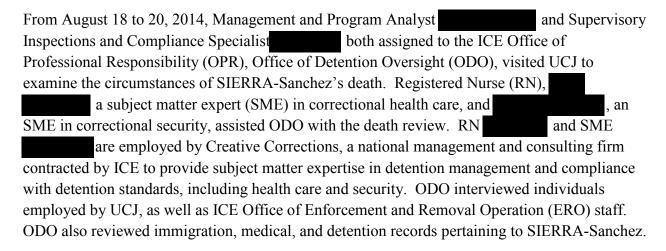
SYNOPSIS

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).

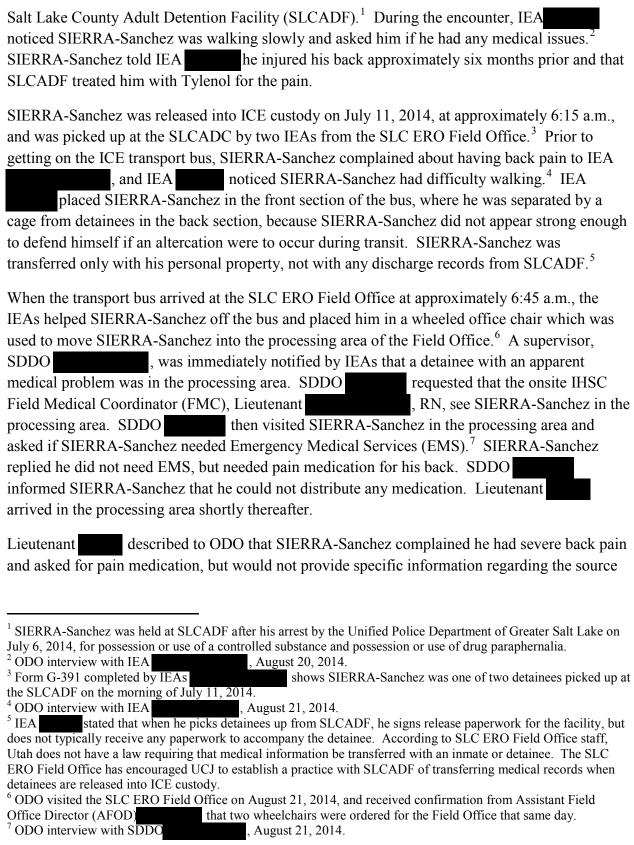


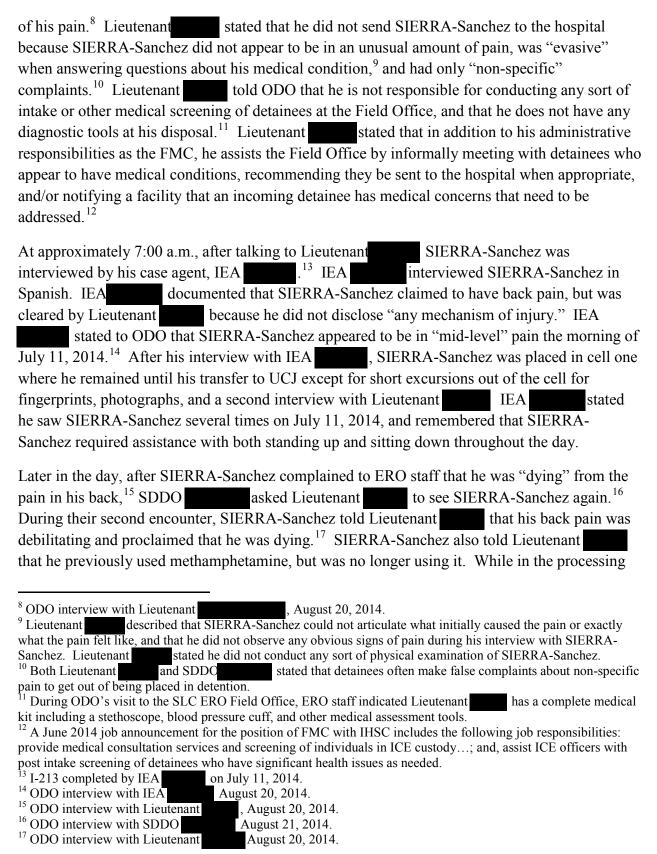
During this review, ODO staff took note of any deficiencies observed in the detention standards, as they relate to the care and custody of the deceased detainee, and documented those deficiencies herein for information purposes only. Their inclusion in the report should not be construed in any way as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

