA-Sanchez throughout the ride to the hospital.[84] When the ambulance arrived at the hospital, SIERRA-Sanchez was taken to the emergency room where hospital staff attempted to resuscitate him. At 4:20 a.m., SIERRA-Sanchez was pronounced dead[85] by Dr. [redacted],[86] and at 5:40 a.m., SIERRA-Sanchez's body was transported to the Utah State Medical Examiner's Office in Salt Lake City, Utah.[87]

[79] ODO interview with Sergeant [redacted] August 19, 2014.
[80] Spanish Fork City Ambulance report, July 12, 2014.
[81] ODO interview with Sergeant [redacted] August 19, 2014.
[82] The Utah County Protocol Team is a section of the Utah County Attorney's Office that investigates all incidents involving an officer employed by the county, as well as incidents occurring in-custody that may involve criminal misconduct by a county employee.
[83] Spanish Fork City Ambulance report, July 12, 2014.
[84] ODO interview with Deputy [redacted] August 19, 2014.
[85] Exhibit 10: Certificate of Death, July 12, 2014.
[86] Utah Valley Regional Medical Center record for SIERRA-Sanchez, July 12, 2014.
[87] Utah County Attorney's Office Summary Report, August 6, 2014.

Immediately after SIERRA-Sanchez was declared dead, Deputy [redacted] notified Sergeant [redacted] via telephone. Sergeant [redacted] then called AFOD [redacted] to inform him SIERRA-Sanchez had died.[88]

Sergeant [redacted] with the Protocol Team, was assigned to investigate SIERRA-Sanchez's death at approximately 4:30 a.m.,[89] and arrived at SIERRA-Sanchez's cell with a second investigator, Sergeant [redacted] and forensic specialist [redacted] at approximately 5:45 a.m.[90] Sergeant [redacted] and Sergeant [redacted] interviewed 14 UCJ staff members including both correctional and medical personnel.[91] After completing the interviews and examining the scene, Sergeant [redacted] attended SIERRA-Sanchez's autopsy at approximately 9:45 a.m. Sergeant [redacted] documented that the preliminary autopsy results indicated SIERRA-Sanchez's cause of death to be severe staph aureus pneumonia.[92] Sergeant [redacted] stated that no criminal misconduct or evidence of foul play was discovered during his investigation of SIERRA-Sanchez's death.[93]

On July 12, 2014, at approximately 10:11 a.m., AFOD [redacted] telephonically notified [redacted] of the Mexican Consulate, Salt Lake City, of SIERRA-Sanchez's death.

On September 18, 2014, SIERRA-Sanchez's autopsy report was finalized by Deputy Chief Medical Examiner, [redacted] M.D. The report documents SIERRA-Sanchez's cause of death as a disseminated Staphylococcus aureus infection which resulted in severe pneumonia.[94]

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 SIERRA-Sanchez while he was detained at UCJ, as well as the medical care he was provided while housed there. Creative Corrections found UCJ did not fully comply with the ICE NDS for Medical Care. The Creative Corrections Healthcare and Security Compliance Analysis is included as an Exhibit to this report.

IMMIGRATION AND DETENTION HISTORY

On February 9, 1996, SIERRA-Sanchez was encountered by the former Immigration and Naturalization Service (INS) in San Diego, California.

---

[88] ODO interview with Sergeant [redacted] August 19, 2014. ODO notes that this statement conflicts with Sergeant [redacted] timeline which documents AFOD [redacted] was notified prior to SIERRA-Sanchez being declared dead. ODO interview with Sergeant [redacted] August 20, 2014.
[90] Video surveillance footage of Aspen, July 12, 2014.
[91] Utah County Attorney's Office Summary Report, August 6, 2014.
[92] Id.
[93] ODO interview with Sergeant [redacted] August 19, 2014. This is also documented in the Summary Report.
[94] Exhibit 11: Autopsy report, September 18, 2014.

On February 14, 1996, SIERRA-Sanchez was deported to Mexico via Calexico, California.

SIERRA-Sanchez subsequently reentered the United States illegally and was removed to MEXICO by INS and ICE on August 23, 1998; May 13, 1999; July 20, 2005; May 19, 2006; April 17, 2007; October 14, 2009; and May 22, 2012.

In 2013, on an unknown date and at an unknown location, SIERRA-Sanchez reentered the United States without admission or parole.

On July 9, 2014, ERO encountered SIERRA-Sanchez at the SLCADC, where he was held on charges of possession or use of a controlled substance, and possession or use of drug paraphernalia.

On July 11, 2014, ERO arrested SIERRA-Sanchez at the SLCADC and reinstated his prior order of removal pursuant to section 241(a)(5) of the U.S. Immigration and Nationality Act. SIERRA-Sanchez was transported to UCJ where he was detained until his death.

CRIMINAL HISTORY

According to the National Crime Information Center (NCIC), SIERRA-Sanchez was assigned an FBI number and state identification (SID) numbers in California and Utah. On July 6, 2014, SIERRA-Sanchez was arrested by the Unified Police Department of Greater Salt Lake for possession or use of a controlled substance, and possession or use of drug paraphernalia.

INVESTIGATIVE FINDINGS

1. ICE NDS Medical Care, section (I), states, "All detainees shall have access to medical services that promote detainee health and general well-being."

