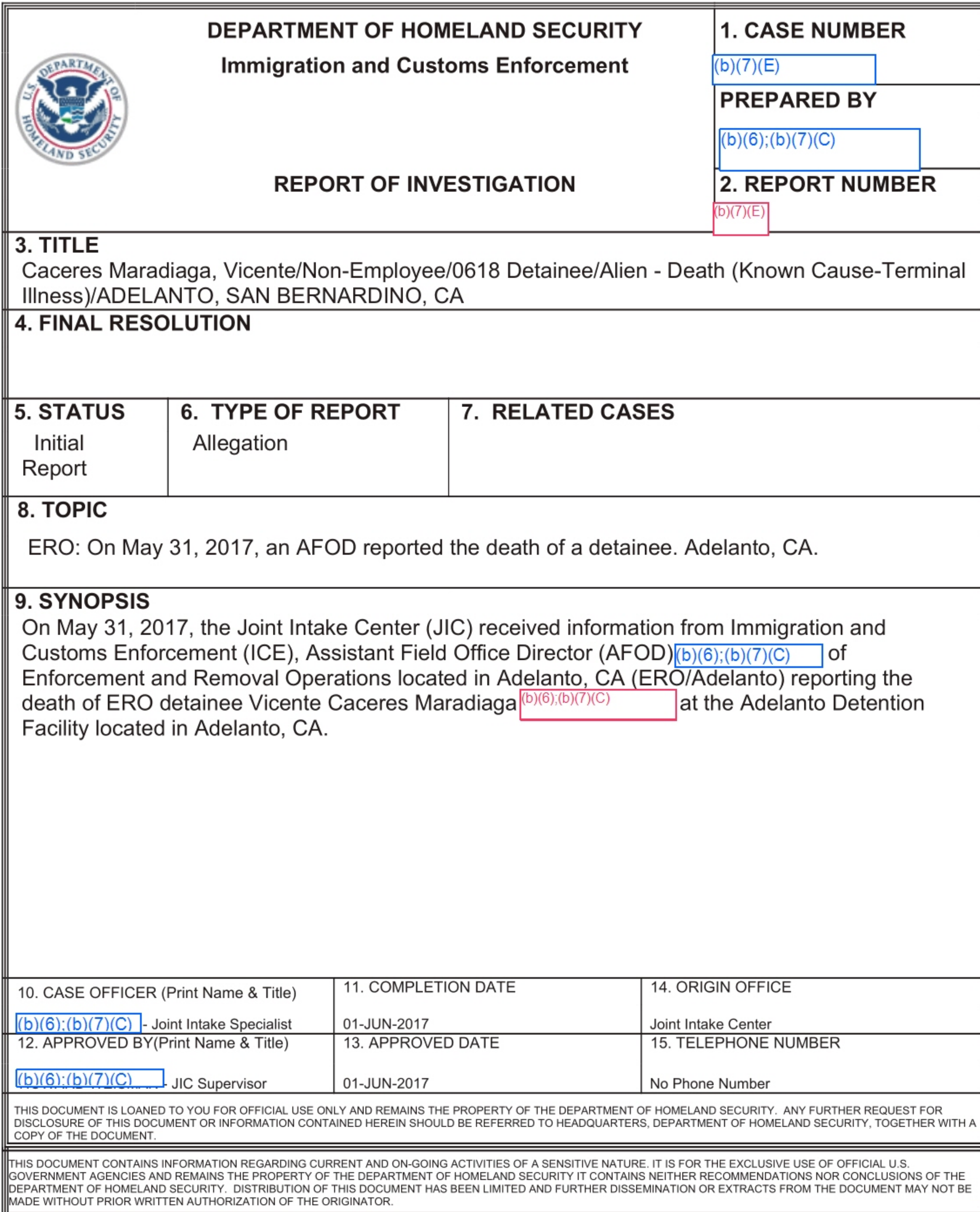

DEPARTMENT OF HOMELAND SECURITY Immigration and Customs Enforcement REPORT OF INVESTIGATION	1. CASE NUMBER (b)(7)(E) PREPARED BY (b)(6);(b)(7)(C) 2. REPORT NUMBER (b)(7)(E)

3. TITLE

Caceres Maradiaga, Vicente/Non-Employee/0618 Detainee/Alien - Death (Known Cause-Terminal Illness)/ADELANTO, SAN BERNARDINO, CA

4. FINAL RESOLUTION

5. STATUS	6. TYPE OF REPORT	7. RELATED CASES
Initial Report	Allegation	

8. TOPIC

ERO: On May 31, 2017, an AFOD reported the death of a detainee. Adelanto, CA.

9. SYNOPSIS

On May 31, 2017, the Joint Intake Center (JIC) received information from Immigration and Customs Enforcement (ICE), Assistant Field Office Director (AFOD) (b)(6);(b)(7)(C) of Enforcement and Removal Operations located in Adelanto, CA (ERO/Adelanto) reporting the death of ERO detainee Vicente Caceres Maradiaga (b)(6);(b)(7)(C) at the Adelanto Detention Facility located in Adelanto, CA.

10. CASE OFFICER (Print Name & Title)	11. COMPLETION DATE	14. ORIGIN OFFICE
(b)(6);(b)(7)(C) - Joint Intake Specialist	01-JUN-2017	Joint Intake Center
12. APPROVED BY(Print Name & Title)	**13. APPROVED DATE**	**15. TELEPHONE NUMBER**
(b)(6);(b)(7)(C) - JIC Supervisor	01-JUN-2017	No Phone Number

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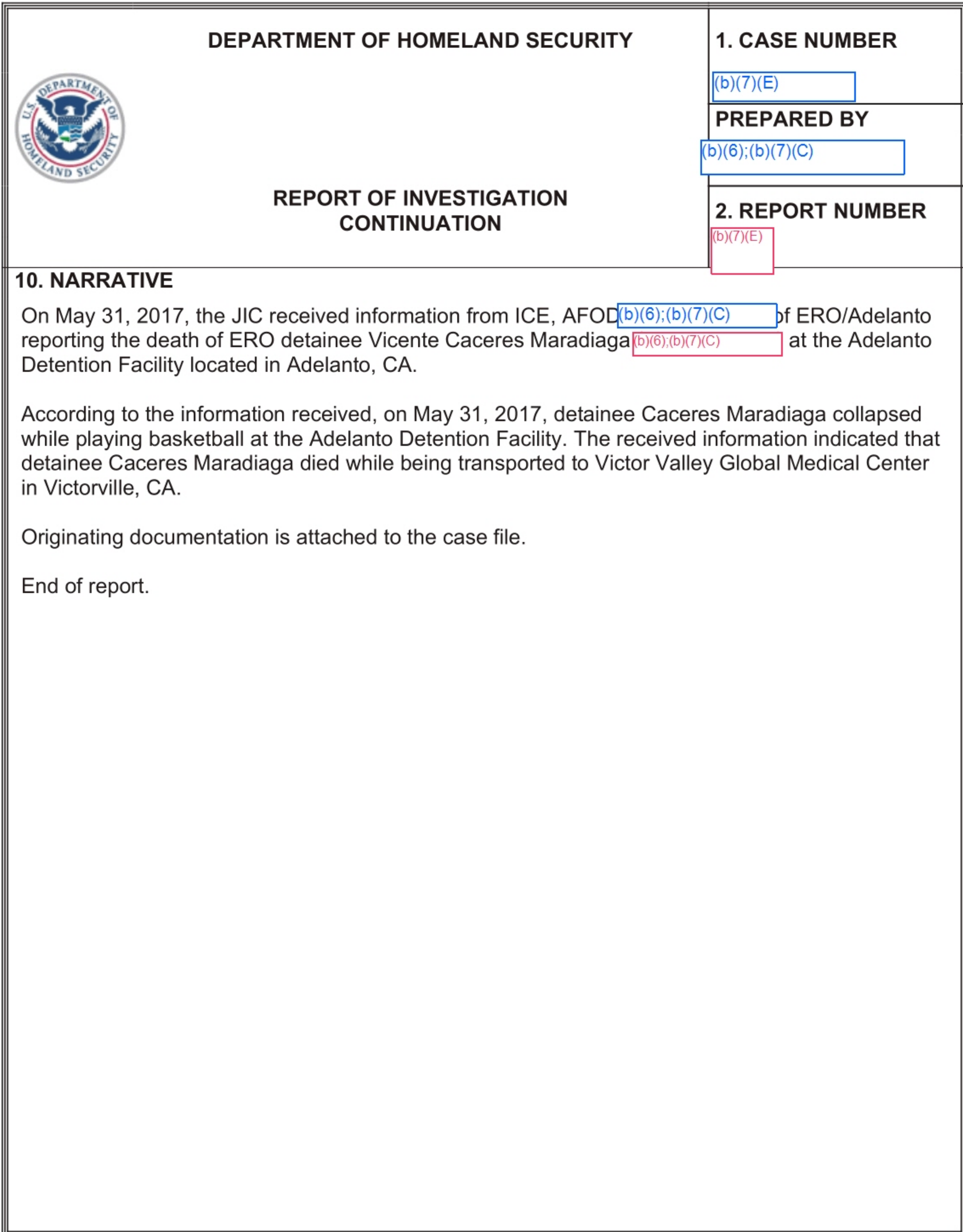


