

# FATAL NEGLECT

How ICE Ignores Deaths in Detention



# Acknowledgements



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# Introduction

Despite the Obama administration's stated commitment to reform the U.S. immigration detention system, driven in part by outrage over the high number of deaths in custody,<sup>1</sup> failure to provide adequate medical care has continued to result in unnecessary deaths. *The New York Times* 2010 investigative report on deaths in immigration detention found evidence of a "culture of secrecy" and a failure to address fatal flaws at detention centers.<sup>2</sup> According to an analysis of newly public government death reviews, these problems persist and poor medical care contributes to the death of immigrants in federal immigration custody with alarming frequency.

This report examines egregious violations of U.S. Immigration and Customs Enforcement's (ICE) own medical care standards that played a significant role in eight in-custody deaths from 2010 to 2012. An American Civil Liberties Union (ACLU), Detention Watch Network (DWN), and National Immigrant Justice Center (NIJC) review of ICE death investigations and facility inspection reports reveals that even though ICE's own death reviews identified violations of ICE medical standards as contributing factors in these deaths, ICE detention facility inspections conducted before and after these deaths failed to acknowledge—or sometimes dismissed—the critical flaws identified in the death reviews. The findings underscore how ICE's deficient inspections system, first exposed by DWN and NIJC in the October 2015 report *Lives in Peril*, exacts a tragic human toll.<sup>3</sup>

The ACLU obtained ICE Office of Detention Oversight (ODO) Detainee Death Review documents summarizing investigations into detention-center deaths through a Freedom of Information Act (FOIA) request. These requests followed up on the ACLU's 2007-2009 FOIA requests on deaths in ICE detention, which formed the basis for an investigative series by *The New York Times* that, along with widespread NGO advocacy, pushed the Obama administration to adopt its 2009 detention reforms.<sup>4</sup> The death reviews are a component of these 2009 reforms, and are carried out by a centralized team of ICE personnel and subject-matter experts who interview local personnel and review medical and custody records to evaluate the medical care related to the death. The ACLU's updated FOIA request sought the ODO reviews of 24 deaths that occurred in ICE custody from January 2010 through May 2012. In response, ICE produced documents regarding 17 deaths, but did not provide investigations for seven individuals. Of these seven outstanding cases, four remained under investigation at the time of ICE's final document production, more than 400 days after these deaths occurred. In the remaining three deaths, ICE did not conduct its own detainee death review; in two cases, this was because the Office of Inspector General (OIG) in the Department of Homeland Security (DHS) conducted the investigation, and in one case (discussed below), it is not clear if anyone conducted an investigation.<sup>5</sup> In nearly half of the death reviews produced by ICE, the documentation suggests that failure to comply with ICE medical standards contributed to deaths.

## Pablo Gracida-Conte

*Pablo Gracida-Conte died at the Eloy Detention Center--the deadliest detention center in the nation--after four months of worsening, untreated medical problems including vomiting after every meal. A doctor concluded that Mr. Gracida's death could have been prevented. Remarkably, the ODO inspection claimed that Mr. Gracida's death was the first death "to ever occur" at Eloy when, in fact, it was the 10th death at the facility.*

## Methodology

*The ACLU, DWN, and NIJC analyzed 24 ICE death reviews that the ACLU received through its FOIA request. The eight cases discussed in this report were identified based on whether ICE investigators found that detention centers were non-compliant with ICE detention standards for medical care. The case summaries for these deaths provide a summary of the evidence provided in the death reviews as well as ICE's own findings on facility lack of compliance with ICE detention standards.*

In addition to creating the death review process, ICE instituted other reforms intended to reduce the number of in-custody deaths. These included the creation of a new detention facility inspection process under ODO that was intended to provide a more rigorous review of detention standards compliance than the routine Enforcement and Removal Operations (ERO) inspections<sup>6</sup>, centralization of healthcare under the ICE Health Service Corps (IHSC), and the introduction of a more robust set of detention standards, the 2011 Performance-Based National Detention Standards (PBNDS 2011).<sup>7</sup>

The PBNDS 2011, which were not in operation at the time of the deaths examined in this report, are the most thorough standards promulgated by ICE. Even these standards, however, fall short in significant respects compared to the National Commission on Correctional Health Care (NCCHC) standards for medical care in prison and jail settings.<sup>8</sup> And although PBNDS 2011 are an improvement over ICE's earlier standards, ICE's adoption of them has been slow; as of January 2014, 139 facilities holding 44 percent of detained immigrants still operated under other, outdated standards that were promulgated as early as 2008 or even in 2000, prior to the creation of ICE.<sup>9</sup> Further, as of January 2014, ICE held 19 percent of detained immigrants in facilities where ICE did not directly contract with the facility and instead contracted through the U.S. Marshals Service (USMS). As two death reviews from such USMS facilities noted, ICE did not have contracts requiring those facilities to comply with any ICE detention standards.<sup>10</sup> This is of particular concern since most USMS contracts are indefinite in duration, and may not be easily modified.<sup>11</sup>

Congress also instituted an important reform in 2009. Since then, congressional appropriations have included a provision that ICE cannot expend funds to immigration detention facilities that fail two consecutive ERO inspections.<sup>12</sup> Although the number of deaths in ICE custody has decreased in recent years,<sup>13</sup> comparison of the death reviews from 2010-2012 with ODO and ERO inspections conducted at facilities before and after deaths occurred demonstrates that the inspection reforms have failed to hold detention facilities accountable for providing adequate medical care. The ACLU, DWN, and NIJC call on ICE to take immediate action to improve the detention-center inspections process and the quality of medical care.

## Contract Types

- **Contract Detention Facilities (CDFs)** are owned and operated by private corporations that contract directly with ICE.
- **Service Processing Centers (SPCs)** are owned and operated by ICE. However, ICE hires contractors to handle many services within the facilities, such as transportation and guard services.
- **Intergovernmental Service Agreements (IGSAs)** are owned and operated by local governmental entities, typically county or city governments. Many local governments subcontract to private corporations to administer the facilities and/or to provide other services.
- **U.S. Marshals Service (USMS) Intergovernmental Agreements (IGAs)** are under contract with the Department of Justice's U.S. Marshals Service. Many of these contracts pre-date the 2003 creation of DHS and frequently do not reference clear applicable standards for detaining immigrants. Further, the majority of the USMS IGA contract terms are indefinite, meaning that there is no clear opportunity to renegotiate facility contracts, upgrade them to the most recent detention standards, or contractually address other concerns.



Photo: Alonso Yáñez/La Opinión

# Key Findings

There have been 56 deaths in ICE custody during the Obama administration, including six suicides<sup>14</sup> and at least one death after an attempted suicide.<sup>15</sup> This report focuses on the eight deaths where ODO identified non-compliance with ICE medical standards as contributing causes; the ODO identified four of these deaths as preventable. However, this focus should not excuse several other cases in which ODO identified similar violations of ICE medical standards without drawing causal links between these violations and the deaths.<sup>16</sup> The risks posed by substandard medical care will continue to endanger people detained in these facilities until the violations are corrected. Indeed, forcing such corrections is perhaps the most important reason to conduct death reviews in the first place. In hospitals, for example, it is a common practice to conduct root cause analyses of serious adverse events (such as death, permanent harm, or severe temporary harm) to identify changes to culture, systems, and processes that could reduce the probability of such events in the future.<sup>17</sup> Our investigation shows that in ICE detention facilities, this process is broken; even in the eight cases where ODO death reviews concluded that violations of ICE medical standards contributed to people's deaths, ICE's deficient inspections system essentially swept those findings under the rug.

Moreover, not all deaths are reviewed. In one case, ICE claimed that it did not have responsibility to review the death because the individual had been in ICE custody for less than six hours in a short-term hold facility, and had not yet been transferred to a detention facility designated for stays longer than 72 hours.<sup>18</sup> This response raises the



**There have been 56 deaths in ICE custody during the Obama administration, including six suicides and at least one death after an attempted suicide.**

Facility Type	Deaths Attributable to Substandard Care <i>Jan. 2010–May 2012</i>	Total Deaths <i>Jan. 2010–May 2012</i>
Intergovernmental Service Agreement (IGSA)	3	10
Adelanto Detention Facility (CA)	1	1
Clinton County Correctional Facility (PA)	0	1
Columbia Regional Care Center (SC)	0	1
Eloy Detention Center (AZ)	1	1
Immigration Centers of America - Farmville (VA)	1	1
Mira Loma Detention Center (CA)	0	1
North Georgia Detention Center (GA)	0	1
Orleans Parish Prison (LA)	0	1
Theo Lacy Facility (CA)	0	1
York County Prison (PA)	0	1
Contract Detention Facility (CDF)	2	4
Denver CDF (CO)	1	1
Elizabeth Detention Center (NJ)	1	1
Houston CDF (TX)	0	2
Service Processing Center (SPC)	1	3
El Paso Processing Center (TX)	1	1
ICE ERO Processing Center (NV)	0	1
Krome SPC (FL)	0	1
U.S. Marshals Service (USMS) IGSA	2	2
Weber County Correctional Facility (UT)	1	1
Albany County Corrections Facility (NY)	1	1
Bureau of Prisons (BOP)	0	3
Oakdale Federal Detention Center (LA)	0	2
Butner Federal Correctional Institute (NC)	0	1
Hold Facility	0	1
San Bernardino Hold Room (CA)	0	1
Staging Area	0	1
Broadview Service Staging Area (IL)	0	1

question of who is responsible for the care of individuals in ICE's short-term detention facilities, and whether such gaps in responsibility are endangering other lives.

Three of the eight deaths profiled here—Fernando Dominguez-Valdivia (also written as Valivia in many ICE documents and some media reports), Irene Bamenga, and Amra Miletic—led to wrongful death lawsuits by surviving family members.<sup>19</sup> However, not only are wrongful death lawsuits an insufficient resolution for families who must still live with the loss of their loved ones, they do not resolve the systemic problems highlighted in this report. As described in further detail below, ICE must take effective measures to improve delivery of medical care in detention and overhaul the inspections process so that both can function to stop more people from dying

preventable deaths in ICE custody.

In addition, six out of the eight deaths involving substandard medical care occurred at privately run facilities.<sup>20</sup> The highest number of deaths during the period covered by the death reviews occurred at facilities in which ICE contracted with local governments through Intergovernmental Service Agreements (IGSA), and the local governments then subcontracted with private, for-profit prison companies to run the facilities. Private prison companies like Corrections Corporation of America (CCA) and the GEO Group, which operate eight of the 10 largest immigration detention centers,<sup>21</sup> have long been criticized by advocacy organizations, government agencies, and the press for inadequate medical care, understaffing, violence, and other issues.<sup>22</sup>

## Failures in Medical Care Cost Lives

### **The ODO death review documents that indicate violations of ICE medical standards reveal a failure to:**

1. Meet health care needs in a timely manner
2. Refer individuals to higher-level medical care providers, including transfer to external services such as emergency services
3. Adequately staff medical personnel
4. Communicate critically important information about individuals' medical conditions between staff and especially during transfers
5. Adequately screen individuals for illnesses
6. Proactively identify and rectify concerns about medical care during ERO and ODO facility inspections

The ERO and ODO inspections should have detected gaps and flawed protocols that ICE or other facility operators should have fixed. Instead, in some inspections, inspectors failed even to mention deaths that had occurred at the facilities under investigation. Also, for all but one of the eight deaths described in this report, ICE ERO inspectors gave facilities passing ratings prior to and following deaths related to egregiously substandard medical care, even where ODO inspections found facilities failed to meet medical care standards, and even where ODO death reviews explicitly identified the deaths as preventable.

