U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: SABONGER-Garcia, Fernando

General Demographic/Background Information

- **Date of Birth:** February 20, 1970
- **Date of Death:** August 28, 2020
- **Age:** 50
- **Gender:** Male
- **Country of Citizenship:** Honduras
- **Marital Status:** Single
- **Children:** N/A

Immigration History

- On August 16, 2019, U.S. Border Patrol (USBP) arrested Mr. SABONGER for unlawful entry into the United States, served him with a Notice and Order for Expedited Removal (Form I-860), and transferred him to Homeland Security Investigations (HSI) custody as a material witness in an alien smuggling case. On this same date, HSI transferred Mr. SABONGER to the U.S. Marshals Service (USMS) custody and issued an Immigration Detainer – Notice of Action (Form I-247).
- On July 7, 2020, the USMS released Mr. SABONGER into ICE Enforcement and Removal Operations (ERO) custody at the Joe Corley Processing Center (JCPC).
- On July 21, 2020, U.S. Citizenship and Immigration Services denied Mr. SABONGER's credible fear claim, and Mr. SABONGER requested an immigration judge's review of the decision.

Criminal History

- None

Medical History

Coastal Bend Detention Center (CBDC)

- **On July 6, 2020**, at CBDC in Robstown, TX, a licensed vocational nurse (LVN) cleared Mr. SABONGER for travel and completed his medical transfer summary which identified no medical conditions, allergies, or current medications; a negative tuberculosis (TB) skin test; and negative COVID-19 symptom screening results.
- **On July 7, 2020**, Mr. SABONGER transferred to JCPC.

JCPC Medical Records

- **On July 7, 2020** a registered nurse (RN) completed Mr. SABONGER's medical pre-screening and intake screening. Mr. SABONGER denied a history of medical or mental health conditions, recent use of tobacco, alcohol or illicit drugs, and the RN documented a negative COVID-19 symptom screening. His vital signs (VS) were normal, except for a blood pressure (BP) reading of 161/95 millimeters of mercury (mmHg). As a result of JCPC's COVID-19 response plan, the RN placed Mr. SABONGER on a routine 14-day intake cohort to monitor for COVID-19 related symptoms, and serial BP checks, three times per week, for two weeks.
- **On July 8, 2020**, Mr. SABONGER's chest x-ray was completed and the results revealed no active TB present. A medical doctor (MD) and licensed clinical social worker (LCSW)

reviewed and signed Mr. SABONGER's intake screening without additional orders or restrictions.

- **On July 11, 2020**, an RN completed Mr. SABONGER's health appraisal. Mr. SABONGER again denied a history of medical or mental health conditions, recent use of tobacco, alcohol, or illicit drugs. His VS and exam were within normal limits, except BP of 131/88 mmHg.
- **On July 14, 2020,** per JCPC's Health Services Administrator, Mr. SABONGER's dorm cohort was restarted due to two detainees in the pod testing positive for COVID-19.
- **On July 26, 2020 at 9:40 a.m.**, during Mr. SABONGER's BP check-in the clinic, he complained of dizziness, shortness of breath, and "feeling like he was going to pass out." An advanced practice provider (APP) evaluated Mr. SABONGER. The APP noted Mr. SABONGER was experiencing tachypnea (rapid respirations), his skin was warm to touch with pale color, temperature (T) of 100.7 degrees Fahrenheit(F), BP - 148/74 mmHg, pulse (P) - 105 beats per minute (bpm), respirations (R) – 24 breaths per minute, blood sugar level (fingerstick) of 94 milligrams per deciliter (mg/dl), and oxygen saturation level (SpO2) of 57 percent (%), which increased to 79% with supplemental oxygen (3L per nasal cannula). The APP ordered ibuprofen 400 mg, one capsule, orally, and to transfer Mr. SABONGER to the local emergency department (ED) via emergency medical services (EMS) for a higher-level evaluation and to rule out COVID-19. Mr. SABONGER remained alert, oriented, but tachypneic and febrile during his departure from JCPC.
    - **At approximately 10:24 a.m.**, while at Conroe Regional Medical Center (CRMC), an ED MD evaluated Mr. SABONGER. Mr. SABONGER reported having worsening shortness of breath, cough for six days, dizziness, fever, and chills. On initial exam, the MD ordered 15L of supplemental oxygen per rebreather mask, but without a noticeable improvement. His arterial blood gas levels showed acute hypoxia and respiratory failure. The MD transferred Mr. SABONGER into a respiratory isolation room, with subsequent admission into the intermediate care unit with a guarded, but improved condition. Laboratory studies were completed, and Mr. SABONGER tested positive for COVID-19. The MD diagnosed Mr. SABONGER with a multi-focal pneumonia, severe COVID-19 infection, hypoxia, and respiratory failure. The MD ordered antibiotics, steroidal therapy, considered bi-level positive airway pressure (BiPAP) therapy, if unresponsive to current treatment, and assigned a full resuscitation code status.
    - **At 2:51 p.m.**, Mr. SABONGER continued to experience tachypnea and unresponsiveness to high flow oxygen therapy. His VS were normal except, T - 100.5 F, R – 32 bpm, and SpO2 – 91%. The MD requested a pulmonology consult, ordered to start BiPAP therapy, and if no improvement, to transfer to the intensive care unit (ICU).
    - **At 11:25 p.m.**, Mr. SABONGER was transferred to the ICU and placed on BiPAP due to increased respiratory distress.
- **On July 27, 2020**, Mr. SABONGER appeared to be doing "fairly well" on BiPAP; however, he required high concentrations of oxygen, remained sedated, required one unit of plasma antibiotic therapy, and close monitoring.
- **On August 1, 2020**, the attending MD diagnosed Mr. SABONGER with acute respiratory distress syndrome, requiring intubation, and ventilatory support with high concentrations of oxygen.
- **On August 2, 2020**, Mr. SABONGER remained intubated, feeding per oral-gastric tube initiated and the attending MD spoke to Mr. SABONGER's family and provided an update to his condition.