DEPARTMENT OF HOMELAND SECURITY

REPORT OF INVESTIGATION CONTINUATION

1. CASE NUMBER	(b)(7)(E)
PREPARED BY	(b)(6);(b)(7)(C)
2. REPORT NUMBER	(b)(7)(E)

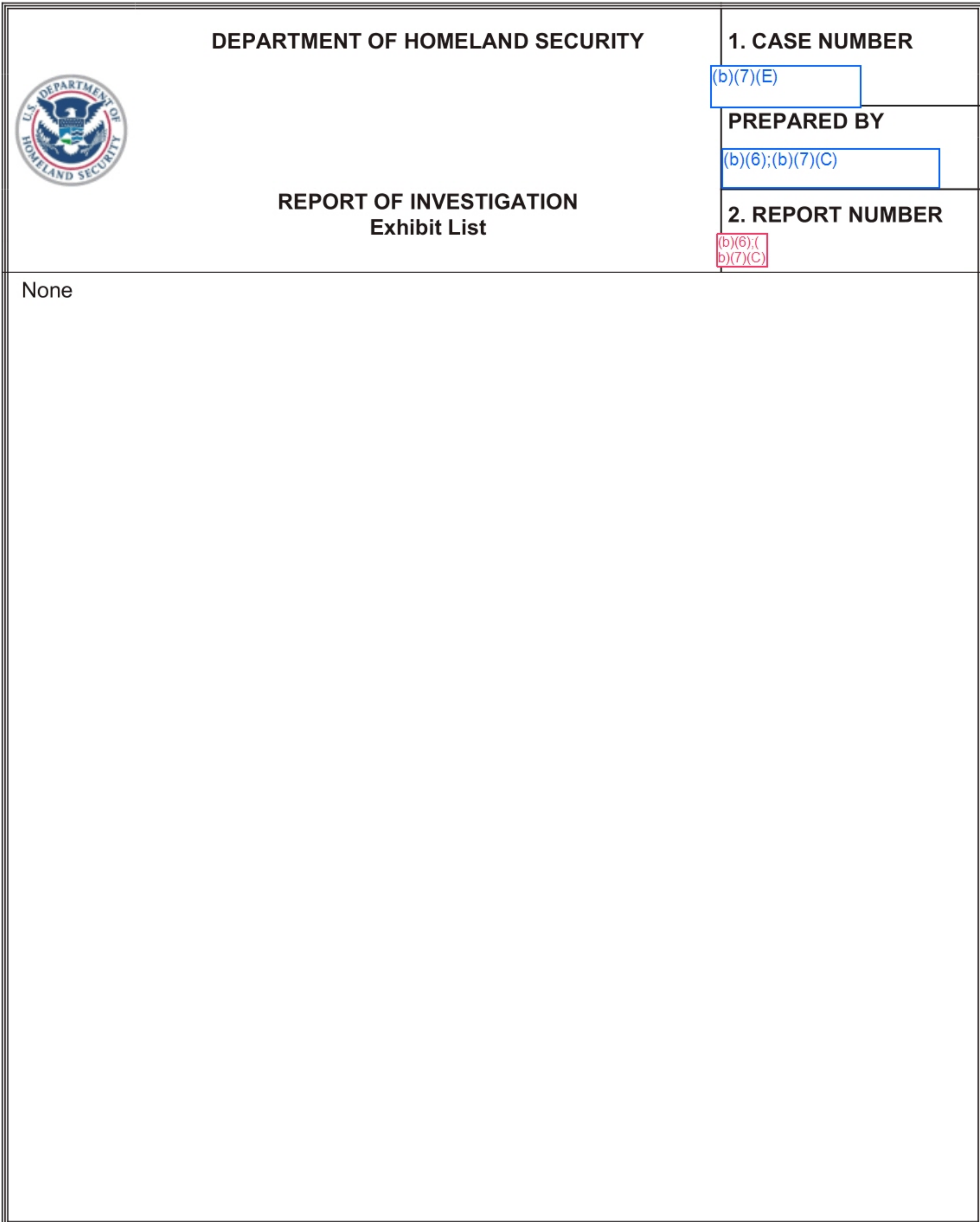
10. NARRATIVE

On May 31, 2017, the JIC received information from ICE, AFOD (b)(6);(b)(7)(C) of ERO/Adelanto reporting the death of ERO detainee Vicente Caceres Maradiaga (b)(6);(b)(7)(C) at the Adelanto Detention Facility located in Adelanto, CA.

According to the information received, on May 31, 2017, detainee Caceres Maradiaga collapsed while playing basketball at the Adelanto Detention Facility. The received information indicated that detainee Caceres Maradiaga died while being transported to Victor Valley Global Medical Center in Victorville, CA.

Originating documentation is attached to the case file.

End of report.



DEPARTMENT OF HOMELAND SECURITY REPORT OF INVESTIGATION Exhibit List	1. CASE NUMBER (b)(7)(E) PREPARED BY (b)(6);(b)(7)(C) 2. REPORT NUMBER (b)(6);(b)(7)(C)

None

Office of Professional Responsibility
U.S. Department of Homeland Security
950 L' Enfant Plaza SW
Washington, DC 20536

U.S. Immigration and Customs Enforcement

JUL 3 1 2018

MEMORANDUM FOR: Matthew Albence
Executive Associate Director
Office of Enforcement and Removal Operations

THROUGH: (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) (b)(6);(b)(7)(C)
Associate Director

FROM: (b)(6);(b)(7)(C) (b)(6);(b)(7)(C)
Assistant Director

SUBJECT: Investigative Findings – Death of ICE detainee
Vincente CACERES (b)(6);(b)(7)(C);(b)(7)(E)

The Office of Professional Responsibility, External Reviews and Analysis Unit (ERAU), has completed its investigation into the death of ICE detainee Vincente CACERES who died on May 31, 2017 at Victor Valley Global Medical Center (VVGMC) in Victorville, California (CA), while in the custody of U.S. Immigration and Customs Enforcement (ICE). The San Bernardino County Sheriff's Department, Coroner's Division, determined CACERES' preliminary cause of death was cardiomegaly[1] and hepatomegaly.[2]

CACERES entered the United States without admission or parole on an unknown date. On August 20, 2011, ERO Los Angeles screened CACERES, as part of a Criminal Alien Program (CAP) operation but did not lodge an immigration detainer. CACERES was later convicted by the Superior Court for the State of California for driving under the influence on September 14, 2011 and for fraud on October 5, 2016. He was sentenced to 13 days incarceration and 36 months' probation for the DUI and 90 days incarceration and 36 months' probation for the fraud. On May 22, 2017, ERO Los Angeles arrested CACERES at his residence in North Hollywood, CA and served him with a Notice to Appear (NTA) charging inadmissibility pursuant to section 212(a)(6)(A)(i) of the Immigration and Nationality Act (INA), as an alien present in the United States without being admitted or paroled. CACERES was transferred to the Adelanto Detention Facility (ADF) that same day.

Following his admission to ADF the night of May 22, 2017, CACERES received a timely intake medical screening during which a nurse determined his blood pressure was

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[1] Cardiomegaly is an enlarged heart with atherosclerotic disease.
[2] Hepatomegaly is an enlarged liver.

elevated. The nurse contacted the on-call provider and received orders to administer two tablets of Clonidine[3] 0.1 mg and perform an electrocardiogram (EKG). CACERES received both, and although the EKG showed abnormalities,[4] the provider determined CACERES did not need treatment for those abnormalities at that time. She instead directed that CACERES be housed in the infirmary for observation and further evaluation the following morning.

The following afternoon, ADF's Medical Director completed CACERES' initial physical assessment. CACERES denied any chest pain, chest discomfort, and shortness of breath. The doctor diagnosed CACERES with primary hypertension, and ordered Lisinopril to treat the hypertension, as well as laboratory work, a baseline EKG,[5] blood pressure checks three times per week for two weeks, and a chronic care follow-up appointment in three to four weeks. The doctor cleared CACERES for housing in general population, and security staff moved him to a general population housing unit that same afternoon. As discussed in the report, because nurses did not transcribe the doctor's order for blood pressure monitoring into CACERES' medical record until May 31, 2017[6], they never monitored his blood pressure prior to his medical emergency that same day.

On May 31, 2017, at approximately 6:07 p.m., CACERES was playing soccer in the facility's recreation area when he grabbed his chest, bent over, and fell to the ground. An officer promptly called a code blue (medical emergency) over his radio, and security and medical staff responded quickly. Medical staff used an automated external defibrillator (AED) on CACERES, and both medical and security staff performed chest compressions. A nurse directed security to call 911 at approximately 6:16 p.m. After the AED established a pulse at approximately 6:22 p.m., medical and security staff placed CACERES on a gurney and transported him to the facility's intake area where, at approximately 6:26 p.m., San Bernardino County Fire Department (SBCFD) responders intubated and started an intraosseous (IO) line[7] on the detainee. American Medical Rescue (AMR) responders arrived with an ambulance approximately one minute later, affixed their AED to CACERES and placed him in the ambulance. The ambulance departed ADF at approximately 6:28 p.m. and arrived at VVGMC at approximately 6:52 p.m. During the transport, CACERES' heart stopped and the responders performed cardiopulmonary resuscitation (CPR).

Upon arrival to VVGMC, emergency room (ER) staff attempted to resuscitate CACERES until an ER physician pronounced him dead at 7:06 p.m.

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[3] Clonidine is an antihypertensive medication.

[4] The abnormalities included a prior anteroseptal infarct (tissue death to the front part of the septum of the heart caused by lack of blood flow) occurring at an unknown time, and a sinus rhythm (normal rhythm of the heart) with an inverted T wave (result of an infarction/heart attack).

[5] The doctor was unaware an EKG was performed the prior night, as the nurse did not scan it into the electronic medical record in a timely fashion.

[6] Medical staff stated during interviews that ADF employs two different eClinicalworks (eCW) procedures to transcribe physician/provider orders: 1) the physician can print new orders and place them in the "to be noted" file in the nurse's station, or 2) the physician can send new orders electronically as a "task" or "action item" to the physician's assigned nurse.

[7] An IO line provides direct access into the bone marrow for fluids and/or medication.

ERAU reviewed the medical care CACERES was provided at ADF, as well as the facility's efforts to ensure that he was safe and secure while detained at the facility. ERAU found two deficiencies in ADF's compliance with certain requirements of the ICE PBNDS 2011 (revised 2016). These deficiencies are noted for informational purposes only and should not be construed as contributory to the detainee's death.

1. The ICE PBNDS 2011 (revised 2016), *Medical Care*, section (V)(A)(2), states, "Every facility shall directly or contractually provide its detainee population with the following: … 2) Medically necessary and appropriate medical, dental and mental health care and pharmaceutical services." A physician discharged CACERES from the infirmary on May 23, 2017 with an order for blood pressure monitoring which nurses never carried out.

2. The ICE PBNDS 2011 (revised 2016), *Medical Care*, section (V)(G)(12), states, "Each detention facility shall have and comply with written policy and procedure for the management of pharmaceuticals, to include:… 12) Documentation of accountability for administering or distributing medications in a timely manner, and according to licensed provider orders." A nurse failed to document administration of Clonidine on May 22, 2017.

In addition to these findings of non-compliance, ERAU identified an area of concern which is discussed in the attached report.

If you have any questions, please contact me or have a member of your staff contact Unit Chief, (b)(6);(b)(7)(C) at (202) 732-(b)(6);(b)(7)(C)

Attachment

cc: Peter T. Edge
(b)(6);(b)(7)(C)

SYNOPSIS

On May 31, 2017, Vincente CACERES-MARADIAGA, a forty-six year old citizen of Hondoras, died while in the custody of U.S. Immigration and Customs Enforcement (ICE) at Victor Valley Global Medical Center (VVGMC), in Victorville, California, (CA). The San Bernardino County Sheriff's Department, Coroner's Division, determined CACERES' preliminary cause of death was cardiomegaly[1] and hepatomegaly.[2]

CACERES was detained at Adelanto Detention Facility (ADF), in Adelanto, CA, from May 22, 2017, until his death. ADF is privately-owned and operated by the GEO Group, Inc. (GEO) and is required to comply with the ICE Performance Based National Detention Standards (PBNDS) 2011. Medical care at ADF is provided by Correctional Care Solutions (CCS). At the time of CACERES's death, ADF housed approximately 1,583 ICE detainees of all classification levels for periods in excess of 72 hours.

DETAILS OF REVIEW

From July 25 to 27, 2017, ICE Office of Professional Responsibility, External Reviews and Analysis Unit (ERAU) staff visited ADF to review the circumstances surrounding CACERES death. ERAU was assisted in its review by contract subject matter experts (SME) in correctional healthcare and security.[3] ERAU's contract SMEs are employed by Creative Corrections, a national management and consulting firm. As part of its review, ERAU examined immigration, medical, and detention records pertaining to CACERES, in addition to conducting in-person interviews of individuals employed by GEO, CCS, and the local field office of ICE's Office of Enforcement and Removal Operations (ERO).

During the review, the ERAU team took note of any deficiencies observed in the detention standards as they relate to the care and custody of the deceased detainee and documented those deficiencies herein for informational purposes only. Their inclusion in this report should not be construed in any way as indicating the deficiencies identified contributed to the detainee's death. ERAU determined the following timeline of events, from the time of CACERES apprehension by ICE, through his detention at ADF, and eventual death at VVGMC.

IMMIGRATION AND CRIMINAL HISTORY[4]

CACERES entered the United States without admission or parole on an unknown date.

On August 20, 2011, ERO Los Angeles screened CACERES, as part of a (b)(7)(E) (b)(7)(E) operation but did not lodge an immigration detainer.