Overall, the systems designed to provide health care and hold facilities accountable failed these eight individuals, and may well have cost them their lives.

# When Substandard Medical Care Can Kill



## Death #1: Evalin-Ali Mandza

<b>Age</b>	46
<b>Country of Origin</b>	Gabon
<b>Cause of Death</b>	Heart attack after egregious delays in calling 911 and referring Mr. Mandza to a higher-level provider.
<b>Date of Death</b>	April 12, 2012
<b>Detention Standards</b>	PBND 2008
<b>Non-Compliance with Detention Standards for Medical Care</b>	Section (II)(2): Meet healthcare needs in a timely and efficient manner; Section (II)(7): Timely transfer to an appropriate facility where care is available for individuals whose healthcare needs are beyond facility resources; Section (V)(O): Medical and safety equipment is available and maintained, and staff is trained in proper use of equipment.
<b>Length of Detention</b>	171 days
<b>Detention Facility</b>	Denver Contract Detention Facility, Aurora, CO
<b>Facility Operator</b>	GEO Group
<b>Facility Contract Type</b>	CDF

Evalin-Ali Mandza, a 46-year-old citizen of Gabon, died of a heart attack after receiving inexcusably delayed emergency care on April 12, 2012, after 171 days in custody at the Denver Contract Detention Facility (DCDF) in Aurora, Colorado. DCDF is operated by GEO Group.

On April 12, 2012, a code-blue emergency was activated at DCDF at approximately 5:24 a.m. when other detained individuals got an officer’s attention to report that Mr. Mandza was experiencing chest pain.<sup>23</sup> At approximately 5:50 a.m., a doctor was finally alerted to the situation, determined that Mr. Mandza needed to go to the emergency room, and directed a nurse to call 911.<sup>24</sup> However, the call was not placed to 911 until approximately 6:20 a.m., nearly one hour after the activation of the code-blue emergency.<sup>25</sup> This unconscionably long delay clearly violated ICE PBND 2008, which requires “detainees who need health care beyond facility resources to be transferred in a timely manner to an appropriate facility where care is available.”<sup>26</sup>

**The call to 911 also was delayed because medical staff prioritized filling out transfer paperwork rather than placing the call.**

Multiple other failures beyond the delays also occurred within that hour. Despite the fact that GEO’s nursing protocol for chest pain<sup>27</sup> requires vital signs to be taken every five minutes, Mr. Mandza’s vital signs were taken at 5:28 a.m. and then not again until 6:20 a.m.<sup>28</sup> Also, during this time an electrocardiogram (EKG) was performed, but the nurse performing the test was initially unable to get a reading because she was unfamiliar with the machine.<sup>29</sup> Then she performed the wrong test.<sup>30</sup> Once she performed the correct test, she was unable to interpret the results because she was not trained on the use of an EKG or in the interpretation of EKG test results.<sup>31</sup> Instead,

the nurse reports relying on her “gut instinct” to send Mr. Mandza to the hospital.<sup>32</sup> These are violations of ICE PBNDS requirements that medical and safety equipment be available and maintained, and that staff be trained in proper use of the equipment. The call to 911 also was delayed because medical staff prioritized filling out transfer paperwork rather than placing the call.<sup>33</sup>

The death review conducted by ODO contractor Creative Corrections found that DCDF medical staff were unfamiliar with the institution’s Chest Pain Protocol, that appropriate cardiac medication was not administered, and that there was a delay in transporting the patient to a higher-level care facility, “all of which may have been contributing factors to Mr. Mandza’s death.”<sup>34</sup> An IHSC review, included in the death review, similarly found that Mr. Mandza “did not have access

to appropriate medical care while detained in the DCDF.”<sup>35</sup>

Despite these documented failings, DCDF passed its ERO inspections immediately before and after Mr. Mandza’s death, including the medical standards with which the facility is found non-compliant in the death review. In the 2012 ERO inspection, there are two descriptions of Mr. Mandza’s death. These summaries are worryingly inaccurate, describing Mr. Mandza as being from Ghana rather than Gabon and failing to mention any concerns. Instead, inspectors state, “He received a timely and comprehensive medical and mental health screening and physical assessment, reported no significant past medical history and denied any significant risk factors for heart disease,”<sup>36</sup> effectively whitewashing the quality of medical care.



## Death #2: Amra Miletic

<b>Age</b>	47
<b>Country of Origin</b>	Bosnia-Herzegovina
<b>Cause of Death</b>	Complications of chronic bowel inflammation and heart arrhythmia after nearly two months of substandard care that failed to address Ms. Miletic’s rectal bleeding, vomiting, abdominal pain, and nausea.
<b>Date of Death</b>	March 20, 2011
<b>Detention Standards</b>	NDS
<b>Non-Compliance with Detention Standards for Medical Care</b>	Section (II)(2): Facilities will provide its detained population with initial medical screening, cost-effective primary medical care, and emergency care; Section (III)(D): All new arrivals shall receive initial medical and mental health screening immediately upon arrival by a healthcare provider or an officer trained to perform this function, and health appraisals and physical examinations will occur within 14 days of arrival in accordance with NCCHC and JCAHO standards.
<b>Length of Detention</b>	47 days
<b>Detention Facility</b>	Weber County Correctional Facility, Ogden, UT
<b>Facility Operator</b>	Weber County Sheriff’s Office
<b>Facility Contract Type</b>	USMS IGA

While detained for nearly two months, Ms. Miletic suffered from rectal bleeding, vomiting, abdominal pain, rapid weight loss, and nausea—conditions that ought to raise alarms even if experienced for a much shorter period

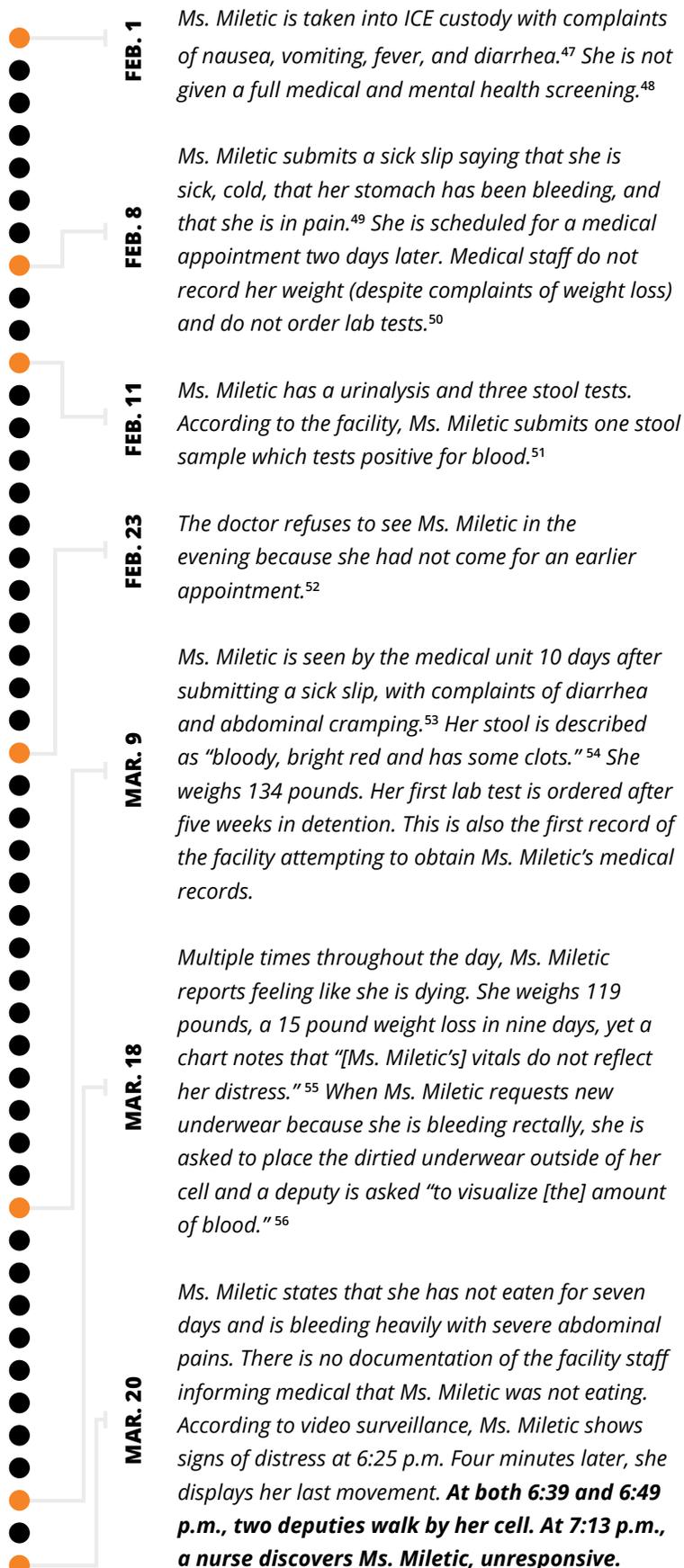
of time. Ms. Miletic, originally from Bosnia-Herzegovina, passed away on March 20, 2011, at the McKay Dee Hospital in Ogden, Utah, from “complications of chronic colitis and atrial fibrillation,”<sup>37</sup> or chronic bowel inflammation

## Fatal Timeline: Amra Miletic

and heart arrhythmia, after 47 days in ICE custody while detained at the Weber County Correctional Facility (WCCF). Colitis is an inflammation of the lining of the colon; it should not be fatal if treated properly. The review completed after her death concluded that “the WCCF was not in compliance with the ICE NDS Medical Care Standard,”<sup>38</sup> citing various egregious violations including failure to provide Ms. Miletic with immediate “off-site specialty care for her medical condition” after serious documented complaints of “rectal bleeding, nausea, vomiting, and diarrhea”<sup>39</sup> as well as failure to document missed meals (even while Ms. Miletic was on medical watch) or to note missed medication.<sup>40</sup>

Despite arriving with seven different medications and complaints of feeling sick and vomiting, Ms. Miletic was not given a full medical and mental health screening.<sup>41</sup> Within her first month at WCCF, Ms. Miletic also submitted three sick call slips (February 8, 21, and 26) with complaints of feeling sick, finding blood in her stool, lower abdominal pain, and a persistent fever.<sup>42</sup> In response, the medical staff prescribed Metamucil, hemorrhoidal suppositories, and Tylenol.<sup>43</sup> Although Ms. Miletic was becoming visibly sicker and thinner (losing 15 pounds in nine days)<sup>44</sup> and other detained women complained about her hygiene and smell due to her medical condition, the medical staff delayed placing Ms. Miletic under observation.<sup>45</sup> Even then, because there was no room in the medical segregation unit, Ms. Miletic was placed in a separate housing unit where no one noticed that she was unresponsive for almost 45 minutes,<sup>46</sup> clearly delaying her transfer to the hospital where she ultimately died.

Ms. Miletic had rectal bleeding for almost two months and yet she did not see a physician until 37 days after her arrival and lab tests



were not ordered until 11 days before she died. Despite a rapid, substantial weight loss and visual evidence that she was sick, WCCF's medical staff repeatedly failed to respond appropriately to the signs that Ms. Miletic's condition was deteriorating. Even while she was ostensibly under their observation, they failed to notice she was unresponsive for 45 minutes.