- **August 3 - 10, 2020**, Mr. SABONGER remained sedated, on ventilator support, with intermittent and unsuccessful weaning attempts.
- **On August 11, 2020**, a consulting MD noted, due to Mr. SABONGER's inability to maintain adequate SpO2 levels, he remained sedated and intubated. Additionally, he experienced worsening leukocytosis despite prescribed empiric high dose/broad spectrum antibiotics for his bilateral pneumonia. His exam was unremarkable, except for episodic hypotension, occasional crepitus and few rales. Mr. SABONGER's chest x-ray results revealed bilateral lower lobe infiltrates, and his sputum culture results showed positive results for bacteria. The MD diagnosed Mr. SABONGER with encephalopathy and continued full ventilatory support, sedation, and to taper his current antibiotics with the following: empirical vancomycin and consideration for convalescent plasma if his oxygen demand continued to remain high. Mr. SABONGER remained in respiratory isolation, and the MD requested an infectious disease consultation.
- **August 12 – 18, 2020**, Mr. SABONGER's BP readings fluctuated, while he remained on ventilatory support and tube feedings. CRMC's medical team made several attempts to wean Mr. SABONGER off ventilatory support but was unsuccessful due to his decreasing SpO2 levels and tachypneic episodes.
- **On August 19, 2020,** Mr. SABONGER's condition began to worsen, to include: decreased BP readings, tachypnea, tachycardia, and increased demand for oxygen (ventilator rate increased from 60% to 100% fraction of inspired oxygen (FiO2). Mr. SABONGER received a transfusion of two units of blood.
- **On August 20, 2020**, Mr. SABONGER's condition continued to deteriorate and a CRMC nurse suggested an initiation of Mr. SABONGER's Do Not Resuscitate (DNR) order.
- **On August 22, 2020**, Mr. SABONGER's condition remained poor, to include: fully sedated, ventilatory support at 100%, low SpO2 levels, episodic tachypnea, tachycardia, hypotension, and decreased urine output. His temperature fluctuated and reduced to as low as 95.3 F, and he required use of warming blankets to increase his T.
- **On August 23, 2020 at 6:40 a.m.**, Mr. SABONGER's condition remained poor and unchanged. His VS were stable, except P – 121 bpm, R – 32 bpm and SpO2 – 82%. A CRMC nurse contacted Mr. SABONGER's family regarding a DNR determination, but a final decision was not made.
    - **At 2:01 p.m.**, the attending MD evaluated Mr. SABONGER and noted he was fully sedated, paralyzed, and in a prone position due to his low SpO2 levels decreasing to 60 - 80% (despite ventilatory support at 100% FiO2). There was no significant respiratory improvement, his chest x-ray remained unchanged with bilateral infiltrates.
- **August 24 – 27, 2020**, Mr. SABONGER's condition remained poor and unchanged: fully sedated, ventilatory support at 100%, facial edema, low SpO2 levels, episodic tachypnea, tachycardia, and hypotension. Mr. SABONGER remained at full code status.
- **On August 28, 2020**, Mr. SABONGER's condition remained poor, despite continual use of maximum ventilatory and pharmaceutical support.

Synopsis of Death

- **On August 28, 2020**:
    - **At 7:05 a.m.**, Mr. SABONGER's BP decreased to 94/49 mmHg along with his SpO2 level to 45%. He continued ventilatory support at 100% FiO2.

- **At 10:56 a.m.**, Mr. SABONGER experienced cardiac arrest requiring life-saving measures; however, CRMC staff efforts were unsuccessful, and the attending MD pronounced him dead at 11:00 a.m., CDT.
- The cause of death and manner was due to complications of COVID-19 virus infection and natural, respectively.