

## SYNOPSIS

On March 28, 2017, Osmar Epifanio GONZALEZ-Gadba, who was a thirty-two year old citizen and national of Nicaragua, died while in the custody of the U.S. Immigration and Customs Enforcement (ICE), at the Victor Valley Global Medical Center (VVGMC) in Victorville, California. The State of California's Certificate of Death, issued June 1, 2017, documented the cause of GONZALEZ's death as hypoxic encephalopathy<sup>1</sup> and hanging, and his manner of death as suicide.

GONZALEZ was detained at Adelanto Detention Facility (ADF)<sup>2</sup> in Adelanto, California (CA), at the time of his death. ADF is owned by the City of Adelanto and operated by the GEO Group, Inc. under a Dedicated Intergovernmental Service Agreement (D-IGSA), which requires the facility to comply with the ICE Performance-Based National Detention Standards (PBNDS) 2011. At the time of GONZALEZ's death, ADF housed approximately 1,783 male and female detainees of all classification levels for periods in excess of 72 hours. Medical care at ADF is provided by Correct Care Solutions (CCS).

## DETAILS OF REVIEW

From April 25 to 27, 2017, ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited ADF to review the circumstances surrounding GONZALEZ's death. ERAU was assisted in its review by contract subject matter experts (SME) in correctional healthcare and security who are employed by Creative Corrections, a national consulting firm.<sup>3</sup> As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to GONZALEZ, in addition to conducting in-person interviews of individuals employed by ADF, CCS, and ICE Office of Enforcement and Removal Operations (ERO).

During the review, ERAU 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 informational purposes only. Their inclusion in the report should not be construed in any way as indicating the deficiency contributed to the death of the detainee. ERAU determined the following timeline of events, from the time of GONZALEZ's apprehension by ICE, through his detention at ADF, and eventual death at VVGMC.

## IMMIGRATION AND DETENTION HISTORY

On February 18, 2016, U.S. Border Patrol (USBP) agents encountered and arrested GONZALEZ near Otay Mesa, CA.<sup>4</sup> USBP processed GONZALEZ for expedited removal pursuant to

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<sup>1</sup> Hypoxic encephalopathy is a brain injury caused by oxygen deprivation to the brain.

<sup>2</sup> ADF is also referred to as Adelanto Correctional Facility or Adelanto ICE Processing Center. For the purposes of this report, the facility will be referred to as ADF.

<sup>3</sup> See [Exhibit 1](#): Creative Corrections Medical and Security Compliance Analysis.

<sup>4</sup> See Form I-213, Record of Deportable/Inadmissible Alien, dated February 20, 2016.

§212(a)(7)(A)(i)(I) of the Immigration and Nationality Act (INA), for entering the United States without admission or parole with credible fear.<sup>5</sup>

On March 3, 2016, U.S. Citizenship and Immigration (USCIS) denied GONZALEZ's claim of fear, and GONZALEZ requested an Immigration Judge (IJ) review his claim.<sup>6</sup> On March 15, 2016, the IJ denied GONZALEZ's claim and ordered he be removed. On April 27, 2016, ICE removed GONZALEZ to Nicaragua.

On December 23, 2016, USBP again encountered GONZALEZ near Otay Mesa, CA and served him a Notice of Intent/Decision to Reinstate Prior Order.<sup>7</sup> On December 29, 2016, USBP transferred GONZALEZ to ICE custody.<sup>8</sup>

## CRIMINAL HISTORY

None.

## NARRATIVE

On December 30, 2016 at 4:45 p.m.,<sup>9</sup> GONZALEZ arrived at ADF.<sup>10</sup> Officer (b) (6), (b) (7)(C) completed GONZALEZ's classification rating using the ICE Classification Worksheet, and appropriately rated the detainee as low security because he did not have any criminal convictions, history of violence, or disciplinary infractions.<sup>11</sup> A supervisor approved the classification rating. Officer (b) (6), (b) (7)(C) the intake officer, inventoried GONZALEZ's property and currency, and GONZALEZ signed a personal property receipt for clothing, shoes, eyeglasses, and a belt, as well as a receipt for foreign currency denoted as one "foreign bill" and five "foreign coins."<sup>12</sup> Officer (b) (6), (b) (7)(C) did not notate the amount and type of currency, as required by the ICE PBDNS 2011. GONZALEZ's Prison Rape Elimination Act (PREA) Risk Assessment, also completed during intake, shows he was not at risk of victimization or abusiveness. Although the intake officer noted GONZALEZ was English speaking, other documented encounters with the detainee, discussed later, indicate his English proficiency was limited.

At 8:50 p.m., GONZALEZ received a medical and mental health intake screening by Registered Nurse (RN) (b) (6), (b) (7)(C).<sup>13</sup> RN (b) (6), (b) (7)(C) documented GONZALEZ's primary language was Spanish, and all his vital signs were within normal limits.<sup>14</sup> RN (b) (6), (b) (7)(C) stated she speaks

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<sup>5</sup> See ICE Significant Incident Report, dated March 28, 2017.

<sup>6</sup> See Id.

<sup>7</sup> See Form I-213, Record of Deportable/Inadmissible Alien, dated February 20, 2016.

<sup>8</sup> See ICE Significant Incident Report, dated March 28, 2017.

<sup>9</sup> See Form I-203, Order to Detain or Release Alien, dated December 30, 2016.

<sup>10</sup> The GEO Housing History Grid documents the arrival time as 11:25 p.m. Multiple time discrepancies were identified on the GEO Housing History Grid.

<sup>11</sup> See ICE Custody Classification Worksheet, dated December 30, 2016.

<sup>12</sup> See Exhibit 2: ADF Property Receipt #074062, dated December 30, 2016.

<sup>13</sup> See Exhibit 3: Receiving Screening form, dated December 30, 2016.

<sup>14</sup> Normal temperature is 98.6; normal range for pulse is 60 to 100 beats per minute; normal range for respirations is 12 to 20 breaths per minute; and, normal blood pressure is 120/80, with 90/60 to 139/89 considered within normal range.

Spanish and completed GONZALEZ's intake screening in Spanish.<sup>15</sup> GONZALEZ denied a history of medical or mental health problems, substance abuse, injuries, and suicidal thoughts or actions. RN (b) (6), (b) (7)(C) noted GONZALEZ reported a pain level of five out of ten on the standardized pain scale,<sup>16</sup> but she did not note the type and location of his pain. During the intake screening, GONZALEZ signed the CCS Patient Authorization and Consent to Medical Examination and/or Treatment form. He also underwent a chest x-ray, which showed he did not have active tuberculosis. At 11:25 p.m., security staff assigned GONZALEZ to general population.

**On January 3, 2017** at 5:05 a.m., RN (b) (6), (b) (7)(C) received a sick call request from GONZALEZ in which he complained of pain throughout his body, specifically noting his "private area."<sup>17</sup> RN (b) (6), (b) (7)(C) reviewed the request and referred GONZALEZ for evaluation by a nurse during sick call. RN (b) (6), (b) (7)(C) stated nurses are expected to see detainees referred for sick call within 24 hours, but the volume of detainees needing sick call often causes a delay.<sup>18</sup> A nurse did not evaluate GONZALEZ until four days later.

**On January 7, 2017**, RN (b) (6), (b) (7)(C) saw GONZALEZ during sick call. She documented his vital signs were within normal limits with the exception of a slow heart rate of 57. GONZALEZ denied any body pain or acute distress. RN (b) (6), (b) (7)(C) did not document use of interpretation assistance for this encounter. According to Health Service Administrator (HSA) (b) (6), (b) (7)(C), RN (b) (6), (b) (7)(C) does not speak Spanish.<sup>19</sup>

**On January 10, 2017**, Dr. (b) (6), (b) (7)(C) conducted GONZALEZ's initial dental examination during which he identified three potential areas of tooth decay.<sup>20</sup> Dr. (b) (6), (b) (7)(C) did not order a follow up.

**On January 12, 2017**, Family Nurse Practitioner (FNP) (b) (6), (b) (7)(C) conducted GONZALEZ's initial health assessment in fluent Spanish and documented the following:<sup>21</sup>

- GONZALEZ complained of a clear watery discharge from his genital area for five days, accompanied by irritation, burning, and itchiness.
- GONZALEZ denied fever, chills, nausea, vomiting, and diarrhea but reported occasional heart palpitations<sup>22</sup> since childhood.
- GONZALEZ reported his surgical history included stitches to his left upper arm in 2008, following a stab wound, and left ear repair in 2012, following a motor vehicle accident.
- GONZALEZ reported a history of marijuana and alcohol use, and a conviction for driving under the influence of alcohol in 2014.<sup>23</sup>

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<sup>15</sup> ERAU interview with RN (b) (6), (b) (7)(C), April 26, 2017.

<sup>16</sup> A standardized pain scale of zero to ten, with ten being worst, is used to determine the level of pain reported by patients.

<sup>17</sup> According to Creative Corrections, genital pain may indicate an infectious disease and requires prompt assessment.

<sup>18</sup> ERAU interview with RN (b) (6), (b) (7)(C), April 26, 2017.

<sup>19</sup> RN (b) (6), (b) (7)(C) was not available for interview over the course of this review.

<sup>20</sup> See Oral Examination, dated January 10, 2017.

<sup>21</sup> See Initial Health Assessment, dated January 12, 2017.

<sup>22</sup> Heart palpitations are a sensation that the heart is racing, pounding, fluttering, or skipping a beat.

- GONZALEZ signed the treatment consent form authorizing an examination of his pubic area. During the examination, FNP (b) (6), (b) (7)(C) found a scant amount of clear watery discharge from clusters of open vesicular lesions.<sup>24</sup>
- GONZALEZ's assessment and vital signs were normal, with the exception of a slow heart rate of 54 and genital discharge.