According to the doctor who was hired to conduct the mortality review as part of the death review, "this was a death that was preventable."<sup>57</sup> The consultant criticized the qualifications of WCCF's medical staff, writing "[c]ompetence in the practice of contemporary medicine

## No one noticed that she was unresponsive for almost 45 minutes.

and nursing must be questioned. The nursing staff, based on documentation, appears to be working outside the scope of nursing practice. There is a general lack of knowledge and application of the nursing triage process. ...The physician's lack of understanding of the urgency of colonoscopy and referral to emergency care begs to question his competency."<sup>58</sup> ERO and ODO inspections are not available for review.



### Death #3: Pablo Gracida-Conte

<b>Age</b>	54
<b>Country of Origin</b>	Mexico
<b>Cause of Death</b>	Mr. Gracida succumbed to cardiomyopathy, a treatable disease of the heart muscle. He died after four months of persistent requests for medical treatment that were ignored.
<b>Date of Death</b>	October 30, 2011
<b>Detention Standards</b>	PBND 2008
<b>Non-Compliance with Detention Standards for Medical Care</b>	Section (II)(2): Meet healthcare needs in a timely and efficient manner; Section (II)(7): Timely transfer to an appropriate facility where care is available for individuals whose healthcare needs are beyond facility resources.
<b>Length of Detention</b>	142 days
<b>Detention Facility</b>	Eloy Detention Center, Eloy, AZ
<b>Facility Operator</b>	Corrections Corporation of America (CCA)
<b>Facility Contract Type</b>	IGSA with the City of Eloy, AZ

Mr. Gracida died of heart disease after repeated failures to provide him with timely and efficient care. After four months of worsening, untreated medical problems, Mr. Gracida died on October 30, 2011, at the University of Arizona's University Medical Center in Tucson, Arizona. He became the 10th person since October 2003 to die while incarcerated at the 1,550-bed, CCA-run Eloy Detention Center in Eloy, Arizona.<sup>59</sup> The autopsy report states the cause of death for the 54-year-old as cardiomyopathy, a treatable disease of the heart muscle.<sup>60</sup>

During Mr. Gracida's 142 days in detention, he complained of ongoing health issues such as vomiting after every meal and extreme upper abdominal pain. Eloy staff had difficulty communicating with Mr. Gracida, who spoke Mixteco. Although the facility has access to telephonic interpreters and had ample time to find an interpreter, it never obtained one.<sup>61</sup> Mr. Gracida's long list of sick call requests reads as a desperate, repeated cry for help that was ignored until it was too late. *[See timeline on the following page]*

## Fatal Timeline: Pablo Gracida-Conte

●	<b>JUN. 10</b>	<i>ICE detains Mr. Gracida at Eloy.</i>
●	<b>JUL. 19</b>	<i>Mr. Gracida visits the medical clinic for vomiting and profuse sweating.</i>
●	<b>AUG. 10</b>	<i>Mr. Gracida reports decreased appetite and is examined by a registered nurse (RN) on August 12.</i>
●	<b>OCT. 5</b>	<i>An RN examines Mr. Gracida for complaints of nausea/vomiting, upper abdominal pain, and bloating.</i>
●	<b>OCT. 8</b>	<i>Mr. Gracida reports a 10 out of 10 pain level,<sup>62</sup> burning abdominal pain, and daily vomiting. Medical staff schedule laboratory tests which occur on October 11 and tell him to eat a bland diet.</i>
●	<b>OCT. 14</b>	<i>Mr. Gracida complains of headache, nausea, and vomiting. He reports an eight-out-of-10 pain level and that upper abdominal pain has kept him from sleeping for one month. An RN refers Mr. Gracida to a nurse practitioner (NP).</i>
●	<b>OCT. 18</b>	<i>Mr. Gracida reports that his nausea, vomiting, and diarrhea has subsided.</i>
●	<b>OCT. 22</b>	<i>Mr. Gracida appears at the medical unit with shortness of breath and reports an increased level of pain during meals, pain while lying down, and difficulty sleeping. When the licensed practical nurse (LPN) asks the NP to see Mr. Gracida because of his shortness of breath, the NP refuses. The LPN seeks assistance from an RN.<sup>63</sup> Later, Mr. Gracida refuses to receive his evening medications.</i>
●	<b>OCT. 23</b>	<i>Mr. Gracida requests to discontinue his medications because they make him feel ill and dizzy, and give him heartburn. He again refuses to take his medication.</i>
●	<b>OCT. 24</b>	<i>An RN examines Mr. Gracida and finds that he has an irregular heart rate, rapid respiratory rate, low blood pressure, and a weight gain of five pounds within six days. He complains of abdominal pain after taking his medications resulting in insomnia, poor appetite, and persistent weakness and dizziness. In addition, he discloses that he had a heart attack in 2000. The NP conducts an electrocardiogram (EKG), which is abnormal. Instead of referring Mr. Gracida to higher-level care, the NP schedules a follow-up visit for the next day after his court hearing, noting that he would be referred to cardiology if he remained in custody.<sup>64</sup></i>
●	<b>OCT. 25</b>	<i>Mr. Gracida is unable to complete a sentence without stopping to breathe. He has a second abnormal EKG and the facility finally refers him to the Casa Grande Regional Medical Center (CGRMC) Emergency Room. CGRMC diagnoses Mr. Gracida with severe cardiomyopathy and possible pneumonia.</i>
●	<b>OCT. 27</b>	<i>A CGRMC doctor notes that Mr. Gracida is ailing from complex cardiac issues and recommends transfer to the University Medical Center in Tucson (UMC).</i>
●	<b>OCT. 28-30</b>	<i>Mr. Gracida is admitted to UMC on October 28 and dies after transfer to the hospital's intensive care unit on October 30.</i>

**After Mr. Gracida's death, the ODO conducted a death review in December 2011 and concluded that:**

1. Eloy failed to provide medical care in accordance with PBNDS 2008.
2. Eloy's medical provider had failed to provide him with timely and efficient care. A doctor who participated in the ODO's death review concluded that "[Mr.] Gracida's death might have been prevented if the providers, including the physician at [Eloy], had provided the appropriate medical treatment in a timely manner."<sup>65</sup>
3. Eloy failed to send Mr. Gracida to the emergency room. In the ODO's investigation, a doctor stated that Mr. Gracida's condition on October 24 "should have been considered urgent, and he should have been referred to a cardiologist."<sup>66</sup>
4. Communication with Mr. Gracida happened only at a "very basic level." Although Spanish-speaking staff documented that Mr. Gracida spoke "very little Spanish," they never obtained a Mixteco interpreter.<sup>67</sup>
5. Language and cultural barriers were contributing factors in the failure to address Mr. Gracida's medical needs.

Despite these concerns, the ODO death investigator chose not to cite Eloy as non-compliant with ICE PBNDS standards related to interpretation assistance.<sup>68</sup> In addition, the ODO investigation uncovered evidence that Eloy staff were well aware of Mr. Gracida's deteriorating condition, revealing that a guard reported that Mr. Gracida had been vomiting after every meal.<sup>69</sup> The ODO death investigator expressed concern that at the time of review, Eloy did not have a clinical director, noting that an Eloy doctor stated that the clinic is understaffed and she "badly needs help."<sup>70</sup> In its investigation, the ODO states that Eloy had been without a clinical director for four of the five years it had been open; however, in its 2012 facility inspection, the ODO states that Eloy opened in 1994.<sup>71</sup> It is unclear how long the facility has been without a clinical director based on these documents.

Eloy passed its 2011 ERO and ODO inspections before Mr. Gracida's death.<sup>72</sup> Both the January 2012 ERO inspection

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and July 2012 ODO inspection mention his death, but do not identify any problems at Eloy. ODO inspectors claim that people at Eloy are seen for sick call in a timely manner and sick call slips are effectively and expediently triaged. They conclude that medical staffing is adequate; however, they also encourage Eloy to fill the clinical director position, which they claim had been vacant since May 2009, as soon as possible.<sup>73</sup> This assertion contradicts the ODO's statement that Eloy had been without a clinical director for the past four years. Remarkably, the ODO inspection claims that Mr. Gracida's death was the first death "to ever occur" at Eloy when, in fact, it was the 10th death at the facility.<sup>74</sup> Today, Eloy is known as the deadliest immigration detention center in the nation. Four years after Mr. Gracida's death, the facility still does not have a doctor on staff.<sup>75</sup> Recent deaths at the facility led Rep. Raúl Grijalva (D-AZ) to write a letter to DHS Secretary Jeh Johnson expressing alarm and calling for greater transparency of facility operations.<sup>76</sup> If ODO and ERO inspectors held Eloy to ICE detention standards for medical care, Mr. Gracida's death and possibly four other deaths since 2011 could have been prevented.<sup>77</sup>



Photo: Diane Ovalle of Puente



## Death #4: Anibal Ramirez-Ramirez

<b>Age</b>	35
<b>Country of Origin</b>	El Salvador
<b>Cause of Death</b>	Liver failure following failure to communicate critically important information, inadequate medical screenings, and inexcusable delays in referral to higher-level care.
<b>Date of Death</b>	October 2, 2011
<b>Detention Standards</b>	PBND 2008
<b>Non-Compliance with Detention Standards for Medical Care</b>	<p>Section (II)(2): Meet healthcare needs in a timely and efficient manner;            Section (II)(28) and (V)(B): Clinical decisions are the sole province of the clinical medical authority and in no event should clinical decisions be made by non-clinicians;</p> <p>Section (V)(I): Assessment of pain required;            Section (V)(O): Medical personnel must be immediately notified when emergency care may be required;</p> <p>Section (V)(C): Facilities required to develop written procedures governing management of administrative segregation units consistent with detention standards.</p>
<b>Length of Detention</b>	5 days (Mr. Ramirez-Ramirez was in ICE custody 2 days prior to his placement at ICAF)
<b>Detention Facility</b>	Immigration Centers of America – Farmville (ICAF), VA
<b>Facility Operator</b>	Immigration Centers of America, LLC
<b>Facility Contract Type</b>	IGSA

Failure to communicate critically important information, negligent medical screenings, and inexcusable delays in referral to higher-level care could have been contributing factors<sup>78</sup> to Anibal Ramirez-Ramirez’s death at the age of 35. Originally from El Salvador, Mr. Ramirez-Ramirez passed away from liver failure on October 2, 2011, seven days after entering ICE custody and five days after being processed into the privately operated Immigration Centers of America in Farmville, Virginia (ICAF).<sup>79</sup>

The narrative of the last week of Mr. Ramirez-Ramirez’s life is a chronicle of medical symptoms ignored or misinterpreted as non-cooperative behavior. The Virginia state troopers who initially took Mr. Ramirez-Ramirez into custody,<sup>80</sup> the magistrate before whom he appeared,<sup>81</sup> officers at the Prince William-Manassas Regional Adult Detention Center (PWMRAD),<sup>82</sup> and the officers who transported Mr. Ramirez-Ramirez to ICAF<sup>83</sup> all had evidence that something was very wrong. A state trooper report stated that Mr. Ramirez-Ramirez “dropped to the ground

and picked himself up on several occasions” and vomited at least three times in the patrol car.<sup>84</sup> While appearing before a magistrate, he defecated on himself and acted oddly enough that the judge made a note that he appeared ill.<sup>85</sup> At PWMRAD, Mr. Ramirez-Ramirez defecated on himself again and facility staff had to support him to keep him from falling when being taken to the shower.<sup>86</sup> During his transfer to ICAF, a driver reported hearing Mr. Ramirez-Ramirez dry heaving, and Mr. Ramirez-Ramirez repeatedly lay across the laps of other men being transferred.<sup>87</sup> None of this was relayed to staff at ICAF, a failure which was then compounded by inadequate care upon arrival there.