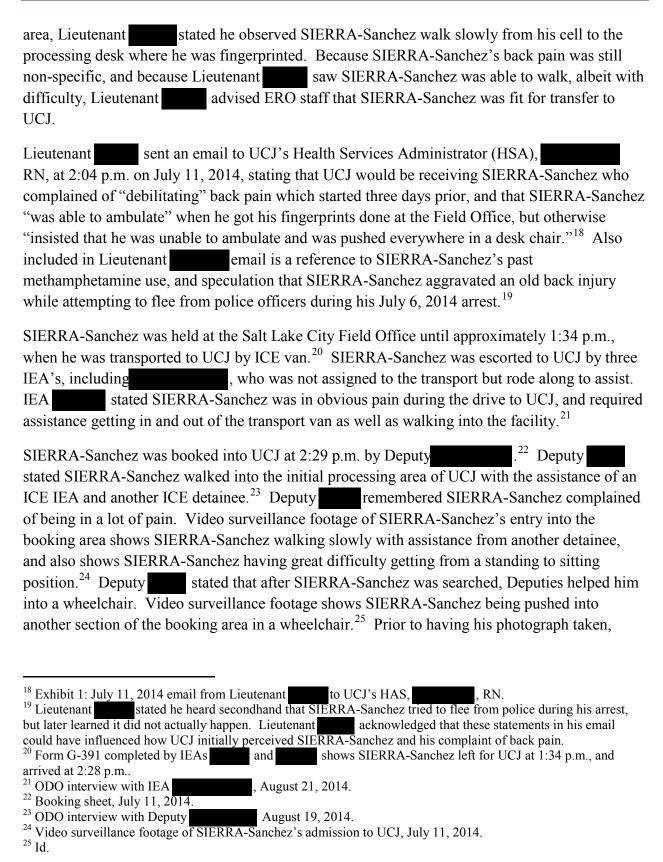
ODO determined the following timeline of events, from the time of SIERRA-Sanchez's apprehension, through his detention at UCJ.

NARRATIVE

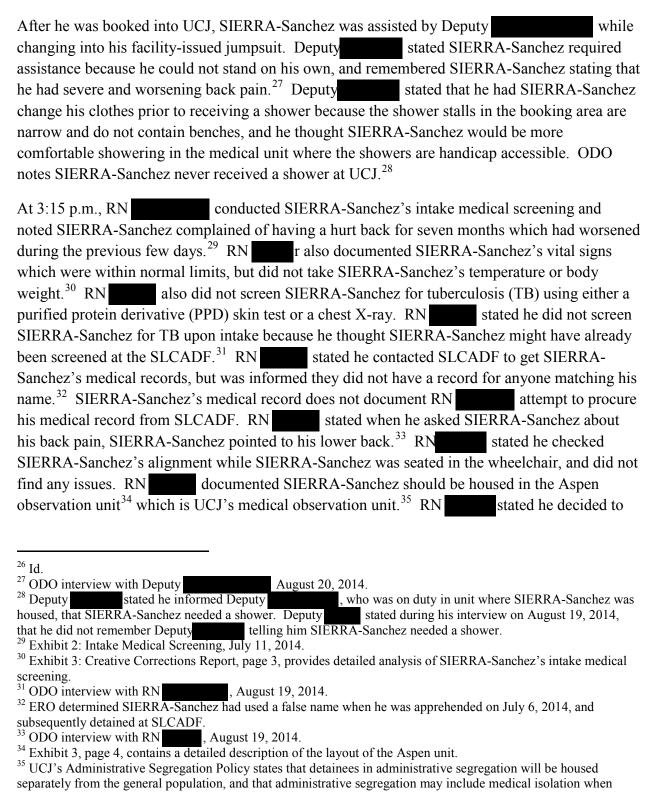
On July 9, 2014, Immigration Enforcement Agent (IEA), based out of the Salt Lake City (SLC) ERO Field Office, encountered SIERRA-Sanchez during a routine check at the







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



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 At 3:43 p.m., Deputy , who was on duty in Aspen, assigned SIERRA-Sanchez to cell 20.³⁷ Deputy stated SIERRA-Sanchez appeared to be in a lot of pain when he entered Aspen and that he asked for pain medications.³⁸ Deputy 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 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 entered Aspen to have SIERRA-Sanchez sign an administrative segregation order. 40 Deputy stated when he entered SIERRA-Sanchez's cell, SIERRA-Sanchez was lying in his cot⁴¹ 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 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 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 , August 19, 2014. ³⁷ Housing record, July 11-12, 2014. ³⁸ ODO interview with Deputy , August 19, 2014. stated during their interviews with ODO that there were "two or ³⁹ Both Deputy and Deputy 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 documented in his incident statement that cell 20 was between two cells requiring 15 minute