FNP (b) (6), (b) (7)(C) determined GONZALEZ had a herpes virus infection,<sup>25</sup> was overweight based on his body mass index,<sup>26</sup> and had heart palpitations. She ordered 800 mg of acyclovir<sup>27</sup> twice daily to treat the genital infection and 600 mg ibuprofen three times daily for genital pain. She also ordered laboratory studies to confirm the herpes virus, and an electrocardiogram (EKG)<sup>28</sup> to determine the cause of slow heart rate. FNP (b) (6), (b) (7)(C) scheduled GONZALEZ for a follow-up evaluation in four weeks.

**On January 17, 2017**, GONZALEZ's EKG was completed and reviewed by Clinical Director Dr. (b) (6), (b) (7)(C) who documented that the results showed sinus bradycardia.<sup>29</sup> Dr. (b) (6), (b) (7)(C) noted the results showed no accompanying symptoms related to the slow heart rate.

**On January 19, 2017** at 7:45 p.m., security staff reassigned GONZALEZ to the Restricted Housing Unit (RHU)<sup>30</sup> after he engaged in a fight with another detainee.<sup>31</sup> Prior to his physical movement to the RHU, RN (b) (6), (b) (7)(C) medically cleared GONZALEZ for administrative segregation, and security staff appropriately completed and issued GONZALEZ an administrative segregation order.

**On January 20, 2017**, Lieutenant (Lt.) (b) (6), (b) (7)(C) reviewed GONZALEZ's administrative segregation order and recommended he remain in administrative segregation.<sup>32</sup> Warden Janecka approved the recommendation. Officer (b) (6), (b) (7)(C) investigated the incident that same day and interviewed GONZALEZ, who acknowledged the fight started after he asked the other involved detainee to clean the toilet after using it, and the detainee refused. After reviewing the investigation report, the Unit Disciplinary Committee referred the incident to the Institution Disciplinary Panel and provided GONZALEZ a written notice of his rights, in Spanish, which included his right to a staff advocate.

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<sup>23</sup> ERAU notes this conviction is not listed on the I-213, Record of Deportable/Inadmissible Alien.

<sup>24</sup> Vesicular lesions are small, fluid-filled sacs, similar to blisters.

<sup>25</sup> Herpes is a common sexually transmitted infection marked by genital pain and sores.

<sup>26</sup> Body Mass Index is a measure of body fat based on height and weight.

<sup>27</sup> Acyclovir is an antiviral drug used to treat shingles, genital herpes, and chickenpox.

<sup>28</sup> An EKG is a test that records the electrical activity of the heart.

<sup>29</sup> Sinus bradycardia is a slower than normal heart rate, which can be a result of physical fitness, effects of medication, or a form of heart disease.

<sup>30</sup> The RHU is a Special Management Unit used to house administrative and disciplinary segregation detainees. RHU has 32 double-occupancy cells with 16 cells on each of the two tiers. The unit is divided by a mesh fence as A and B-side. Detainees in protective custody are typically housed on the A-side to afford detainees access to the dayroom. A control room is located at the entrance of the unit, and there are two staircases on each end of the unit. There are cameras in the unit; however, ERAU was informed only one camera, located at the end of the unit, is programmed to record, and all other cameras are monitored in real time.

<sup>31</sup> See Special Management Unit Housing Record, dated January 19, 2017.

<sup>32</sup> See Administrative Segregation Review by Lt. (b) (6), (b) (7)(C), dated January 20, 2017.

**On January 22, 2017**, the Institution Disciplinary Panel held GONZALEZ’s hearing, found him guilty of fighting, and sanctioned him to seven days in disciplinary segregation<sup>33</sup> with no visitation or commissary privileges.<sup>34</sup> The Segregation Housing Unit Housing Record shows medical staff saw GONZALEZ one to three times per day, he accepted all meals, and he was offered daily recreation and showers while segregated.

**On January 24, 2017**, FNP (b) (6), (b) (7)(C) reviewed the laboratory results ordered during GONZALEZ’s initial health assessment which showed he was negative for herpes but had elevated lymphocytes and eosinophils,<sup>35</sup> which Creative Corrections notes is indicative of an infectious process. Later that day, Dr. (b) (6), (b) (7)(C), a psychologist and ADF’s Mental Health Director, completed his daily rounds in the RHU and documented that GONZALEZ stated he was doing okay and gave a “thumbs up.”<sup>36</sup> Dr. (b) (6), (b) (7)(C) stated he is fluent in Spanish,<sup>37</sup> and his segregation rounds typically involve knocking on the cell door and asking the detainee whether he is ok. If the detainee has no concerns, Dr. (b) (6), (b) (7)(C) does not conduct a further assessment.<sup>38</sup>

**On January 26, 2017**, Officer (b) (6), (b) (7)(C) completed GONZALEZ’s classification review prior to his scheduled release from disciplinary segregation later that same day.<sup>39</sup> GONZALEZ remained classified as a level one detainee and a supervisor approved the rating.<sup>40</sup> At 1:41 p.m., security staff moved GONZALEZ from disciplinary segregation back to general population.

**On January 30, 2017**, GONZALEZ submitted a sick call request in Spanish complaining of an infection with blisters, blood, and pus.<sup>41</sup> In the request, he asked to be seen as soon as possible and noted medical staff was already aware of the problem. RN (b) (6), (b) (7)(C), who received and triaged the request, determined it was a routine request and scheduled GONZALEZ to see a nurse during sick call.

**On February 1, 2017**, RN (b) (6), (b) (7)(C) evaluated GONZALEZ during sick call without the use of an interpreter. She noted GONZALEZ complained of a tooth infection, skin irritation on both legs, and pus on the tip of his penis.<sup>42</sup> She gave him hydrocortisone<sup>43</sup> cream for the skin irritation and noted he was already receiving ibuprofen for pain. RN (b) (6), (b) (7)(C) also referred GONZALEZ to a provider, though he was not seen by a provider until seven days later.

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<sup>33</sup> GONZALEZ was given credit for time spent in the RHU starting January 19, 2017.

<sup>34</sup> See Institution Disciplinary Panel Report, dated January 22, 2017.

<sup>35</sup> Lymphocytes and eosinophils are types of white blood cells in the immune system which fight infection.

<sup>36</sup> See Clinical Segregation Data Checklist, dated January 24, 2017.

<sup>37</sup> Dr. (b) (6), (b) (7)(C) stated during interview that he conducted all of his interactions with GONZALEZ in Spanish.

<sup>38</sup> ERAU interview with Dr. (b) (6), (b) (7)(C) April 25, 2017.

<sup>39</sup> See ICE Custody Classification Worksheet, dated January 26, 2017; *see also* Segregation Housing Unit Housing Record, dated January 25, 2017.

<sup>40</sup> A review of the form determined no points were applied for “Number of Sustained Disciplinary Infractions Involving Violence or Behavior Representing a Threat to the Facility” even though he was found guilty of fighting.

<sup>41</sup> See CCS Patient Health Services Request Form, dated January 30, 2017.

<sup>42</sup> See ADF eClinical Works Progress Note by RN (b) (6), (b) (7)(C) dated February 1, 2017.

<sup>43</sup> Hydrocortisone is a steroid used to treat inflammation.



On February 8, 2017, FNP (b) (6), (b) (7)(C) evaluated GONZALEZ pursuant to RN (b) (6), (b) (7)(C) referral and documented the following:<sup>44</sup>

- GONZALEZ had a rash with pus and blood on his penile area and both thighs for 17 days, and applied hydrocortisone cream to the area for ten days with good results in the penile area, but minimal results on the thighs.
- GONZALEZ complained of itching in the pubic region and between his toes.
- GONZALEZ was taking ibuprofen 600 mg three times daily and his vital signs were normal, with the exception of a low-grade fever of 99.5.<sup>45</sup>

Based on her evaluation, FNP (b) (6), (b) (7)(C) found the following:

- GONZALEZ had macerated<sup>46</sup> skin tissue between his toes on the right foot.
- GONZALEZ had redness and maculopapular lesions<sup>47</sup> on his pubic area, non-draining and demarcated<sup>48</sup> skin lesions on his groin area, with tenderness and increased warmth in both areas.
- GONZALEZ had fluid-filled raised lesions on both thighs and his right buttock area which were tender and warm.

FNP (b) (6), (b) (7)(C) diagnosed GONZALEZ with a fungal infection of the feet (athlete's foot), genitals, inner thighs and buttocks, as well as cellulitis<sup>49</sup> of other sites. His treatment plan consisted of application of an anti-fungal cream to his feet and genital area twice daily for 28 days, application of an antibiotic cream to the affected area twice daily for ten days, and an oral antibiotic twice daily for ten days. FNP (b) (6), (b) (7)(C) ordered a follow-up in two weeks. However, she did not schedule the follow-up appointment, and medical staff never saw GONZALEZ again for these conditions.<sup>50</sup>

On February 13, 2017, security staff moved GONZALEZ to the RHU for fighting with another detainee.<sup>51</sup> RN (b) (6), (b) (7)(C) medically cleared GONZALEZ for segregation, noting his vital signs were normal at the time of the evaluation, with the exception of an abnormally low heart rate of 58.<sup>52</sup>

On February 14, 2017, security staff released GONZALEZ from the RHU after an investigation resulted in the charges being dropped. ERAU notes GONZALEZ's detention file does not

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<sup>44</sup> See ADF eClinical Works Progress Note by FNP (b) (6), (b) (7)(C), dated February 8, 2017.

<sup>45</sup> A low grade fever is classified as above 98.6 degrees, but lower than 100.4 degrees, and may suggest a possible infection.

