Kane, Katrina S

From: [redacted]
Sent: Wednesday, January 17, 2007 8:26 PM
To: Kane, Katrina S; Perry, Timothy L
Cc: [redacted] Torres, John P; Mead, Gary E
Subject: Re: RODRIGUEZ-Torres

Katrina,

Thanks for the advance notice. Please include sometime about the consulate's response to our notication in the SEN.

I copied Mr. Torres and Mr. Mead with this message, so that they are aware.

Sent from my BlackBerry Wireless Handheld

-----Original Message-----
From: Kane, Katrina S
To: [redacted]
CC: [redacted]
Sent: Wed Jan 17 20:05:13 2007
Subject: Fw: RODRIGUEZ-Torres

For your information. A SEN will be forthcoming in the AM when we have a bit more info re: the family's decision, poss. removal from life support, etc. (Unless you want one sooner). Just wanted you to be aware of the situation and request DMD assistance in ensuring that PHS at HQ is made aware of this case. SDDO [redacted] at Eloy will be the AZDRO POC for this case. Of course, you may always call me as well.
Thank you,
~ KK.

-----Original Message-----
From: [redacted]
To: [redacted] Kane, Katrina S
CC: [redacted]
Sent: Wed Jan 17 16:32:55 2007
Subject: RODRIGUEZ-Torres

The following is a synopsis of RODRIGUEZ-Torres' case.

On December 27, 2006, Mr. Felix Franklin RODRIGUEZ-Torres, (A [redacted] a native and citizen of Ecuador was taken to Maricopa Medical Center (MMC), due to a lump/swelling on his neck. On December 28, 2006, a biopsy revealed germ cell lymphoma. The cancer had spread from his testes through his abdominal cavity and up to his neck. CCA medical staff advised that this particular form

of cancer is extremely aggressive. On January 12, 2007 the hospital advised CCA that his condition was terminal and was given only seven to thirty days to live. His condition continued to decline until he was placed on life support.

On January 17, 2007, at approximately 13:20, CCA medical staff notified EAZ that medical staff from MMC wanted to disconnect life support. Contact was made with (b)(6), (b)(7)(C) Mr. Rodriguez's sister, and she provided us with her father's cellular telephone number. Several unsuccessful attempts were made to contact the father, Mr (b)(6), (b)(7)(C) at his cell number and at MMC's ICU number. At approximately 15:00 contact was made with M(b)(6), (b)(6), (b)(7)(C) He stated that the doctor had in fact met with him but he had not yet decided how to proceed. He stated he needed more time and was going to consult with the rest of the family. He also stated that the family did not have the funds for the funeral or for the transportation of the body to Ecuador. Mr. (b)(6), (b)(7)(C) was advised to contact his consulate for assistance. Several unsuccessful attempts were made to contact the consulate of Ecuador. At approximately 15:45, contact was made with Consular Agent Rubio. Ms. Rubio was informed of Mr. RODRIGUEZ-Torres' condition and the telephone number for Mr. (b)(6), (b)(7)(C) was provided.

The following is a brief synopsis of Mr. RODRIGUEZ-Torres' immigration case:

On November 8, 2006, ICE VRK New York took custody of Mr. Rodriguez after his release from Riker's Island, New York, where he was serving time for a Petit Larceny conviction. On November 9, 2006, he was transferred to Eloy, Arizona. On November 30, 2006, the Immigration Judge rescheduled his immigration case because Mr. Rodriguez wanted an attorney. On December 21, 2006 he had a hearing and his case was rescheduled.

Mr. Rodriguez was seen by CCA medical staff on numerous occasions prior to his transfer to MMC. (b)(6), (b)(7)(C) Clinical Supervisor is currently compiling a full medical report.

[redacted]

From: [redacted]
Sent: Thursday, January 18, 2007 8:34 AM
To: [redacted]
Subject: RE: RODRIGUEZ-Torres

Do you have any from CCA?

-----Original Message-----
From: [redacted]
Sent: Thursday, January 18, 2007 8:33 AM
To: [redacted]
Subject: RE: RODRIGUEZ-Torres

I do not have any medical records from the hospital.

-----Original Message-----
From: [redacted]
Sent: Thursday, January 18, 2007 7:51 AM
To: [redacted]
Subject: FW: RODRIGUEZ-Torres

Do either of you have medical records from CCA and the hospital? If so when this detainee is taken off life support my I get a copy for my death chart?