In its comprehensive review as part of the death review, ICE contractor Creative Corrections found that in addition to information about Mr. Ramirez-Ramirez’s vomiting, involuntary bowel movements, and extreme disorientation not being communicated upon transfer between facilities, the intake screening at ICAF was inadequate, and when

the nurses checked on Mr. Ramirez-Ramirez, they failed to take his vital signs.<sup>88</sup> They also concluded that the multiple delays in referring him to higher-level care may have contributed to Mr. Ramirez-Ramirez's death,<sup>89</sup> violating medical-care standards which require detainees' medical needs to be met in a timely manner.<sup>90</sup>

The ICE Health Services Corp (IHSC) investigation, also included in the death review, similarly lists several concerns about Mr. Ramirez-Ramirez's time at ICAF, including that he was placed on suicide watch for non-cooperative behavior during transfer early in the morning of September 29 but he was not scheduled to see a doctor until the afternoon of October 1,<sup>91</sup> despite several nurses raising concerns, including one nurse reporting her belief that Mr. Ramirez-Ramirez's behavior was not due to a "psychological issue but a medical issue."<sup>92</sup> IHSC investigators also note that he was monitored every two hours instead of every 15 minutes while on suicide watch.

Even more concerning, Creative Corrections inspectors document allegations that non-medical facility staff interfered with medical recommendations from nurses<sup>93</sup> violating standards which require clinical decisions to be the sole province of the clinical medical authority and never made by non-clinicians.<sup>94</sup> On October 1, a nurse requested access to Mr. Ramirez-Ramirez's cell in order to take his vital signs, but facility staff told her to wait since he was already scheduled to see a doctor 15 hours later.<sup>95</sup> When she insisted, she was told to take his vital signs through the slot in the solitary confinement cell door. She further insisted that he required a "higher level of medical care, including intravenous hydration and laboratory tests."<sup>96</sup> When she was finally allowed to take his vital signs, she discovered that he had a "perilously high" heart rate and recommended that he be transferred to emergency care. Instead, corrections staff decided to wait for the doctor's appointment 14 hours later. Mr. Ramirez-Ramirez never made this appointment; three hours later nurses called 911 after finding him lying on the ground with blood coming out of his mouth.<sup>97</sup>

Ultimately, after being transferred to the community hospital and then quickly airlifted to a larger regional

hospital, Mr. Ramirez-Ramirez died at 3:10 p.m., 10 minutes after his scheduled appointment with a psychiatrist, who would have been the first doctor ever to see him at ICAF.

The inspection which preceded Mr. Ramirez-Ramirez's death indicates that ICE was aware of the problems at ICAF. The ODO's April 2011 inspection found seven deficiencies, which included failing a mandatory component regarding staff responsiveness to medical emergencies.<sup>98</sup> ICE has not made ERO inspections prior to Mr. Ramirez-Ramirez's death publicly available; however, the October 2011 ERO inspection two days after Mr. Ramirez-Ramirez's death concluded that the facility did not meet standards,<sup>99</sup> though it did give ICAF a passing rating on its medical care. If these failings had been addressed during the six months between the ODO inspection and Mr. Ramirez-Ramirez's death, then Mr. Ramirez-Ramirez would likely have received the care he critically needed in a timely manner.

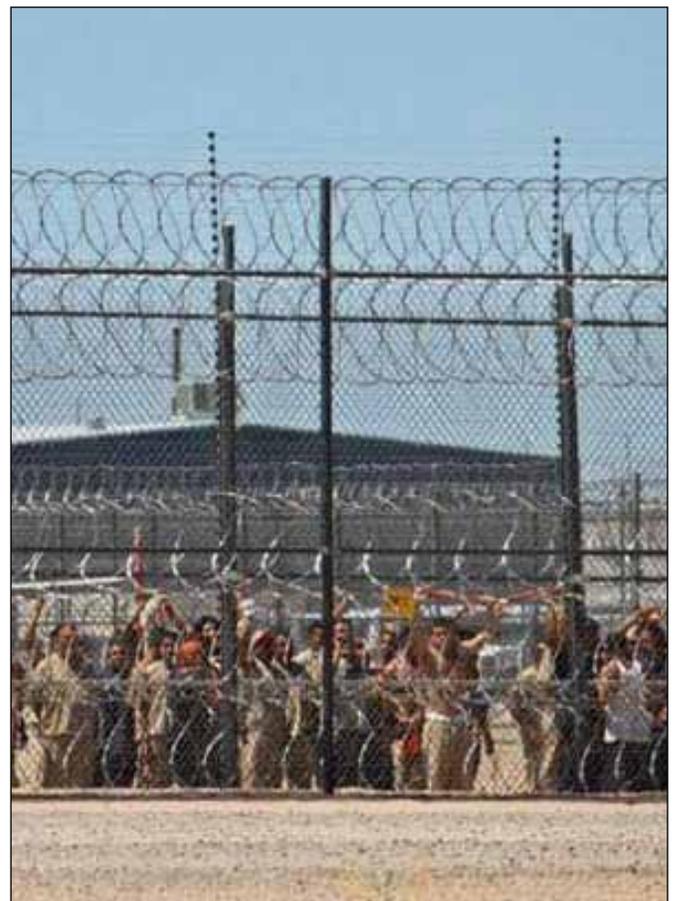


Photo: Diane Ovalle of Puente



## Death #5: Irene Bamenga

<b>Age</b>	29
<b>Country of Origin</b>	France
<b>Cause of Death</b>	Ms. Bamenga died after being given the incorrect dosages of medication. Although the death certificate indicates that cardiomyopathy was the immediate cause of death, a doctor reviewing Ms. Bamenga’s death questioned this conclusion.
<b>Date of Death</b>	July 27, 2011
<b>Detention Standards</b>	NDS
<b>Non-Compliance with Detention Standards for Medical Care</b>	Section (I): Access to medical services that promote detainee health and general well-being; Section (III)(D): all new arrivals shall receive tuberculosis screening; Section (III)(F): healthcare provider shall review request slips and determine when detainees will be seen.
<b>Length of Detention</b>	12 days
<b>Detention Facility</b>	Albany County Corrections Facility, Albany, NY
<b>Facility Operator</b>	Albany County Sheriff’s Office
<b>Facility Contract Type</b>	USMS IGA

Ms. Bamenga’s case—which is currently the subject of a wrongful death lawsuit filed by her widower<sup>100</sup>—is painfully straightforward. After only 12 days in ICE custody, the French citizen died after being given the incorrect dosages of medication. She passed away on July 27, 2011,<sup>101</sup> at the Albany Memorial Hospital in Albany, New York.<sup>102</sup> The certificate of death lists the immediate cause of death as cardiomyopathy<sup>103</sup> although the mortality review report conducted by a doctor<sup>104</sup> as part of the death review questions this conclusion.<sup>105</sup> The August 2011 death investigation following Ms. Bamenga’s death revealed “the [Allegany County Jail] (ACJ) and the [Albany County Correctional Facility] (ACCF) were not in compliance with the ICE NDS, Medical Care [Standard],”<sup>106</sup> including specific complaints that the ACCF and ACJ “failed to dispense ordered medications, delayed in starting medications, failed to verify medications, and provided incorrect dosing of medications.”<sup>107</sup>

Ms. Bamenga was consecutively held at two different facilities— first at the ACJ in Belmont, New York, for five days and then ACCF in Albany, New York, for the remaining seven days. ODO identified substandard care in both facilities.

Ms. Bamenga did not begin receiving medication at ACJ until her fourth day in detention.<sup>108</sup> Despite Ms. Bamenga submitting two health-services request forms at ACCF in the days preceding her death,<sup>109</sup> the ACCF medical staff did not take steps to address Ms. Bamenga’s concerns or deteriorating condition.<sup>110</sup> The first request on July 25, 2011, stated: “I am not being given the full dosage of my medications. Two of the six different meds are meant to be take [sic] twice a day and so far I have only be[en] given 1 dosage in the morning.” The second request reported “[s]hortness of breath at night especially when laying down, palpitations when laying down. Dizziness upon standing up when palpitation and shortness of breath occur.” This was exacerbated by ACCF medical staff administering incorrect medicine dosages—both in missed and excessive dosages—which contributed directly to Ms. Bamenga’s death.<sup>111</sup> In fact, on the morning of July 27, 2011, before Ms. Bamenga was found unresponsive in her jail cell, an ACCF nurse practitioner gave Ms. Bamenga a physical assessment and found nothing wrong even though Ms. Bamenga insisted that she was receiving incorrect medicine dosages.<sup>112</sup> Upon reviewing the symptoms noted in Ms. Bamenga’s medical file, a doctor participating in the death review

states that Ms. Bamenga’s death could have resulted from a cardiac arrhythmia brought on by “digoxin toxicity and alterations in potassium levels” due to incorrectly prescribed high dosages of her medications.<sup>113</sup> According to the doctor, “missed medication dosing as well as incorrect medication dosing were significant factors that contributed to the decompensation of [Ms. Bamenga’s] congestive heart failure.”<sup>114</sup> Regardless, the doctor concludes that, even if “this patient’s death was indeed [caused by] cardiomyopathy due to congestive heart failure, then this death could have been prevented if the appropriate steps were taken to determine the severity of her congestive heart failure followed by an appropriate

treatment plan to control her cardiac condition.”<sup>115</sup>

ERO and ODO inspections were not available for either facility around the time of Ms. Bamenga’s death. Administering untimely and incorrect dosages of medication, especially for life-threatening conditions like congestive heart failure, is an obvious violation of even the outdated detention standards that ICE applied to ACCF.<sup>116</sup> Ms. Bamenga’s death is a clear failure by ACJ and ACCF medical staff to treat Ms. Bamenga’s worsening condition and to appropriately medicate her for a known medical condition.