<sup>46</sup> Maceration is the softening and breaking down of skin resulting from prolonged exposure to moisture.

<sup>47</sup> A maculopapular rash is a flat, red area on the skin that is covered by small merging bumps.

<sup>48</sup> The skin lesions were separate and different in appearance from others.

<sup>49</sup> Cellulitis is a common infection of the skin and surrounding soft tissue.

<sup>50</sup> ERAU interview with FNP (b) (6), (b) (7)(C), April 27, 2016. During her interview, FNP (b) (6), (b) (7)(C) stated she may have instructed GONZALEZ to request a sick call for follow-up, if needed. HSA (b) (6), (b) (7)(C) informed ERAU that if a provider determines a follow-up appointment is necessary, it is his or her responsibility to schedule the appointment and not put the onus on a patient.

<sup>51</sup> See After Action Review by STG Sergeant (b) (6), (b) (7)(C) dated April 1, 2017.

<sup>52</sup> See ADF eClinical Works Progress Note by RN (b) (6), (b) (7)(C) dated February 13, 2017.

contain any documentation related to this incident or the detainee's assignment to the RHU, including an administrative segregation order. Security staff only documented the incident and assignment to the RHU in an After-Action Report and in the facility's Housing History Grid, which shows GONZALEZ was housed in the RHU for approximately 13 hours, from 11:40 p.m., February 13, to 12:23 p.m., February 14.

**On February 15, 2017** at 7:00 a.m., while triaging sick call requests, RN (b) (6), (b) (7)(C) reviewed a sick call request from GONZALEZ dated February 14, 2017, in which the detainee complained of a heart condition.<sup>53</sup> RN (b) (6), (b) (7)(C) referred GONZALEZ to nursing sick call for an evaluation. That same day, security staff moved GONZALEZ to the RHU for fighting with another detainee. LVN (b) (6), (b) (7)(C) medically-cleared GONZALEZ for segregation and noted his vital signs were normal. Security staff completed and issued GONZALEZ an administrative segregation order.

**On February 16, 2017**, Lt. (b) (6), (b) (7)(C) reviewed and recommended continuation of GONZALEZ's placement in administrative segregation.<sup>54</sup> Warden Janecka approved the recommendation. At 1:05 p.m., Officer (b) (6), (b) (7)(C) investigated the February 15, 2018 incident, and noted that GONZALEZ refused to provide a statement. After reviewing the investigation report, the Unit Disciplinary Committee referred the incident to the Institution Disciplinary Panel.

**On February 17, 2017**, RN (b) (6), (b) (7)(C) evaluated GONZALEZ in response to his February 14, 2017, sick call request.<sup>55</sup> She noted GONZALEZ denied any pain and stated he felt fine. RN (b) (6), (b) (7)(C) did not document use of interpretation assistance for this encounter. According to Creative Corrections, given GONZALEZ's medical history of heart palpitations and his sick call request concerning heart conditions, use of interpretation assistance was particularly critical to ensure an adequate assessment.

**On February 18, 2017**, the Institution Disciplinary Panel conducted GONZALEZ's hearing, found him guilty of fighting, and sanctioned him to 30 days in disciplinary segregation with no contact visitation or commissary privileges, in accordance with the ICE PBNDS 2011.<sup>56</sup>

**On February 21, 2017**, Officer (b) (6), (b) (7)(C) completed GONZALEZ's 60-day reclassification review, which resulted in a continuation of level one (low level) classification.<sup>57</sup> Even though GONZALEZ was found guilty of fighting on two occasions, Officer New did not apply any points to the point category entitled, "Number of Sustained Disciplinary Infractions Involving Violence or Behavior Representing a Threat to the Facility." A supervisor approved the rating.

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<sup>53</sup> See CCS Patient Health Services Request Form, dated February 14, 2017. ERAU notes a check mark appears next to "Urgent, called provider" in the staff triage section of the form. HSA (b) (6), (b) (7)(C) surmised that because GONZALEZ wrote in both the detainee complaint and staff triage sections of the form, that he may have checked the box himself.

<sup>54</sup> See Administrative Segregation Review by Lt. (b) (6), (b) (7)(C) dated February 16, 2017.

<sup>55</sup> RN (b) (6), (b) (7)(C) was unavailable for interview.

<sup>56</sup> GONZALEZ was given credit for time spent in the RHU starting February 15, 2017.

<sup>57</sup> See ICE Custody Classification Worksheet, dated February 21, 2017.

On February 22, 2017 and March 1, 2017, Dr. (b) (6), (b) (7)(C) completed RHU rounds and noted GONZALEZ reported feeling okay and gave a “thumbs up.”<sup>58</sup>

On March 6, 2017, GONZALEZ refused all three meals and told security staff he would not eat until he was deported. Dr. (b) (6), (b) (7)(C) evaluated GONZALEZ at the request of Assistant Warden (AW) (b) (6), (b) (7)(C) who was concerned about the detainee’s meal refusals and documented the following:<sup>59</sup>

- GONZALEZ’s speech, mood and affect, thought form and content, and behavior were appropriate.
- GONZALEZ was oriented and demonstrated average intelligence, intact memory, good insight and judgment.
- GONZALEZ denied suicidal and homicidal ideation and past mental health issues.
- GONZALEZ reported he was unhappy because he had a sexually transmitted disease, and even though he was prescribed cream and antibiotics, the infection persisted.

During the appointment, GONZALEZ agreed to eat his lunch. Dr. (b) (6), (b) (7)(C) instructed GONZALEZ to submit a sick call request and emailed RN (b) (6), (b) (7)(C) to schedule a follow-up appointment with the detainee. GONZALEZ’s medical record does not contain any record of a corresponding sick call request, and RN (b) (6), (b) (7)(C) did not document the scheduling of an appointment.

Dr. (b) (6), (b) (7)(C) stated during his interview that GONZALEZ expressed frustration during the encounter because he could not contact the Nicaragua consulate.<sup>60</sup> Dr. (b) (6), (b) (7)(C) stated he spoke with Lt. (b) (6), (b) (7)(C) to arrange a phone call to the consulate for the detainee. Lt. (b) (6), (b) (7)(C) stated during interview that instructions for making telephone calls, including to consulates, are on the telephones, in the facility handbook, and on the PIN card issued to detainees during intake.<sup>61</sup> She stated that on two occasions, she issued GONZALEZ a new Personal Identification Number (PIN) so that he could make telephone calls. Telephone records from the time of GONZALEZ’s detention show he attempted to place telephone calls on January 20 and 29, 2017 but neither were completed.<sup>62</sup> ERAU was unable to determine whether GONZALEZ’s failed attempts to call the consulate were due to user error or a problem with consulate’s phone number or system.

On March 7, 2017, GONZALEZ refused breakfast and lunch.<sup>63</sup> At 12:45 p.m., Captain (b) (6), (b) (7)(C) notified Warden Janecka that GONZALEZ refused his third meal,<sup>64</sup> and Warden Janecka directed Captain (b) (6), (b) (7)(C) to notify ICE, which he did shortly thereafter.<sup>65</sup>

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<sup>58</sup> See Clinical Segregation Data Checklist, dated February 22, 2017.

<sup>59</sup> See ADF eClinical Works Progress Note by Dr. (b) (6), (b) (7)(C) dated March 6, 2017.

<sup>60</sup> ERAU interview with Dr. (b) (6), (b) (7)(C) April 25, 2017.

<sup>61</sup> ERAU interview with Lt. (b) (6), (b) (7)(C) April 25, 2017. ERAU reviewed both the facility handbook and PIN card and determined neither contains instructions regarding the use of PINs or the procedures for calling a consulate.

<sup>62</sup> It is unknown whether GONZALEZ’s failed attempts to call his consulate were due to user error, or a problem with the consulate’s phone number or system.

<sup>63</sup> See Segregation Housing Unit Housing Record, dated March 7, 2017.

<sup>64</sup> As noted, GONZALEZ refused all three meals the day before, making this his fifth consecutive meal refused.

<sup>65</sup> See Email from Captain (b) (6), (b) (7)(C) dated March 7, 2017.



AW (b) (6), (b) (7)(C) who learned from Captain (b) (6), (b) (7)(C) that GONZALEZ refused several meals, visited the detainee while making rounds in the RHU shortly after lunch. AW (b) (6), (b) (7)(C) spoke to GONZALEZ, with interpretation assistance from Officer (b) (6), (b) (7)(C). During their conversation, GONZALEZ stated he stopped eating because he was sexually assaulted while housed in general population.<sup>66</sup> Following the conversation, AW (b) (6), (b) (7)(C) went directly to ADF's PREA Compliance Administrator, (b) (6), (b) (7)(C), and directed that PREA staff interview GONZALEZ immediately.

At 2:04 p.m., Dr. (b) (6), (b) (7)(C) unaware of AW (b) (6), (b) (7)(C) conversation with GONZALEZ, met with the detainee while conducting daily rounds in the RHU and documented the following:<sup>67</sup>

- GONZALEZ appeared psychotic and refused to eat.
- GONZALEZ reported he was raped a couple of weeks prior by black detainees; however, he was asleep at the time and did not notice it until the next day when he saw discharge and blood in his stool.
- GONZALEZ was illogical, tangential, and delusional in his psychological process.
- GONZALEZ reported he would rather die from hunger than from a sexually-transmitted infection.

