Office of Professional Responsibility

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

U.S. Immigration and Customs Enforcement

MEMORANDUM FOR: (b)(6);(b)(7)(C)
Executive Associate Director
Enforcement and Removal Operations

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

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

SUBJECT: Investigative Findings – Death of ICE Detainee Fernando DOMINGUEZ-Valivia (JICMS Case 201205740)

The Office of Professional Responsibility, Office of Detention Oversight (ODO), completed the Detainee Death Review regarding ICE Detainee Fernando DOMINGUEZ-Valivia. DOMINGUEZ died on March 4, 2012, at the Victor Valley Community Hospital, Victorville, California. Prior to his death, DOMINGUEZ was housed by ICE at the Adelanto Detention Facility (ADF), Adelanto, California.

A medical review of the care provided to DOMINGUEZ while housed at the ADF determined the ADF was not compliant with the ICE Performance Based National Detention Standards (PBNDS) for medical care. Specifically, ADF failed to perform proper physical examinations in response to symptoms and complaints, failed to pursue any records critical to continuity of care, and failed to assure appropriate, timely follow up and access to off-site care. Additionally, a doctor's review of the medical care provided to DOMINGUEZ determined that DOMINGUEZ's demise could have been prevented and that DOMINGUEZ received an unacceptable level of medical care while detained at ADF.

A San Bernardino County Division of the Medical Examiner's Office Autopsy Report was generated regarding DOMINGUEZ. According to the autopsy report, DOMINGUEZ's immediate cause of death was multi-organ failure, sepsis, bronchopneumonia, and alcoholic liver disease.

This review revealed the ADF did not comply with the ICE PBNDS Medical Care Standard. The Medical Care standard ensures detainees have access to emergent, urgent,

or non-emergent medical care to ensure their health care needs are met in a timely and efficient manner. The findings of the review are in the attached report.

If you have any questions, please contact me or have a member of your staff contact Acting Deputy Division Director (b)(6);(b)(7)(C) OPR, ODO, at (202) 732-(b)(6);(b)(7)

Attachment

cc: (b)(6);(b)(7)(C)

(b)(6);(b)(7)(C)

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REPORT OF INVESTIGATION

HB 4200-01 (37), Special Agent Handbook

1. CASE NUMBER
(b)(7)(E)

PREPARED BY
(b)(6);(b)(7)(C)

2. REPORT NUMBER
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3. TITLE
DOMINGUEZ-VALIVIA, FERNANDO/Unknown/0109 Detainee/Alien - Death (Known Cause -Terminal Illness)/ADELANTO, SAN BERNARDINO, CA

4. FINAL RESOLUTION
Referred to Management

5. STATUS	6. TYPE OF REPORT	7. RELATED CASES
Closing Report	Detainee Death Review	(b)(7)(E)

8. TOPIC
Closing Report - Detainee Death Review of Fernando DOMINGUEZ-Valivia

9. SYNOPSIS
On March 4, 2012, the Joint Intake Center, Washington D.C., received notification regarding the death of U.S. Immigration and Customs Enforcement Detainee Fernando DOMINGUEZ-Valivia. DOMINGUEZ, a citizen of Mexico, died on March 4, 2011, at Victor Valley Community Hospital in Victorville, California. The California State Medical Examiner reported DOMINGUEZ died of multi-organ failure, sepsis, bronchopneumonia, and alcoholic liver disease.

On March 27, 2012, the ICE Office of Professional Responsibility, Office of Detention Oversight initiated a Detainee Death Review of Fernando DOMINGUEZ-Valivia's death. This report documents the findings of the review.

10. CASE OFFICER (Print Name & Title)	11. COMPLETION DATE	14. ORIGIN OFFICE
(b)(6);(b)(7)(C) ICE-OPR Special Agent	25-JUN-2012	ICE OPR Office of Detention Oversight (ODO)
12. APPROVED BY(Print Name & Title)	**13. APPROVED DATE**	**15. TELEPHONE NUMBER**
(b)(6);(b)(7)(C) ICE-OPR Special Agent Supervisor	26-JUN-2012	No Phone Number

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10. NARRATIVE

On March 4, 2012, the Joint Intake Center (JIC), Washington D.C., was notified of the death of Detainee Fernando DOMINGUEZ-Valivia (Alien Number 083 344 871). DOMINGUEZ, a citizen of Mexico who was born on May 10, 1953, died on March 4, 2012, at Victor Valley Community Hospital (VVCH) in Victorville, California. DOMINGUEZ was 58 years old when he died.

At the time of his death, DOMINGUEZ was in U.S. Immigration and Customs Enforcement (ICE) custody, and was housed at the Adelanto Detention Facility (ADF), located at 10400 Rancho Road, Adelanto, California 92301. The GEO Group, Inc. operates ADF under contract with the City of Adelanto, California. ADF is a designated ICE facility and holds adult male ICE detainees of all classification levels for periods of over 72 hours. There are no female detainees held at ADF. On August 29, 2011, ICE began housing detainees at ADF via an Intergovernmental Service Agreement. Healthcare is provided by the GEO Group, Inc. ADF opened in August 2011 and currently holds no accreditations. The medical clinic is open 24 hours a day, seven days a week and is administered by Health Care Services Administrator (HSA) (b)(6);(b)(7)(C) who has previously run a nursing home and several small mental health facilities. Medical oversight is provided by a physician contracted through Maxim Healthcare. The physician and a nurse practitioner (NP) share on-call coverage. Additional staff includes a part-time x-ray technician and three administrative staff. There is a dentist who works half-time. A contract psychiatrist and psychologist provide mental health services. These positions are augmented by a complement of Registered Nurses (RN) and Licensed Vocational Nurses (LVN). Per the staffing plan, there is one LVN vacancy and a vacant dental assistant position. Staffing is sufficient to meet the basic healthcare needs of ICE detainees.

On March 27, 2012, Special Agent (SA) (b)(6);(b)(7)(C) and SA (b)(6);(b)(7)(C) of the ICE, Office of Professional Responsibility (OPR), Office of Detention Oversight (ODO), conducted a review of the death of detainee Fernando DOMINGUEZ-Valivia. SA (b)(6);(b)(7 and SA (b)(6);(b)(were assisted by subject matter expert (SME) RN (b)(6);(b)(7)(C) RN (b)(6);(b)(is employed by Creative Corrections, a national management and consulting firm contracted by ICE to provide subject matter expertise in detention management with an emphasis on health care. As part of the review, agents interviewed staff at ADF and G4S Secure Solutions USA, and personnel assigned to the ICE, Office of Enforcement and Removal Operations (ERO). Agents also reviewed immigration, medical, and detention records pertaining to DOMINGUEZ.

The following is a time-line of events which occurred while DOMINGUEZ was in ICE custody:

On November 22, 2011, DOMINGUEZ was arrested by the Rialto Police Department on a warrant issued by Los Angeles County under California Penal Code (PC) 647(F), disorderly conduct/drunk

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in public (Exhibit 01). After his arrest, DOMINGUEZ was incarcerated at the West Valley Detention Center (WVDC) in Rancho Cucamonga, California. Deputy (b)(6);(b)(7)(C) a designated 287(g) officer with the San Bernardino County Sheriff's Office, encountered DOMINGUEZ at the WVDC while conducting Criminal Alien Program (CAP) checks of foreign born immigrants. During the encounter with Officer (b)(6);(b)(7)(C) DOMINGUEZ stated he was a citizen and national of Mexico. Subsequently, Officer (b)(6);(b)(7)(C) conducted records checks in the Central Index System (CIS) database and received positive results which confirmed that DOMINGUEZ was in the United States illegally (Exhibit 02). Officer (b)(6);(b)(7)(C) processed DOMINGUEZ and charged him with violation of the Immigration and Nationality Act (INA), Section 212(a)(6)(A)(i) (Exhibit 03). DOMINGUEZ remained at the WVDC until his transfer to the ICE ERO Field Office in San Bernardino, CA, for additional immigration processing.