## Death #6: Fernando Dominguez-Valdivia<sup>117</sup>

<b>Age</b>	58
<b>Country of Origin</b>	Mexico
<b>Cause of Death</b>	Pneumonia, a preventable and treatable illness, following facility failures to perform proper physical examinations and provide timely and appropriate access to off-site treatments.
<b>Date of Death</b>	March 4, 2012
<b>Detention Standards</b>	PBND 2008
<b>Non-Compliance with Detention Standards for Medical Care</b>	“Failure to perform proper physical examinations in response to symptoms and complaints, failure to pursue any records critical to continuity of care, and failure to facilitate timely and appropriate access to off-site treatments” <sup>118</sup> (specific standards not cited within ODO inspection).
<b>Length of Detention</b>	82 days
<b>Detention Facility</b>	Adelanto Detention Facility, Adelanto, CA
<b>Facility Operator</b>	GEO Group
<b>Facility Contract Type</b>	IGSA

Mr. Dominguez-Valdivia contracted pneumonia—a preventable and treatable illness—during his 82 days in immigration detention, but died from it after receiving what ODO described as an “unacceptable level of medical care.”<sup>119</sup> He passed away on March 4, 2012, at the Victor Valley Community Hospital in Victorville, California. Originally from Mexico, Mr. Dominguez was 58 years old at the time and had been detained at the Adelanto Detention Facility (ADF) in Adelanto, California, since November 26,

2011. The autopsy report, according to the 2012 ERO inspection of ADF, lists the cause of death as “multi-organ failure due to sepsis, due to bronchopneumonia and chronic alcoholic liver disease.”<sup>120</sup>

In the three months leading up to his death, Mr. Dominguez-Valdivia was taken to the hospital twice with “complaints of dizziness.” He was subsequently given a “stress test and an echocardiogram” but there was “no

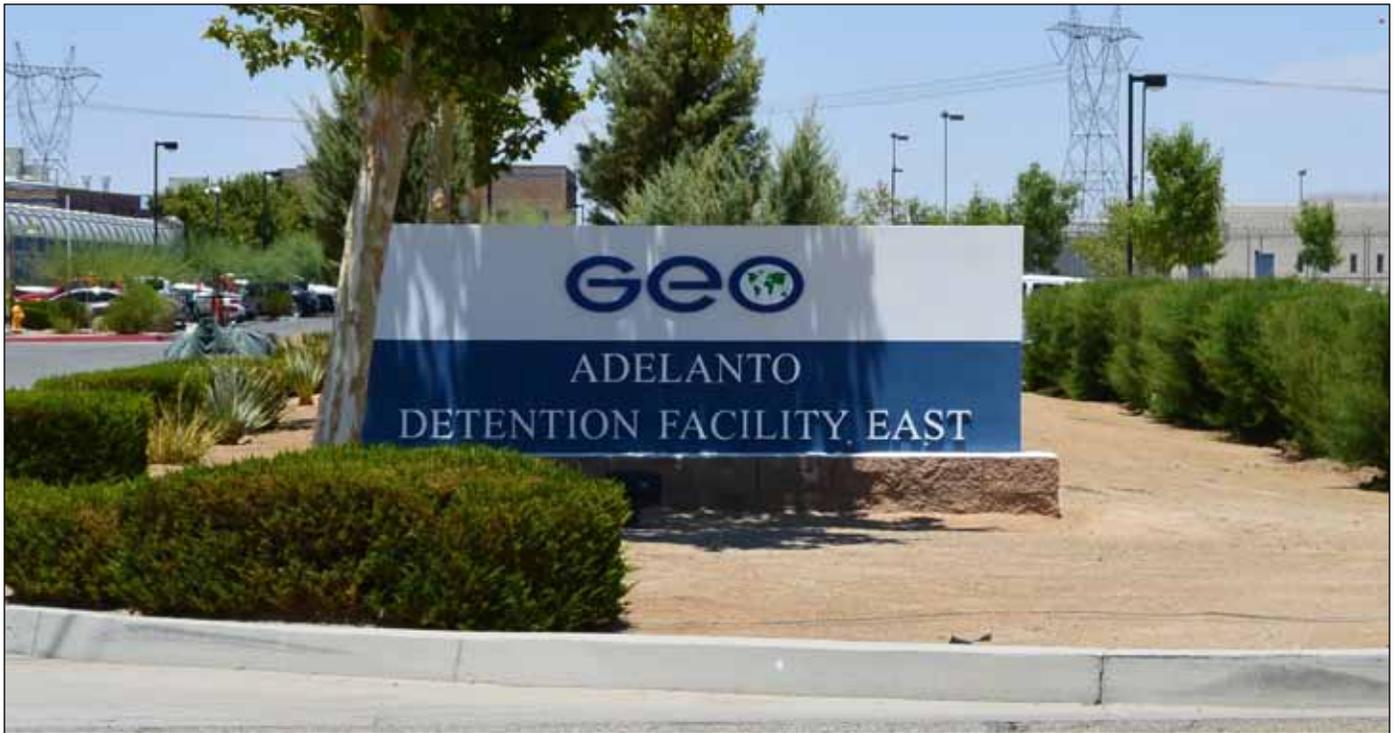


Photo: Christina Fialho

definitive diagnosis.”<sup>121</sup> On the morning of February 16, 2012, a nurse administering medications observed Mr. Dominguez in the housing unit. It is unclear what she observed, but Mr. Dominguez was taken to the medical department with complaints of “dizziness, tiredness and weakness.”<sup>122</sup> He was later admitted to the emergency room at the Victor Valley Community Hospital where he died.

According to the 2012 ODO inspection of ADF, a death review was conducted after Mr. Dominguez’s death. The death review is not publicly available; it was one of four that remained incomplete at the time of ACLU’s FOIA request. The ACLU submitted a follow-up request for these reviews, but ICE denied the organization’s request for expedited processing, claiming that there is no “urgency to inform your limited audience about past ICE actions” and that the information in Mr. Dominguez’ death review would not “have a bearing on immediate or resultant future situations.” Because it is not clear when ICE will produce the full death review, report authors have instead relied on a summary of the death review in the 2012 ODO inspection. The review found that ACF<sup>123</sup> medical staff failed to provide adequate health care to [Mr. Dominguez], and failed to comply with the requirements

of the ICE PBNDS 2008. The death review disclosed several egregious errors committed by ACF medical staff in Mr. Dominguez’s case, including “failure to perform proper physical examinations in response to symptoms and complaints, failure to pursue any records critical to continuity of care, and failure to facilitate timely and appropriate access to off-site treatments.”<sup>124</sup> The death review summary concludes that Mr. Dominguez’s death “could have been prevented and that [he] received an unacceptable level of medical care while detained at ACF.”<sup>125</sup>

Despite this unambiguous finding of medical neglect by ODO, ADF passed its October 2012 ERO inspection later that year following Mr. Dominguez’s death. However, ADF had failed the 2011 ERO inspection prior to Mr. Dominguez’s death<sup>126</sup> because of a deficient mandatory medical standard component. The component required health appraisals and physical examinations to be performed within 14 days of arrival, and review of 25 medical records showed that this was not being done.<sup>127</sup> The summary of Mr. Dominguez’s death review demonstrates that this and other fatal deficiencies persisted, making it even more troubling that ADF passed its 2012 inspection.



## Death #7: Victor Ramirez-Reyes

Age	56
Country of Origin	Ecuador
Cause of Death	Heart disease after health care providers failed to monitor and control Mr. Ramirez's blood pressure.
Date of Death	September 26, 2011
Detention Standards	PBND 2008
Non-Compliance with Detention Standards for Medical Care	Section (V)(F): Accountability for administering or distributing medications in a timely manner and according to licensed provider orders; Section (II)(5): Timely follow-up to healthcare requests
Length of Detention	20 days
Detention Facility	Elizabeth Detention Center, Elizabeth, NJ
Facility Operator	CCA
Facility Contract Type	CDF

Victor Ramirez-Reyes died of heart disease—a treatable condition—after health care providers delivered grossly substandard care by failing to monitor and control Mr. Ramirez's blood pressure. The 56-year-old Ecuadorian died on September 26, 2011, at Trinitas Hospital in Elizabeth, New Jersey, following 20 days in ICE custody at the CCA-run Elizabeth Detention Center in New Jersey. According to the New York State Medical Examiner, the immediate cause of death was hypertensive and atherosclerotic cardiovascular disease, or heart problems related to high blood pressure and plaque buildup of the arteries.<sup>128</sup>

Despite Mr. Ramirez's disclosure at his initial interviews with ICE and subsequent interview with Elizabeth medical staff that he had a medical history of high blood pressure, medical staff did not properly monitor his vital signs to ensure his blood pressure was under control. Mr. Ramirez received double doses of his medications on a daily basis because medical staff did not follow proper protocols.<sup>129</sup> A sick call slip submitted by Mr. Ramirez was not forwarded to medical staff scheduled to see him. Consequently, medical staff failed to address the symptoms documented on the slip, including trouble breathing.<sup>130</sup> On the morning of Mr. Ramirez's death, he collapsed after receiving his medication. Cardiopulmonary resuscitation and use of an

### Medical staff did not properly monitor Mr. Ramirez's vital signs.

automated external defibrillator machine did not begin until emergency medical technicians arrived approximately 10 minutes later.<sup>131</sup> A doctor declared Mr. Ramirez dead nearly an hour later, after he arrived at the hospital.

The ERO and ODO inspections after Mr. Ramirez's death draw mutually inconsistent conclusions about the quality of care at Elizabeth. ERO's October 2011 inspection occurred 22 days after Mr. Ramirez's death. The inspection notes his death, but does not flag any areas of concern about the quality of medical care. In fact, the ERO inspectors found the facility in compliance with all 66 medical standards reviewed. The inspectors note that the health services unit is "appropriately" staffed and provides coverage 24 hours a day, seven days a week.<sup>132</sup> At the time of inspection, the facility was in the process of expanding, making it even more critical to identify and address existing deficiencies.<sup>133</sup> It is troubling that Elizabeth's November 2011 expansion was allowed to continue given Mr. Ramirez's death and the clear failure to improve the quality of medical care.<sup>134</sup>



Photo: American Friends Service Committee Immigrant Rights Program

In contrast, the January 2012 ODO inspection found 22 deficiencies. Four of the deficiencies are for failure to meet PBNDS medical care standards related to inadequate medical staffing and failure to provide timely and appropriate medical care.<sup>135</sup> ODO notes that staffing levels are “inadequate to address the health care needs of the detainee population” and that the staff vacancy rate is particularly concerning given that the facility does not have an on-site physician or weekend provider coverage.<sup>136</sup>

The ODO inspection does not mention Mr. Ramirez’s death, but it does identify a case very similar to Mr. Ramirez’s in which an individual also reported a history

of hypertension and was not given appropriate care. Although this second case occurred less than one month after Mr. Ramirez’s death, the facility made the same mistakes that led to Mr. Ramirez’s death. For instance, healthcare providers did not refer the individual to higher-level care or to an external provider despite the person’s having a “dangerously” high blood pressure for more than 24 hours.<sup>137</sup> Although this second individual was released, it is deeply concerning that Elizabeth had not made changes to its medical procedures to address the flaws that led to Mr. Ramirez’s death. It is unclear whether ICE has addressed all medical-care deficiencies because ICE has not publicly released more recent inspections.