Based on his evaluation of GONZALEZ, Dr. (b) (6), (b) (7)(C) ordered the detainee be transported to the Alvarado Parkway Institute (API), a behavior health hospital in La Mesa, CA, for medication and stabilization. Following Dr. (b) (6), (b) (7)(C) order, RN (b) (6), (b) (7)(C) called both API to confirm availability, and the GEO shift supervisor to arrange for GONZALEZ's transport,<sup>68</sup> and completed a Transport/Escort Authorization for GONZALEZ's admission to API.<sup>69</sup>

While Dr. (b) (6), (b) (7)(C) was talking to GONZALEZ, PREA Compliance Administrator (b) (6), (b) (7)(C) and PREA Investigator (b) (6), (b) (7)(C) arrived to the RHU. They were followed by ICE Supervisory Deportation and Detention Officers (SDDO) (b) (6), (b) (7)(C) and (b) (6), (b) (7)(C) who intended to speak with GONZALEZ about his meal refusals.<sup>70</sup> When the SDDOs arrived at GONZALEZ's cell, Dr. (b) (6), (b) (7)(C) informed them he decided to send GONZALEZ to API, and the PREA staff informed them of GONZALEZ's sexual assault allegation. The SDDOs left without speaking with GONZALEZ, and SDDO (b) (6), (b) (7)(C) submitted a Significant Event Notification (SEN) to the Joint Intake Center (JIC) for both the PREA allegation and the transfer to API.

After learning of GONZALEZ's pending transfer to API, Ms. (b) (6), (b) (7)(C) and Ms. (b) (6), (b) (7)(C) decided not interview him regarding the sexual assault allegation and did not complete the PREA validation tool.<sup>71</sup> Ms. (b) (6), (b) (7)(C) Ms. (b) (6), (b) (7)(C) and Dr. (b) (6), (b) (7)(C) all agreed that Dr. (b) (6), (b) (7)(C) would

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<sup>66</sup> ERAU interview with AW (b) (6), (b) (7)(C) April 27, 2017.

<sup>67</sup> See ADF eClinical Works Progress Note by Dr. (b) (6), (b) (7)(C) dated March 7, 2017.

<sup>68</sup> ERAU interview with RN (b) (6), (b) (7)(C) April 26, 2017.

<sup>69</sup> See GEO Transport/Escort Authorization Form, dated March 7, 2017.

<sup>70</sup> During his interview with ERAU, SDDO (b) (6), (b) (7)(C) stated when possible, he attempts to deter hunger strikes by speaking with detainees (April 26, 2017).

<sup>71</sup> ERAU interview with Ms. (b) (6), (b) (7)(C) and Ms. (b) (6), (b) (7)(C) April 26 and 27, 2017. ADF uses the PREA Validation Tool to collect a summary of the sexual abuse allegation and to determine whether the incident will be classified as a PREA incident.

complete a mental health assessment before GONZALEZ left for API,<sup>72</sup> as required by the DHS PREA Regulation.<sup>73</sup> According to Ms. (b) (6), (b) (7)(C) she verbally instructed GEO officers to take GONZALEZ to Dr. (b) (6), (b) (7)(C) office for the mental health assessment prior to staging him for transfer.<sup>74</sup> However, the GEO officers departed for API with GONZALEZ at 2:35 p.m.<sup>75</sup> before Dr. (b) (6), (b) (7)(C) was able to conduct the mental health assessment. At 6:50 p.m., GONZALEZ arrived at API.<sup>76</sup>

**On March 8, 2017**, Officer (b) (6), (b) (7)(C) completed a routine classification review for GONZALEZ and did not apply the correct number of points for disciplinary infractions related to his two fights. As a result, Officer (b) (6), (b) (7)(C) erroneously maintained GONZALEZ's classification level as low instead of medium-low.<sup>77</sup> A supervisor reviewed and approved the classification rating.

**From March 8 to 15, 2017**, ADF medical staff obtained daily updates from API concerning GONZALEZ. Entries in GONZALEZ's medical record note he was placed on an anti-psychotic medication (Seroquel), an antidepressant (Remeron), an anti-anxiety medication (Ativan), and an anti-seizure medication also used to manage manic episodes (Depakote). API reported that GONZALEZ was cooperative throughout his stay, although on March 13, 2017, he exhibited a delusional thought process when he asserted he was the son of George Bush.

**On March 9, 2017**, the Resident Agent in Charge (RAC) of the local ICE OPR field office, assigned responsibility to investigate GONZALEZ's PREA allegation to (b) (6), (b) (7)(C). SA (b) (6), (b) (7)(C) stated during interview that GONZALEZ's allegation seemed unusual to her because ERO typically does not submit PREA allegations to the JIC until ADF completes the PREA validation tool. Upon receiving the case, SA (b) (6), (b) (7)(C) immediately called AFOD (b) (6), (b) (7)(C) who referred her to Assistant Warden (AW) (b) (6), (b) (7)(C) and Ms. (b) (6), (b) (7)(C). AW (b) (6), (b) (7)(C) and Ms. (b) (6), (b) (7)(C) informed SA (b) (6), (b) (7)(C) that GONZALEZ was at API, and they would notify her upon his return to ADF. SA (b) (6), (b) (7)(C) called AW (b) (6), (b) (7)(C) on one occasion while Gonzalez was at API to get an update on his status (she did not recall the date), and AW (b) (6), (b) (7)(C) informed her that the detainee was still at API, and again promised to call when he returned to ADF. SA (b) (6), (b) (7)(C) stated no one from ADF notified her when GONZALEZ returned on March 15, 2017, and she only learned of his return when her RAC received the SEN notification concerning his death. SA (b) (6), (b) (7)(C) spoke to AW (b) (6), (b) (7)(C) and (b) (6), (b) (7)(C) after the detainee died, and they informed her that the Adelanto PREA team waited to complete the PREA validation tool until he was mentally stable enough to answer the questions, several days after his return following his release from medical housing. They informed SA (b) (6), (b) (7)(C) that when they finally completed the tool for Gonzalez, because they determined his allegation did not meet the PREA threshold, they did not think it necessary to reach back out to her.

<sup>72</sup> ERAU interview with Dr. (b) (6), (b) (7)(C) April 25, 2017.

<sup>73</sup> 6 CFR Part 115, Standards to Prevent, Detect, and Respond to Sexual Abuse and Assault in Confinement Facilities, §115.81(c) states, "When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral."

<sup>74</sup> ERAU was unable to verify Ms. (b) (6), (b) (7)(C) accounts of these events.

<sup>75</sup> See Segregation Housing Unit Housing Record, dated March 7, 2017.

<sup>76</sup> See API Admission/Discharge Record, dated March 7, 2017. ERAU notes ADF's Housing History Grid does not document his transfer to API until 3:44 a.m. the following day, March 8, 2017.

<sup>77</sup> See ICE Custody Classification Worksheet, dated March 8, 2017.

On March 15, 2017, GONZALEZ returned to ADF at approximately 9:05 p.m. RN [REDACTED] contacted ADF's Psychiatrist, Dr. [REDACTED], by telephone to notify him of API's discharge instructions which indicated GONZALEZ primary diagnoses were paranoid schizophrenia, asthma, dysuria,<sup>78</sup> and which recommended the detainee receive Haldol<sup>79</sup> twice daily and Depakote at nighttime.<sup>80</sup> API also recommended a complete blood count, liver function studies, and measurement of GONZALEZ's Depakote level in one week. Dr. [REDACTED] directed that GONZALEZ be housed in medical observation on psychiatric observation status, and gave orders for administration of 1500 mg of Depakote at night for 90 days, and 10 mg of Haldol twice a day for 90 days. Creative Corrections notes that ADF medical staff never completed the laboratory studies recommended by API, did not have GONZALEZ sign a consent for psychiatric medications, and an ADF provider never reviewed the API summary or recommendations.

On March 16, 2017, at 12:34 a.m., RN [REDACTED] conducted a nursing round and noted GONZALEZ was resting. She did not obtain his vital signs. At 10:59 a.m., RN [REDACTED] completed a nursing round and noted GONZALEZ's vital signs were within normal limits.

At 12:41 p.m., Dr. [REDACTED], Ph.D. Psychologist, conducted a mental health evaluation and a suicide risk assessment using the Columbia Suicide Severity Rating Scale<sup>81</sup> and documented the following:<sup>82</sup>

- GONZALEZ reported feeling very well and denied anxiety, depression, and auditory hallucinations.
- GONZALEZ denied taking any medication, even though his medical record listed Depakote and Haldol as current medications.
- GONZALEZ appeared delusional when asked why he was in the psychiatric hospital.
- GONZALEZ reported someone cut him on his left forearm in the middle of night. Dr. [REDACTED] did not observe a wound, but noted a slight scar on the detainee's left forearm.
- GONZALEZ demonstrated poor insight and poor judgment.
- GONZALEZ's prescribed medications were for the treatment of bipolar disorder with psychotic features.

Dr. [REDACTED] did not document use of interpretation assistance during the encounter but stated during interview that he uses interpretation assistance "as a matter of course" for mental health assessments.<sup>83</sup> Dr. [REDACTED] documented that GONZALEZ was at low risk for suicide based on the evaluation, and that the treatment plan included developing a relationship with GONZALEZ.

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<sup>78</sup> Dysuria is the feeling of pain, burning, or discomfort when urinating.

<sup>79</sup> Haldol is an antipsychotic drug used to treat acute psychosis, schizophrenia, and Tourette's syndrome.

<sup>80</sup> See API Physician Discharge Order, dated March 15, 2017.

<sup>81</sup> The Columbia Suicide Severity Rating Scale is a tool developed by researchers at Columbia University to probe the presence of suicidal thinking using specific standardized questions.

<sup>82</sup> See ADF eClinical Works Progress Note by Dr. [REDACTED] dated March 16, 2017.

<sup>83</sup> ERAU interview with Dr. [REDACTED] April 25, 2017.