On November 23, 2011, at approximately 5:30 a.m., DOMINGUEZ, and 16 other detainees were picked up by (b)(4) a private security company contracted by ICE to provide detainee transportation, and driven in two vans from WVDC to the ICE, ERO Field Office in San Bernardino, CA (Exhibit 04). On March 29, 2012, SA (b)(6);(b)(7)(C) SA (b)(6);(b)(7)(C) and RN (b)(6);(b)(7)(C) interviewed the four G4S Officers who transported the detainees from WVDC to the San Bernardino Field Office. The officers did not recall interacting with DOMINGUEZ, or which van had carried DOMINGUEZ as a passenger.

At approximately 9:00 a.m., DOMINGUEZ arrived at the ICE, ERO Field Office in San Bernardino. DOMINGUEZ was processed by ICE Immigration Enforcement Agent (IEA) (b)(6);(b)(7)(C) and IEA (b)(6);(b)(7)(C) SA (b)(6);(b)(7)(C) SA (b)(6);(b)(7)(C) and RN (b)(6);(b)(7)(C) interviewed IEA (b)(6);(b)(7)(C) and IEA (b)(6);(b)(7)(C) at the ICE ERO Adelanto Field Office in Adelanto, California on March 27, 2012. IEA (b)(6);(b)(7)(C) stated he completed a Los Angeles Field Office (LAFO) Custody Information Sheet (Exhibit 05), a Classification Assessment (Exhibit 06), and an In-Processing Health Screening Form (Exhibit 07) for DOMINGUEZ. The LA Custody Information Sheet and In-Processing Health Screening Form reflect that DOMINGUEZ did not disclose any pre-existing medical conditions during processing by ICE. The Classification Assessment reflects that DOMINGUEZ was recommended for Level 1 based on a comprehensive custody score. IEA (b)(6);(b)(7)(C) stated he noticed during processing that DOMINGUEZ's hands were shaking and had cuts. IEA (b)(6);(b)(7)(C) stated he was unaware of any medical issues regarding DOMINGUEZ. IEA (b)(6);(b)(7)(C) did not recall reporting his observations to anyone. IEA (b)(6);(b)(7)(C) stated he did not recall encountering DOMINGUEZ, but IEA (b)(6);(b)(7)(C) verified he conducted the fingerprint analysis of DOMINGUEZ during intake screening, which is documented on the final disposition report (Exhibit 08). DOMINGUEZ remained at the ICE ERO San Bernardino Field Office until his transfer to the ADF late in the day on November 23, 2011.

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On November 23, 2011, at approximately 2:45 p.m., DOMINGUEZ was transported by (b)(4) (b)(4) Transportation Officers from the ICE ERO San Bernardino Field Office to ADF. SA (b)(6);(b)(7)(SA (b)(6);(b)(7 and RN (b)(6);(b)(interviewed Transportation Officer (TO) (b)(6);(b)(7)((b)(6);(b) and TO (b)(6);(b)(7)(C) on March 29, 2012. TO (b)(6);(b and (b)(6);(b) did not recall interacting with DOMINGUEZ. TO (b)(6);(b) confirmed he was one of the transporting officers and verified his signature on the (b)(4) ansportation records (Exhibit 09).

On November 23, 2011, at approximately 4:00 p.m., DOMINGUEZ was admitted to ADF by Detention Officer (DO) (b)(6);(b)(7)(C) as documented on a Form I-385, Alien Booking Record (Exhibit 10). On March 27, 2012, SA (b)(6);(b)(7) SA (b)(6);(b)(and RN (b)(6);(b)(7 nterviewed DO (b)(6);(b)(7) regarding the ADF booking process. DO (b)(6);(b)(7) explained admission procedures for arriving detainees. DO (b)(6);(b)(7)(stated that arriving detainees are interviewed by multiple GEO officers within the ADF intake area who conduct interviews, complete personal property inventory forms, classify detainees, and complete an Emergency Notification and Property Disposition Form. DO (b)(6);(b)(7)(verified he was one of the booking officers that processed DOMINGUEZ. During processing, DO (b)(6);(b)(7) completed a Detainee Personal Property Inventory Form Receipt, and an Emergency Notification and Property Disposition Form (Exhibit 11). DO (b)(6);(b)(7 stated he did not recall any significant health issues with DOMINGUEZ during the booking process. DO (b)(6);(b)(7)(stated he completed the necessary paperwork and referred DOMINGUEZ to DO (b)(6);(b)(7)(C) for security classification.

SA (b)(6);(b)(7)(C) SA (b)(6);(b)(7)(C) and RN I (b)(6);(b) interviewed DO (b)(6);(b)(7)(C) on March 28, 2012. DO (b)(6);(b)(7 stated she did not remember encountering DOMINGUEZ, but verified that on November 23, 2011, she conducted a Classification Assessment of DOMINGUEZ during the booking process (Exhibit 12). DO (b)(6);(b)(7) stated she classified DOMINGUEZ as a Level I (lowest threat) detainee, because his prior convictions were misdemeanors. After completing the classification process, DOMINGUEZ was referred to the Medical Unit.

On November 23, 2011, at approximately 10:45 p.m., RN (b)(6);(b)(7)(C) conducted a medical intake screening of DOMINGUEZ (Exhibit 13). SA (b)(6);(b)(7)(SA (b)(6);(b)(7 and RN (b)(6);(b)(7)(interviewed RN (b)(6);(b at ADF on March 27, 2012. RN (b)(6);(stated the medical intake screening is performed by GEO nursing staff, and at medical intake DOMINGUEZ received the following exams: vital signs check; weight measurement; visual acuity exam; H1N1 exam; mental health exam; immunizations; tuberculosis; syphilis tests; medical history and physical assessment; and chest X-ray.

RN (b)(6);(b) stated he did not remember interacting with DOMINGUEZ, but RN (b)(6);(b was assisted by

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LVN (b)(6);(b)(7)(C) during the intake processing of DOMINGUEZ. RN (b)(6);(stated LVN (b)(6);(b)(7)(C is bilingual in the Spanish language and provided translation services. According to the medical intake screening records, RN (b)(6);(did not observe or confirm any medical concerns during the intake screening process. DOMINGUEZ's vital signs were evaluated as normal. LVN (b)(6);(b)(7)(C) is no longer employed with ADF and was not available for interview.

After completing the booking process and medical screening, DOMINGUEZ was assigned to ADF Housing Unit H2, Block B, Bed 36L (Exhibit 14). The GEO housing unit log confirms that DOMINGUEZ arrived at Housing Unit H2, Block B at approximately 8:08 p.m. DOMINGUEZ did not have any remarkable interactions or activity until November 27, 2011.

On November 27, 2011, DOMINGUEZ submitted a sick call slip indicating he had a headache and sore throat (Exhibit 15). The sick call slip was triaged by LVN (b)(6);(b)(7)(C and DOMINGUEZ was referred to RN sick call. According to the sick call slip, DOMINGUEZ was provided cold tablets and throat lozenges by RN (b)(6);(b)(7)(C) on November 28, 2011. RN (b)(6);(b)(7)(referred DOMINGUEZ to NP (b)(6);(b)(7)(C)

On November 28, 2011, at approximately 10:30 a.m., a Progress Note by NP (b)(6);(b)(documents DOMINGUEZ was seen by an RN during sick call for a sore throat (Exhibit 16). DOMINGUEZ was given throat lozenges and cold tablets containing Tylenol. NP (b)(6);(b)(documented that DOMINGUEZ had an elevated temperature of 99.5 and noted that observation for increased temperature was required. NP (b)(6);(b)(no longer works at ADF and was not available for an interview.