-----Original Message-----
From: USPublicHealthService
Sent: Thursday, January 18, 2007 7:47 AM
To: #US Public Health Service Members
Subject: FW: RODRIGUEZ-Torres

From: [redacted]
Sent: Thursday, January 18, 2007 6:46:56 AM
To: USPublicHealthService; [redacted]
Subject: Re: RODRIGUEZ-Torres
Auto forwarded by a Rule

We will fu thursday with team and dr [redacted]

Sent from my BlackBerry Wireless Device

-----Original Message-----
From: USPublicHealthService
To: #US Public Health Service Members
Sent: Wed Jan 17 23:52:07 2007
Subject: FW: RODRIGUEZ-Torres

From: Migliaccio, Gene A
Sent: Wednesday, January 17, 2007 10:52:06 PM
To: USPublicHealthService
Subject: Fw: RODRIGUEZ-Torres
Auto forwarded by a Rule

Gene Migliaccio, Dr.P.H
Director, Immigration Health Services
U.S.Public Health Service

202-732-(b)(6), (b)(7)

-----Original Message-----
From: (b)(6), (b)(7)(C)
To: Migliaccio, Gene A; (b)(6), (b)(7)(C)
Sent: Wed Jan 17 22:55:34 2007
Subject: Fw: RODRIGUEZ-Torres

FYI.

Please reach out to Phoenix and provide all necessary assistance to ensure that proper protocols are followed.

Sent from my BlackBerry Wireless Handheld

-----Original Message-----
From: Kane, Katrina S
To:
CC: (b)(6), (b)(7)(C)
Sent: Wed Jan 17 20:05:13 2007
Subject: Fw: RODRIGUEZ-Torres

For your information. A SEN will be forthcoming in the AM when we have a bit more info re: the family's decision, poss. removal from life support, etc. (Unless you want one sooner). Just wanted you to be aware of the situation and request DMD assistance in ensuring that PHS at HQ is made aware of this case. SDDO (b)(6), (b)(7)(C) at Eloy will be the AZDRO POC for this case. Of course, you may always call me as well.
Thank you,
~ KK.

-----Original Message-----
From: (b)(6), (b)(7)(C)
To: (b)(6), (b)(7)(C) Kane, Katrina S
CC: (b)(6), (b)(7)(C)
Sent: Wed Jan 17 16:32:55 2007
Subject: RODRIGUEZ-Torres

The following is a synopsis of RODRIGUEZ-Torres' case.

On December 27, 2006, Mr. Felix Franklin RODRIGUEZ-Torres, (A (b)(6), (b)(7)(C), a native and citizen of Ecuador was taken to Maricopa Medical Center (MMC), due to a lump/swelling on his neck. On December 28, 2006, a biopsy revealed germ cell lymphoma. The cancer had spread from his testes through his abdominal cavity and up to his neck. CCA medical staff advised that this particular form of cancer is extremely aggressive. On January 12, 2007 the hospital advised CCA that his condition was terminal and was given only seven to thirty days to live. His condition continued to decline until he was placed on life support.

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The following is a brief synopsis of Mr. RODRIGUEZ-Torres' immigration case:

On November 8, 2006, ICE VRK New York took custody of Mr. Rodriguez after his release from Riker's Island, New York, where he was serving time for a Petit Larceny conviction. On November 9, 2006, he was transferred to Eloy, Arizona. On November 30, 2006, the Immigration Judge rescheduled his immigration case because Mr. Rodriguez wanted an attorney. On December 21, 2006 he had a hearing and his case was rescheduled.

Mr. Rodriguez was seen by CCA medical staff on numerous occasions prior to his transfer to MMC. (b)(6) (b)(7)(C) Clinical Supervisor is currently compiling a full medical report.

(b)(6), (b)(7)(C)

From: (b)(6), (b)(7)(C)
Sent: Monday, March 12, 2007 12:23 PM
To: (b)(6), (b)(7)(C)
Subject: OPR Case No. (b)(2)High
Importance: High

(b)(6), (b)(7)(C)

A management inquiry was conducted in reference to the above OPR case number. The due date for this OPR is March 24, 2007.

The detainee in question died due to aggressive cancer. A management inquiry into this case indicates that this situation was handled appropriately. There is no evidence of negligence in this matter.

No further action is deemed necessary. We respectfully request that this case be closed.

Please let me know if you require any further information on this case.

Thank you,
(b)(6), (b)(7)(C)
Mission Support Specialist
Phoenix DRO Field Office
602-379(6), (b)(7)

Call up (b)(2)High

OP R## (b)(2)High

Office of Detention and Removal Operations

U.S. Department of Homeland Security
425 I Street, NW
Washington, DC 20536

U.S. Immigration and Customs Enforcement

MEMORANDUM FOR: John P. Torres
Director
Office of Detention and Removal Operations

FROM: (b)(6), (b)(7)c
Detention and Deportation Officer
Detention Standards Compliance Unit

SUBJECT: Suicide, Lopez-Gregorio, Jose (b)(6), (b)(7)c

Matter Under Review

Type of Event: Suicide, LOPEZ-Gregorio, Jose (b)(6), (b)(7)c
Event Date: September 29, 2006
Location of Event: Eloy Detention Center – Eloy, Arizona
Date of Assessment: October 11, 2006

The attached report contains our review and report on the above listed incident. The Assessment Team consisting of various subject matter experts concluded after reviewing all reports, data, detainee files, and medical records that general oversight of the detainee and the subsequent response that followed were consistent with existing policy, procedure, and practice. However, the team noted findings of non-compliance with Access to Medical Care.