**On March 16, 2016** at 9:05 p.m., security staff moved GONZALEZ to a different medical cell, though the reasoning for this change was not documented in his medical record.<sup>84</sup> According to the MAR, GONZALEZ received all ordered medications on this date.

**On March 17, 2017** at 2:24 a.m., RN (b) (6), (b) (7)(C) conducted a nursing round and noted GONZALEZ was resting in bed, had no signs or symptoms of distress, and his vital signs were normal.<sup>85</sup> According to the MAR, GONZALEZ received all ordered medications on this date.

At 11:41 a.m., Dr. (b) (6), (b) (7)(C) assessed GONZALEZ and determined the detainee was at low risk for suicidal or homicidal behavior, was eating and taking his medications, and appeared to be much more mentally stable.<sup>86</sup> During the encounter, GONZALEZ stated he wanted to talk to his consulate. After the encounter, Dr. (b) (6), (b) (7)(C) ordered GONZALEZ's discharge from the medical housing unit and informed Deportation Officer (DO) (b) (6), (b) (7)(C) that the detainee wished to contact his consulate. The DO told Dr. (b) (6), (b) (7)(C) that GONZALEZ should call the consulate using housing unit telephones.<sup>87</sup> Neither the medical record nor detention file document whether GONZALEZ received this instruction.

Pursuant to Dr. (b) (6), (b) (7)(C) order, medical staff discharged GONZALEZ from the medical unit and notified Lt. (b) (6), (b) (7)(C) that he required transfer to a housing unit. Even though GONZALEZ had ten days of his February 18, 2017 disciplinary segregation sanction still pending, Lt. (b) (6), (b) (7)(C) initially decided to place him in general population instead of returning him to the RHU.<sup>88</sup> However, before his move to general population, GONZALEZ informed medical staff that he wished to be placed in protective custody because he did not get along with other detainees in general population. Lt. (b) (6), (b) (7)(C) accordingly completed an administrative segregation order noting GONZALEZ's request for protective custody.

At 12:08 p.m., RN (b) (6), (b) (7)(C) medically cleared GONZALEZ for housing in the RHU but noted the detainee was withdrawn and had auditory hallucinations.<sup>89</sup> RN (b) (6), (b) (7)(C) stated her notation on this form of auditory hallucinations was based on the detainee's documented mental health history and not on any personal observations.<sup>90</sup> At 2:33 p.m., security staff moved GONZALEZ to RHU cell 205.<sup>91</sup>

ERAU notes RHU post orders require officers to check each cell every 30 minutes on an irregular schedule and document checks in the RHU logbook and 30-minute check form located outside each occupied cell. The irregular checks must begin within 30 minutes of the last

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<sup>84</sup> See Medical Observation Unit Housing Record, dated March 15, 2017. Upon interview with ERAU, medical staff presumed this change occurred because GONZALEZ's original cell, which was regularly used for suicide observation, was needed for a detainee on suicide watch.

<sup>85</sup> See ADF eClinical Works Progress Note by RN (b) (6), (b) (7)(C) dated March 17, 2017.

<sup>86</sup> See ADF eClinical Works Progress Note by Dr. (b) (6), (b) (7)(C) dated March 17, 2017.

<sup>87</sup> ERAU interview with Dr. (b) (6), (b) (7)(C) April 25, 2017.

<sup>88</sup> ERAU interview with Lt. (b) (6), (b) (7)(C) April 25, 2017.

<sup>89</sup> See CCS Restricted Housing Units History & Physical, dated March 17, 2017.

<sup>90</sup> ERAU interview with RN (b) (6), (b) (7)(C) April 26, 2017.

<sup>91</sup> See Segregation/RHU Detention 30 Minute Check, dated March 17, 2017. Cell 205 is located on B-side of the RHU, typically used for disciplinary purposes, because there were no available beds on A-side. As previously noted, the A-side is for detainees in protective custody. The RHU housing unit log shows GONZALEZ was afforded daily opportunities to use the dayroom on the A-side of the RHU.

completed check. Additionally, officers must electronically record their rounds using the electronic pipe system. Both the pipe system report and the 30-minute check log for March 17, 2017, show that at least one security check for GONZALEZ’s cell exceeded the 30-minute timeframe by five minutes. Creative Corrections notes the five minutes on March 17, 2017 may be due to officers commencing rounds on different sides or different tiers of the RHU to ensure detainees cannot predict when rounds are made.

**On March 18, 2017**, GONZALEZ’s Medication Administration Record (MAR) documents that he received both his morning and evening doses of Haldol and Depakote;<sup>92</sup> however, his medical record contains a “Refusal of Medical Services and Release Form” which documents that he refused all medication on this date.<sup>93</sup> Although the detainee’s signature does not appear on the form, both LVN (b) (6), (b) (7)(C) and Officer (b) (6), (b) (7)(C) signed it. LVN (b) (6), (b) (7)(C) stated GONZALEZ did not want the medications and refused to sign the form.<sup>94</sup> LVN (b) (6), (b) (7)(C) stated she explained the consequences for refusing to take the medication to GONZALEZ with assistance from Officer (b) (6), (b) (7)(C) who provided Spanish interpretation.

**On March 19, 2017**, GONZALEZ’s MAR shows he refused his morning dose of Haldol but accepted his evening doses of Haldol and Depakote. GONZALEZ’s medical record does not contain a refusal form for the morning dose of Haldol. Officers completed all required 30-minute security rounds on this date.

**On March 20, 2017**, at 4:33 a.m., an officer logged a security round. An officer did not complete the next security round until 5:24 a.m., 51 minutes later.<sup>95</sup>

At 2:24 p.m., Dr. (b) (6), (b) (7)(C) conducted a 72-hour mental health follow-up during which GONZALEZ denied suicidal ideations and reported that he was doing relatively well, though he continued to have problems with a genital infection.<sup>96</sup> During the encounter, GONZALEZ again expressed his desire to call his consulate but stated ADF never provided him a PIN to use the telephone. Following the encounter, Dr. (b) (6), (b) (7)(C) forwarded GONZALEZ’s request for a PIN to Lt. (b) (6), (b) (7)(C) and emailed RN (b) (6), (b) (7)(C) concerning GONZALEZ’s genital infection treatment. RN (b) (6), (b) (7)(C) responded that GONZALEZ completed the treatment regimen on January 17, 2017 for his genital infection as ordered and required re-examination if he needed additional treatment. Dr. (b) (6), (b) (7)(C) scheduled a follow-up appointment with GONZALEZ to discuss his PREA allegation on March 22, 2017.<sup>97</sup>

GONZALEZ’s MAR shows he refused all medications on this date. Because he refused to sign the refusal forms, they were signed by LVN (b) (6), (b) (7)(C) and (b) (6), (b) (7)(C).<sup>98</sup>

<sup>92</sup> See Medication Administration Record, March 2017.

<sup>93</sup> See Refusal of Medical Services and Release form, dated March 18, 2017. ERAU notes medical staff used the English version of the form.

<sup>94</sup> ERAU interview with LVN (b) (6), (b) (7)(C) April 26, 2017.

<sup>95</sup> See Exhibit 4: ADF (b) (6), (b) (7)(C) Check Log, March 20, 2017.

<sup>96</sup> See ADF eClinicalWorks Progress Note by Dr. (b) (6), (b) (7)(C) dated March 20, 2017.

<sup>97</sup> According to HSA (b) (6), (b) (7)(C) mental health staff maintains a PREA log to follow-up with detainees who allege they were sexually assaulted.

<sup>98</sup> See Refusal of Medical Services and Release form, dated March 20, 2017.



Lt. (b) (6), (b) (7)(C) also completed GONZALEZ's initial administrative segregation review, which resulted in a continuation of protective custody. Lt. (b) (6), (b) (7)(C) noted GONZALEZ refused to sign the segregation review form. Officer (b) (6), (b) (7)(C) also completed GONZALEZ's 90-day reclassification review which resulted in no change to his classification level, and a supervisor approved the rating.

**On March 21, 2017**, officers conducted regular security rounds of the RHU, though two were completed outside the required 30-minute timeframe: a 50 minute lapse occurred after an 8:46 a.m. round, and a 40 minute lapse occurred after a 1:58 p.m. round.<sup>99</sup>

GONZALEZ also refused both his morning and evening medications and refused to sign the refusal forms; consequently, his evening medication refusal on March 21, 2017, marked the fourth consecutive refusal of twice-per-day Haldol and the second consecutive refusal of once-per-day Depakote.<sup>100</sup>

HSA (b) (6), (b) (7)(C) acknowledged during ERAU's interview that the LVNs dealing with GONZALEZ failed to follow the facility's medication administration policy by not notifying a provider after GONZALEZ missed three doses of any medication, and by not having Spanish language refusal forms readily available when distributing his medications.<sup>101</sup> HSA (b) (6), (b) (7)(C) stated that following GONZALEZ's death, he issued written guidance to medical staff reiterating requirements related to medication refusals (i.e. proper documentation of refusals, and education to detainees on potential medical consequences of refusals).

Ms. (b) (6), (b) (7)(C) also met with GONZALEZ to complete the ADF PREA Allegation Validation Tool with respect to his March 7, 2017 sexual assault allegation.<sup>102</sup> Ms. (b) (6), (b) (7)(C) provided interpretation assistance. During the meeting, GONZALEZ retracted the allegation, and Ms. (b) (6), (b) (7)(C) provided him with information pamphlets for sexual assault services available in San Bernardino County.<sup>103</sup>

**On March 22, 2017**, Lt. (b) (6), (b) (7)(C) completed GONZALEZ's administrative segregation review, which resulted in continuation of protective custody.<sup>104</sup> Lt. (b) (6), (b) (7)(C) did not document whether GONZALEZ was interviewed as part of the review. Warden Janecka approved the recommendation the same day.