On November 29, 2011, at approximately 12:10 p.m., a Progress Note by NP (b)(6);(b)(documents DOMINGUEZ was brought to the ADF Medical Unit for treatment of an acute onset of respiratory distress (Exhibit 16). NP (b)(6);(b)(documented the assessment of DOMINGUEZ and vital signs were recorded as: pulse (P) 172 (normal is 60-100), blood pressure (BP) 116/79, and oxygen saturation (O2) was 99 percent; 100 percent would indicate full oxygen level in his blood. NP (b)(6);(b)(noted diaphoresis (perspiring), though DOMINGUEZ denied any pain. NP (b)(6);(b)(7 documented DOMINGUEZ was given treatment with albuterol. Per open source information, albuterol is a bronchodilator that relaxes muscles in the airways and increases air flow to the lungs (www.drugs.com). At approximately 12:15 p.m., DOMINGUEZ was given 25 mg of promethazine. Per open source information, promethazine is an antihistamine for allergic reactions, but is also used to treat nausea and vomiting (www.drugs.com). There is no indication in the medical record that DOMINGUEZ was experiencing nausea, vomiting or an allergic reaction.

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At approximately 12:18 p.m., American Medical Response (AMR) Emergency Medical Services (EMS) arrived at ADF (Exhibit 16). At 12:25 p.m., 6 mg of adenosine was administered to DOMINGUEZ intravenously by EMS staff, which brought his heartbeat down to 122. Per open source information, adenosine is medication used to slow the heart rate, or normalizing heart rhythm (www.drugs.com). At 12:32 p.m., EMS personnel transported DOMINGUEZ from the ADF to VVCH. ADF facility logs document GEO DO (b)(6);(b)(7)(C) and DO (b)(6);(b)(7)(C) departed the ADF with EMS to VVCH (Exhibit 17).

DO (b)(6);(b)(7)(and DO (b)(6);(were not available for interviews.

On November 29, 2011, at approximately 4:00 p.m., DOMINGUEZ was transported from the VVCH to ADF. At 6:00 p.m., DOMINGUEZ was seen by (b)(6);(b)(7)(C) at the ADF. DOMINGUEZ returned to the ADF with aftercare instructions for a "cardiologist referral" from his primary doctor within one week (Exhibit 18). (b)(6);(b)(documented in a Progress Note that DOMINGUEZ was evaluated at VVCH, where he was diagnosed with supraventricular tachycardia (SVT), but had stabilized (Exhibit 16). Per open source information, SVT is a condition where your heart beats much faster than it should (www.drugs.com). According to the Progress Note, (b)(6);(b)(7 ordered the medication Atenolol 25 mg once daily for 30 days. Per open source information, Atenolol is used to treat and prevent heart attack (www.drugs.com). (b)(6);(b)(7 ordered an urgent cardiology consult, and noted he intended to have a follow-up appointment with DOMINGUEZ on the following day, Wednesday, November 30, 2011. The follow-up appointment the next day with Dr. (b)(6); did not take place.

SA (b)(6);(b)(7)(SA (b)(6);(b)(7) and RN (b)(6);(b)(interviewed (b)(6);(b)(on March 28, 2012. (b)(6);(b)(stated he intended to see DOMINGUEZ on November 30, 2011, for a follow up appointment; however, the appointment "fell through." (b)(6);(b)(7 could not explain the reasons why the appointment "fell through." No other remarkable activity regarding DOMINGUEZ occurred until December 7, 2011.

On December 7, 2011, DOMINGUEZ submitted a sick call slip requesting an eye exam (Exhibit 19). The sick call slip was triaged by LVN (b)(6);(b and referred to (b)(6);(b)(7) The sick call slip was signed by HSA (b)(6);(b)(on February 11, 2012, and noted DOMINGUEZ was seen by the Physician on February 8, 2012. Interviews of HSA (b)(6);(b)(determined that she falsified the completion date on the sick call slip. (Agent's note: ODO reported an allegation of falsification to the JIC for evaluation and assignment to an investigator via appropriate channels.)

On December 8, 2011, at approximately 2:15 p.m., a Progress Note by (b)(6);(b)(7) documented DOMINGUEZ was seen for his sick call complaint regarding difficulty seeing without glasses

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(Exhibit 20). (b)(6);(b)(7 also noted DOMINGUEZ complained of cramping/cold feet during the visit. (b)(6);(b)(7 stated he performed an assessment of DOMINGUEZ on December 8, 2011, during a sick call follow-up. The assessment included checking vital signs, which all fell within the normal range. After the assessment, (b)(6);(b)(7 ordered DOMINGUEZ Ibuprofen, Atenolol, and lab work for a complete metabolic profile (CMP). DOMINGUEZ was also issued a pair of reading glasses.

On December 12, 2011, blood was drawn from DOMINGUEZ for the CMP ordered by (b)(6);(b)(7)(C On December 13, 2011, the CMP results were reported to ADF via fax (Exhibit 21). According to the CMP results, DOMINGUEZ had the following abnormal results: glucose 170 (normal range is 65-99 and can detect diabetes), albumin 2.5 (normal is 3.5-5.5, used to detect liver or kidney disease), alkaline phosphate 154 (normal is 25-150 and helps detect liver or bone disorders), and aspartate aminotransferase (AST) 78 (normal is 0-40, also used to detect liver disorders). ADF physicians were not notified of the abnormal results for DOMINGUEZ until December 22, 2011. Medical staff could not clarify or explain why the abnormal results were received on December 13, 2011, but not addressed until nine days later on December 22, 2011.

SA (b)(6);(b)(7)(SA (b)(6);(b)(7) and RN (b)(6);(b)(interviewed HSA (b)(6);(b)(RN (b)(6);(b)(7)(C and RN (b)(6);(b)(7)((b)(6);(b)(7)(on March 27, 2012. According to HSA (b)(6);(b)(7 he Shift Charge RN for each shift is responsible for reviewing the laboratory results for abnormal values. During an interview with RN (b)(6);(b)(7)(C) it was determined that she was the Shift Charge RN on December 13, 2011. RN could not clarify or explain why the CMP reports were not reported to the Physician sooner than December 22, 2011. RN (b)(6);(b)(7)(stated DOMINGUEZ's abnormal results were reported to (b)(6);(b)(7)(C) on December 22, 2011, because that was when (b)(6);(b)(7)(C) asked RN (b)(6);(b)(7) to report to him any abnormal results for DOMINGUEZ. HSA (b)(6);(b)(and RN (b)(6);(b)(7) were also unable to explain the delay in reporting the CMP report results to the Physician. DOMINGUEZ's next interaction with the medical staff was during a cardiology consult.

On December 20, 2011, DOMINGUEZ received a cardiology consult from (b)(6);(b)(7)(C) of Western Medical Center (WMC), located in Anaheim, California (Exhibit 22). According to the WMC medical record, DOMINGUEZ was diagnosed with paroxysmal SVT. (b)(6);(b)(7)(C) ordered an echocardiogram (sonogram of the heart), a treadmill stress test, and scheduled DOMINGUEZ for a return visit for three months later. There is no documentation to confirm that the abnormal CMP results were sent with the detainee to the cardiology consult.

On December 22, 2011, at approximately 11:00 a.m., RN (b)(6);(b)(7)(documented DOMINGUEZ's abnormal CMP results in a Progress Note (Exhibit 23). According to the Progress Note, Dr.