During admission to the facility, the detainee received a classification assignment and received a medical and mental health screening. After being screened, the detainee was placed into a general population unit where he remained until September 24 when he was removed to the segregation unit due to concerns he intended to harm himself. Lopez was referred to segregation after two detainees advised a Contract Detention Officer that they believed Lopez intended to commit suicide. On September 24, the detainee was placed on a suicide watch from approximately 1600 hours to 1900 hours. A staff psychologist arrived at the facility and conducted an interview of Lopez at 1900 hours and reduced the suicide watch to 15-minute checks. Lopez remained on 15-minute checks until his suicide on September 29.

The team did identify that Medical care in this facility does not meet ICE standards. Physical examinations are not occurring within 14 days and a sick call request made by detainee Lopez was deferred for seven days. Any request made by a detainee who is known to be despondent and who is on an intensive watch schedule should have been responded to with some sense of

urgency. Based on the information provided and reviewed, it appears the detainee was attempting to communicate with medical staff and he was not provided with proper care and treatment with regards to his physical examination or his request to be seen by medical staff while under their care and treatment. Medical staff appeared to have been overwhelmed due to a sudden loss of veteran staff and no emergency plan to properly address this deficiency in operations.

Areas of concern were discovered which might have contributed to the suicide of this detainee. Care and treatment were ongoing and limited efforts were being made to assist the detainee. The detainee did display suicidal ideologies prior to his death. His suicide appears to have been planned in advance and did not appear to be spontaneous.

The failure of the medical staff to give priority to sick call requests by a detainee previously described as despondent and suicidal is of great concern to the Reviewer-In-Charge. The lack of attention to the deterioration of the medical department by the Facility Warden is viewed as a contributing factor in this event. Staff were viewed as caring and considerate and tried to communicate with the detainee, however, lacking critical expertise, such as that possessed by medical staff, did not foresee the outcome. The medical staff did not respond to detainee request in a time appropriate manner.

An additional factor noted by the Reviewer- In- Charge was the failure by CCA to notify the medical unit that the detainee did not depart as scheduled. This should have triggered further follow up by the staff psychologist. However, on September 27, the detainee filed his request for sick call and this should have alerted staff the detainee was not removed as planned. Staff took no action.

A significant amount of documentation has been retrieved and reviewed relative to this event. The most significant concern was found in the areas of 14-day physical examinations that are being conducted at 21 days and the lack of responsiveness to requests for sick call, particularly in the case of detainee Lopez. Medical operations at this facility are currently at risk and detainee welfare is in jeopardy. Safeguards need to be put in place to ensure a proper level of medical care is provided to ICE detainees.

A closeout was conducted with the facility Deputy Warden, ICE Officer-In-Charge, team members, and key CCA management team members.

Special Assessment
Detainee Mario CHAVEZ-Torres [redacted]

Office of Detention and Removal
Detention Management Division
425 I Street
Washington DC

Immigration and Customs Enforcement
Office of Detention and Removal

After Action Review
Phoenix Field Office
Eloy Detention Center
Eloy, Arizona

December 8, 2006

Finding 3: The following standards were reviewed during this Special Assessment. The last audit of the facility was conducted in June 8-9, 2006. It was determined that the facility was compliance with the detention standards.

a. Admission and Release
b. Classification
c. Access to Medical
d. Post Orders
e. Security Inspections
f. Staff / Detainee Communication

Summary

The facility has failed on multiple levels to perform basic supervision and provide for the safety and welfare of ICE detainees. The facility failed to communicate serious problems regarding ICE detainees held at this location with ICE management. Staff did not follow established policy, procedure, and practice. In numerous instances, medical supervisors do not properly supervise and instruct medical line staff.

There is not documentation of a physical examination in the record within 14 days of admission. The facility does not routinely do physical examinations on detainees that are in the facility greater than 14 days, nor was there any documentation of why detainee placed on 15-minute watch and in SMU. The detainee requested to be seen for sick call from SMU, but was not seen until four days later. When Officer requested medical to see detainee for weakness and dizziness, it took approximately one hour to respond to a building that is two minutes away from medical. The first nurse that arrived in SMU responded to the officer's request that he was not qualified, "I am only a pill pusher."
According to the medical record, there is no record of the detainee ever being seen by a Physician.

The medical health care unit does not meet minimum ICE standards. It was noted through verbal interviews that detainee CHAVEZ displayed symptoms of that of an *Aneurysm*, and should have been referred to an outside provider for treatment. The screening nurse did not make such referrals, which lead to detainee CHAVEZ placement in SMU to deal with these symptoms without proper treatment. Staff selectively follows policy and procedure and admits they do not follow established custodial medical policy and procedure.

reported including a finding that the facility responded as required by policy and procedure, staff were advised the matter continued to be under review and any subsequent changes to our initial findings would be relayed as necessary in this final report.