## Death #8: Mauro Rivera Romero

<b>Age</b>	43
<b>Country of Origin</b>	El Salvador
<b>Cause of Death</b>	Disseminated cryptococcosis, an infection associated with immune-suppressed individuals, following inadequate medical screenings, failure to transfer critical medical information, and failure to timely address Mr. Rivera’s medical issues and refer him to a higher-level provider.
<b>Date of Death</b>	October 5, 2011
<b>Detention Standards</b>	PBNDS 2008
<b>Non-Compliance with Detention Standards for Medical Care</b>	Section (II)(2): Meet healthcare needs in a timely and efficient manner
<b>Length of Detention</b>	3 days
<b>Detention Facility</b>	El Paso Processing Center, El Paso, TX
<b>Facility Operator</b>	ICE, Doyon-Akal JV oversees the detained population. <sup>138</sup>
<b>Facility Contract Type</b>	SPC

Negligent medical screening and failure to transfer critical medical information led to Mauro Rivera Romero’s death from an infection at the age of 43. Mr. Rivera, a Salvadoran citizen, died on October 5, 2011, at the Del Sol Medical Center in El Paso, Texas, following three days in detention at the El Paso Processing Center (EPC). The County of El Paso Office of the Medical Examiner found that the cause of death was disseminated cryptococcosis, an infection associated with immune-suppressed individuals.<sup>139</sup>

The ODO investigation of Mr. Rivera’s death found that medical personnel at EPC failed to review information in Mr. Rivera’s medical record, and should have referred Mr. Rivera to a higher-level medical care provider. The ODO also found that important medical information was not transferred from U.S. Border Patrol when Mr. Rivera was taken into ICE custody, and that EPC medical staff consistently failed to properly document his medical encounters.<sup>140</sup> The ODO notes that Mr. Rivera’s death could have been prevented if he had accepted medical care from Border Patrol or disclosed earlier that he was HIV positive.<sup>141</sup> However, individuals with HIV are typically hesitant to disclose their status due to the stigma associated with the disease. Though the ODO death review

does not examine this possibility, a thorough and private screening process sensitive to this dynamic may have been able to induce Mr. Rivera to disclose his HIV status during his initial screening. Regardless, the ODO found that EPC failed to provide adequate care in several instances. *[See timeline on the following page]*

The ODO concluded that EPC failed to comply with PBNDS requiring healthcare needs to be met in a timely and efficient manner. Although the ODO does not cite failure to follow up with Mr. Rivera’s doctor following his October 2 screening as a technical deficiency, it acknowledges that such lack of action compromised Mr. Rivera’s initial medical screening and missed “an opportunity to obtain more accurate medical history critical to his care.”<sup>142</sup>

The inspections process failed to meaningfully address inadequate medical care beforehand or account for failure to provide adequate care afterwards. For example, the 2010 ODO inspection cites interviews with people in detention who complained about the facility’s medical care, specifically that “the wait to receive medical care after submitting a sick call request is too long, that medical personnel complain about detainees having medical

## Fatal Timeline: Mauro Rivera Romero

problems, and that there is a lack of attention to detainee complaints about pain.”<sup>143</sup> The September 2011 ERO inspection gave EPC passing ratings on medical care, although it found one deficiency related to dental care.<sup>144</sup>

EPC passed its September 2012 ERO inspection.<sup>145</sup> Similar to the 2011 ERO inspection, it finds no deficiencies with EPC’s medical care. In addition to the ERO inspections, ODO inspected EPC in March 2012 – just five months after Mr. Rivera’s death – but failed to mention his death in the report and did not identify any deficiencies with medical care. If ODO and ERO inspections properly documented and investigated medical care failures at detention facilities, Mr. Rivera’s death may well have been prevented.

● **OCT. 1**

*Border Patrol apprehends Mr. Rivera aboard a Greyhound bus at a checkpoint in Texas. Mr. Rivera reports experiencing stomach pains and nausea and states that he had been diagnosed with a stomach infection and released from a hospital on Sept. 29. He declines Border Patrol medical care and is transferred to EPC.*

● **OCT. 2**

*Mr. Rivera discloses at his initial medical screening that he had been hospitalized in 2011 for gastritis (related to stomach inflammation), but could not remember the medication he was prescribed for his condition.*

● **OCT. 3**

*During Mr. Rivera’s first sick visit to the medical unit, a registered nurse (RN) finds that he has an elevated pulse of 129, but fails to refer Mr. Rivera for review by a higher-level provider.<sup>146</sup>*

● **OCT. 3-4**

*Mr. Rivera submits written complaints on three separate occasions regarding his ailments, including abdominal discomfort and his inability to walk. Despite the seriousness of these complaints, approximately 24 hours pass between Mr. Rivera’s first complaint and when he was first seen for treatment.<sup>147</sup>*

● **OCT. 5**

*Mr. Rivera dies.*



Photo: Diane Ovalle of Puente

# Conclusion

Deaths in detention are the most egregious and permanent consequence of an unaccountable and negligent immigration detention system. DWN, NIJC, and ACLU's review of deaths that occurred from 2010 to 2012 provide new evidence that ICE inspections fail to hold detention centers accountable. The difficulties that the ACLU has experienced in obtaining additional deaths reviews demonstrate that DHS's culture of secrecy persists. Based on the findings in this report, the ACLU, DWN, and NIJC call on DHS and ICE to:

## **1. Immediately reduce immigration detention.**

- a. Release people with serious medical and mental health needs, particularly when individuals require higher-level care.
- b. Immediately terminate contracts for facilities with repeated preventable deaths, such as the Eloy Detention Center in Arizona.
- c. Shift current funding for detention to community-based alternatives, which will allow people to seek medical attention and receive support from family, legal counsel, and community.
- d. Apply current ICE detention standards to all facilities used by ICE and discontinue contracts where current standards are not being met.

## **2. Improve delivery of medical care in detention.**

- a. Revise PBNDS 2011 to require that medical care providers be held responsible for meeting the health care needs of individuals in ICE custody as opposed to simply providing "access" to health care.
- b. Revise PBNDS 2011 medical care standards to meet or exceed all analogous NCCHC standards for prison and jail health care.
- c. End the use of private for-profit detention facilities and for-profit medical care sub-contractors. Instead, ensure that IHSC is the direct health care provider at all immigration detention facilities.
- d. Remove IHSC from ICE supervision to maintain clinical independence and independent oversight.
- e. Ensure all detention facilities have appropriate clinical staffing plans, and include whether or not positions are filled as a compliance component during ERO and ODO inspections.

## **3. Ensure inspections provide meaningful oversight.**

- a. Improve the inspections process by ensuring that inspections are more effectively used to hold facilities accountable, as set forth in the appendix.
- b. Require ERO and ODO inspectors to read the death review documents for all deaths that have occurred at a given facility under inspection, and explicitly and publicly report on whether the issues raised in the death reviews have been addressed.
- c. In response to each death where an ODO death review identifies violations of ICE standards, concludes the death was preventable, or identifies other areas of concern, require ERO and IHSC to develop a corrective action plan with clear deadlines to reduce the risk of future deaths or other significant events, and to provide those corrective action plans to ODO.

## **4. Increase transparency of inspections, deaths, and serious medical incidents in detention.**

- a. Make the inspections process more transparent by making ERO inspections, ODO inspections, and ODO death reviews available to the public within three months of being finalized, and by providing regular public and congressional reporting on the frequency and circumstances of sentinel events (as defined by the Joint Commission<sup>148</sup>) in detention.
- b. Require ICE to publish all death reviews that occur, including by the Office of Inspector General and Office for Civil Rights and Civil Liberties.
- c. Create an independent medical advisory committee to investigate deaths that occur in detention.

# Appendix

In addition to the recommendations provided in the conclusion, inspections recommendations from DWN and NIJC's inspections report, *Lives in Peril* are included below, recognizing the need for meaningful, robust reforms to ICE's inspections system:<sup>149</sup>

## **1. Increase Transparency and Oversight of the Inspections Process**

- a. Make ERO and ODO inspections available to the public in a timely manner. To date, ICE has released its inspections to the public only as a result of FOIA requests. FOIA requests are unnecessarily time-consuming and expensive obstacles to accessing information about how the federal government treats thousands of people in its custody and spends billions of taxpayer dollars. Instead, this information should be freely available.
- b. Provide public reporting on suicide attempts, hunger strikes, work program stoppages, use of solitary confinement, use of force, and other significant events at detention centers.
- c. Submit quarterly reporting to Congress on inspection and oversight activities of detention facilities, which should be made publicly available.

## **2. Improve the Quality of Inspections**

- a. Establish a DHS ombudsman outside of ICE to conduct unannounced inspections of immigration detention facilities at least once per year, with complete findings made available to the public. These third-party inspections should examine compliance with applicable detention standards and determine whether contracts will be renewed in accordance with congressional appropriations requirements.
- b. Prohibit facilities from taking an "à la carte" approach to compliance and make all detention standards provisions mandatory during inspections. ICE must stop permitting some facilities to opt out of detention standards they have been contracted to apply. If a facility cannot abide by detention standards in their entirety then it should not be permitted to enter into or continue a contract with ICE.
- c. Ensure that inspections involve more than checklists. Inspectors must rely on more than assurances by jail administrators of compliance with detention standards and instead seek and document proof of their effective implementation.
- d. Engage detained immigrants during inspections, as well as other stakeholders such as legal service providers and those who regularly conduct visitation, in order to capture the range of concerns at a facility that may not be reported through formal institutional channels. Inspectors should document the content of those interviews.

## **3. Institute Consequences for Failed Inspections**

- a. Place detention facilities on probation and subject them to more intensive inspections after the first finding of substantial non-compliance.
- b. Terminate contracts within 60 days for those facilities with repeat findings of substantial non-compliance, including inadequate or less than the equivalent median score in two consecutive inspections.