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Otuchere ordered a hepatitis panel, with a follow-up appointment. When interviewed on March 27, 2012, RN (b)(6);(b)(7) verified she wrote the Progress Note on December 22, 2011. RN (b)(6);(b)(7)(stated she notified (b)(6);(b)(7)(C) regarding DOMINGUEZ's abnormal lab results, but could not determine why these results were reported nine days after they were received by ADF. Dr. (b)(6);(b)(7) is no longer employed at ADF and was not available for interview.

On December 24, 2011, DOMINGUEZ's hepatitis panel results confirmed DOMINGUEZ had low albumin of 2.5, and elevated liver enzymes (Exhibit 24). A handwritten note by (b)(6);(b)(7)(C) on the lab results printout, and dated the same day, states "schedule to see." There are no reports to document a follow-up appointment for DOMINGUEZ was scheduled or took place.

On December 25, 2011, at approximately 9:55 p.m., a Progress Note by LVN (b)(6);(b)(7)(C) documented that DOMINGUEZ was taken to medical because he was feeling shaky and having difficulty breathing (Exhibit 23). LVN (b)(6);(b assessed vital signs for DOMINGUEZ as: P-100, BP -127/71, O2-100 percent. The Medical Detention Officer's Logbook reflects that EMS was called at 9:51 p.m. and arrived at 10:02 p.m. EMS transported DOMINGUEZ from ADF to VVCH (Exhibit 25). A Medical Information Transfer was completed by LVN (b)(6);(b)(7)(C) which noted DOMINGUEZ had cardiac dysrhythmia (Exhibit 26). There is no documentation of a telephone call or any attempt to notify Dr. Otuchere, who was the medical provider for DOMINGUEZ. LVN (b)(6);(b)(7)(is no longer employed with ADF and was not available for interview.

SA (b)(6);(b)(7)(SA (b)(6);(b)(7 and RN (b)(6);(b)(interviewed LVN (b)(6);(b)(on March 29, 2012. LVN (b)(6);(b) stated she assisted LVN (b)(6);(b)(7)(C) in completing the Medical Information Transfer form and with preparing DOMINGUEZ for transport to the hospital. LVN (b)(6);(b) stated DOMINGUEZ was alert, oriented, and speaking Spanish clearly during his visit to medical on December 25, 2011. LVN (b)(6);(b stated DOMINGUEZ was feeling shaky and having difficulty breathing. LVN (b)(6);(b)(stated she witnessed RN (b)(6);(b)(7)(C) conducting a medical interview of DOMINGUEZ prior to his transport to VVCH.

SA (b)(6);(b)(7)(SA (b)(6);(b)(7 and RN (b)(6);(b)(interviewed RN (b)(6);(on March 28, 2012. RN (b)(6);(b)(stated she did not recall interacting with DOMINGUEZ on December 25, 2011; however, she verified that she signed the Medical Information Transfer form for DOMINGUEZ prior to his transport to VVCH.

On December 26, 2012, at approximately 4:50 a.m., RN (b)(6);(b)(7)(C) documented in a Progress Note that she spoke to an unknown RN at the VVCH emergency room (Exhibit 27). According to the Progress Note, DOMINGUEZ was cleared to be discharged from the VVCH.

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DOMINGUEZ was no longer short of breath and his cardiac enzymes had returned to normal range. At 5:30 a.m., DOMINGUEZ returned to ADF with aftercare instructions for treatment of non-specific dizziness, and to follow-up with his primary care doctor (Exhibit 28). According to the Progress Note written by RN (b)(6);(b)(7) DOMINGUEZ returned to ADF from VVCH with no dizziness (Exhibit 27).

SA (b)(6);(b)(7)(SA (b)(6);(b)(7) and RN (b)(6);(b)(interviewed RN (b)(6);(b)(7 on March 27, 2012. RN Roberts stated she included DOMINGUEZ on a list to see the Physician per the aftercare recommendations. RN (b)(6);(b)(stated that when DOMINGUEZ returned from VVCH, he was examined by (b)(6);(b)(7)(C) There is no documentation to confirm that (b)(6);(b)(7)(C) examined DOMINGUEZ. The next interaction with the medical staff for DOMINGUEZ was during a treadmill stress test previously ordered by (b)(6);(b)(7)(C)

On January 24, 2012, at 9:20 a.m., DOMINGUEZ was transported from the ADF to the WMC and performed a treadmill stress test (Exhibit 29). The stress test report stated DOMINGUEZ had poor to fair exercise tolerance limited by fatigue after less than two minutes of physical exertion. At 3:05 p.m., DOMINGUEZ was returned from the WMC to the ADF. A Progress Note by NP McIlroy documented the stress test was inconclusive and DOMINGUEZ was referred to (b)(6);(b)(7 the following morning (Exhibit 30).

On January 25, 2012, DOMINGUEZ was seen by (b)(6);(b)(7)(A Progress Note by (b)(6);(b)(7)(documents DOMINGUEZ complained of having a "persistent cough" for several weeks, with purulent sputum. Per open source information, purulent sputum is a disease of the air passage (www.drugs.com). (b)(6);(b)(7) assessed DOMINGUEZ with the following vital signs: T-98, P-96, R-16, and BP-108/56. (b)(6);(b)(7 documented that DOMINGUEZ had an upper respiratory infection (URI), and anxiety. (b)(6);(b)(7) ordered Benadryl (antihistamine), and Cold Tabs for DOMINGUEZ (Exhibit 31).

During an interview on March 28, 2012, (b)(6);(b)(7 stated he should have followed up with additional testing after DOMINGUEZ performed so poorly during the stress test (b)(6);(b)(7)(stated he decided not to follow up because the cardiologist did not recommend tests other than the stress test and an echocardiogram. (b)(6);(b)(7)(stated he was primarily interested in treating the URI. DOMINGUEZ did not have any other remarkable interactions or activity until February 7, 2012.

On February 7, 2012, DOMINGUEZ submitted a sick call slip complaining of flu and stomach pains (Exhibit 32). LVN (b)(6);(b documented the sick call slip was received and referred to an RN for sick call. Although HSA (b)(6);(b)(added notes on the sick call slip stating DOMINGUEZ was

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seen on February 8, 2012, medical record entries reflect DOMINGUEZ was actually seen on February 10, 2012. Interviews with HSA (b)(6);(b)(confirmed she falsified the completion date.

On February 9, 2012, DOMINGUEZ submitted a sick call slip complaining of pain in his mouth, with a cold and cough (Exhibit 33). On February 10, 2012, LVN (b)(6);(b triaged the sick call slip and referred DOMINGUEZ to an RN for sick call. HSA (b)(6);(b)(documented that DOMINGUEZ was seen by the Physician on February 8, 2012; however, medical record entries show DOMINGUEZ was actually seen by (b)(6);(b)(7 on February 10, 2012. HSA (b)(6);(b)(a non-clinician, signed and dated the sick call slip form. Interviews of HSA (b)(6);(b)(confirmed she falsified the completion date on the sick call slip.

On February 10, 2012, a Progress Note by (b)(6);(b)(7 documented vital signs for DOMINGUEZ as: T-97.8, P-85, R-18, O2-98 percent, BP-104/69. (b)(6);(b)(7 also noted he performed a physical examination and DOMINGUEZ had a slightly tender abdomen with epigastric pain that increased during the day (Exhibit 34). (b)(6);(b)(7 further noted DOMINGUEZ had gastrointestinal reflux disease (GERD) and a URI. (b)(6);(b)(7)(ordered Maalox 30 ml every 4-6 hr., Prilosec 40 mg twice a day for 30 days, Chlorphenamine Maleate 4 mg twice a day for 14 days, and Tylenol. Per open source information Chlorphenamine Maleate is an allergy antihistamine (www.drugs.com). During an interview (b)(6);(b)(7) stated he believed the antihistamine would not have been contraindicated for a patient who had been diagnosed with SVT.