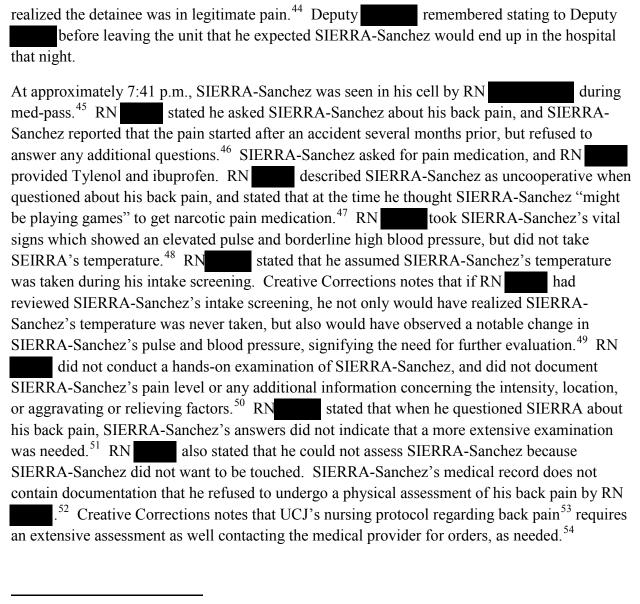
rounds. These statements were not supported by housing unit records, the electronic rounds system records, or available surveillance footage from the unit. ODO went through individual housing records for Aspen from July 11,

^{2014,} with HSA 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. 2014, with HSA

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

with Deputy August 20, 2014.
stated SIERRA-Sanchez was in too much pain to put his jumpsuit back on by himself after he used the bathroom.



⁴⁴ ODO interview with Deputy , August 20, 2014.

⁴⁵ Exhibit 4: Medical notes, July 11-12, 2014.

⁴⁶ ODO interview with RN August 19, 2014.

⁴⁷ Id.

⁴⁸ Exhibit 3, page 5.

⁴⁹ Id.

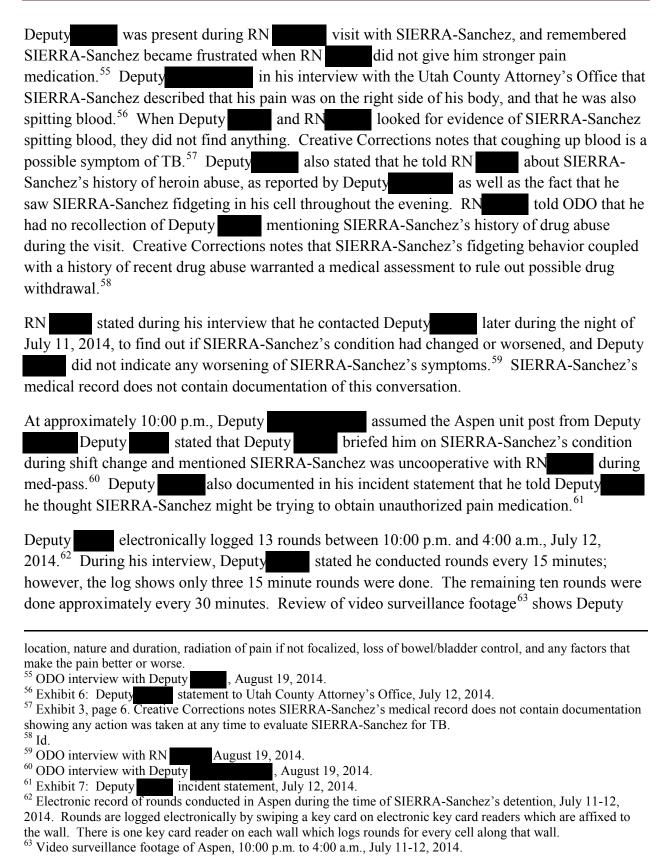
⁵⁰ Id.