GONZALEZ's MAR and refusal form, signed by LVN (b) (6), (b) (7)(C) show he refused his morning dose of Haldol, the fifth consecutive missed dose. At 12:59 p.m., LVN (b) (6), (b) (7)(C) Alenbaugh sent an

<sup>99</sup> See Exhibit 5: ADF (b) (6), (b) (7)(C) Check Log, March 21, 2017.

<sup>100</sup> See Medication Administration Record, March 2017. See also Refusal of Medical Services and Release Form signed by LVNs (b) (6), (b) (7)(C) and (b) (6), (b) (7)(C) and Refusal of Medical Services and Release Form signed by LVNs (b) (6), (b) (7)(C) and (b) (6), (b) (7)(C) both dated March 21, 2017.

<sup>101</sup> ERAU interview with HSA (b) (6), (b) (7)(C) April 25, 2017.

<sup>102</sup> See ADF PREA Allegation Validation Tool, dated March 21, 2017. During interview, Ms. (b) (6), (b) (7)(C) stated she waited until Dr. (b) (6), (b) (7)(C) released GONZALEZ from medical housing before completing the PREA Validation tool. ERAU notes Dr. (b) (6), (b) (7)(C) released GONZALEZ from medical housing on a Friday, and Ms. (b) (6), (b) (7)(C) who typically works Monday-Friday, completed the tool the following Tuesday.

<sup>103</sup> ERAU interview with Ms. (b) (6), (b) (7)(C) April 26, 2017.

<sup>104</sup> See Administrative Segregation Review, dated March 22, 2017.

email to Dr. (b) (6), (b) (7)(C) notifying him that GONZALEZ refused multiple doses of prescribed medications and that she planned to request that a provider see the detainee.

At approximately 3:24 p.m., prior to reading LVN (b) (6), (b) (7)(C) email, Dr. (b) (6), (b) (7)(C) arrived in the RHU to follow-up with GONZALEZ regarding his PREA allegation.<sup>105</sup> Dr. (b) (6), (b) (7)(C) noted GONZALEZ answered “no” to all questions related to his risk for sexual victimization, denied suicidal and/or homicidal ideations, and appeared clearer in his thinking. According to Dr. (b) (6), (b) (7)(C) GONZALEZ stated he was compliant with his medications and expressed frustration due to his inability to contact his consulate during the encounter. Dr. (b) (6), (b) (7)(C) stated he did not know GONZALEZ was not compliant with his medications until the following day when he read LVN (b) (6), (b) (7)(C) email.<sup>106</sup>

At approximately 5:22 p.m.,<sup>107</sup> Officer (b) (6), (b) (7)(C) gave GONZALEZ a dinner tray which the detainee took and threw against his cell door.<sup>108</sup> Lt. (b) (6), (b) (7)(C) stated he tried to speak with GONZALEZ after he threw the tray, but the detainee did not respond.<sup>109</sup> A few minutes later, GONZALEZ told Officer (b) (6), (b) (7)(C) that the food was bad, and he did not want it.

Following this incident, officers completed security rounds at 6:02 p.m. (ten minutes over the 30-minute threshold), 7:02 p.m., and 7:16 p.m.<sup>110</sup> Video surveillance of the 7:16 p.m. round shows an officer inserted a pipe into the sensor at GONZALEZ’s cell and made an entry on the 30-minute check log outside his cell but did not look inside the cell.<sup>111</sup> As noted by Creative Corrections, the primary purpose of security rounds is to confirm detainee welfare through direct observation.

At approximately 7:53 p.m., Officer (b) (6), (b) (7)(C) and LVN (b) (6), (b) (7)(C), who were in the RHU distributing medications, walked toward cell 205, and LVN (b) (6), (b) (7)(C) immediately noticed food on the floor outside the cell door and on the cell window.<sup>112</sup> LVN (b) (6), (b) (7)(C) and Officer (b) (6), (b) (7)(C) looked inside the cell window and saw GONZALEZ hanging with one end of a bedsheet wrapped around his neck and the other end attached to the bunk bed ladder. ERAU notes the last security round was logged approximately 35 minutes before LVN (b) (6), (b) (7)(C) and Officer (b) (6), (b) (7)(C) found GONZALEZ. LVN (b) (6), (b) (7)(C) immediately directed Officer (b) (6), (b) (7)(C) to retrieve a cut down tool<sup>113</sup> and to call a Code Blue.<sup>114</sup> Officer (b) (6), (b) (7)(C) stated he used his radio to call a Code Blue in the Bravo 1 segregation unit and asked for a cut-down tool,<sup>115</sup> several officers and medical staff, including RN (b) (6), (b) (7)(C) and (b) (6), (b) (7)(C) reported during interviews they heard the Code Blue call for the Bravo 5 unit.<sup>116</sup>

<sup>105</sup> See ADF eClinicalWorks Progress Note by Dr. (b) (6), (b) (7)(C) dated March 22, 2017.

<sup>106</sup> ERAU interview with Dr. (b) (6), (b) (7)(C) April 25, 2017.

<sup>107</sup> See ADF (b) (6), (b) (7)(C) Check Log, dated March 22, 2017.

<sup>108</sup> See WIB RHU Logbook, dated March 22, 2017. Although the logbook reflects the meal was refused, Officer (b) (6), (b) (7)(C) and Lt. (b) (6), (b) (7)(C) reported that GONZALEZ accepted the meal and then threw it against his cell door.

<sup>109</sup> ERAU interview with Lt. (b) (6), (b) (7)(C) April 27, 2017.

<sup>110</sup> See Exhibit 6: ADF (b) (6), (b) (7)(C) Check Log, dated March 22, 2017.

<sup>111</sup> See Video surveillance footage of WIB, dated March 22, 2017.

<sup>112</sup> ERAU interview with LVN (b) (6), (b) (7)(C) April 26, 2017.

<sup>113</sup> A cut down tool is designed to safely and effectively cut through fabric in rescue and emergency situations.

<sup>114</sup> A Code Blue signifies a medical emergency.

<sup>115</sup> See ADF General Incident Report by Officer (b) (6), (b) (7)(C) dated March 22, 2017.

<sup>116</sup> ERAU interview with RN (b) (6), (b) (7)(C) and (b) (6), (b) (7)(C) April 26, 2017.

At approximately 7:53:34 p.m., Officer (b) (6), (b) (7)(C) opened GONZALEZ’s cell door.<sup>117</sup> Officer (b) (6), (b) (7)(C) stated GONZALEZ was in a partially seated position with tension from the bedsheet slightly elevating him off the floor.<sup>118</sup> Officer (b) (6), (b) (7)(C) lifted GONZALEZ upward, untied and removed the bedsheet, and laid GONZALEZ on the floor. LVN (b) (6), (b) (7)(C) then checked for a pulse and when she did not find one, she initiated chest compressions.<sup>119</sup>

After Officer (b) (6), (b) (7)(C) called for the cut-down tool, Officer (b) (6), (b) (7)(C) who was in the RHU, attempted to open the unit’s emergency box where the tool is kept. After three unsuccessful attempts to open the padlock using his keys, he proceeded to GONZALEZ’s cell. When he arrived at approximately 7:54 p.m.,<sup>120</sup> he observed GONZALEZ on the floor with Officer (b) (6), (b) (7)(C) and LVN (b) (6), (b) (7)(C) performing chest compressions.<sup>121</sup> Officer (b) (6), (b) (7)(C) stated he then placed two more Code Blue calls, specifying the correct housing unit, and then held the door for responders.<sup>122</sup>

RN (b) (6), (b) (7)(C) and (b) (6), (b) (7)(C) were in the clinic when they heard the Code Blue call. RN (b) (6), (b) (7)(C) immediately went to the medication room to retrieve the emergency bag. She did not find the bag, so she and RN (b) (6), (b) (7)(C) gathered the automated external defibrillator (AED), vital signs machine, and a wheelchair, and exited the clinic for Bravo 5.<sup>123</sup> RN (b) (6), (b) (7)(C) stated that as they left the clinic, they heard the location of the emergency corrected to Bravo 1, the segregation unit, so they redirected and were followed by FNP (b) (6), (b) (7)(C).<sup>124</sup> When the nurses arrived at GONZALEZ’s cell, at approximately 7:56 p.m., LVN (b) (6), (b) (7)(C) was performing chest compressions. RN (b) (6), (b) (7)(C) applied the AED pads to the detainee,<sup>125</sup> and FNP (b) (6), (b) (7)(C) assessed the detainee and found he was unresponsive to verbal and deep stimuli, his pupils were dilated and fixed, he was not breathing, and did not have a pulse.<sup>126</sup> FNP (b) (6), (b) (7)(C) directed officers to call 911 and then initiated rescue breaths using a mouth guard. At approximately 7:58 p.m., central control called 911.<sup>127</sup>

LVN (b) (6), (b) (7)(C) who also responded to the Code Blue, brought a gurney to GONZALEZ’s cell, and then went back to the medical unit to retrieve the emergency bag.<sup>128</sup> She was unable to locate the bag but later learned LVN (b) (6), (b) (7)(C) found it in a cabinet and took it to the scene.<sup>129</sup>

<sup>117</sup> See Video surveillance footage of W1B RHU, dated March 22, 2017.

<sup>118</sup> ERAU interview with Officer (b) (6), (b) (7)(C) April 26, 2017.

<sup>119</sup> See ADF General Incident Report by Officer (b) (6), (b) (7)(C) dated March 22, 2017.

<sup>120</sup> See Video surveillance footage of W1B, dated March 22, 2017.

<sup>121</sup> See ADF General Incident Report by Officer (b) (6), (b) (7)(C) dated March 22, 2017.