On February 14, 2012, at approximately 1:00 p.m., DOMINGUEZ was transported from the ADF to the WMC for an echocardiogram (Exhibit 35). The test performed by (b)(6);(b)(7)(C) revealed " unremarkable" results (Exhibit 36). The copy of the echocardiogram report was not faxed to ADF until March 7, 2012. There is no documentation to confirm that a copy of this report was requested earlier.

On February 16, 2012, at approximately 5:45 a.m., a Progress Note by RN (b)(6);(b)(7 documents that detainees notified nursing staff and DO (b)(6);(b)(7) that DOMINGUEZ was groggy, had difficulty waking up, and was not eating (Exhibit 37). RN (b)(6);(b)(7 took DOMINGUEZ's vital signs with the following results: P (resting)-126, BP-100/50. At 5:55 a.m., DOMINGUEZ was taken to the Medical Unit and placed in an observation bed located across from the nursing desk. At 6:15 a.m., a Progress Note by RN (b)(6);(b)(documents DOMINGUEZ was able to follow directions and states "he will be added to MD list to be seen." A complete set of vital signs was not obtained, nor was a more complete assessment performed by RN (b)(6);(b)(7)(

During an interview on March 27, 2011, DO (b)(6);(b)(7) stated he encountered DOMINGUEZ in his

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assigned housing unit on February 16, 2012. DO (b)(6);(b)(7) stated that on February 16, 2012, detainees expressed concerns to him, because DOMINGUEZ had not eaten that morning. DO (b)(6);(b)(7) stated he performed a bed check and observed DOMINGUEZ shivering under his bedcovers. DOMINGUEZ stated to DO (b)(6);(b)(7) that he felt ill. DO (b)(6);(b)(7) notified medical personnel, who responded to the housing unit and took vital signs. DOMINGUEZ was transferred to the Medical Unit.

During an interview on March 27, 2012, RN (b)(6);(b)(7) stated DOMINGUEZ seemed okay despite an elevated pulse and low blood pressure. RN (b)(6);(b)(7)(C) stated there was no indication that DOMINGUEZ was critically ill, because he was walking and talking. RN (b)(6);(b)(7) stated she did not notify (b)(6);(b)(7) of the assessment of DOMINGUEZ. RN (b)(6);(b)(7) stated that when the morning shift arrived, she advised that DOMINGUEZ needed to be seen by (b)(6);(b)(7) After the shift change, six hours passed before vital signs were taken again.

On February 16, 2012, at approximately 12:15 p.m., a Progress Note by RN (b)(6);(b)(7)(C) documented that DOMINGUEZ remained "lethargic and somewhat confused." RN (b)(6);(b)(7) assessed DOMINGUEZ with the following vital signs: T-101.6, P-119, R-24, O2-93 percent, BP-138/80. At approximately 12:30 p.m., a verbal order for Tylenol was given by (b)(6);(b)(7) (Exhibit 37).

SA (b)(6);(b)(7)(C) SA (b)(6);(b)(7) and RN (b)(6);(b)(7) interviewed RN (b)(6);(b)(7) on March 27, 2012. RN (b)(6);(b)(7) stated that on February 16, 2012, while under medical observation, DOMINGUEZ was lethargic, disheveled, and disoriented when RN (b)(6);(b)(7) woke him. RN (b)(6);(b)(7) stated she provided DOMINGUEZ with a lunch tray and DOMINGUEZ attempted to eat his lunch from the lid of his meal tray. RN (b)(6);(b)(7) spoke with (b)(6);(b)(7) concerning the declining health of DOMINGUEZ and recommended DOMINGUEZ be sent to VVCH. RN (b)(6);(b)(7) stated (b)(6);(b)(7) told her to keep DOMINGUEZ under observation and give him Tylenol. RN (b)(6);(b)(7) gave DOMINGUEZ the Tylenol; however, she observed DOMINGUEZ let the Tylenol dissolve in his mouth, which she interpreted as a sign of disorientation. RN (b)(6);(b)(7) stated she was not satisfied with (b)(6);(b)(7) decision, and expressed her concerns to HSA (b)(6);(b)(7) RN (b)(6);(b)(7)(C) stated that HSA (b)(6);(b)(7) convinced (b)(6);(b)(7) that DOMINGUEZ required hospitalization.

During an interview on March 28, 2012, (b)(6);(b)(7) stated he did not remember the conversation with RN (b)(6);(b)(7) or her insistence that DOMINGUEZ be transported to VVCH. (b)(6);(b)(7) stated he was reluctant to send DOMINGUEZ to the hospital, because he did not find vital signs from DOMINGUEZ to be alarming, and wanted to see if the Tylenol was effective in lowering his temperature. (b)(6);(b)(7) said he did not remember the conversation with HSA (b)(6);(b)(7) but surmises

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he acquiesced due to strange behavior by DOMINGUEZ. (b)(6);(b)(stated he was reluctant to send DOMINGUEZ to VVCH based on his belief that DOMINGUEZ was suffering from a viral syndrome. (b)(6);(b)(7 also stated that if he was not in a correctional setting with security concerns, he would have sent DOMINGUEZ to the VVCH Emergency Room sooner. (b)(6);(b)(7 stated he never performed a hands-on evaluation of DOMINGUEZ on February 16, 2012, because he had security problems getting into the cell.

(b)(6);(b)(7) stated he was not informed of DOMINGUEZ's condition until 12:30 p.m. on February 16, 2012. (b)(6);(b)(7 stated he realized he should have evaluated DOMINGUEZ when he was informed of his condition. (b)(6);(b)(7 stated he wished the nursing staff had called him, because DOMINGUEZ's blood pressure and pulse indicated he was experiencing blood loss and was in danger of going into shock. (b)(6);(b)(7 stated he made the decision to transport DOMINGUEZ to the hospital via ADF van rather than an ambulance, because he is always respectful of financial resources.

On February 16, 2012, at approximately 2:34 p.m., DOMINGUEZ was transported from the ADF to the VVCH via GEO transport van as documented in the Progress Note by RN (b)(6);(b)(7)((Exhibit 37). DO (b)(6);(b)(7)(C) and DO (b)(6);(b)(7)(C) transported DOMINGUEZ to the VVCH. SA (b)(6);(b)(7)(SA (b)(6);(b)(and RN (b)(6);(b)(interviewed DO (b)(6);(b)(7)(C) on March 27, 2012, and DO (b)(6);(b)(7 on March 28, 2012. Both stated the ADF medical unit staff told them DOMINGUEZ was very sick. Neither DO (b)(6);(b)(7)(C) nor DO (b)(6);(b)(7) recalled conversing with DOMINGUEZ. Both stated DOMINGUEZ did not exhibit any abnormal behavior during the transport to VVCH.

On February 16, 2012, at approximately 2:45 p.m., DOMINGUEZ arrived at the VVCH. According to VVCH medical records, DOMINGUEZ was examined by (b)(6);(b)(7)(C) at 3:50 p.m. (Exhibit 38). (b)(6);(b)(7)(C) assessment was that DOMINGUEZ was suffering from acute renal insufficiency, possible sepsis, pneumonia, and altered mental status. Laboratory tests were ordered for DOMINGUEZ which revealed he had leukocytosis (increased white blood cell count), anemia (low red blood cell count), metabolic acidosis (kidneys are not working properly), and hypocalcaemia (low calcium level). The VVCH medical records also indicate DOMINGUEZ was suffering from bilateral pneumonia, septic shock, respiratory failure, hypoxemia (low oxygen level), and renal failure. DOMINGUEZ remained in the care of VVCH.