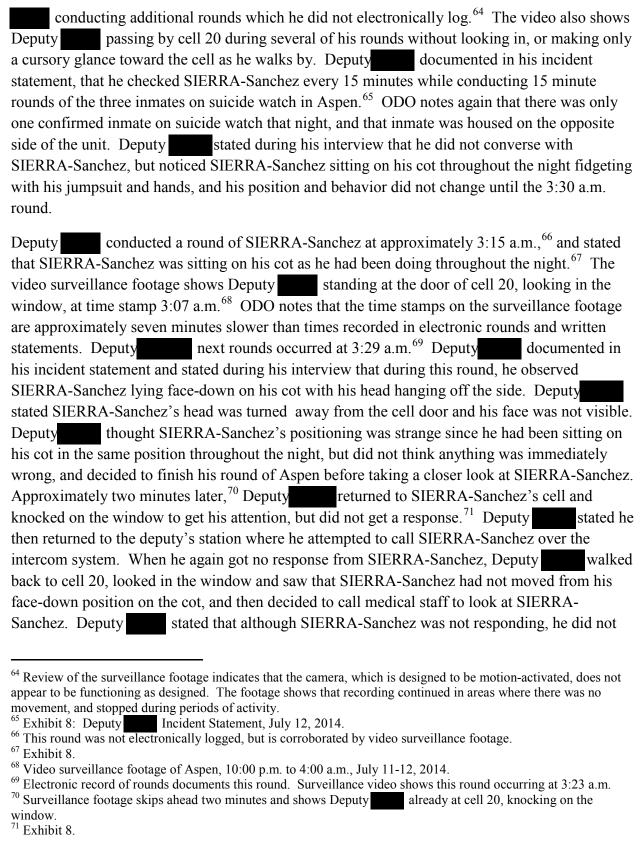
⁵¹ ODO interview with RN August 19, 2014.

Exhibit 3, page 5. Creative Corrections also notes that RN failed to document SIERRA-Sanchez's refusal to sign a release form to obtain previous medical records and X-rays. During his interview, RN 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.

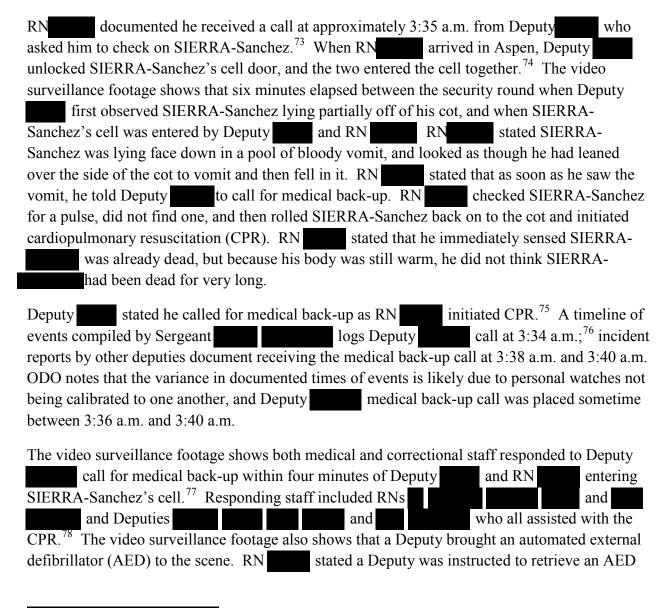
⁵³ Exhibit 5: UCJ's RN Back Pain Protocol.

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





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.



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 August 19, 2014.

⁷⁵ ODO interview with Deputy August 19, 2014.

⁷⁶ Exhibit 9: Sergeant timeline of events. ODO notes that the times documented by Sergeant do not exactly match times documented by officers in incident statements, and should only be considered as approximate.

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. one of the officers who responded to Deputy medical back-Sergeant specified he needed medical back-up for an unresponsive up call, stated that Deputy inmate when he made the call. ⁷⁹ Sergeant 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 called for an ambulance, Sergeant who also responded to the scene, notified both his supervisor, Lieutenant and the ICE agent on-call, that SIERRA-Sanchez was found unresponsive in his cell and was being sent to the hospital.⁸¹ Lieutenant then notified Chief 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 escorted SIERRA-Sanchez in the ambulance, and Deputy followed the ambulance in a UCJ van. Deputy 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 dead⁸⁵ by Dr. , 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 August 19, 2014.

⁸⁰ Spanish Fork City Ambulance report, July 12, 2014. ⁸¹ ODO interview with Sergeant August 19, 2014.