<sup>122</sup> ERAU interview with Officer (b) (6), (b) (7)(C) April 26, 2017.

<sup>123</sup> See CCS Memorandum by RN (b) (6), (b) (7)(C) dated March 22, 2017.

<sup>124</sup> See CCS Memorandum by RN (b) (6), (b) (7)(C) dated March 22, 2017.

<sup>125</sup> ERAU interview with RN (b) (6), (b) (7)(C) April 26, 2017.

<sup>126</sup> See CCS Memorandum by FNP (b) (6), (b) (7)(C), dated March 22, 2017.

<sup>127</sup> See Central Control Log, dated March 22, 2017.

<sup>128</sup> See CCS Memorandum by LVN (b) (6), (b) (7)(C) dated March 22, 2017.

<sup>129</sup> ERAU interview with LVN (b) (6), (b) (7)(C) April 26, 2017.

Lt. (b) (6), (b) (7)(C), a shift supervisor, was in the Alpha unit when he heard the Code Blue call.<sup>130</sup> He initially proceeded to Bravo 5, but redirected to Bravo 1 when he heard Officer (b) (6), (b) (7)(C) calls. Lt. (b) (6), (b) (7)(C) stated three medical staff and approximately five officers were on the scene when he arrived. He returned to his office to assign officers to GONZALEZ's hospital detail, and notified the Assistant Warden that GONZALEZ was found unresponsive on the floor of his cell.

At approximately 8:04 p.m.,<sup>131</sup> Officer (b) (6), (b) (7)(C) began recording the emergency response with a handheld video camera.<sup>132</sup> The footage shows that GONZALEZ lay on his back on the floor, that a nurse performed chest compressions with periodic relief by an officer, that the AED did not find a pulse and thus did not advise any shocks, and that chest compressions continued.

At approximately 8:08 p.m., two paramedics and an emergency medical technician (EMT) from the San Bernardino County Fire Department (SBCFD) arrived on the scene and observed GONZALEZ in full arrest with staff performing cardiopulmonary resuscitation (CPR).<sup>133</sup> The paramedics placed GONZALEZ on a cardiac monitor, intubated him, and inserted a venous line<sup>134</sup> in his tibia.<sup>135</sup> Because the cardiac monitor showed no heartbeat, the paramedics administered epinephrine twice.<sup>136</sup> The second round of epinephrine established a pulse which quickly turned into a rapid heart rate, ADF medical staff discontinued CPR, and the paramedics placed GONZALEZ on a backboard.

At approximately 8:18 p.m., medical and security staff exited the cell with GONZALEZ on the backboard.<sup>137</sup> They placed him on a gurney, and at 8:20 p.m., American Medical Rescue (AMR) ambulance personnel arrived, also in response to the 911 call, moved GONZALEZ to an AMR gurney, and transported him to their ambulance.<sup>138</sup> At 8:26 p.m., the ambulance departed the facility with Officer (b) (6), (b) (7)(C) riding in the ambulance.<sup>139</sup> Officer (b) (6), (b) (7)(C) stated that during the ride to the hospital, GONZALEZ had a pulse and his eyes were open, but he appeared unconscious.<sup>140</sup> At 8:41 p.m., the ambulance arrived at VVGMC, where GONZALEZ was admitted and remained until his death.<sup>141</sup>

From March 23 to 27, 2017, ADF medical staff obtained regular updates from VVGMC including the following:

- GONZALEZ remained in critical condition, unresponsive, and intubated.

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<sup>130</sup> ERAU interview with Lt. (b) (6), (b) (7)(C) April 25, 2017.

<sup>131</sup> See Video surveillance footage of W1B RHU, dated March 22, 2017.

<sup>132</sup> The handheld video camera did not have a timestamp. Footage from the handheld video camera is referenced in the report when it provides additional detail not otherwise documented or reported.

<sup>133</sup> See San Bernardino County Fire Billing Report, dated March 22, 2017.

<sup>134</sup> A venous line is a long, thin, flexible tube used to give medicines, fluids, nutrients, or blood products

<sup>135</sup> The tibia is an area of the shin bone.

<sup>136</sup> Epinephrine is commonly known as adrenaline and works by quickly improving breathing, stimulating the heart, and rising blood pressure.

<sup>137</sup> See Video surveillance footage of W1B RHU, dated March 22, 2017.

<sup>138</sup> See American Medical Response, dated March 22, 2017.

<sup>139</sup> See American Medical Response, dated March 22, 2017.

<sup>140</sup> ERAU interview with Officer (b) (6), (b) (7)(C) April 26, 2017.

<sup>141</sup> See American Medical Response, dated March 22, 2017.

- A CT scan showed major swelling GONZALEZ’s brain.<sup>142</sup>
- GONZALEZ was given digoxin<sup>143</sup> for an elevated heart rate, but it was ineffective.
- GONZALEZ received an electroencephalogram (EEG),<sup>144</sup> which showed little to no brain activity.
- GONZALEZ required a Bair Hugger<sup>145</sup> to maintain his body temperature.
- GONZALEZ’s condition significantly declined during the night of March 27, 2017. Specifically, he had no reflexes, his pupils were fixed and his blood pressure was dropping.

On March 28, 2017 at 1:07 a.m., Doctor (b) (6), (b) (7)(C) pronounced GONZALEZ dead.<sup>146</sup> Officer (b) (6), (b) (7)(C) notified Lt. (b) (6), (b) (7)(C) via telephone that GONZALEZ passed away. Lt. (b) (6), (b) (7)(C) instructed Officer (b) (6), (b) (7)(C) and Officer (b) (6), (b) (7)(C) who was also at the hospital, to remain with the body until a body receipt was issued.<sup>147</sup> At 2:26 a.m., ERO notified the Consulate of Nicaragua of GONZALEZ’s death.<sup>148</sup> At 4:09 a.m., VVGMC transferred custody of GONZALEZ’s body to Victor Valley Mortuary, a receipt for the body was issued, and the officers returned to ADF where they completed incident reports.<sup>149</sup>

### Post-Death Events

On March 31, 2017, (b) (6), (b) (7)(C), of the San Bernardino County Sheriff Coroner Division, determined an autopsy was unnecessary.<sup>150</sup> Mr. (b) (6), (b) (7)(C) documented GONZALEZ’s cause of death as hypoxic encephalopathy and hanging. On June 1, 2017, the State of California issued a Certificate of Death which recorded GONZALEZ’s cause of death as hypoxic encephalopathy and hanging.<sup>151</sup>

### MEDICAL CARE AND SECURITY REVIEW

ERAU reviewed the medical care GONZALEZ was provided by ADF, as well as the facility’s efforts to ensure that he was safe and secure while detained at the facility. ERAU found deficiencies in ADF’s compliance with certain requirements of the ICE PBNDS 2011:

1. **ICE PBNDS 2011, Medical Care, section (V)(E), *Translation and Language Access for Detainees with Limited English Proficiency***, which states, “Facilities shall provide appropriate interpretation and language services for LEP detainees related to medical and mental health care. Where appropriate staff interpretation is not available, facilities will make use of professional interpretation services.”

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<sup>142</sup> A CT scan is an x-ray image that produces cross-sectional images of the body.

<sup>143</sup> Digoxin is a medication used to treat heart failure and heart rhythm problems.

<sup>144</sup> An electroencephalogram is a test to detect abnormalities related to electrical activity of the brain.

<sup>145</sup> A Bair Hugger is a hospital gown with a built-in warming system.

<sup>146</sup> See Medical Bag #6 Logbook, dated March 28, 2017.

<sup>147</sup> ERAU interview with Officer (b) (6), (b) (7)(C) April 27, 2017.

<sup>148</sup> See Email from AFOD (b) (6), (b) (7)(C), dated March 28, 2017.

<sup>149</sup> See Medical Bag #6 Logbook, dated March 28, 2017.

<sup>150</sup> See Email from Mr. (b) (6), (b) (7)(C) dated March 31, 2017.

<sup>151</sup> See Exhibit 7: State of California Certificate of Death.



- On January 7, February 1, and February 17, 2017, RN (b) (6), (b) (7)(C) conducted sick call encounters and did not use interpretation assistance. Given the nature of the complaints, including genital symptoms potentially of an infectious nature and a heart condition, interpretation assistance was critical.

2. **ICE PBNDS 2011, Medical Care, section (V)(X)(4), *Informed Consent and Involuntary Treatment***, which states, “Prior to the administration of psychotropic medications, a separate documented informed consent, that includes a description of the medication’s side effects, shall be obtained.”

- GONZALEZ’s medical record does not contain a consent form for psychotropic medications.

This also violates **Adelanto Detention Facility Healthcare Policies, D-02 (Essential), Section (10)**, which states, “Health care staff shall complete a Consent for Examination/Treatment/Procedure Form for the patient’s signature when a patient is initially prescribed psychotropic medications, or prior to receiving psychotropic medications which were prescribed prior to incarceration.”

3. **ICE PBNDS 2011, Medical Care, sections (V)(X)(7)(9) and (10), *Informed Consent and Involuntary Treatment***, which states... “(7) If the detainee refuses to consent to treatment, medical staff shall make reasonable efforts to explain to the detainee the necessity for and propriety of the recommended treatment; ... (9) Medical staff shall explain the medical risks if treatment is declined and shall document their treatment efforts and refusal of treatment in the detainee’s medical record. Detainees will be asked to sign a translated form that indicates that they have refused medication.”

- Nurses did not use the Spanish version of refusal forms for eight doses of psychotropic medication refused by GONZALEZ on March 18, 20, 21, and 22, 2017.
- Nurses did not document whether GONZALEZ was counseled about the medical risks for refusing medication or whether they made efforts to encourage medication compliance.