[1] Cardiomegaly is an enlarged heart with atherosclerotic disease.
[2] Hepatomegaly is an enlarged liver.
[3] *See* Exhibit 1: Creative Corrections Medical and Security Compliance Analysis.
[4] *See* Detainee Death Notice.

On September 14, 2011, the Superior Court for the State of California, County of Los Angeles convicted CACERES for the offense of driving under the influence and sentenced him to 13 days incarceration and 36 months' probation.

On October 5, 2016, the Superior Court for the State of California, County of Los Angeles convicted CACERES for the offense of fraud and sentenced him to 90 days incarceration and 36 months' probation.

On May 22, 2017, ERO Los Angeles arrested CACERES at his residence in North Hollywood, CA without incident. ERO Los Angeles served CACERES a Notice to Appear (NTA) charging inadmissibility pursuant to section 212(a)(6)(A)(i) of the Immigration and Nationality Act (INA), as an alien present in the United States without being admitted or paroled, and transported CACERES to ADF that same day.

NARRATIVE

May 22, 2017
At 8:45 p.m., CACERES arrived at ADF. Security staff appropriately classified him as medium-low based on his criminal history and assigned him to a general population housing unit.[5] At approximately 11:30 p.m., prior to being housed, CACERES received a medical intake screening by Registered Nurse (b)(6);(b)(7)(C) (b)(6);(b)(7) noted that CACERES spoke Spanish and telephonic interpretation was used during the intake screening. CACERES's vital signs were: temperature 97.7, pulse 80, respiration 18, and a significantly elevated blood pressure of 181/105.[6] His height was five feet, seven inches tall, and his weight was 250 pounds.[7]

Because (b)(6);(b)(7)(was new to ADF, he consulted with (b)(6);(b)(7)(C) a more experienced nurse, regarding CACERES' vital signs, and (b)(6);(b)(7) decided to take over the intake screening due to the elevated blood pressure.[8] (b)(6);(b)(7) conducted a second blood pressure test, found the detainee's blood pressure was still elevated at 169/106, and contacted (b)(6);(b)(7)(C) for orders.[9] (b)(6);(b)(7)(C) prescribed Clonidine[10] 0.1 mg two tablets by mouth and ordered an electrocardiogram (EKG).[11]

Although, (b)(6);(b)(7) documented she gave CACERES the medication in a progress note,[12] she did not enter the NP's orders into the electronic medical record (eClinicalWorks or eCW),

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[5] *See* ICE Custody Classification Worksheet, dated May 22, 2017.
[6] Normal temperature is considered 98.8; normal range for pule is 70 to 100 beats per minute; normal range for respirations is 16 to 20 breaths per minute; and, normal blood pressure is 90/60 to 139/89.
[7] *See* Exhibit 2: GEO Medical Intake Screening by (b)(6);(b)(dated May 22, 2017.
[8] ERAU Interview with (b)(6);(b) dated July 27, 2017.
[9] *See* Exhibit 2: GEO Medical Intake Screening by (b)(6);(b)(dated May 22, 2017.
[10] Clonidine is an antihypertensive medication.
[11] An EKG is a a recording of the heart's electrical impulses used to identify problems with heart rate and rhythm.
[12] *See* GEO Medical Progress Note by (b)(6);(b)(dated May 22, 2017. Of note (b)(6);(b)(initially only gave CACERES one tablet of Clonidine 0.1 mg, but (b)(6);(b)(7) instructed him to administer the second tablet and to re-check CACERES's blood pressure. (b)(6);(b) stated that his experience administering Clonidine was to give one tablet followed by the second tablet 30 minutes later to prevent a rapid drop in blood pressure. (b)(6);(b)(7) stated she ordered both tablets be given at the same time to bring the blood pressure down quickly.

nor did she create a medication administration record (MAR) to document the administration of the medication. (b)(6) (b)(6);(b)(7)(C indicated that when she or another provider gives a verbal order, the nurse enters the order into the eCW, and the provider signs it within 24 hours. She stated she did not notice the order for Clonidine was not in the eCW when she reviewed CACERES' record later that day.[13]

(b)(6);(b)(7)(C (b)(6);(b)(7) completed an EKG on CACERES and gave the EKG report to (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) who reviewed it and noted it indicated CACERES had a prior anteroseptal infarct[14] occurring at an unknown time. The EKG also documented a sinus rhythm[15] with an inverted T wave.[16] Although (b)(6);(b)(7)((b)(6);(b)(7)(C noted the abnormalities, she determined no treatment was necessary at that time.[17]

Following the administration of Clonidine and the EKG, (b)(6) (b)(7 (b)(6);(b)(7)(C instructed (b)(6);(b)(7)((b)(6);(b)(7) to admit CACERES to the infirmary for observation and further evaluation in the morning.[18]

May 23, 2017

At 4:08 am.,[19] (b)(6);(b)(7)(C) (b)(6);(b)(7 took CACERES' vital signs, which were within normal limits, with the exception of an elevated blood pressure of 166/95.[20]

At 8:22 a.m., (b)(6);(b)(7)((b)(6);(b)(7)(C gave a verbal order to (b)(6);(b)(7)((b)(6);(b)(7)(C) to administer CACERES Lisinopril[21] 10 mg one tablet by mouth every morning for 30 days.[22] (b)(6);(b)(7)((b)(6);(b)(7 administered the medication as ordered, and (b)(6) (b)(7 (b)(6);(b)(7)(C signed the order later that day.[23]

At 12:34 p.m., (b)(6 (b)((b)(6);(b)(took CACERES vital signs, which were within normal limits with the exception of an elevated blood pressure of 162/102.[24]

At 2:00 p.m., (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) completed CACERES physical assessment. CACERES denied any medical, dental, or mental health conditions except for an umbilical hernia.[25] CACERES stated that he did not have any chest pain, chest discomfort, or shortness of breath, and did not take any medication. (b)(6) (b)(6);(b)(diagnosed CACERES with essential

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[13] ERAU Interview with (b)((b)(6);(b)(7)(dated July 27, 2017.
[14] Anteroseptal infarct is tissue death to the front part of the septum of the heart caused by lack of blood flow.
[15] Sinus rhythm is the normal rhythm of the heart.
[16] Inverted T wave is the result of an infarction/heart attack.
[17] ERAU Interview with (b)((b)(6);(b)(7) dated July 27, 2017.
[18] *See* CCS Medical/Psychiatric Alert by (b)(6) (b)(7 (b)(6);(b)(dated May 22, 2017.
[19] (b)(6);(b)(7)(C (b)(6 stated he does not work the night shift, and the vital signs were done at approximately 2 p.m. on May 23, 2017 prior to the physician's examination. During interviews, staff reported on-going problems with the GEO data base interfacing with the (b)(7)(E) system. The interface should occur within 15 minutes but that does not consistently happen. As a result, the time automatically uploaded to Progress Notes is often inaccurate.
[20] *See* GEO Medical Progress Note by (b)(6) (b)(6);(b)(dated May 23, 2017.
[21] Lisinopril is an angiotensin converting enzyme (ACE) inhibitor used to treat hypertension.
[22] ERAU Interview with (b)((b)(6);(b)(7), dated July 27, 2017.
[23] *See* GEO Medical Administration Record, dated May 23, 2017.
[24] *See* GEO Medical Progress Note by (b)((b)(6);(b) dated May 23, 2017.
[25] An umbilical hernia is a condition in which the intestine protrudes through the abdominal muscles at the navel.

(primary) hypertension,[26] changed his Lisinopril order to Lisinopril 10 mg tablet by mouth every day for 120 days, and ordered Hydrochlorothiazide[27] 25 mg tablet by mouth every morning for 120 days. (b)(6);(b)(7)(C) ordered several laboratory tests including: hemoglobin A1c;[28] routine urinalysis;[29] complete blood count (CBC);[30] and comprehensive metabolic panel (CMP).[31] (b)(6);(b)(7)(C) ordered blood pressure checks three times per week for two weeks, a baseline EKG, and a chronic care follow-up appointment in three to four weeks. (b)(6);(b)(7)(C) discharged CACERES and cleared him for general population housing.[32] (b)(6);(b)(7)(C) stated he was unaware an EKG had been done during the night, as it had not been scanned into the medical record. However, he stated that regardless of the EKG results, in the absence of chest pain, the initial EKG is considered a baseline.[33]

ERAU notes (b)(6);(b)(7)(C)'s order to monitor CACERES' blood pressure three times per week for two weeks was not transcribed until May 31, 2017, and nurses did not monitor his blood pressure prior to his medical emergency that same day. Medical staff stated during interviews that ADF employs two different (b)(7)(E) procedures to transcribe physician/provider orders: 1) the physician can print new orders and place them in the "to be noted" file in the nurse's station, or 2) the physician can send new orders electronically as a "task" or "action item" to the physician's assigned nurse. (b)(6);(b)(7)(C) who was assigned to (b)(6);(b)(7)(C) at the time of CACERES' detention, stated he did not know how the order was missed because he normally reviews all physician documentation at the end of the day to ensure he has accounted for everything.[34] (b)(6);(b)(7)(C) stated blood pressure monitoring gives the physician an opportunity to adjust or change medication based on blood pressure results.[35]

At 4:17 p.m., security staff transferred CACERES to general population housing unit West 4C.

May 31, 2017, – Day of Death

At approximately 6:07 p.m., CACERES was playing with a soccer ball in the excersise area/recreation yard when he grabbed his chest, bent over, and fell to the ground.[36] Several detainees on the recration yard approached (b)(6);(b)(7)(C) who was the assigned West 4C housing unit officer, to inform him that CACERES was down.[37] (b)(6);(b)(7)(C) responded to the recreation yard and immediately called a code blue (medical emergency); (b)(6);(b)(7)(C) attempted to speak to CACERES and noted the detainee nodded his head in reponse, but was unable to speak.[38]

[26] Essential hypertension, referred to as primary, is high blood pressure that doesn't have a known secondary cause.
[27] Hydrochlorothiazide is a diuretic to reduce fluid retention
[28] A1c measures blood sugar over time to rule out diabetes.
[29] Urine test that can reveal diseases that have previously gone undetected due to lack of overt symptoms.
[30] CBC, with differential and platelets is a blood test that measures the levels of red blood cells; white blood cells; platelets (clotting cells); hemoglobin (oxygen transport cells); hematocrit (ratio of red blood cells to the total blood volume); and lipid panel (tests for high cholesterol).
[31] CMP is a group of blood tests that provide an overall picture of the body's chemical balance and metabolism.
[32] *See* GEO Medical Progress Note by (b)(6);(b)(7)(C) dated May 23, 2017.
[33] ERAU Interview with (b)(6);(b)(7)(C), dated July 27, 2017.
[34] ERAU Interview with (b)(6);(b)(7)(C) dated July 25, 2017.
[35] ERAU Interview with (b)(6);(b)(7)(C) dated July 25, 2017.
[36] GEO CCTV Footage, dated May 31, 2017.
[37] ERAU Interview with (b)(6);(b)(7)(C), dated July 26, 2017.
[38] *Id.*

At 6:09 p.m., (b)(6);(b)(7)(C) responded to West 4C recreation yard when he heard the code blue call, observed CACERES on the ground breathing shallowly and cleared the other detainees from the recreation yard to facilitate the emergency response.[39]