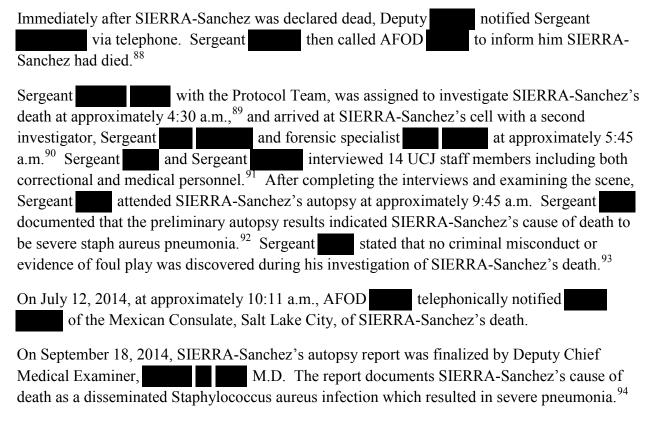
⁸² The Utah County Protocol Team is a section of the Utah County Attorney's Office that investigates all incidents involving an officer employed by the county, as well as incidents occurring in-custody that may involve criminal misconduct by a county employee.

⁸³ Spanish Fork City Ambulance report, July 12, 2014.

⁸⁴ ODO interview with Deputy 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.

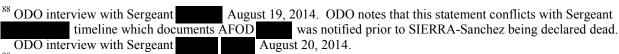


SECURITY AND HEALTHCARE REVIEW

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.



⁹⁰ Video surveillance footage of Aspen, July 12, 2014.

⁹¹ Utah County Attorney's Office Summary Report, August 6, 2014.

⁹³ ODO interview with Sergeant August 19, 2014. This is also documented in the Summary Report. 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

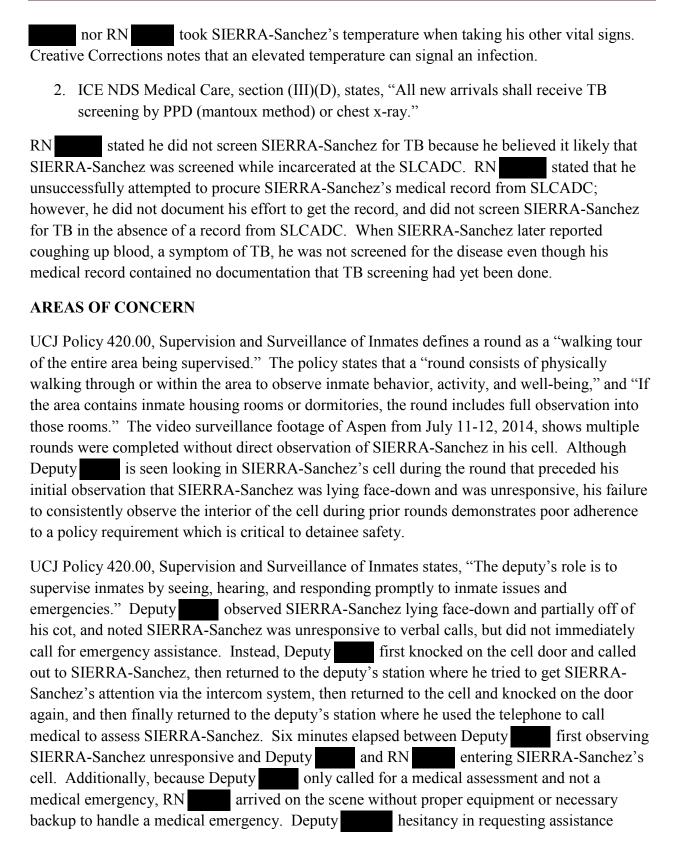
According to the National Crime Information Center (NCIC), SIERRA-Sanchez was assigned an FBI number and state identification (SID) numbers in California and Utah. On July 6, 2014, SIERRA-Sanchez was arrested by the Unified Police Department of Greater Salt Lake for possession or use of a controlled 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 during intake medical screening, or RN on the evening of July 11, 2014. RN 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 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 approximately 4.5 hours later, which, Creative Corrections advises, warranted a consultation with a provider. Further, neither RN



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

odd notes that documentation in SIERRA-Sanchez's medical record is lacking. RN 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 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 stated that Deputy 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 that SIERRA-Sanchez's symptoms had not worsened. RN 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 to HSA
- 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 statement to Utah County Attorney's Office
- 7. Deputy Incident Statement
- 8. Deputy Incident Statement
- 9. Sergeant Timeline of Events
- 10. SIERRA-Sanchez's Certificate of Death
- 11. SIERRA-Sanchez's Autopsy Report