# Endnotes

1. Nina Bernstein, "Officials Hid Truth of Immigrant Deaths in Jail," *The New York Times*, Jan. 9, 2010, available at: <http://www.nytimes.com/2010/01/10/us/10detain.html>; Dana Priest & Amy Goldstein, "System of Neglect," *The Washington Post*, May 11, 2008, available at: [http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc\\_d1p1.html](http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc_d1p1.html).
2. Id.
3. Detention Watch Network and National Immigrant Justice Center, *Lives in Peril: How Ineffective Inspections Make ICE Complicit in Immigration Detention Abuse*, Oct. 2015, available at: <http://immigrantjustice.org/sites/immigrantjustice.org/files/THR-Inspections-FOIA-Report-October-2015-FINAL.pdf> [hereinafter "Lives in Peril"].
4. *The New York Times*, *In Custody Deaths*, available at: [http://topics.nytimes.com/top/reference/timestopics/subjects/i/immigration\\_detention\\_us/incustody\\_deaths/index.html](http://topics.nytimes.com/top/reference/timestopics/subjects/i/immigration_detention_us/incustody_deaths/index.html) (collecting reporting on deaths); Nina Bernstein, "U.S. to Reform Policy on Detention of Immigrants," *The New York Times*, at A1, Aug. 5, 2009, available at: <http://www.nytimes.com/2009/08/06/us/politics/06detain.html>.
5. Since then, the ACLU has issued two FOIA requests seeking additional death reviews, including the four investigations that were still in progress at the time of the original FOIA request. ICE has not yet produced documents in response to either of the new FOIA requests, and responded to each by claiming, among other things, that the ACLU had not established "why you feel there is an urgency to inform your limited audience about past ICE actions [i.e., deaths in ICE custody]," concluding that the FOIA request would not make a "significant" contribution to public understanding of government operations or activities, and further concluding that the FOIA request was "primarily in the commercial interest" of the ACLU. The ACLU has filed an administrative appeal with the ICE Office of the Principal Legal Advisor and is awaiting the results of this appeal.
6. For more information about the creation of the ODO, see U.S. Department of Homeland Security (DHS), Written testimony of U.S. Immigration and Customs Enforcement Office of Detention Policy and Planning Assistant Director Kevin Landy for a House Committee on the Judiciary, Subcommittee on Immigration Policy and Enforcement hearing on Performance-Based National Detention Standards (PBNDS) 2011 (Mar. 27, 2012), available at: <http://www.dhs.gov/news/2012/03/27/written-testimony-us-immigration-and-customs-enforcement-house-judiciary>.
7. U.S. Immigration & Customs Enforcement (ICE), *2011 Operations Manual ICE Performance-Based National Detention Standards*, available at: <https://www.ice.gov/detention-standards/2011>.
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11. National Immigrant Justice Center, *Freedom of Information Act Litigation Reveals Systemic Lack of Accountability in Immigration Detention Contracting, Aug. 2015*, available at: <http://immigrantjustice.org/sites/immigrantjustice.org/files/images/NIJC%20Transparency%20and%20Human%20Rights%20Project%20August%202015%20Report%20FINAL3.pdf>, p. 6.
12. Department of Homeland Security Appropriations Act, 2010, H.R. 2892, P.L. 111-83, 111th Cong., available at: <https://www.gpo.gov/fdsys/pkg/PLAW-111publ83/pdf/PLAW-111publ83.pdf>, p. 9.
13. Megan Granski, Allen Keller & Homer Venters, *Death Rates among Detained Immigrants in the United States*, *International Journal of Environmental Research and Public Health*, Nov. 2015.
14. According to ICE's 2016 list of deaths in custody, there were five suicides during the Obama Administration. The authors counted Jose Nelson Reyes-Zelaya's July 2010 death as the sixth suicide because initial reports from ICE and news outlets indicate that the death was a suicide. The 2012 ICE list of deaths in custody indicates Mr. Reyes-Zelaya's death was due to asphyxia, but ICE changed the cause of death in more recent lists to "Cancer." ICE, *List of Deaths in ICE Custody: October 2003-January 25, 2016*, Accessed Jan. 26, 2016, available at: <https://www.ice.gov/sites/default/files/documents/Report/2016/DetaineeDeaths2003Jan2016.pdf> [hereinafter "ICE Deaths List 2016"]; ICE, *List of Deaths in ICE Custody, October 2003-December 6, 2012*, available at: <http://immigrantjustice.org/sites/immigrantjustice.org/files/Detainee%20Deaths%20in%20ICE%20Custody%202003-2012.pdf>; Seth Freed Wessler, *Salvadoran Man Commits Suicide in Immigration Detention*, *Colorlines*, Jul. 21, 2010, <http://www.colorlines.com/articles/salvadoran-man-commits-suicide-immigration-detention>; *Man Held on Immigration Charges Dies in Orleans Prison*, *The Times-Picayne*, Jul. 18, 2010, available at: [http://www.nola.com/crime/index.ssf/2010/07/man\\_held\\_on\\_immigration\\_charge.html](http://www.nola.com/crime/index.ssf/2010/07/man_held_on_immigration_charge.html).
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16. Qi Gen Guo (died 2/23/2011, detained at Clinton County Correctional Facility, Pennsylvania): The ODO concluded that the facility was in compliance with ICE NDS; however, the ODO noted that the facility did not meet NDS standards related to intake screening, communication during medical evaluation and examinations, completion of thorough physical examination, medical visits in Special Management Unit, and documentation of refusal of medications. DHS, *Death Investigation for Qi Gen Guo*, Jun. 16, 2011, <https://www.documentcloud.org/documents/2698743-Guo-Qi-Gen.html>, pp. 12-13. Jose Aguilar-Espinoza (died 1/31/2011, detained at Theo Lacy Facility, California): The ODO found that the facility was not compliant with PBNDS on medical care, specifically the initial screening form was incomplete, consent forms were not adequately documented, and a physical exam was not completed. DHS, *Death Investigation for Jose Aguilar-Espinoza, Mar. 6, 2012*, available at: <https://www.documentcloud.org/documents/2698802-Aguilar-Espinoza-Jose.html>, pp. 11-12. Ricardo Rojas-Martinez (died 12/19/2011, detained at Houston Contract Detention Facility, Texas): The ODO identified issues with clinical processes that require improvement. DHS, *Death Investigation for Ricardo Rojas-Martinez*, Aug. 16, 2012, available at: <https://www.documentcloud.org/documents/2698740-Rojas-Martinez-Ricardo.html>, pp. 147-148.

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23. DHS, *Death Investigation for Evalin-Ali Mandza*, Oct. 2012, available at: <https://www.documentcloud.org/documents/2695514-Mandza-Evalin-Ali.html>, pp. 153-164 (describes timeline of events) [hereinafter "Mandza."]
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31. Id., available at: <https://www.documentcloud.org/documents/2695514-Mandza-Evalin-Ali.html#document/p12/a273179>, p. 12.
32. Id., available at: <https://www.documentcloud.org/documents/2695514-Mandza-Evalin-Ali.html#document/p19/a273180>, p. 19.
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34. Id., available at: <https://www.documentcloud.org/documents/2695514-Mandza-Evalin-Ali.html#document/p16/a273194>, p. 16.
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37. Miletic, available at: <https://www.documentcloud.org/documents/2695509-Miletic-Amra.html#document/p134/a273127>, p. 134 (State of Utah, Department of Health, Office of the Medical Examiner Report).
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41. Non-compliance with ICE NDS, Medical Care, section (III)(D), Medical Screening (New Arrivals); Miletic, available at: <https://www.documentcloud.org/documents/2695509-Miletic-Amra.html#document/p149/a273141>, p. 149.
42. Miletic, available at: <https://www.documentcloud.org/documents/2695509-Miletic-Amra.html>, pp.75-77.
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44. Id., available at: <https://www.documentcloud.org/documents/2695509-Miletic-Amra.html#document/p28/a273146>, p. 28.
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46. Id., available at: <https://www.documentcloud.org/documents/2695509-Miletic-Amra.html#document/p22/a273147>, p. 22.
47. Id., available at: <https://www.documentcloud.org/documents/2695509-Miletic-Amra.html>, pp. 148-149.
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59. ICE Deaths List 2016.
60. DHS, *Death Investigation for Pablo Gracida-Conte*, Aug. 15, 2012, available at: <https://www.documentcloud.org/documents/2695513-Gracida-Conte-Pablo.html#document/p1/a272669>, p. 1 [hereinafter “Gracida.”]
61. Non-compliance with PBNDS 2008, Medical Care, section (II)(37) or section (V)(I), require translation assistance for non-English speaking detainees; Gracida, available at: <https://www.documentcloud.org/documents/2695513-Gracida-Conte-Pablo.html#document/p14/a272707>, p. 14.
62. Health professionals use this pain scale as a way to measure pain. Ten describes the worst pain the person has ever known.
63. Non-compliance with PBNDS 2008, Medical Care, section (II)(2) requiring that health care needs be met in a timely and efficient manner; Gracida, available at: <https://www.documentcloud.org/documents/2695513-Gracida-Conte-Pablo.html#document/p13/a272770>, p. 13.
64. Non-compliance with PBNDS 2008, Medical Care, section (II)(7), available at: <https://www.documentcloud.org/documents/2695513-Gracida-Conte-Pablo.html#document/p13/a272773>, p. 13.
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66. Non-compliance with PBNDS 2008, Medical Care, section (II)(7) requiring that “A detainee who needs health care beyond facility resources will be transferred in a timely manner to an appropriate facility where care is available.” Gracida, available at: <https://www.documentcloud.org/documents/2695513-Gracida-Conte-Pablo.html#document/p9/a272777>, p. 9.
67. Gracida, available at: <https://www.documentcloud.org/documents/2695513-Gracida-Conte-Pablo.html#document/p6/a272778>, p. 6; Gracida, available at: <https://www.documentcloud.org/documents/2695513-Gracida-Conte-Pablo.html#document/p14/a272707>, p. 14.
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70. Id., available at: <https://www.documentcloud.org/documents/2695513-Gracida-Conte-Pablo.html#document/p13/a272779>, p. 13.
71. Id., available at: <https://www.documentcloud.org/documents/2695513-Gracida-Conte-Pablo.html#document/p14/a272780>, p. 14; 2012 Eloy Inspection, available at: <https://www.documentcloud.org/documents/2644422-Eloy.html>, p. 1.
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73. Id., available at: <https://www.documentcloud.org/documents/2644422-Eloy.html#document/p3/a266239>, p. 3.
74. 2012 Eloy ODO Inspection, available at: <https://www.documentcloud.org/documents/2644422-Eloy.html#document/p4/a266241>, p. 4; ICE Deaths List 2016.
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77. ICE Deaths List 2016.
78. DHS, *Death Investigation for Anibal Ramirez-Ramirez*, May 31, 2012, available at: <https://www.documentcloud.org/documents/2695511-Ramirez-Ramirez-Anibal.html#document/p26/a273198>, p. 26 [hereinafter “Ramirez-Ramirez.”]
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80. Ramirez-Ramirez, available at: <https://www.documentcloud.org/documents/2695511-Ramirez-Ramirez-Anibal.html>, pp. 3-4 (describes apprehension of Mr. Ramirez-Ramirez by Virginia State Police).
81. Id., available at: <https://www.documentcloud.org/documents/2695511-Ramirez-Ramirez-Anibal.html#document/p4/a5>, p. 4.
82. Ramirez-Ramirez, pp. 5-7 (describes interactions between PWMRAD staff and Mr. Ramirez-Ramirez).
83. Id., available at: <https://www.documentcloud.org/documents/2695511-Ramirez-Ramirez-Anibal.html#document/p10/a273301>, pp. 10-11.
84. Id., available at: <https://www.documentcloud.org/documents/2695511-Ramirez-Ramirez-Anibal.html#document/p3/a273307>, pp. 3-4.
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86. Id., available at: <https://www.documentcloud.org/documents/2695511-Ramirez-Ramirez-Anibal.html#document/p5/a273221>, p. 5.
87. Id., available at: <https://www.documentcloud.org/documents/2695511-Ramirez-Ramirez-Anibal.html#document/p10/a273301>, pp. 10-11.
88. Id., available at: <https://www.documentcloud.org/documents/2695511-Ramirez-Ramirez-Anibal.html#document/p119/a273314>, p. 119.
89. Id., <https://www.documentcloud.org/documents/2695511-Ramirez-Ramirez-Anibal.html#document/p120/a273318>, p. 120.
90. Non-compliance with ICE PBNDS 2008 Medical Care, section (II)(2), Ramirez-Ramirez, available at: <https://www.documentcloud.org/documents/2695511-Ramirez-Ramirez-Anibal.html#document/p27/a273319>, pp. 27-28.