At 6:11 p.m. (b)(6);(b)(7)(C) the first medical responder, noted that CACERES had agonal breathing[40] and no carotid pulse. (b)(6);(b)(7)(C) initiated a sternal rub[41] to CACERES' chest to evaluate his response to painful stimuli and assess his degree of unconsciousness, but he did not respond.[42] Additional medical responders[43] brought emergency equipment to the scene including the medical emergency bag, automated external defibrillator (AED), vital sign machine, gurney, wheelchair, and oxygen.[44] After a second attempt at a sternal rub was unsuccessful, (b)(6);(b)(7)(C) attached the AED leads to CACERES' chest. The AED detected a pulse and gave a shock, but CACERES did not respond.[45]

At approximately 6:13 p.m. (b)(6);(b)(7)(C) initiated chest compressions. She was assisted by (b)(6);(b)(7)(C) and (b)(6);(b)(7)(C) who rotated positions as needed over the following 11 minutes to prevent fatigue. Also at approximately 6:13 p.m. (b)(6);(b)(7)(C) attempted to assemble an ambu bag to provide rescue breathing and oxygen but was unable to do so because the ambu bag was defective; therefore, (b)(6);(b)(7)(C) instead initiated rescue breathing using a non-rebreather mask.[46] At approximately the same time, (b)(6);(b)(7)(C) also instructed (b)(6);(b)(7)(C) to prepare CACERES' medical record for transport to the hospital.[47]

At approximately 6:16 p.m.,[48] (b)(6);(b)(7)(C) directed that security call 911, and (b)(6);(b)(7)(C) directed Unit 4 Control to make the call to 911.[49] (b)(6);(b)(7)(C) used the non-rebreather mask and an oxygen tank to administer oxygen to CACERES. (b)(6);(b)(7)(C) noted that although CACERES had a large amount of fluid/mucus in his throat, medical responders were able to continue giving CACERES oxygen with the mask.[50] (b)(6);(b)(7)(C) left for the medical unit to retrieve a bulb syringe to suction the fluid from his throat but could not find one, and instead grabbed two 10 cc syringes to use for suction.[51]

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[39] ERAU Interview with (b)(6);(b)(7)(C) dated July 25, 2017.
[40] Agonal breathing is characterized by labored/gasping respirations.
[41] A sternal rub occurs when a provider makes a fist and places thier knuckles against the patients mid-breast bone applying firm downward pressure and rubs up and down across the breast bone.
[42] ERAU Interview with (b)(6);(b)(7)(C) dated July 25, 2017.
[43] (b)(6);(b)(7)(C)
[44] *See* GEO West 4 Control Room Logbook, dated May 31, 2017.
[45] *See* GEO General Incident Report by (b)(6);(b)(7)(C) dated May 31, 2017.
[46] GEO CCTV Footage, dated May 31, 2017. A non-rebreather mask is a one-way valve in the mask which prevents exhaled air from entering into the tubing or bag containing the oxygen that is to be inhaled and prevents the patient from inhaling any room air.
[47] *See* GEO General Incident Report by (b)(6);(b)(7)(C) dated May 31, 2017.
[48] Although (b)(6);(b)(7)(C) reported the time of the call as approximately 6:11 p.m., medical documentation and the Control Room Log documents the time of the call as 6:16 p.m. ERAU was unable to determine the exact time of the call.
[49] ERAU Interview with (b)(6);(b)(7)(C) dated July 25, 2017.
[50] ERAU Interview with (b)(6);(b)(7)(C) dated July 25, 2017.
[51] ERAU Interview with (b)(6);(b)(7)(C) dated July 25, 2017.

(b)(6);(b)(7)(C) (b)(6);(continued performing chest compression on CACERES while the AED analyzed his cardiac status and delivered additional shocks. At approximately 6:19 p.m. (b)(6);(b)(7) (b)(6);(b arrived on scene and took over chest compression. Once the AED established a pulse, at approximately 6:22 p.m., (b)(6); (b)(6);(b and (b)(6);(b)(7)((b)(6);(decided to transport CACERES to the medical unit while they waited for Emergency Medical Services (EMS) to arrive.

At 6:22 p.m., medical and security staff moved CACERES onto a backboard and placed him on the gurney. (b)(6);(b)(7)((b)(6);(b and (b)(6);(b)(7)(C) (b)(6);(b)(7)(pushed the gurney to the medical unit while (b)(6);(b)(7)(C) (b)(6);(b held the oxygen mask and (b)(6);(b)(7 (b)(6);(b)(carried the oxygen tank.[52] Before they reached the medical unit, the AED indicated CACERES had no pulse, so the team stopped, and (b)(6);(b)(7)(C) initiated chest compressions.[53] (b)(6);(b)((b)(6);(b)(who was exiting the medical unit at this time, met the group in the hallway and gave the syringes to (b)(6);(b)(7)((b)(6); to suction CACERES' throat.[54]

At 6:24 p.m., the San Bernardino County Fire Department (SBCFD) arrived with one paramedic and one EMT. At approximately 6:26 p.m., the SBCFD responders encountered (b)(6);(b)(7)(C) (b)(6);(b)((b)(6); (b)(6);(b, and the other staff transporting CACERES to medical, and stated that an American Medical Response (AMR) ambulance was on the way, and CACERES should be transported directly to the intake to wait for it. (b)(6);(b)(7)(C) took CACERES directly to intake, while performing chest compressions continuously.[55] Upon reaching the intake area, the SBCFD responders immediately intubated[56] CACERES and started an intraosseous (IO) line.[57] The SBCFD responders also administered three doses of epinephrine[58] via the IO. While the SBCDF responders were treating CACERES, the AED delivered CACERES a shock which resulted in restablishing his pulse.[59]

At 6:27 p.m., the AMR ambulance arrived with one paramedic and one EMT. The AMR responders placed their AED on CACERES, transferred him to their gurney, and placed him in the ambulance. (b)(6);(b)(7)((b)(6);(b)(7)(C) accompanied CACERES in the ambulance, and (b)(6);(b)(7)((b)(6);(b)(7)(C) followed in a chase vehicle. The AMR ambulance departed ADF at 6:28 p.m. for the Victor Valley Global Medical Center (VVGMC) in Victorville, California.[60] CACERES' heart stopped again during the AMR transport, and the AMR responders performed cardiopulmonary resuscitation (CPR) until they arrived at the hospital at 6:52 p.m.[61] VVGMC ER staff assumed responsibility for CACERES at 6:53p.m and noted the detainee was unresponsive with fixed and dilated pupils. The ER staff initiated Advanced Cardiac Life

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[52] GEO CCTV Footage, dated May 31, 2017.
[53] ERAU Interview with (b)(6);(b)((b)(6); dated July 26, 2017.
[54] GEO CCTV Footage, dated May 31, 2017.
[55] GEO CCTV Footage, dated May 31, 2017.
[56] Intubation is the placement of a tube into the trachea to maintain an open airway.
[57] An IO line provides direct access into the bone marrow for fluids and/or medication.
[58] Epinephrine is a medication used to increase blood flow to muscles including output of the heart.
[59] *See* VVGMC Emergency Record, dated May 31, 2017.
[60] *See* GEO General Incident Report by (b)(6);(b)(7 (b)(6);(b)(dated May 31, 2017.
[61] *Id.*

Support (ACLS) protocols,[62] but their efforts were unsuccessful.[63] At 7:06 p.m., VVGMC (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) pronounced CACERES's dead.[64]

Post-Death Events

(b)(6);(b)(7)(C) (b)(6);(b)(7)(C) immediately notified (b)(6);(b)(7)(C) (b)(6);(of CACERES' death.[65] (b)(6);(b)(7)(C) (b)(6);(then notified (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) who notified (b)(6);(b)(7)((b)(6);(b)(7)(C) (b)(6);(b)((b)(6);(b)(7)(C) and GEO (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) [67] Both officers remained at the hospital until CACERES' body was released to the coroner for autopsy at approximately 10:40 p.m.[68]

On June 14, 2017, the Deputy Coroner Investigator reported CACERES' preliminary cause of death was cardiomegaly, and hepatomegaly.[69] The autopsy report was not available at the time of the DDR.

MEDICAL CARE AND SECURITY REVIEW

ERAU reviewed the medical care CACERES was provided at ADF, as well as the facility's efforts to ensure that he was safe and secure while detained at the facility. ERAU found deficiencies in ADF's compliance with certain requirements of the ICE PBNDS 2011 (revised 2016).

1. **ICE PBNDS 2011 (revised 2016),** ***Medical Care*****, section (V)(A)(2)**, which states, "Every facility shall directly or contractually provide its detainee population with the following: … 2) Medically necessary and appropriate medical, dental and mental health care and pharmaceutical services."

   - CACERES was discharged from the infirmary with an order for blood pressure monitoring three times per week for two weeks. Medical staff did not transcribe this until May 31, 2017, eight days after his discharge.

2. **ICE PBNDS 2011 (revised 2016),** ***Medical Care*****, section (V)(G)(12)**, which states, "Each detention facility shall have and comply with written policy and procedure for the management of pharmaceuticals, to include: … 12) Documentation of accountability for administering or distributing medications in a timely manner, and according to licensed provider orders."

   - (b)(6);(b)(7)(C) did not document administration of Clonidine on May 22, 2017, on CACERES' MAR, nor did she enter it into the (b)(7)(E)

[62] ACLS protocols include managing the airway, establishing IV access, interpreting electrocardiograms (recording the electrical activity of the heart) and administering emergency IV medications such as epinephrine.
[63] *See* VVGMC Emergency Record, dated May 31, 2017.
[64] *See* VVGMC Death Notification/Adult Mortuary Information Form, dated May 31, 2017.
[65] *See* GEO General Incident Report by (b)(6);(b)(7) (b)(6);(b)(dated May 31, 2017.
[66] *See* GEO Memorandum by (b)(6);(b)(7)((b)(6); dated May 31, 2017.
[67] ERAU Interview with (b)(6) (b)(6);(b)(7)(dated July 25, 2017.
[68] *See* GEO General Incident Report by (b)(6);(b) (b)(6);(b) dated May 31, 2017.
[69] *See* electronic message from San Bernardino County Sheriff's Department, Coroner's Division, to GEO.

AREA OF NOTE

ERAU identified the following concern with emergency response equipment, and the corrective actions implemented by the facility staff following CACERES' death.

- Nursing staff identified medical equipment issues during the emergency response to include: the ambu bag did not function properly, the back board did not have a security strap, oxygen was not available on the gurney, and suction was not available on-site.
  - Prior to ERAU's onsite review, medical staff stocked two additional emergency bags for a total of six located throughout the facility. Each bag now contains a suction device and bulb syringe, and medical staff were trained on using both the suction equipment and the ambu bags. Additionally, the facility ordered a new security strap for the backboard, and added a holder for the oxygen tank to the gurney.

EXHIBITS

1. Creative Corrections Medical and Security Compliance Analysis (Bifurcated)
2. GEO Medical Intake Screening by (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) dated May 22, 2017.

Detainee Death Review: Vincente CACERAS-Maradiagra, (b)(6);(b)(7)(C)
Security Report

The purpose of this review was to provide the Office of Detention Oversight (ODO) with a summary report concerning the death of an Immigration and Customs Enforcement (ICE) detainee. On May 31, 2017, at 6:38 p.m. detainee Vincente CACERAS-Maradiagra (b)(6);(b)(7)(C) a 46-year old male citizen of Honduras, was transported by American Medical Response (AMR) ambulance from Adelanto Detention Facility West (ADFW) to Victor Valley Global Medical Center (VVGMC) in Victorville, CA, after being found unresponsive and without a pulse. AMR paramedics reported detainee CACERAS flat lined enroute to Victor Valley Global Medical Center (VVGMC). Once at VVGMC, detainee CACERAS, was pronounced dead by (b)(6);(b)(7)(C) (b)(6);(b)(on May 31, 2017, at 7:06 p.m. with a preliminary cause of death being Acute Coronary Syndrome. This Death Review was conducted July 25-27, 2017. This section focuses on security and control issues surrounding the death.