On February 18, 2012, at 10:00 a.m., RN (b)(6);(b)(7) spoke with VVCH RN (b)(6);([sic] concerning the condition of DOMINGUEZ. According to a Progress Note by RN (b)(6);(b)(7) DOMINGUEZ was in the intensive care unit (ICU), and was provided intravenous (IV) antibiotics and fluids (Exhibit 39). ODO was unable to positively identify VVCH RN Dove [sic] due to the fact the name was illegibly

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written in the Progress Note.

On February 19, 2012, at 9:30 a.m., RN (b)(6);(b)(7)(spoke with VVCH Emergency Room RN (b)(6);(b)([sic] concerning the condition of DOMINGUEZ. According to a Progress Note by RN (b)(6);(b)(7)(DOMINGUEZ was intubated (a tube was inserted into the detainee's windpipe) and required a ventilator (machine that breathes for him) (Exhibit 39).

On February 21, 2012, at 6:10 a.m., RN (b)(6);(b)(spoke with a VVCH unidentified RN in the ICU concerning the condition of DOMINGUEZ. According to a Progress Note by RN (b)(6);(b)(7)(DOMINGUEZ's electrolytes and albumin were severely imbalanced (Exhibit 39). ADF medical staff continued to monitor the condition of DOMINGUEZ while he remained in the care of VVCH. Progress Notes by ADF staff document that the condition of DOMINGUEZ continued to deteriorate (Exhibit 39).

On March 4, 2012, at 5:38 a.m., DOMINGUEZ died at the VVCH when his heart failed. On March 6, 2010, ICE ERO Field Office Director, Los Angeles, CA, provided notification regarding the death of DOMINGUEZ to immediate family members and the Mexican Consulate. A State of California, County of San Bernardino Certificate of Death was generated regarding DOMINGUEZ and signed by Deputy (b)(6);(b)(7)(C) Exhibit 40). According to the Certificate of Death, the immediate cause of death was multi-organ failure, sepsis, bronchopneumonia, and alcoholic liver disease. The death certificate lists the manner of death as natural and documents that an autopsy was performed.

On May 22, 2012, SA (b)(6);(b)(7 received the San Bernardino County Sheriff's Department, Coroner Division, Division of the Medical Examiner, Autopsy Report for DOMINGUEZ. The autopsy report lists DOMINGUEZ's manner of death as natural. The autopsy report indicates the immediate cause of death was multi-organ failure, sepsis, bronchopneumonia, and alcoholic liver disease (Exhibit 41). Per open source information, multi-organ failure is failure of two or more organ systems in a critically ill patient because of a complex and interrelated series of events (www.medical-dictionary.com). Sepsis is a bacterial infection in the bloodstream or body tissues (www.medical-dictionary.com). Bronchopneumonia is inflammation of the bronchi and lungs, usually beginning the terminal bronchioles (www.medical-dictionary.com). Alcoholic liver disease is a condition caused by chronic excess of alcohol consumption (www.medical-dictionary.com).

MEDICAL COMPLIANCE REVIEW:

ICE OPR ODO contractor CC conducted a Medical Compliance Review (MCR) as part of ODO's

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investigation into the death of DOMINGUEZ. The review was performed by RN (b)(6);(b)(CC Health Care Service Subject Matter Expert. RN (b)(6);(b)(found the health care provided to detainee DOMINGUEZ at the ADF was inadequate and did not meet the ICE PBNDS. It is an egregious error that ADF failed to perform proper physical examinations in response to symptoms and complaints, failed to pursue any records critical to continuity of care, and failed to assure appropriate, timely follow up and access to off-site care. The CC report is attached to this ROI (Exhibit 42).

MORTALITY REVIEW:

CC conducted a Mortality Review (MR) as part of the ODO investigation into the death of DOMINGUEZ. (b)(6);(b)(7)(C) M.D., CC Chief Medical Officer, conducted the MR and prepared the report detailing the findings and conclusion. (b)(6);(b)(7) opined in his report that the death of DOMINGUEZ could have been prevented, and DOMINGUEZ received an unacceptable level of medical care while detained at ADF. The Certificate of Death report cites the immediate cause of death as multi-organ failure, sepsis, bronchopneumonia, and alcoholic liver disease. (b)(6);(b)(7)(C) Mortality Review Report is attached to this report (Exhibit 43).

IMMIGRATION AND DETENTION HISTORY:

Fernando DOMINGUEZ-Valivia, a native and citizen of Mexico, entered the United States without having been admitted or paroled after inspection by an Immigration Officer.

On November 22, 2011, DOMINGUEZ was encountered by 287(g) personnel during Criminal A (b)(7)(E) and was processed for removal.

On November 23, 2011, DOMINGUEZ was released to ICE custody and served with a Notice to Appear pursuant to section 212(a)(6)(A)(i) of the Immigration and Nationality Act.

On January 30, 2012, DOMINGUEZ appeared before an Immigration Judge and was granted Voluntary Departure. While DOMINGUEZ appealed his immigration case, he was detained in ICE custody at ADF pending a decision on his appeal.

CRIMINAL HISTORY:

DOMINGUEZ was assigned (b)(7)(E) and State of California SID# (b)(7)(E)

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The following criminal history information on DOMINGUEZ was recovered from the National Crime Information Center, Superior Court of California, County of Solano, and his Alien File.

On April 7, 1989, DOMINGUEZ was convicted in Superior Court of California, County of Solano, California, for the offense of forgery, in violation of the California Penal Code 470, for which he was sentenced to 180 days in jail and 180 days probation. The case number is V290876.

On November 7, 2001, DOMINGUEZ was convicted in Superior Court of California, County of Dinuba, California, for the offense of theft, in violation of the California Penal Code 484(A), for which he was sentenced to 12 days in jail. The case number is 270038.

On November 22, 2011, DOMINGUEZ was arrested by Rialto Police Department on a Los Angeles County warrant under California Penal Code (PC) 647(F), disorderly conduct/drunk in public. The case number is LAM8FF009300. DOMINGUEZ was placed in ICE custody subsequent to this arrest.

INVESTIGATIVE FINDINGS:

Detainee DOMINGUEZ came into ICE custody on November 22, 2011, and was not provided medical care in accordance with the ICE Performance Based National Detention Standards (PBNDS) while housed at ADF. Based on interviews and documentation discovered during this review, ADF medical staff did not comply with the requirements of the ICE PBNDS. Per the mortality review by (b)(6);(b)(7)(the death of DOMINGUEZ could have been prevented, and DOMINGUEZ received an unacceptable level of medical care while detained at ADF.

This review confirmed ADF was not in compliance with the ICE PBNDS Medical Care Standard.

The ICE PBNDS, Medical Care, section (II)(1), requires detainees to have access to a continuum of treatment.

Upon arrival to ADF, DOMINGUEZ was processed by ICE IEA (b)(6);(b)(7)(C) When interviewed, IEA (b)(6);(b)(7)(stated he noticed during processing that DOMINGUEZ's hands were trembling and had cuts. IEA (b)(6);(b)(7)(did not route the ICE Health Service Corps intake screening form to the medical department.

On January 24, 2012, DOMINGUEZ performed a treadmill stress test at WMC. A continuum of diagnosis and treatment was not accomplished when (b)(6);(b)(7 failed to follow-up with additional

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testing after DOMINGUEZ performed poorly during the stress test.

The ICE PBNDS, Medical Care, section (II)(2), requires detainee healthcare needs be met in a timely manner.