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93. Id., available at: <https://www.documentcloud.org/documents/2695511-Ramirez-Ramirez-Anibal.html#document/p114/a273320>, pp. 114-115.
94. Non-compliance with ICE PBNDS, Medical Care, sections (II)(28) and (V) (B), Ramirez-Ramirez, available at: <https://www.documentcloud.org/documents/2695511-Ramirez-Ramirez-Anibal.html#document/p28/a273327>, p. 28.
95. Ramirez-Ramirez, available at: <https://www.documentcloud.org/documents/2695511-Ramirez-Ramirez-Anibal.html#document/p19/a273322>, p. 19.
96. Id., available at: <https://www.documentcloud.org/documents/2695511-Ramirez-Ramirez-Anibal.html#document/p19/a273333>, p. 19.
97. Id., available at: <https://www.documentcloud.org/documents/2695511-Ramirez-Ramirez-Anibal.html#document/p21/a273334>, p. 21.
98. 2011 Immigration Center of America – Farmville (ICAF) ODO Inspection, available at: <http://www.documentcloud.org/documents/2388774-ica-farmville-va-2011-odo-inspection.html>
99. 2011 ICAF ERO Inspection, available at: <https://www.documentcloud.org/documents/2388770-ica-farmville-va-2011-ero-inspection.html#document/p166/a267849>, p. 166.
100. Valencia.
101. Bamenga, available at: <https://www.documentcloud.org/documents/2695498-Bamenga-Irene.html>, pp. 14-15 (Although the Certificate of Death lists time of death at 1:17 a.m., the emergency room physician announced it at 1:15 a.m. as stated in ODO’s DDR narrative).
102. Id., available at: <https://www.documentcloud.org/documents/2695498-Bamenga-Irene.html#document/p2/a273341>, pp. 1-2.
103. Id., available at: <https://www.documentcloud.org/documents/2695498-Bamenga-Irene.html#document/p120/a273285>, p. 120 (Certificate of Death).
104. This doctor’s name was redacted under (b)(6), (b)(7)(c) exemptions.
105. Bamenga, available at: <https://www.documentcloud.org/documents/2695498-Bamenga-Irene.html#document/p137/a273344>, pp. 136-138.
106. Id., available at: <https://www.documentcloud.org/documents/2695498-Bamenga-Irene.html#document/p20/a272807>, p. 19; “INS Detention Standard, Medical Care,” available at: <https://www.ice.gov/doclib/dro/detention-standards/pdf/medical.pdf>.
107. Bamenga, available at: <https://www.documentcloud.org/documents/2695498-Bamenga-Irene.html#document/p20/a273346>, p. 20.
108. Id., available at: <https://www.documentcloud.org/documents/2695498-Bamenga-Irene.html#document/p10/a273421>, p. 10.
109. On July 25, 2011, Ms. Bamenga submitted two health services request forms. The first stated that, “I am not being given the full dosage of my medications. Two of the six different meds are meant to be take [sic] twice a day and so far I have only be given 1 dosage in the morning.” The second stated that the problem was “[s]hortness of breath at night especially when laying down, palpitations when laying down. Dizziness upon standing up when palpitation and shortness of breath occur.” Bamenga, available at: <https://www.documentcloud.org/documents/2695498-Bamenga-Irene.html#document/p77/a273348>, p. 77; Id., available at: <https://www.documentcloud.org/documents/2695498-Bamenga-Irene.html#document/p78/a273349>, p. 78.
110. Non-compliance with ICE NDS, Medical Care, section (III)(F), Sick Call; Bamenga, available at: <https://www.documentcloud.org/documents/2695498-Bamenga-Irene.html#document/p131/a273422>, p. 131.
111. Non-compliance with ICE NDS, Medical Care, section (III)(I), Delivery of Medication; Bamenga, available at: <https://www.documentcloud.org/documents/2695498-Bamenga-Irene.html>, pp. 127, 130-132; Id., available at: <https://www.documentcloud.org/documents/2695498-Bamenga-Irene.html#document/p135>, p. 135. Id., available at: <https://www.documentcloud.org/documents/2695498-Bamenga-Irene.html#document/p139>, p. 139.
112. Bamenga, available at: <https://www.documentcloud.org/documents/2695498-Bamenga-Irene.html#document/p132/a273426>, p. 132.
113. The results of digoxin toxicity and alterations in potassium levels would not have been detectable in an autopsy. Regardless, results of the autopsy were withheld from DHS due to New York privacy laws. Bamenga, available at: <https://www.documentcloud.org/documents/2695498-Bamenga-Irene.html#document/p138/a273432>, p. 138; Id., available at: <https://www.documentcloud.org/documents/2695498-Bamenga-Irene.html#document/p122>, p. 122.
114. Bamenga, available at: <https://www.documentcloud.org/documents/2695498-Bamenga-Irene.html#document/p139/a273434>, p. 139.
115. Id., available at: <https://www.documentcloud.org/documents/2695498-Bamenga-Irene.html#document/p139/a273436>, p. 139.
116. Non-compliance with NDS, Medical Care, Section (I), Policy, indicates all detainees shall have access to medical services that promote detainee health and general well-being; Bamenga, available at: <https://www.documentcloud.org/documents/2695498-Bamenga-Irene.html#document/p19/a273447>, p. 19.
117. The results of Mr. Dominguez-Valdivia’s death review have not been released yet. The account of his death in this report is based on ODO inspection reports.
118. 2012 Adelanto ODO Inspection, available at: <https://www.documentcloud.org/documents/2644420-2012-09-18-Adelanto.html#document/p4/a266231>, p. 4
119. Mr. Dominguez-Valdivia arrived at ADF on November 26, 2011 and although the 2012 ERO inspection notes are vague, it is believed that he was transferred to the hospital on February 16, 2012; 2012 Adelanto East ERO Inspection, available at: <https://www.documentcloud.org/documents/1692931-adelanto-east-2012-ero-inspection.html#document/p110/a237926>, p. 111.
120. 2012 Adelanto East ERO Inspection, available at: <https://www.documentcloud.org/documents/1692931-adelanto-east-2012-ero-inspection.html#document/p110/a237926>, p. 111.
121. Id.
122. Id.
123. The Adelanto Detention Facility (ADF) is also referred to as the Adelanto Correctional Facility (ACF).
124. 2012 Adelanto ODO Inspection, available at: <https://www.documentcloud.org/documents/2644420-2012-09-18-Adelanto.html#document/p4/a266231>, p. 4.
125. Id.
126. Although the facility was marked as not having met standards at the end of the review, this was changed to having met standards in the final memo to the Los Angeles Field Office Director. 2011 Adelanto East ERO Inspection, available at: <https://www.documentcloud.org/documents/1692930-adelanto-2011-ero-inspection.html#document/p161/a248078>, p. 161; Id, available at: <https://www.documentcloud.org/>

# Endnotes cont.

- [org/documents/1692930-adelanto-2011-ero-inspection.html#document/p162/a248079](http://www.documentcloud.org/documents/1692930-adelanto-2011-ero-inspection.html#document/p162/a248079), p. 162.
127. 2011 Adelanto East ERO Inspection, available at: <https://www.documentcloud.org/documents/1692930-adelanto-2011-ero-inspection.html#document/p91/a248080>, p. 91.
128. Chronic obstructive pulmonary disease was also listed as a contributing factor in Mr. Ramirez's death, although it was not considered an underlying cause; DHS, Death Investigation for Victor Ramirez-Reyes, Feb. 29, 2012, available at: <https://www.documentcloud.org/documents/2695510-Ramirez-Reyes-Victor.html#document/p1/a272787>, p. 1 [hereinafter "Ramirez-Reyes."]
129. Non-compliance with PBNDS, Medical Care, section (V)(F) which requires "[a]ccountability for administering or distributing medications in a timely manner and according to licensed provider orders;" Ramirez-Reyes, available at: <https://www.documentcloud.org/documents/2695510-Ramirez-Reyes-Victor.html#document/p12/a272788>, p. 12.
130. Non-compliance with PBNDS, Medical Care, section (II)(5), which requires timely follow-up to health care requests; Ramirez-Reyes, available at: <https://www.documentcloud.org/documents/2695510-Ramirez-Reyes-Victor.html#document/p12/a272790>, p. 12.
131. ODO did not name these as deficiencies, but expressed concern that the staff nurse was unaware of 2010 guidelines for basic life support and failing to respond to the situation by using an AED machine; Ramirez-Reyes, available at: <https://www.documentcloud.org/documents/2695510-Ramirez-Reyes-Victor.html#document/p13/a272792>, p. 13.
132. 2011 Elizabeth ERO Inspection, available at: <https://www.documentcloud.org/documents/1735436-elizabeth-nj-2011-ero-inspection.html#document/p117/a267558>, p. 117.
133. Id., available at: <https://www.documentcloud.org/documents/1735436-elizabeth-nj-2011-ero-inspection.html#document/p117/a267555>, p. 117.
134. Id, available at: <https://www.documentcloud.org/documents/1735436-elizabeth-nj-2011-ero-inspection.html#document/p117/a267555>.
135. 2012 Elizabeth ODO Inspection, available at: <https://www.documentcloud.org/documents/2647144-2012-ODO-Inspection-Elizabeth-NJ.html#document/p20/a267550>.
136. Id, available at: <https://www.documentcloud.org/documents/2647144-2012-ODO-Inspection-Elizabeth-NJ.html#document/p5/a267552>.
137. Id, available at: <https://www.documentcloud.org/documents/2647144-2012-ODO-Inspection-Elizabeth-NJ.html#document/p19/a267551>.
138. 2012 El Paso SPC ODO Inspection, available at: <https://www.documentcloud.org/documents/2644418-El-Paso-SPC-TX-2012-ODO-Inspection.html>.
139. DHS, Death Investigation for Mauro Rivera-Romero, 2011, available at: <https://www.documentcloud.org/documents/2695515-Rivera-Romero-Mauro.html#document/p4/a272643>, p.4 [hereinafter "Rivera."]
140. U.S. Border Patrol apprehended Mr. Rivera on October 1, 2011 at a checkpoint in Arizona. At the time, Mr. Rivera disclosed that he had recently been discharged from the Los Angeles County Medical Center in California and had been diagnosed with a stomach infection. In addition, he complained of stomach pains and nausea for which he refused medical attention. This is documented in his Form I-213, Record of Deportable/Inadmissible Alien; however, no documented proof exists demonstrating that this information was relayed to EPC upon his transfer on October 2 to await removal proceedings.
141. Rivera, available at: <https://www.documentcloud.org/documents/2695515-Rivera-Romero-Mauro.html#document/p12/a272698>, p. 13.
142. Rivera, available at: <https://www.documentcloud.org/documents/2695515-Rivera-Romero-Mauro.html#document/p45/a272664>, p. 45.
143. 2010 El Paso Service Processing Center ODO Inspection, available at: <https://www.documentcloud.org/documents/1865586-el-paso-spc-tx-2010-odo-inspection.html#document/p9/a263165>, p. 5.
144. 2011 El Paso Service Processing Center ERO Inspection, available at: <https://www.documentcloud.org/documents/1865569-el-paso-spc-tx-2011-ero-inspection.html#document/p83/a263156>, p. 83.
145. 2012 El Paso Service Processing Center ERO Inspection, available at: <https://www.documentcloud.org/documents/1865570-el-paso-spc-tx-2012-ero-inspection.html#document/p102/a263147>, p. 102.
146. Non-compliance with PBNDS, Medical Care, section (II)(2) requiring that health care needs be met in a timely and efficient manner; Rivera, available at: <https://www.documentcloud.org/documents/2695515-Rivera-Romero-Mauro.html#document/p13/a272700>, p. 13.
147. Non-compliance with PBNDS, Medical Care, section (II)(2) requiring that health care needs be met in a timely and efficient manner; Rivera, available at: <https://www.documentcloud.org/documents/2695515-Rivera-Romero-Mauro.html#document/p13/a272701>, p. 13.
148. The Joint Commission, Sentinel Events Policy, available at: [http://www.jointcommission.org/assets/1/6/CAMH\\_24\\_SE\\_all\\_CURRENT.pdf](http://www.jointcommission.org/assets/1/6/CAMH_24_SE_all_CURRENT.pdf) (defining a sentinel event as a patient safety event, not primarily related to the natural course of the patient's illness or underlying condition, that reaches a patient and results in death, permanent harm, severe temporary harm, or certain other specified harms).
149. Lives in Peril.