During the review, reviewers observed current facility operations; toured the West 4-C Housing Unit, West 4-C Recreation Yard, Medical Unit, Intake, Vehicle Sally-Port and corridors leading from the West 4-C Recreation Yard to the intake area, watched video surveillance of the (b)(7)(E) (b)(7)(E) on the day of the incident, and reviewed records and all incident related documentation. The findings of this review are based on review of the policies and post orders, staff interviews, and other supporting documentation.

Summary of Events

Per the I-213, Vincente CACERAS's criminal history included a 2011 conviction for Driving Under Influence of Liquor and a 2016 conviction for Fraud.

On May 22, 2017, CACERAS was taken into custody by Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO), Los Angeles Field Office (LAFO), (b)(7)(E) (b)(7)(E) On May 22, 2017, at 6:01 a.m. (b)(7)(E) observed CACERAS exit his apartment in North Hollywood, CA, and enter a late model Toyota. As CACERAS departed in the Toyota (b)(7)(E) initiated a vehicle stop and CACERAS was arrested moments later. At the time of his arrest, CACERAS was interviewed and stated he was a native and citizen of Honduras by virtue of birth and claimed he had entered the U.S. illegally at an unknown time and location. Due to CACERAS's past criminal history he was taken into custody for processing without incident and transported to LAFO. On May 22, 2017, CACERAS was transferred to ADFW and per Form I-203, he arrived at 8:45 p.m.

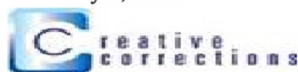
ADFW is privately owned and operated by the GEO Group, Inc. (GEO) of Boca Raton, Florida. ADFW was purchased by GEO in June 2010 from the City of Adelanto. The facility was originally developed in 1991 to house a population of adult males sentenced by the California Department of Corrections and Rehabilitation. On May 27, 2011, GEO entered into a contract to house federal immigration detainees with U.S. Immigration & Customs Enforcement (ICE), through an intergovernmental service agreement with the City of Adelanto. The initial intake of detainees began in August 2011. The facility achieved initial accreditation through the American Correctional Association in 2014 with a score of 100%. On the date of the incident there were (b)(7)(E) full time staff at ADFW; (b)(7)(E) security staff comprised of supervisors, detention officers and transportation officers.

ADFW houses detainees on both the East and West side of the facility complex. On the date of detainee CACERAS's death, the on-site population at ADFW was 1,583; the East side housed 522 detainees (278 males and 244 Females), and the West side 1,061 male detainees. This incident took place on the West side of the complex.

The facility (b)(7)(E) (b)(7)(E) Visitors must display identification before being admitted through a secure door and passing through a metal detector. Personal items must be placed on a belt for screening through an X-ray machine. (b)(7)(E) are used throughout the facility to monitor and record events.

Upon arrival at ADFW, detainee CACERAS's classification review and PREA Risk Assessment were completed by an ADFW detention officer. The officer utilized the ICE Custody Classification Worksheet (Appendix 2.2.A) from the PBNDS 2011 standards and appropriately rated detainee CACERAS medium-low custody based on his single most serious prior conviction and additional prior convictions. On May 22, 2017, this classification rating was approved by a supervisor.

Detainee CACERAS's personal property consisted of one pair each of socks, pants, shoes and underwear as well as one shirt, a belt, a cup, an ID card, one wallet and shoelaces. Detainee CACERAS signed a receipt for these items as well as a receipt for a gold chain, chase card and one set of keys. The gold chain, chase card and keys were stored in the property area in bin #1360. He also signed a receipt for cash totaling $50.00 which was placed into his account. Detainee CACERAS was issued facility clothing, hygiene supplies, linens, Prison Rape Elimination Act information, and the facility handbook. Detainee CACERAS signed an Emergency Notification and Property Disposition Form and gave the name and telephone number of (b)(6);(b)(7)(C) as his emergency contact. Forms and receipts were all completed in English.

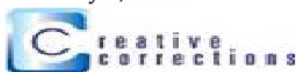


During medical screening, detainee CACERAS denied all chronic health conditions, self-reported previous treatment for umbilical hernia and intake vital signs indicated elevated blood pressure of 181/105. After a second blood pressure was taken, CACERAS still presented an elevated pressure. A verbal order was obtained to medicate hypertension with 0.1mg Clonidine and a baseline EKG was completed. After three doses of 0.1mg Clonidine his blood pressure was reduced to 149/95. After intake was completed detainee CACERAS was escorted to the infirmary to monitor his blood pressure and a verbal order was obtained for Lisinopril 10mg daily for 30 days. According to the ADFW Housing History Grid detainee CACERAS remained in the infirmary in Ward 544 until May 23, 2017. At 4:17 p.m. on May 23, 2017 he was assigned to Unit West 4, Block C (W4C), upper tier room 202, lower bunk #2.

Unit W4C is a general population (b)(7)(E) cell block housing (b)(7)(E) detainees. There are (b)(7)(E) (b)(7)(E) and (b)(7)(E) (b)(7)(E) cells in the unit. Upon entrance to the unit, the officer's podium is (b)(7)(E). There are (b)(7)(E) (b)(7)(E) The dayroom has 20 tables with attached stools that are used for dining and card and game playing. A microwave, telephones, and shower stalls are all located along the walls. An exercise area is immediately adjacent to the dayroom and two large screen televisions are mounted from the ceiling near the center. A staircase to the upper tier is near the center of the dayroom. Cell 202 is a four person cell and is located on the upper level of the unit to the right of the staircase. The cell has four bunk beds, a table with two stools, a toilet/sink combination, a small shelf with four collapsible coat hooks and a stainless steel mirror. The door to the cell has large windows on both the lower and upper portions of the door.

There is a central control at ADFW staffed (b)(7)(E) officers and a housing pod control staffed by (b)(7)(E) The housing West 2 pod control officer controls the (b)(7)(E) to the four housing units (A through D) surrounding the (b)(7)(E) The pod control (b)(7)(E) while the housing units do not. ADFW utilizes (b)(7)(E) n the housing units. An (b)(7)(E) by the housing unit (b)(7)(E) can be used by the assigned officer to communicate to the (b)(7)(E) and the (b)(7)(E) which can be used to communicate with central control or for emergency calls.

At 2:45 p.m. on May 31, 2017, (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) assumed the post as housing unit officer in Unit W4C after being held over from his previous shift. At the time, the count in this unit was 71. (b)(6);(b)(7)(C) (b)(6);(was interviewed on July 26, 2017 at 8:55 a.m. and during the interview stated he had previously been assigned to the 6 a.m. to 2 p.m. shift and had been held over to work the 2 p.m. to 10:30 p.m. shift. He was assigned to Unit W4C and assumed his shift at approximately 2:45 p.m. Shortly after assuming his post, (b)(6);(b)(7)(C) (b)(6);(b states he began pertinent security checks within the housing unit and recreation yard. Unit W4C shares a small recreation yard with Unit W4D which is located between the two units. Detainees in W4C had access to the recreation yard



during this time and (b)(6);(b)(7)(C) (b)(6);(b) observed six detainees playing soccer and two detainees sitting on the exercise rack.

(b)(6);(b)(7)(C) b)(6);(b stated during interview all appeared normal in the unit as he began a security check at approximately 6:00 p.m. As he returned to the officers podium in the unit, detainees came from the recreation yard and informed him a detainee, later identified as detainee CACERAS, had collapsed on the recreation yard. He immediately responded to the recreation area and observed a detainee on the ground lying on his stomach with other detainees surrounding him being attentive to detainee CACERAS. He estimates the time to be approximately 6:07 p.m. and immediately called a medical emergency (Code Blue) via his hand-held radio. After announcing a code blue he checked on detainee CACERAS on the ground and he observed detainee CACERAS struggling for air with his eyes open. He communicated with detainee CACERAS by telling him medical was on the way and detainee CACERAS blinked his eyes and nodded but said nothing. He noticed a large number of detainees had entered the yard and began instructing the detainees to return to the housing unit.

(b)(6);(b)(7)(C) b)(6);(b stated during interview, between announcing the code blue and the arrival of medical staff on the recreation yard he continued to instruct and order detainees to return to the housing unit. He stated four to five detainees were attending to detainee CACERAS by fanning him with t-shirts and attempting to communicate with detainee CACERAS. (b)(6);(b)(7)(C) b)(6);(stated he continued to move about the recreation yard attempting to gain detainee cooperation to return to the housing unit while maintaining eye contact on detainee CACERAS. He stated within approximately 2 minutes of calling the code blue (b)(6);(b)(7)(C) (b)(6);(arrived and made a quick assessment of detainee CACERAS and then began assisting clearing the recreation yard of detainees.

(b)(6);(b)(7)(C))(6);(b stated during interview he kept a close eye on detainee CACERAS while he and b)(6); cleared the recreation yard and observed the four to five detainees who originally were attending to detainee CACERAS remained near CACERAS fanning him in an attempt to cool him down. As other staff arrived on scene he stated all but the four to five detainees attending to detainee CACERAS had been removed from the recreation yard and shortly afterwards these detainees were also returned to the housing unit.

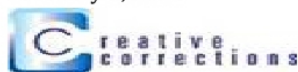
(b)(6);(b)(7)(C) (b)(6);(b stated during interview upon medical staff's arrival he departed the recreation yard and returned to the housing unit to compete a lock-down of Unit 4WC. He stated the stress of the situation had affected him emotionally and he felt he needed to remove himself from the situation unfolding on the recreation yard. (b)(6);(b)(7)(C) 6);(b during the interview process was visually emotional while he recounted the events of May 31, 2017.

On July 25, 2017, at 4:45 p.m. (b)(6);(b)(7)(C) (b)(6);(b)(7)(C was interviewed and during interview stated he responded to a code blue in Unit W4C which had been called by (b)(6);(b)(7)(C) b)(6);(b) He estimated the time to be approximately 6:07 p.m. and upon his arrival to Unit W4C he entered the recreation yard. He observed a detainee, later identified as detainee CACERAS, lying on the ground on his back with several detainees standing near detainee CACERAS as was (b)(6);(b)(7)(C) (b)(6);(b) He observed detainee CACERAS appearing to take shallow breaths with his eyes open. He began to remove detainees from the recreation yard in an attempt to secure the area. He departed the recreation area and entered the pod control area to continue his efforts to secure the area and upon his return to the recreation yard he observed medical staff on site attending to detainee CACERAS.

(b)(6);(b)(7)(C) b)(6);(stated during interview he was advised by (b)(6);(b)(7)(C))(6);(b)(to contact 911 for a medical transport to an outside hospital. He stepped out of the recreation yard and advised the Unit 4 Control Officer to notify Central Control to call for an ambulance and estimated the time to be approximately 6:11 p.m. He returned to the recreation yard to assist as needed and observed medical staff performing CPR and using an Automated External Defibrillator (AED) on detainee CACERAS. He began assigning officers to assist with escorts of outside medical persons into the facility. Upon the arrival of San Bernardino County Fire Department (SBCFD) he assisted with placing detainee CACERAS onto a back board and then lifting him onto a gurney. He estimates the time to be 6:17 p.m. when detainee CACERAS was rolled out of the recreation yard through the Unit 4 corridor to the main corridor enroute to the medical department.