On November 29, 2011, DOMINGUEZ was seen by (b)(6);(b)(7) who documented in a Progress Note that DOMINGUEZ was evaluated at VVCH where he was diagnosed with supraventricular tachycardia, but had stabilized. DOMINGUEZ returned with aftercare instructions noting he needed a "cardiologist referral" from his primary doctor within one week. (b)(6);(b)(7 ordered the medication Atenolol 25 mg once daily (medication used to slow down the heart), an urgent cardiology consult, and a follow-up on the next day. (b)(6);(b)(7)(C follow-up appointment with DOMINGUEZ did not take place and he did not see DOMINGUEZ until December 8, 2011, as a sick call referral. The urgent cardiology consult ordered by (b)(6);(b)(7 did not take place until December 20, 2011.

On December 8, 2011, a Progress Note by (b)(6);(b)(documents DOMINGUEZ was seen for a sick call follow-up for complaints of difficulty seeing without glasses. (b)(6);(b)(7 noted DOMINGUEZ also complained of cramping and cold feet during the sick call follow-up. After his assessment of DOMINGUEZ, (b)(6);(b)(7 ordered Ibuprofen and Atenolol, ordered lab work for a Complete Metabolic Profile, and issued a pair of reading glasses. The lab work ordered by (b)(6);(b)(7 on December 8, 2011, was not drawn until December 12, 2011. Although the Complete Metabolic Profile lab results were reported to ADF on December 13, 2011, (b)(6);(b)(7 was not aware of the abnormal results until December 22, 2011.

On February 16, 2012, a Progress Note by RN (b)(6);(b)(7 documents DOMINGUEZ was brought to the Medical Unit due to grogginess and difficulty waking up. RN (b)(6);(b)(7) assessment of DOMINGUEZ's vital signs revealed abnormally high pulse and low blood pressure, as well as lethargic behavior and symptoms of septic shock. RN (b)(6);(b)(7 failed to fully assess DOMINGUEZ from 12:15 p.m. until 2:34 p.m. on February 16, 2012. There were no additional vital sign checks or new assessments documented. During interviews with (b)(6);(b)(7 he stated he never actually performed a hands-on evaluation of DOMINGUEZ on February 16, 2012.

The ICE PBNDS, Medical Care, section (II)(5), requires detainees to receive timely follow-up to their healthcare requests.

On February 9, 2012, DOMINGUEZ submitted a sick call slip complaining of pain in his mouth, with a cold and cough. On February 10, 2012, LVN (b)(6);(b) referred DOMINGUEZ for sick call.

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There is no documentation to confirm DOMINGUEZ was seen by an RN.

The ICE PBNDS, Medical Care, section (II)(6), requires continuity of care from admission to transfer, discharge, or removal.

On November 28, 2011, a Progress Note documents DOMINGUEZ was seen by NP (b)(6);(b)(7)(C) during sick call for a sore throat. NP (b)(6);(b)(documented DOMINGUEZ had an elevated temperature of 99.5. The ADF medical staff did not perform periodic temperature readings on DOMINGUEZ to ensure continuity of the Medication Administration Record.

On November 29, 2011, (b)(6);(b)(documented in a Progress Note that DOMINGUEZ was evaluated at VVCH, where he was diagnosed with SVT, but had stabilized. (b)(6);(b)(7 ordered the follow-up for the next day. Nursing staff failed to schedule (b)(6);(b)(7)(follow-up appointment for the next day. (b)(6);(b)(7 did not write an order or make any effort to obtain the medical records from VVCH, which contained the initial confirmation of a low albumin value.

On December 26, 2011, DOMINGUEZ returned to ADF with aftercare instructions for treatment of non-specific dizziness, and for a follow-up with his primary care doctor. Interviews with RN (b)(6);(b)(7 determined she included DOMINGUEZ on a list to see the Physician per the aftercare recommendations. RN (b)(6);(b)(7 stated that although (b)(6);(b)(7)(C) had conducted an examination of DOMINGUEZ, he made no effort to obtain the VVCH medical records, which indicated DOMINGUEZ had elevated red blood cells in his urine. (b)(6);(b)(7) signed the stress test results, but did not date them or discuss them with DOMINGUEZ.

On February 14, 2012, DOMINGUEZ was sent to VVCH for an echocardiogram. The copy of the echocardiogram report was not faxed to ADF until March 7, 2012. There is no documentation to confirm a copy of this report was requested earlier.

The ICE PBNDS, Medical Care, section (II)(7), requires detainees who need health care beyond facility resources be transferred in a timely manner to an appropriate facility where care is available.

On February 16, 2012, at approximately 5:45 a.m., a Progress Note by RN (b)(6);(b)(7 documents DOMINGUEZ was brought to the Medical Unit due to grogginess and difficulty waking up. During interviews with (b)(6);(b)(7) he stated he never actually performed a hands-on evaluation of DOMINGUEZ on February 16, 2012. On February 16, 2012, at approximately 12:15 p.m., (b)(6);(b)(7) was informed of the condition of DOMINGUEZ; it was only after insistence by RN (b)(6);(b)(7)(and

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HSA (b)(6);(b) that (b)(6);(b)(7 agreed to send DOMINGUEZ to VVCH at 2:34 p.m. There was approximately a nine-hour delay between the time DOMINGUEZ was first evaluated by RN (b)(6);(b)(at 5.45 a.m. to the time he was sent to VVCH at 2:34 p.m. for emergency care.

The ICE PBNDS, Medical Care, section (II)(8), requires a transportation system to be available that ensures timely access to health care services that are only available outside the facility, including: prioritization of medical need, urgency (such as the use of ambulance instead of standard transportation) and transfer of medical information.

On February 16, 2012, DOMINGUEZ was transported to VVCH via an ADF transport van. Dr. (b)(6);(stated he made the decision to use the ADF van rather than an ambulance due to concerns regarding financial resources. DOMINGUEZ's history of legitimate medical crises and the symptoms of septic shock would have justified the use of an ambulance, which was located within the Fire Department adjacent to ADF.

The ICE PBNDS, Medical Care, section (II)(15), requires detainees with chronic conditions to receive care and treatment for conditions where non-treatment would result in negative outcomes.

(b)(6);(b)(7 failed to follow DOMINGUEZ as a chronic care patient. (b)(6);(b)(7)(opines that DOMINGUEZ's medical record documented repeated instances where delivery of care was delayed. Specifically, results of lab tests ordered by ADF were not reviewed by a physician in a timely manner, follow up appointments were not scheduled as ordered by facility physicians, vital signs were not monitored when indicated, and initiation of medication was delayed. Most critically, the patient was not examined by a physician and was not transferred to the hospital for approximately eight hours after being determined to be medically and mentally unstable on February 16, 2012.

The ICE PBNDS, Medical Care, section (II)(37)(I)(1), requires non-English speaking detainees be provided translation services.

On November 28, 2011, a Progress Note documents DOMINGUEZ was seen by NP (b)(6);(b)(7)(during sick call for a sore throat. NP (b)(6);(b)(who is not bilingual, did not obtain translation services.

The ICE PBNDS, Medical Care, section (V)(F), requires accountability for administering or distributing medications in a timely manner according to licensed provider orders.

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On November 29, 2011 (b)(6);(b)(7 documented via a Progress Note that he ordered the medication Atenolol 25 mg once daily. The Atenolol was not ordered KOP (Keep on Person). LVN (b)(6);(b stated it is ADF practice to allow detainees to keep approved medications on their person. LVN Carter stated RN (b)(6);(b)(7)(C) transcribed the order and created the Medication Administration Record (MAR). RN (b)(6);(b)(7 instructed LVN (b)(6);(b to provide the detainee with a three-day supply of the medication. The Medication Sign-out Sheet reflected DOMINGUEZ did not receive his full prescription until December 6, 2011, which caused DOMINGUEZ to miss four doses of the medication.