This also violates **Adelanto Detention Facility Healthcare Policies, D-02 (Essential), Section (9)**, which states, “Patients who refuse to take their medication as directed, may have them discontinued pursuant to the following procedure: a) A patient’s first refusal of medication shall be documented in the medical record and MAR; b) Upon a patient’s second refusal of medication, a qualified health care professional will counsel the patient on the risks and benefits of non-compliance and will document the refusal in the MAR and the counseling in the medical record; c) Upon a patient’s third or subsequent refusal of medication, the patient will be asked to sign a Refusal of Medical Services and Release form. If the patient refuses to sign the form, two witnesses shall sign the form documenting the refusal. After the third refusal, the patient will be scheduled to see the responsible physician on the next available clinician call line. Health care staff shall notify the responsible physician and, if in the opinion of the responsible physician, the refusal could result in serious

medical consequences, the patient should be housed in the medical unit for observation until seen by the responsible physician. The patient will be counseled by the responsible physician and after considering the patient's medical condition, the responsible physician may discontinue the patient's medication. The counseling and reason for discontinuing the medication shall be documented in the medical record; d) Patients who refuse three or more doses of critical medication (i.e., ...psychotropic medications) shall also be referred to a qualified mental health professional for counseling, if available. Documentation of the counseling shall be placed in the medical file." Nurses did not notify either a mental health provider, physician, or the HSA until after GONZALEZ already missed six doses of Haldol and two doses of Depakote.

4. **ICE PBNDS 2011, Sexual Abuse and Assault Prevention and Intervention, section (V)(H), *Prompt and Effective Intervention***, which states, "Any detainee who alleges that he/she has been sexually assaulted shall be offered immediate protection from the assailant and shall be referred for a medical examination and/or clinical assessment for potential negative symptoms."

- On March 7, 2017, GONZALEZ reported he was sexually assaulted, but medical staff did not conduct a medical assessment in response to that allegation.

5. **ICE PBNDS 2011, Special Management Units, section (V)(A)(2), *Administrative Segregation*** Order, which states, "A written order shall be completed and approved by the facility administrator or designee before a detainee is placed in administrative segregation, except when exigent circumstances make such documentation impracticable. In such cases, an order shall be prepared as soon as possible."

- GONZALEZ's detention file does not contain a written order for his placement in administrative segregation pending the investigation of the February 13, 2017 disciplinary incident.

6. **ICE PBNDS 2011, Special Management Units, section (V)(A)(3)(c), *Review of Detainee Status in Administrative Segregation***, which states, "The review shall include an interview with the detainee, and a written record shall be made of the decision and its justification."

- On March 22, 2017, Lt. [REDACTED] documented review of GONZALEZ's administrative segregation status but did not document whether GONZALEZ was interviewed as part of the review.

This also violates **ADF Policy Special Management Detainees, section (IV)(F)(2)**, which states, "The SMU review committee shall conduct the same type of review after the detainee has spent seven days in administrative segregation, and every week thereafter for the first two months and at least every 30 days thereafter. The review shall include an interview with the detainee. A written record shall be made of the decision and the justification."

7. **ICE PBNDS 2011, Special Management Units, section (V)(L)**, which states, “Detainees in SMU shall be personally observed and logged at least every 30 minutes on an irregular schedule.”

- On several occasions, security rounds in RHU exceeded the 30-minute requirement. Of note, on the day of the emergency, an officer logged a security round at 7:16 p.m., and GONZALEZ was discovered hanging at 7:53 p.m., 37 minutes later.

This also violates **ADF Restrictive Housing Units Post Orders, section (V)(A)**, which states, “Inspect the following items upon assuming the RHU post and every 30 minutes thereafter, at irregular intervals, to assure that security is maintained and to assure sanitation standards are being maintained. This security check will be entered in the RHU Log as well as the 30-minute check form located near each occupied cell also the "PIPE" device will be used to log checks by pressing the "PIPE" against the metal discs mount on every cell door. Irregular 30-minute checks must begin within one-half hour from the time the last RHU check was completed.”

8. **ICE PBNDS 2011, Custody Classification System, Appendix 2.2.B, section (2)(C)(7), Number of Sustained Institutional Disciplinary Infractions**, which states, “Sustained disciplinary infractions should be counted if they involved violence or behavior representing a threat to the facility. Using records from a current period of ICE detention and/or prior periods of detention or imprisonment, calculate and enter the appropriate number of points. As a general matter, disciplinary offenses that involve violence or behavior representing a threat to the facility are those listed in the “Greatest” and “High” offense categories in standard ‘3.1 Disciplinary System’, Appendix 3.1.A. These offenses are also listed in Appendix 2.2.D.”

- On four occasions, officers completing GONZALEZ’s classification reviews failed to properly apply points for his disciplinary infractions. On January 26, 2017, an officer applied a score of zero in the disciplinary infractions section of the reclassification form, even though GONZALEZ was found guilty of fighting on January 22, 2017. On February 21, 2107, three days after GONZALEZ was found guilty of fighting a second time, an officer again failed to apply any corresponding points during a classification review. On March 8, 2017, an officer applied points for only one of the two fighting infractions. On March 20, 2017, the officer who completed GONZALEZ’s 90-day classification review repeated this error.

9. **ICE PBNDS 2011, Funds and Personal Property, section (V)(G)(1)** states, “Separate documentation should be made for each kind of currency and negotiable instrument, and should include detainee identification information and a description of the amount and type of currency or other negotiable instrument inventoried.”

- GONZALEZ’s receipt for funds did not list the amount and type of foreign currency.

## AREAS OF CONCERN

ERAU noted the following additional concerns related to medical documentation and patient encounters:

- On December 30, 2016, GONZALEZ complained of pain during his intake screening, but the intake nurse did not ask for the type or location of pain.
- On January 3, 2017, GONZALEZ submitted a sick call request complaining of pain in his genital area, but the nurse who triaged the request did not refer him to a provider. A provider did not evaluate GONZALEZ until his initial physical examination on January 12, 2017.
- As a result of complaints GONZALEZ made during his January 12, 2017 initial physical examination of pain and irritation in his genital area, laboratory tests were ordered and completed. A provider did not review the test results or follow-up with GONZALEZ until he submitted a sick call request on February 8, 2017, complaining of continued symptoms.
- As a result of the February 8, 2017 evaluation, a provider prescribed topical medications, and ordered a follow-up evaluation in two weeks. The follow-up appointment was never scheduled, and a provider did not evaluate the effectiveness of the treatment prior to GONZALEZ's death.
- GONZALEZ's medical record does not contain documentation that any ADF provider reviewed the Physician Discharge Order from API. As a result, ADF medical staff did not implement the API physician's recommendation that an ADF provider order laboratory tests to monitor the effects of GONZALEZ's medications.

ERAU noted the following areas of concern pertaining to communication gaps between medical staff at ADF:

- Nurses failed to notify a provider that GONZALEZ refused multiple consecutive doses of psychiatric medications in the days preceding his suicide. Per ADF policy, nurses must notify a provider when a detainee refuses psychotropic medications, which should trigger the scheduling of a provider appointment with the detainee to determine whether intervention and/or an alternative treatment is necessary.

ERAU noted the following concern related to the accessibility of the emergency response bag in the event of an emergency:

- The emergency bag was not located in the designated location for quick access in response to the Code Blue.

ERAU noted the following concerns regarding security-related documentation and detainee interactions:

- Lt. (b) (6), (b) (7)(C) decision to suspend the balance of GONZALEZ's disciplinary segregation term following his return from API was not documented in his detention file. Per Creative Corrections, documentation of such decisions by authorized individuals and/or with appropriate approval is important for accountability purposes.
- Event times on the Housing History Grid are noticeably discrepant from times documented elsewhere. Although minor deviations in written entries and electronic and video documentation are to be expected, considerable deviations as consistently documented on the Housing History Grid work against record integrity.
- As noted by Dr. (b) (6), (b) (7)(C) GONZALEZ's inability to contact the consulate of Nicaragua was an ongoing source of concern and frustration to the detainee. Lt. (b) (6), (b) (7)(C) stated she arranged for issuance of two new PINs, but at no point did GEO or ERO staff assist him to facilitate a phone call to the consulate.

ERAU noted the following concern related to security rounds:

- Video surveillance footage of officers completing security rounds in the RHU show the officers did not look into cells to directly observe and ensure the well-being of the detainee occupants. As noted by Creative Corrections, the primary purpose of security rounds is to confirm detainee welfare through direct observation.

#### AREAS OF NOTE

- Dr. (b) (6), (b) (7)(C) promptly ordered GONZALEZ's transfer to API after determining that his mental health needs exceeded the level of care available at ADF. Dr. (b) (6), (b) (7)(C) also notified facility and ERO staff that the detainee was unable to contact the Nicaraguan consulate, and twice attempted to arrange an appointment with a provider to evaluate GONZALEZ's complaints related to his genital infection.
- HSA (b) (7)(C), (b) (6) proactively identified process failures by medical staff with regard to GONZALEZ's care and initiated corrective actions in advance of ERAU's review.
- Following GONZALEZ's death, Security Chief (b) (6), (b) (7)(C) instituted a requirement that officers in segregation units complete security rounds every 20 minutes to help ensure those officers do not exceed the mandated 30-minute timeframe for those rounds.



**EXHIBITS:**

1. Creative Corrections Medical and Security Compliance Analysis
2. ADF Property Receipt #074062
3. Receiving Screening form
4. ADF Pipe Check Log, March 20, 2017.
5. ADF Pipe Check Log, March 21, 2017.
6. ADF Pipe Check Log, March 22, 2017.
7. State of California Certificate of Death.