(b)(6);(b)(7)(C))(6); stated during the interview he followed the gurney carrying detainee CACERAS and observed staff performing chest compressions as the gurney rolled down the corridor. While still in the main corridor they were met by SBCFD personnel where they continued to intake where they were met by AMR personnel who also responded. He assisted in cutting detainee CACERAS's pants off to provide access for medical treatment. He then departed the intake area returning to the Watch Office. Upon his return to intake he observed detainee CACERAS being treated by AMR, SBCFD and ADFW medical staff just prior to being loaded into the AMR ambulance and departing the facility

On July 26, 2017, at 11:00 a.m. (b)(6);(b)(7)(C) (6);(b)(7)(C) was interviewed by telephone and during interview stated he was the shift supervisor on May 31, 2017, when a code blue in Unit W4C had been called by (b)(6);(b)(7)(C) b)(6);(b) He estimated the time to be approximately 6:08 p.m. He stated upon his arrival to the W4C recreation yard he observed a detainee, later identified as detainee CACERAS, laying on his back unresponsive to touch or sound. He observed staff clearing the recreation yard of detainees and medical staff arrived shortly after him and estimates that time to be approximately 6:11 p.m. He observed medical staff begin chest compressions and other CPR related steps. He returned back to the West Watch Office and began emergency



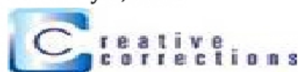
notifications and initiated the Incident Command Center within the West Watch Office. He recalled outside medical assistance was called by the West Control Center and estimates the time was approximately 6:16 p.m. Shortly thereafter the SBCFD arrived and soon after AMR medical staff arrived. He estimates AMR and ADFW Detention Officers escort staff departed with detainee CACERAS at approximately 6:34 p.m. via ambulance enroute to VVGMC.

(b)(6);(b)(7)(C) (b)(6);(stated during interview after detainee CACERAS's departure by ambulance he began the notification process with the first notification being the (b)(6);(b)(7)(C) (b)(6);(b)(7)(b)(6);(b)(7)(C) (b)(6);(b)(7)(C) via telephone. He stated he received a telephone call from (b)(6);(b)(7)(C) b)(6);(b)(7)(C) informing him that medical staff at VVGMC had declared detainee CACERAS dead at 7:06 p.m. He stated (b)(6);(b)(7)(made telephonic notification of detainee CACERAS's death to (b)(6);(b)(7)(C))(6);(b)(7)(C) GEO (b)(6);(b)(7)((b)(6);(b)(7)(C) (b)(6);(b)(7)(C, and ICE (b)(6);(b)(7))(6);(b)(7)(C)

(b)(6);(b)(7)(C) (b)(6);(b stated during interview at approximately 8:45 p.m. he notified the San Bernardino Sheriff's Department (SBSD) of the death of detainee CACERAS. He estimates the time to be approximately 9:22 p.m. when a representative from the SBSD arrived to initiate a formal investigation of the incident. (b)(6);(b)(7)(C) (b)(6);(b stated at approximately 10:25 p.m. he conducted an exit briefing with all staff on shift in the front lobby of the facility.

On July 25, 2017, at 10:10 a.m. (b)(6);(b)(7)(C) was interviewed and during interview stated she was the ADO on May 31, 2017. She stated she received a call at her residence informing her a code blue in Unit W4C had been called by (b)(6);(b)(7)(C))(6);(b)((b)(6);(b)(7)(C (b)(6);(b informed her a detainee had collapsed while playing soccer on the recreation yard of Unit W4C and ADFW medical staff began CPR and continued through the transition of care to the SBCFD and AMR personnel.

(b)(6);(b)(7)(C stated during interview she made telephonic notifications to (b)(6);(b)(7)(C) b)(6);(b)(7)(C) and GEO (b)(6);(b)(7)(C))(6);(b)(7)(C) of the emergency medical situation and transfer by ambulance of detainee CACERAS to VVGMC. She stated (b)(6);(b)(7)(C) (b)(6);(called her a second time shortly after 7:00 p.m. and notified her detainee CACERAS had been declared deceased by VVGMC medical staff. She directed (b)(6);(b)(7)(C) (b)(6);(b) to get all pertinent documents together for any after-action needs. She again made notifications to (b)(6);(b)(7 (b)(6);(b)(7)(C) and GEO (b)(6);(b)(7)(C))(6);(b)(7)(C and ICE (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) of the death of detainee CACERAS. Shortly afterwards she departed her residence enroute to VVGMC and arrived at approximately 7:45 p.m. where she met with (b)(6);(b)(7)(C)(6);(b)(7)(and (b)(6);(b)(7)(She remained at VVGMC until personnel from the Coroner's office showed up and began to examine and process detainee CACERAS's body.



On July 27, 2017, at 8:35 a.m. (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) was interviewed and stated he was the Medical Post Officer on May 31, 2017, when a code blue in Unit W4C had been called by (b)(6);(b)(7)(C) (b)(6);(b)(He estimated the time of the code blue to be 6:06 p.m. He was one of (b)(7)(E) officers assigned to the Medical Post and remained in the unit as other staff responded to the code blue. He stated shortly after the code blue was called he was directed by (b)(6);(b)(7)(C) (b)(6); along with (b)(6);(b)(7) (b)(6);(b)(7) to prepare for transportation of a detainee, later identified as detainee CACERAS, outside the facility for medical care. While in the intake area he observed ADFW, AMR and SBCFD working together performing medical assistance to detainee CACERAS.

(b)(6);(b)(7)(C) (b)(6);(b)(7)(stated during interview once the decision was made to transport detainee CACERAS to VVGMC he boarded the transport ambulance along with three AMR personnel. He estimates departing the ADFW vehicle sally-port at approximately 6:36 p.m. enroute to VVGMC with (b)(6);(b)(7) (b)(6);(b)(7) in a chase vehicle. He stated AMR personnel continued with CPR until arrival at VVGMC which he estimates to be approximately 6:52 p.m. He stated AMR and VVGMC personnel removed detainee CACERAS from the ambulance and rolled him into Emergency Room (ER) #3 where VVGMC personnel continued with CPR.

(b)(6);(b)(7)((b)(6);(b)(7 stated during the interview after approximately 15 minutes of CPR by VVGMC personnel he and (b)(6);(b)(7)((b)(6);(b)(7) were advised by (b)(6);(b)(7)(C) (b)(6);(b)(ceased the CPR and called the time of death at 7:06 p.m.

(b)(6);(b)(7)(C) (b)(6);(b)(stated during interview he immediately called (b)(6);(b)(7)(C) (b)(6);(and informed him of the death of detainee CACERAS. He stated at approximately 7:46 p.m. (b)(6);(b)(7 arrived at VVGMC. He stated at approximately 9:33 p.m. (b)(6);(b)(7)(C) (b)(6); (b)(6);(b)(7)(C) arrived and began examining, photographing and documenting the condition of detainee CACERAS's body and at approximately 10:33 p.m. (b)(6);(b)((b)(6);(b)(7 and (b)(6);(b) completed their examination. He stated at approximately 10:37 p.m. a (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) (b)(6);(b)(7)(took custody of detainee CACERAS's body and the remainder of his clothes for further examination. He stated at approximately 10:40 p.m. (b)(6);(b)(7) departed VVGMC with detainee CACERAS body and at approximately 10:53 p.m. he and (b)(6);(b)(7) (b)(6);(b)(7) departed VVGMC enroute back to ADFW.

On July 26, 2017, at 8:10 a.m (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) was interviewed and during the interview stated she was returning from her meal break on May 31, 2017, when a code blue in Unit W4C had been called by (b)(6);(b)(7)(C) (b)(6);(b)(She estimated the time to be approximately 6:07 p.m. She stated she immediately reported to Unit W4C to assist. She stated she is a certified Emergency Medical Technician (EMT) and is also employed by AMR. She stated upon her arrival on the recreation yard of Unit W4C she observed a detainee, later identified as detainee CECERES-

MARDIAGA, lying in a supine position on the ground and appeared to be unresponsive with ADFW medical staff performing CPR and using an AED.

(b)(6);(b)(7)(C) (b)(6);(b)(7)(C) stated during interview she relieved (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) who was performing chest compressions. She stated she continued chest compressions until the AED advised analyzing rhythm and a shock should occur. The AED automatically initiated shock and shortly afterwards she continued chest compressions pausing momentarily for a pulse check. She stated it appeared detainee CACERAS had agonal respirations with a pulse. She stated (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) and (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) performed a log roll in order to place the back board under detainee CACERAS . She stated (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) and herself placed the back board under detainee CACERAS at which time the AED again advised analyzed rhythm and a shock should occur. She stated after the AED automatically initiated a shock (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) checked for a pulse and found none. CPR resumed as detainee CACERAS was lifted with the back board and placed on a gurney.

(b)(6);(b)(7)(C) (b)(6);(b)(7)(C) stated during interview CPR was continued by her and (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) as the gurney was rolled from the recreation yard through the Unit 4 corridor and into the main corridor. She stated these compressions were continued as they rolled detainee CACERAS down the main corridor enroute to medical until such time as the AED advised analyzing rhythm and a shock should occur.

(b)(6);(b)(7)(C) (b)(6);(b)(7)(C) stated during interview after the AED automatically initiated shock and shortly afterwards she continued chest compressions pausing momentarily for a pulse check. She stated at this time they were met by personnel from SBCFD in the main corridor. She stated it was determined at this time by SBCFD they should continue to intake in preparation for the arrival of AMR's ambulance. She stated once in intake SBCFD began preparing to perform Advanced Life Support (ALS) measures. She stated ADFW staff continued with chest compressions until AMR's arrival at which time detainee CACERAS was placed on the AMR gurney and readied for transport by ambulance.

On July 27, 2017, at 10:00 a.m. (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) was interviewed and during interview stated he responded on May 31, 2017, when a code blue in Unit W4C had been called by (b)(6);(b)(7)(C) stated upon his arrival at Unit W4C Recreation Yard he observed a detainee, later identified as detainee CACERAS, laying on the ground and appeared unresponsive. He stated ADFW medical staff were performing CPR and he was instructed by (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) to get the oxygen tank from the 4&5 side satellite medical room. He stated he and (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) retrieved the oxygen tank and brought it to the recreation yard. He stated he stood by while CPR was being performed until such time as ADFW medical staff requested assistance with placing detainee CACERAS on the gurney to which he provided needed

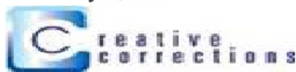
assistance. He stated as detainee CACERAS was being rolled on the gurney he carried the oxygen tank walking next to the gurney.

On July 26, 2017, at 1:45 p.m. (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) was interviewed and during interview stated he was assigned as the Utility Officer on May 31, 2017, when a code blue in Unit W4C had been called by (b)(6);(b)(7)(C) stated he was instructed by (b)(6);(b)(7)(C) (b)(6);(b)(7) to escort AMR personnel into Intake from the vehicle sally-port. He stated as he entered Intake with the AMR personnel he observed (b)(6);(b)(7)(C) (b)(6);(b) performing chest compressions on a detainee, later identified as detainee CACERAS. (b)(6);(b)(7)(C) (b)(6);(b)(7) stated he was then instructed by (b)(6);(b)(7)(C) (b)(6);(to help inventory detainee CACERAS's property in Unit W4C. He stated upon his arrival in Unit W4C at detainee CACERAS's cell, #202, he observed the property inventory had already been completed by (b)(6);(b)(7)(C) and (b)(6);(b)(7) (b)(6);(b)(7)(

On July 25, 2017, at 3:35 p.m (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) was interviewed and during interview stated he was the Intake Sergeant on May 31, 2017, when a code blue in Unit W4C had been called by (b)(6);(b)(7)(C) (b)(6);(b)(He stated he observed ADFW staff roll a detainee, later identified as detainee CACERAS, into Intake with ADFW medical staff performing chest compressions and followed by SFCFD personnel. He stated he assisted with getting SFCFD and AMR personnel into and out of Intake from and to the vehicle sally-port.