AREAS OF CONCERN:

Three sick call slips provided to ODO electronically in advance of the site visit were found to have been altered by HSA (b)(6);(b)(This was verified when ODO compared the sick call slips to hardcopies reviewed onsite. Specifically, additional information and signatures were recorded. According to the HSA, she routinely audits medical records to ensure documentation is complete and accurate, and had added notations on the sick call slips for this purpose. It is noted the additional information was not accurate and was not documented as a late entry.

DEPARTMENT OF HOMELAND SECURITY

1. CASE NUMBER

(b)(7)(E)

PREPARED BY

(b)(6);(b)(7)(C)

REPORT OF INVESTIGATION
Exhibit List

HB 4200-01 (37), Special Agent Handbook

2. REPORT NUMBER

002

01 Western Valley Booking Status (11/22/2011)
02 Central Index System (11/22/2011)
03 Form I-213, Record of Deportable/Inadmissible Alien (11/22/2011)
04 G4S Secure Solutions USA Transport Log (11/23/2011)
05 Los Angeles Field Office Custody Information Sheet (11/23/2011)
06 Immigration and Customs Enforcement Detainee Classification Assessment (11/23/2011)
07 Division of IHSC In-Processing Health Screening Form (11/23/2011)
08 Fingerprint Analysis (11/23/2011)
09 G4S Transportation Logs (11/23/2011)
10 GEO Property Inventory Sheet (11/23/2011)
11 GEO Emergency Notification and Property Disposition Form (11/23/2011)
12 GEO Classification Assessment (11/23/2011)
13 Intake Medical Intake Screening (11/23/2011)
14 GEO Housing History Grid (11/23/2011)
15 GEO Request for Health Services (11/27/2011)
16 Medical Progress Note (11/28/2011)
17 ADF Facility Log (11/29/2011)
18 Victor Valley Community Hospital Aftercare Instructions (11/29/2011)
19 GEO Request for Health Services & GEO Request for Health Services (Falsely dated)
20 Medical Progress Note (12/8/2011)
21 Complete Metabolic Profile Lab Results (12/13/2011)
22 Western Medical Center Cardiology Consult (12/20/2011)
23 Medical Progress Note (12/22/2011)
24 Hepatitis Panel Lab Results (12/23/2011)
25 Medical Detention Officer's Log Book (12/25/2011)
26 Medical Information Transfer (12/25/2011)
27 Medical Progress Note (12/26/2011)
28 Victor Valley Community Hospital Aftercare Instruction (12/26/2011)
29 Western Medical Center Treadmill Stress Test (1/24/2012)
30 Medical Progress Note (1/24/2012)
31 Medical Progress Note (1/25/2012)
32 GEO Request for Health Services and GEO Request for Health Services (Falsely dated)
33 GEO Request for Health Services and GEO Request for Health Services (Falsely dated)
34 Medical Progress Note (2/10/2012)
35 GEO Medical Transport Escort Authorization (2/14/2012)
36 Western Medical Center Echocardiogram (2/14/2012)
37 Medical Progress Note (2/16/2012)
38 VVCH admission History and Physical (2/16/2012)

DEPARTMENT OF HOMELAND SECURITY

1. CASE NUMBER

201205740

PREPARED BY

(b)(6);(b)(7)(C)

REPORT OF INVESTIGATION
Exhibit List

HB 4200-01 (37), Special Agent Handbook

2. REPORT NUMBER

002

39 Medical Progress Note (2/18/2012)
40 Death Certificate (3/29/2012)
41 Autopsy Report
42 Creative Corrections Compliance Review
43 Creative Corrections Mortality Review

Office of Professional Responsibility

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

U.S. Immigration and Customs Enforcement

DETAINEE DEATH REVIEW

Case Number	(b)(7)(E)
Detainee	Fernando DOMINGUEZ-Valivia
Alien Number	083 344 871
Citizenship	Mexico
Date of Death	March 4, 2012
Detention Facility	Adelanto Detention Facility, Adelanto, California
Facility Type	IGSA

OVERVIEW

The U.S. Immigration and Customs Enforcement (ICE), Office of Professional Responsibility, Office of Detention Oversight, initiated this review after receiving information that ICE Detainee Fernando DOMINGUEZ-Valivia, a citizen and national of Mexico, died at the Victor Valley Community Hospital (VVCH) located in Victorville, California. At the time of his death, DOMINGUEZ was in ICE custody at the Adelanto Detention Facility (ADF) pending removal. DOMINGUEZ died on March 4, 2012, due to multi-organ failure, sepsis, bronchopneumonia, and alcoholic liver disease.

On November 22, 2011, DOMINGUEZ was arrested by the Rialto Police Department on a Los Angeles County warrant under California Penal Code (PC) 647(F), disorderly conduct/drunk in public (Exhibit 01). After his arrest, DOMINGUEZ was remanded under the custody of the West Valley Detention Center (WVDC) located in Rancho Cucamonga, California. On November 22, 2011, DOMINGUEZ was encountered by 287(g) personnel during Criminal Alien Program operations at WVDC. On November 23, 2011, DOMINGUEZ was released to ICE custody and served with a Notice to Appear pursuant to section § 212(a) of the Immigration and Nationality Act (INA). On January 30, 2012, DOMINGUEZ appeared before an Immigration Judge and was granted Voluntary Departure from the United States. DOMINGUEZ was placed in ICE Enforcement and Removal Office custody at ADF pending the expiration of his appeal period.

On February 16, 2012, DOMINGUEZ was transported to VVCH due to a high fever. DOMINGUEZ remained in the care of VVCH until his death. A California Department of Health Certificate of Death was generated regarding DOMINGUEZ's death. According to the Certificate of Death report, DOMINGUEZ's immediate cause of death was multi-organ failure, sepsis, bronchopneumonia, and alcoholic liver disease. The

Death Certificate, which is signed by Deputy Coroner (b)(6);(b)(7)(C) also indicates an autopsy was performed on DOMINGUEZ.

Creative Corrections, a national management and consultant firm, contracted by ICE to provide subject matter expertise in detention management including health care, reviewed the medical care of DOMINGUEZ while housed at the ADF. Creative Corrections found that the ADF was not compliant with the ICE PBNDS for medical care. Specifically, the ADF failed to perform proper physical examinations in response to symptoms and complaints, failed to pursue any records critical to continuity of care, and failed to assure appropriate, timely follow up and access to off-site care.

A mortality review was conducted by (b)(6);(b)(7)(C) a clinical consultant medical doctor contracted by ICE to evaluate the medical care provided to DOMINGUEZ while in ICE custody. (b)(6);(b)(7 assessed the care provided by the ADF as inadequate. Specifically (b)(6);(b)(7)(documented in his report that the ADF clinical staff failed to recognize the signs and symptoms of serious medical conditions contributed to DOMINGUEZ's eventual demise. According to (b)(6);(b)(7) ADF clinical staff failed to recognize and take appropriate action to address two ensuing conditions listed as causes of death: bronchopneumonia, which is a respiratory illness; and sepsis, which is a massive infection. DOMINGUEZ presented with respiratory symptoms six days following his arrival at ADF and was seen repeatedly for continued respiratory problems throughout the course of his detention. (b)(6);(b)(7 further stated that had a chest x-ray been completed when the respiratory problems did not resolve, pneumonia may have been identified and treated. In addition, had ADF clinical staff treated the bacterial infection diagnosed by VVCH on December 25, 2011, sepsis may not have developed. The mortality review is attached to this report.

On May 22, 2012, ODO received the San Bernardino County Division of the Medical Examiner's Office Autopsy Report for DOMINGUEZ. The autopsy report indicates DOMINGUEZ's manner of death as natural. The autopsy report indicates the immediate cause of death was multi-organ failure, sepsis, bronchopneumonia, and alcoholic liver disease.