Correctional and medical staff at UCJ stated that SIERRA-Sanchez appeared to be in pain and had difficulty walking when he entered the facility on July 11, 2014. Although SIERRA-Sanchez was a reluctant and poor historian regarding his back pain, the pain was not thoroughly assessed by either RN [redacted] during intake medical screening, or RN [redacted] on the evening of July 11, 2014. RN [redacted] stated that SIERRA-Sanchez did not want to undergo a physical examination for his back pain, but refusal of an examination was not documented by RN [redacted] in SIERRA-Sanchez's medical record. Both RNs failed to follow UCJ protocol regarding back pain, and did not call a provider. Although SIERRA-Sanchez was scheduled to see a physician assistant (PA) for follow-up, UCJ's PA was not scheduled to visit the facility until four days after SIERRA-Sanchez's admission.

SIERRA-Sanchez's pulse and blood pressure both increased between the time of his intake medical screening, and his evaluation by RN [redacted] approximately 4.5 hours later, which, Creative Corrections advises, warranted a consultation with a provider. Further, neither RN

[redacted] nor RN [redacted] took SIERRA-Sanchez's temperature when taking his other vital signs. Creative Corrections notes that an elevated temperature can signal an infection.

2. ICE NDS Medical Care, section (III)(D), states, "All new arrivals shall receive TB screening by PPD (mantoux method) or chest x-ray."

RN [redacted] stated he did not screen SIERRA-Sanchez for TB because he believed it likely that SIERRA-Sanchez was screened while incarcerated at the SLCADC. RN [redacted] stated that he unsuccessfully attempted to procure SIERRA-Sanchez's medical record from SLCADC; however, he did not document his effort to get the record, and did not screen SIERRA-Sanchez for TB in the absence of a record from SLCADC. When SIERRA-Sanchez later reported coughing up blood, a symptom of TB, he was not screened for the disease even though his medical record contained no documentation that TB screening had yet been done.

AREAS OF CONCERN

UCJ Policy 420.00, Supervision and Surveillance of Inmates defines a round as a "walking tour of the entire area being supervised." The policy states that a "round consists of physically walking through or within the area to observe inmate behavior, activity, and well-being," and "If the area contains inmate housing rooms or dormitories, the round includes full observation into those rooms." The video surveillance footage of Aspen from July 11-12, 2014, shows multiple rounds were completed without direct observation of SIERRA-Sanchez in his cell. Although Deputy [redacted] is seen looking in SIERRA-Sanchez's cell during the round that preceded his initial observation that SIERRA-Sanchez was lying face-down and was unresponsive, his failure to consistently observe the interior of the cell during prior rounds demonstrates poor adherence to a policy requirement which is critical to detainee safety.

UCJ Policy 420.00, Supervision and Surveillance of Inmates states, "The deputy's role is to supervise inmates by seeing, hearing, and responding promptly to inmate issues and emergencies." Deputy [redacted] observed SIERRA-Sanchez lying face-down and partially off of his cot, and noted SIERRA-Sanchez was unresponsive to verbal calls, but did not immediately call for emergency assistance. Instead, Deputy [redacted] first knocked on the cell door and called out to SIERRA-Sanchez, then returned to the deputy's station where he tried to get SIERRA-Sanchez's attention via the intercom system, then returned to the cell and knocked on the door again, and then finally returned to the deputy's station where he used the telephone to call medical to assess SIERRA-Sanchez. Six minutes elapsed between Deputy [redacted] first observing SIERRA-Sanchez unresponsive and Deputy [redacted] and RN [redacted] entering SIERRA-Sanchez's cell. Additionally, because Deputy [redacted] only called for a medical assessment and not a medical emergency, RN [redacted] arrived on the scene without proper equipment or necessary backup to handle a medical emergency. Deputy [redacted] hesitancy in requesting assistance

delayed both the commencement of CPR on SIERRA-Sanchez, and placement of a call to dispatch for emergency medical services.

ODO notes that documentation in SIERRA-Sanchez's medical record is lacking. RN [redacted] neglected to document any attempts he made to obtain SIERRA-Sanchez's medical record from SLCADF, and SIERRA-Sanchez's medical record does not contain any documentation showing the detainee was asked to sign an authorization releasing his medical record from SLCADF to UCJ. Further, during a 7:41 p.m. evaluation of SIERRA-Sanchez on July 11, 2014, RN Jensen did not document SIERRA-Sanchez's pain level or any additional information concerning the intensity, location, or aggravating or relieving factors. Additionally, although RN [redacted] stated SIERRA-Sanchez refused a physical assessment of his back pain during the evaluation, the detainee's medical record does not contain documentation of the refusal. Finally, RN [redacted] stated that Deputy [redacted] provided an update on SIERRA-Sanchez sometime between the 7:41 p.m. evaluation and shift change at 10:00 p.m., and stated to RN [redacted] that SIERRA-Sanchez's symptoms had not worsened. RN [redacted] did not document this conversation in SIERRA-Sanchez's medical record. Without documentation of this information, it is impossible to assess whether the stated events actually took place.

EXHIBITS

1. July 11, 2014 email from Lieutenant [redacted] to HSA [redacted]
2. SIERRA-Sanchez's intake medical screening
3. Creative Corrections Healthcare and Security Compliance Analysis
4. Medical notes regarding SIERRA-Sanchez
5. UCJ's RN Back Pain Protocol
6. Deputy [redacted] statement to Utah County Attorney's Office
7. Deputy [redacted] Incident Statement
8. Deputy [redacted] Incident Statement
9. Sergeant [redacted] Timeline of Events
10. SIERRA-Sanchez's Certificate of Death
11. SIERRA-Sanchez's Autopsy Report