The written log of events from that evening, witness statements as well as video surveillance footage from various cameras throughout (b)(7)(E) were reviewed. Footage was reviewed from the period when just before detainee CACERAS entered the recreation yard on May 31, 2017, until the departure of the ambulance from the vehicle sally-port. The video has a time and date stamp on the footage. (NOTE: the time on the surveillance footage adapts to the time on the computer settings of the person reviewing the footage. Since this reviewer's computer is set to Central Daylight Time, the date stamp is two hours later than the actual time of the events. Times have been adjusted accordingly in this report to reflect actual times.) The log entries, video footage and witness statements are within minutes of each other as to the time of events.

The small recreation yard located between Unit's W4C and D is a rectangular shape with all four walls and the floor being constructed of concrete. (b)(7)(E) forms a ceiling over the larger (North) part of the recreation yard allowing for direct sunlight. A smaller (South) portion of the recreation yard is covered with (b)(7)(E) and directly under it is a pull-up bar/exercise station. The recreation yard contains (b)(7)(E) one on the (b)(7)(E) which provides (b)(7)(E) (b)(7)(E) a second on (b)(7)(E) and a third on (b)(7)(E) (b)(7)(E) This recreation yard contains



(b)(7)(E). The video begins at 6:03.00 p.m. and six detainees can be seen playing kick-ball on the North section of the recreation yard and two detainees can be seen sitting on the pull-up/exercise station. The security camera captured the events as they unfolded on the recreation yard as follows:

6:03:15 p.m. Detainee CACERAS enters the recreation yard and appears to observe the six detainees playing kick-ball.

6:03:48 p.m. Detainee CACERAS takes the place of one of the detainees playing kick-ball. The video shows detainee CACERAS continuing to play kick-ball for the next three minutes until such time as he took a position, still playing, on the Northwest corner of the recreation yard and places his hands on his knees.

6:06:21 p.m. Detainee CACERAS continues to play kick-ball and after each time he kicks the ball he would bend at the waist and place his hands on his knees. He did this a total of five times.

6:07:31 p.m. Detainee CACERAS takes two steps forward and placed his hands on the side of his head, taking an additional four steps forward placing his right hand against the West wall appearing to balance himself.

6:07:32 p.m. Detainee CACERAS dropped to both knees and then fell forward on his stomach and lay motionless with the exception of lifting his head once. Several detainees gathered around detainee CACERAS while others alerted the officer of the situation.

6:07:55 p.m. (b)(6);(b)(7)(C) (b)(6);(entered the recreation yard and immediately removed his hand-held radio from its pouch and made a radio transmission (code blue).

6:08:03 p.m. (b)(6);(b)(7)(C) (b)(6);(b approached detainee CACERAS and again raised his radio and made a radio transmission. The video shows several additional detainees entering the recreation yard from the housing unit in apparent curiosity; the detainees whom had been playing kick-ball remained gathered around detainee CACERAS and were now fanning detainee CACERAS in an effort to cool him.

6:08:20 p.m. (b)(6);(b)(7)(C) (b)(6);(began efforts to clear the recreation yard of detainees by motioning towards the West egress door leading into W4C. The video shows some detainees depart the recreation yard as others enter the recreation yard and those closest to

detainee CACERAS were bent over him with one and at times two fanning him. The video shows (b)(6);(b)(7)(C) continuing to attempt to clear the recreation yard and paying close attention to detainee CACERAS.

6:09:07 p.m. (b)(6);(b)(7)(C) enters the recreation yard from the South door and immediately motions for detainees to clear the recreation yard.

6:09:16 p.m. (b)(6);(b)(7)(C) after clearing most detainees from the recreation yard, approached detainee CACERAS's position. The video shows (b)(6);(b)(7)(C) instructing those detainees who were gathered around detainee CACERAS to clear the recreation yard as (b)(6);(b)(7)(C) remains next to detainee CACERAS. The video shows together (b)(6);(b)(7)(C) and (b)(6);(b)(7)(C) continuing to clear the recreation yard.

6:09:27 p.m. (b)(6);(b)(7)(C) follows stragglers as they depart the recreation yard and enters 4WC for a short time as (b)(6);(b)(7)(C) remains close to detainee CACERAS.

6:09:34 pm. (b)(6);(b)(7)(C) returns to the recreation yard and approaches the five detainees who remain gathered around detainee CACERAS as he continues to lay prone on his stomach. The video shows (b)(6);(b)(7)(C) instructing these detainees to depart the recreation yard and these detainees are reluctant to follow these instructions.

6:09:37 p.m. (b)(6);(b)(7)(C) attempts to enter W4C but the (b)(7)(E) is secure. Because the (b)(7)(E) is secure the last five detainees cannot depart the recreation yard. The video shows (b)(6);(b)(7)(C) go off frame as he heads towards the South part of the recreation yard.

6:09:57 p.m. (b)(6);(b)(7)(C) comes back into frame from the South end of the recreation yard and approaches (b)(6);(b)(7)(C) who is now close to detainee CACERAS as the five detainees remain near the W4C egress door.

6:10:02 p.m. With (b)(6);(b)(7)(C) now close to detainee CACERAS two of the five remaining detainees on the recreation yard approach detainee CACERAS.

6:10:05 p.m. (b)(6);(b)(7)(C) leaves (b)(6);(b)(7)(C) and goes off frame as he approaches the South end of the recreation yard. The video shows (b)(6);(b)(7)(C) close to detainee CACERAS along with two detainees.

6:10:07 p.m. As (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) observes detainee CACERAS one of the two detainees who returned to the immediate area of detainee CACERAS reaches down and turns detainee CACERAS from his stomach to his back.

6:10:16 p.m. (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) comes back into frame from the South end of the recreation yard with four other staff members, one which appears to be a medical person. The video shows each of these four additional staff members approaching detainee CACERAS's location.

6:10:33 p.m. The W4C (b)(7)(E) opens and thee of the five remaining detainees exit the recreation yard. The video shows the two remaining detainees on the recreation yard close to detainee CACERAS's location and continue to use clothing to fan detainee CACERAS as several other staff members enter the recreation yard from the West and South restraining doors.

6:10:52 p.m. The final two detainees are escorted off the recreation yard and through the W4C (b)(7)(E) The video shows several staff members gathering around detainee CACERAS's location.

6:11:07 p.m. Several medical staff members enter the recreation yard from the South end bringing a gurney, vital machine and wheel chair. They each approach the location of detainee CACERAS. For the next 11 minutes several staff members, both medical and security, come and go from the video frame. The video shows several staff members performing CPR on detainee CACERAS.

6:23:06 p.m. Detainee CACERAS is lifted from the floor and placed on a gurney.

6:24:02 p.m. Detainee CACERAS is rolled from the recreation yard toward the South end of the recreation yard. The video showed staff continuing CPR efforts walking beside the gurney.

6:24:12 p.m. Detainee CACERAS and staff escorting him go off frame as they head to the South end of the recreation yard. The recreation yard video ends at 6:24:30 p.m. with no one remaining on the recreation yard.

6:24:13 p.m. Detainee CACERAS and staff escorting him enter the Unit W4 Control Pod area. The video shows staff escorting detainee CACERAS performing CPR as they walk alongside the gurney. Staff negotiated several corridors enroute to Intake with

detainee CACERAS. Video footage was available for viewing (b)(7)(E) and staff could be observed performing CPR as they walked beside the gurney enroute to Intake.

6:26:08 p.m. SBCFD personnel met detainee CACERAS and staff escorting him through the main corridor. The video shows SBCFD personnel fall in behind the gurney as it is rolled toward Intake.

6:26:52 p.m. Detainee CACERAS and staff escorting him arrived at the Intake corridor.

6:27:05 p.m. Detainee CACERAS and staff escorting him entered Intake.

6:27:17 p.m. Detainee CACERAS was rolled near the vehicle sally-port door in Intake.

6:28:25 p.m. AMR personnel are escorted through the vehicle sally-port into Intake with their gurney and equipment. The video shows for the next six minutes a collaborative effort in performing CPR by the ADFW medical staff, SBCFD personnel and AMR personnel.

6:34:30 p.m. Detainee CACERAS is lifted from the ADFW gurney and placed onto the AMR gurney for transport out of the facility.

6:35:25 p.m. Detainee CACERAS is wheeled from the Intake area through the vehicle sally-port enroute to the AMR ambulance.

6:36:27 p.m. Detainee CACERAS is loaded into the AMR ambulance. The video shows staff performing CPR on detainee CACERAS as they walked next to the gurney.

6:38:00 p.m. The SBCFD and the AMR ambulance departed the facility with detainee CACERAS enroute to VVGMC.

The West 4C and West 4 Control Room Logbooks were reviewed. The West 4C Logbook reports on May 31, 2017 verbatim the following three late entry's in this order: 6:05 p.m. -- "Late Entry Code Blue"; 6:21 – "To Medical (10226)", and 6:12 (b)(6);(b)(6);(arrives on post & relieves (b)(6);(b)(7)(C) b)(6);(of all duties all equipment acct. for to include (b)(7)(E) (b)(7)(E)

The West 4 Control Room Logbook reports on May 31, 2017 verbatim the following: 6:07 p.m. "code blue 4C Yard"; 6:08 p.m. (b)(6);(b)(7)(C) advised central call 911 AMR"; 6:16 p.m. "-1 4C 202 2L (Med Run)"; "L/E (b)(6);(b)(7)(C) enters 4C yard 1806" and 6:36 p.m. "code blue code C4". Additionally, after an entry at 7:39 p.m. regarding a clear count the West 4 Control Room Logbook reports "Note: Approx. 1807 (b)(6);(b)(7)(C) called a code blue on 4C Mini Rec Yard and I second called blue on the radio and advise all dorm officers to secure all detainees in their cells. Upon doing my visual check I observed detainee Caceres (b)(6);(b)(7)(C) 202, 2L down on the floor of the Mini Rec yard. I access all doors connecting to 4C so all supervisors and officers, medical personnel have a easy access to the detainees. At approx. 1816 detainee (b)(6);(b)(7)(C) Caceres, 2002, 2L was take to medical by medical personnel guided by (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) and officers on site".

Further documentation reveals (b)(6);(b)(7)(C) and (b)(6);(b)(7)(C) were dispatched by (b)(6);(b)(7)(C) to provide escort for detainee CACERAS to VVGMC. (b)(6);(b)(7)(C) rode in the back of the ambulance with detainee CACERAS and (b)(6);(b)(7)(C) followed in a chase vehicle. ADFW transportation officers are required to bring a logbook with them on medical trips to record events. The West Medical Bag Logbook reports the following:

6:36 p.m. (b)(6);(b)(7)(C) departs ADFW with AMR enroute to VVGMC with detainee CACERAS.

6:52 p.m. AMR ambulance arrived at VVGMC with detainee CACERAS escorted by (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) and (b)(6);(b)(7)(C) in the (b)(7)(E) vehicle.

6:54 p.m. Detainee CACERAS admitted into emergency room #3 at VVGMC and staff are performing CPR. (b)(6);(b)(7)(C) and his medical staff assisted detainee CACERAS upon arrival. Additionally, at this time Central Control West was advised of the arrival.

7:00 p.m. Medical staff is still performing CPR on detainee CACERAS.

7:06 p.m. (b)(6);(b)(7)(C) informs both (b)(6);(b)(7)(C) and (b)(6);(b)(7)(C) that time of death (7:06 p.m.) had been called by (b)(6);(b)(7)(C)

7:46 p.m. (b)(6);(b)(7)(C) arrives on site at VVGMC.

8:36 p.m. Medical Bag #8 phone is low on battery. (b)(6);(b)(7)(C) phone is used to advise Central Control West that (b)(6);(b)(7)(C) and (b)(6);(b)(7)(C) are (b)(7)(E)

9:33 p.m. (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) and (b)(6);(b)(7)(C) arrive on at VVGMC's emergency room #3. Additionally, Central Control West was advised all is Code 4.

9:41 p.m. Deputy Coroner Investigators begin the process of inspecting and documenting the condition of detainee CACERAS's body.

9:48 p.m. Deputy Coroner Investigators begin taking images and continue inspecting detainee CACERAS. Additionally, (b)(6);(b)(7)(C))(6);(b)(7)(C) provided (b)(6);(b)(7)(C) b)(6);(b)(7) and (b)(6);(b)(7)(with a case number which is (b)(7)(E)

10:13 p.m. (b)(6);(b)(7)(C) b)(6);(b)(7)(arrives on site.

10:17 p.m. Deputy Coroner Investigators inserts detainee CACERAS body into a bag and applies a toe tag with (b)(7)(E)

10:27 p.m. Deputy Coroner Investigators take finger prints of detainee CACERAS.

10:28 p.m. Central Control West notified all code 4.

10:33 p.m. Deputy Coroner Investigators complete examination of detainee CACERAS and gather the remainder of detainee CACERAS clothes and effects.

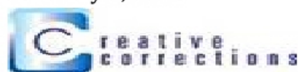
10:37 p.m. (b)(6);(b)(7)(C) b)(6);(b)(7)(C) takes possession of detainee CACERAS's body.

10:40 p.m. (b)(6);(b)(7)(C) b)(6);(b)(7)(departs VVVMC with detainee CACERAS's body.

10:53 p.m. (b)(6);(b)(7)(C) b)(6);(b)(7) and (b)(6);(b)(7)(depart VVGMC enroute to ADFW.

23:14 p.m. b)(6);(b)(7)(and (b)(6);(b)(7)(arrive at ADFW.

On May 31, 2017 at 9:19 p.m., (b)(6);(b)(7)(C) (b)(6);(b)(from the San Bernardino County Sheriff's Department (SBCSD) arrived at ADFW to perform a investigation of the incident. Deputy (b)(6);(b)(report indicates he inspected the incident location (Unit W4C Recreation Yard) and viewed the video from (b)(7)(E). Deputy (b)(6);(b)(investigative report provides the following analysis:



Observations/Scene: "I observed a group of detainees were kicking a ball on the North end of the recreation yard. He observed the following: detainee CACERAS kicking the ball to other detainees and after each kick detainee CACERAS would bend over at the waist and put his hands on his knees as if he was attempting to gain his breath; detainee CACERAS kicked the ball a final time and then collapsed to the ground; an unknown detainee ran inside the W4C Unit and an Officer came out of the unit to the recreation yard; an unknown detainee rolled detainee CACERAS over onto his back; other detainees were seen coming out to see the downed detainee and the officer was trying to have the detainees re-enter the unit."

Body Position: "In the video I noticed Vicente standing upright and on occasion bending over a the waist. It appeared Vicente was bending at the waist and placing his hands on his knees he was short of breath, attempting to breathe. Vicente bent over multiple times and finally collapsed to the ground lying face down. An unknown inmate rolled Vicente over to his back."

Victim Information: 'Vicente was an inmate at the GEO Group facility he arrived on 05-22-2017. Vicente was diagnosed with hypertension at the GEO Group a few days prior to the incident. Vicente was 5' 6" tall and 240 pounds."

Witness Statements: "At about 2200 hours, I made contact with (b)(6);(b)(7)(C) at the GEO Group. (b)(6);(is a Registered Nurse who works at the GEO Group and is employed by Correct Care Solutions. The following is a summary of (b)(6);(b) statements: (b)(6);(b stated at about 1810 hours, she responded to the recreation yard in reference a man down call. (b)(6);(b performed a sternum rub on his chest in an attempt to help correct his breathing, however there was no response. (b)(6);(b stated Vicente had no pulse, at about 1812 hours, she placed an AED on Vicente and shocked him approximately six times along with giving CPR in between applying the AED with no response. The fire department and AMR arrived on scene and the medical staff at the The GEO Group released care to AMR. (b)(6);(did not recall the time AMR of the fire department arrived. The fire department and AMR also applied the (AED) on Vicente with no response, shortly after AMR transported Vicente to Victor Valley Hospital. (b)(6);(stated there was another nurse, (b)(6);(b)(7)(C) on scene. She was not at the incident location at time of interviews. This concluded my contact with (b)(6);(b

"At about 2217 hours, I interviewed (b)(6);(b)(7)(C) in an interview room at the GEO Group in reference Vicente. (b)(6);(b is an inmate at the GEO Group. The following is a summary of (b)(6);(b)(statements: On 05-31-17, (b)(6);(b)(7)(C) stated he was watching Vicente kick a ball around with a group of other guys during outside rec., and all of a sudden he saw Vicente fall to the ground. He does not know Vicente very well; they slept in the same room together. After Vicente fell to the ground

an unknown inmate ran inside to advise the officer of the incident. The officer ran outside and told everyone to go back inside. I asked (b)(6);(if he noticed anything different in Vicente's normal daily activity's, he answered no, all seemed to be normal. This concluded my contact with (b)(6);(b)(7)(C)"

"The officer in charge of 4C was not present at the time of my interviews. (b)(6);(b)(7)(C) (b)(6);(b)((b)(6);(said the officer took the incident very personal and was given time off to gather his thoughts."

Medical History: Vicente was diagnosed with hypertension approximately a week prior to the incident. The Geo Group was unable to provide me with any further information of Vicente's medical history. Vicente did have other medical issues and was taking medication to treat his condition. Vicente die take his morning medication the day of the incident."

Medication Prescribed: "The Geo Facility was unable to provide me with a list of Vicente's medications, however Coroner (b)(6);(b)(stated he was taking Lisinopril to treat his hypertension."

Additional Information: "A member of the GEO Group facility will get in contact with Deputy (b)(6); and provide him with video of the incident along with the medical records of Vicente."

Coroner Statement; (b)(6);(b)(7)(C): "On 05-31-2017, at about 2255 hours, I made contact with (b)(6);(b)(7 at Victor Valley Hospital. The following is a summary of (b)(6);(b)(7)(statements. (b)(6);(b)(stated Vicente was transferred by AMR ambulance to Victor Valley Hospital from the GEO Group. Vicente flat lined during transportation my AMR and was pronounced dead by (b)(6);(b)(7)((b)(6);(b)(7)(at Victor Valley Hospital. Time of death was approximately 1906 hours. Vicente was diagnosed with hypertension, however, Vicente was taking Lisinopril in order to treat his hypertension it appeared Vicente died of natural causes. There appeared to be no signs of trauma or foul play at th time of Vicente's death. This concluded my contact with (b)(6);(b)(7 Refer to (b)(6);(b)(report for more information. Coroner case number (b)(7)(E)

Disposition: Vicente appears to have died of natural causes, report taken for documentation.

Personal property, including a gold chain, wallet with a chase credit card, a key ring and $35.50 in funds belonging to detainee CACERAS were turned over to (b)(6);(b)(7)(C) (b)(6);(b)(7 on June 5, 2017 according to a signed receipt. A check dated June 5, 2017 was made out to (b)(6);(b)(7)(C)

Conclusions

Detainee CACERAS was housed at ADFW from May 22 to May 31, 2017, when he was transported via ambulance to VVGMC for emergency treatment. During his detention at ADFW, detainee CACERAS received no disciplinary sanctions and filed no grievances. During his stay, money was deposited into his account upon on his arrival and he used available funds to purchase phone time on six occasions and commissary on one occasion. His account balance at the time of his death was $35.50. Records reflect he received no visits during his detention at ADFW.

Surveillance footage for the detainee's last day at ADFW was retained and from the footage reviewed, it appears detainee CACERAS, while playing kick-ball on the W4C Recreation Yard, fell to his knees than to his stomach at 6:07 p.m. on May 31, 2017. Detainee CACERAS appeared to be motionless with the exception for one attempt to raise his head. Within seconds the situation was brought to the attention of (b)(6);(b)(7 (b)(6);(b) who, using a hand-held radio, immediately announced a medical emergency (code blue). (b)(6);(b)(7(b)(6); being the first supervisor to arrive at the W4C Recreation Yard, using a hand-held radio, instructed Central Control to call 911 for outside medical assistance at 6:08 p.m (b)(6);(b)(7)(C) b)(6);(arrived within seconds of (b)(6);(b)(7)(C) 6);(and together began clearing detainees from the recreation yard. ADFW medical staff arrived at the W4C Recreation Yard at 6:11 p.m. and shortly thereafter began CPR techniques in concert with the use of an AED. ADFW staff lift detainee CACERAS from the floor, place him on a gurney and exit the W4C Recreation Yard continuing with CPR at 6:23 p.m. SBCFD personnel meet ADFW staff with detainee CACERAS during escort through the main corridor and fall in behind the gurney and follow behind as it is rolled down the main corridor at 6:26 p.m. ADFW staff and SBCFD personnel enter Intake at 6:27 p.m. AMR personnel enter Intake and join SBCFD and ADFW in performing CPR at 6:28 p.m. At 6:38 p.m. detainee CACERAS was transported by ambulance to VVGMC arriving at 6:52 p.m. Within this 45 minute period of time ADFW medical staff, SBCFD personnel and AMR EMT's continuously performed life saving techniques in concert with the efforts by VVGMC emergency room personnel until his death at 7:06 p.m. on at May 31, 2017.

Prior to the death of detainee CACERAS, (b)(6);(b)(7)(C) 6);(obtained written statements from all involved staff at ADFW and after the death of detainee CACERAS he obtained written statements from the transportation officers who rode in the back of the ambulance with the detainee and followed in a chase vehicle on the trip to the hospital. After obtaining the witness statements (b)(6);(b)(7)(C) 6);(prepared the Incident Report and continued the notification process. (b)(6);(b)(7)(C) (b)(6);(notified the SBCSD of the death of detainee CACERAS at 8:45 p.m. A representative from SBCSD arrived to initiate a formal investigation of the incident at 9:22 p.m. (b)(6);(b)(7)(C)

(b)(6);(conducted an exit briefing with all staff on shift in the front lobby of the facility at 10:25 p.m.

The written log of events, witness statements, police report as well as video surveillance footage from various cameras (b)(7)(E) (b)(7)(E) indicate staff responded timely and appropriately to a medical emergency involving outside emergency resources. While the use of a hand-held audio visual camera would have benefited the review of this incident, no security deficiencies or noted concerns have been identified which contributed to the death of detainee CACERAS.

Prepared by:
(b)(6);(b)(7)(C)
Security Subject Matter Expert