April 23, 2024

The Honorable Patrick J. Lechleitner
Deputy Director and Senior Official Performing the Duties of the Director
Immigration and Customs Enforcement
Department of Homeland Security
Washington, DC 20528

Via Email

Re: Torrance County Detention Facility

Dear Mr. Lechleitner,

We appreciate your efforts to ensure that the Biden Administration fulfills its mission to deliver "a safe, humane, and orderly immigration system."[1]

We write to bring newly uncovered information to your attention. The ACLU has obtained a document showing that ICE officials misled the public about the treatment of Kesley Vial, a 23-year-old man who died in ICE custody following a fatal suicide attempt at Torrance County Detention Facility in August 2022. We urge you to order an immediate review of this matter.

In short, the document shows that ICE's own medical investigators concluded that Mr. Vial was not provided "health care within the safe limits of practice"—yet this ICE report was never made public.[2] Instead, ICE resumed transfers of people to Torrance County Detention Facility in December 2022 on the basis of a subsequent agency report that inexplicably omitted these damning agency findings.

We urge ICE to course correct. The Torrance detention contract is set to expire on May 14, 2024. Now is a critical time for the agency to review the appropriateness of this contract, under which the federal government pays a for-profit company, CoreCivic, more than $24.5

[1] Statement of Patrick J. Lechleitner before the U.S. House of Representatives House Committee on Appropriations, Subcommittee on Homeland Security, April 17, 2024, https://www.congress.gov/118/meeting/house/117154/witnesses/HHRG-118-AP15-Wstate-LechleitnerP-20240417.pdf.

[2] *See* ICE Office of Enforcement and Removal Operations, ICE Health Service Corps, "Mortality Review Report of Findings Kelsey VIAL, A240 899 412," Oct. 20, 2022 (attached).

million annually. The public and members of Congress deserve this full accounting.

While this review continues, ICE should let the contract for Torrance expire. From a good governance perspective, it makes no sense to renew a contract for operations that have repeatedly resulted in dangerous conditions and chronic violation of federal standards. Below, we set out the matter in further detail.

Conflicting ICE Reports on Mr. Vial's Death

Through a Freedom of Information Act (FOIA), the ACLU of New Mexico obtained a "Mortality Review" report for Mr. Vial. ICE's Health Service Corps, consisting of medical professionals, conducts mortality reviews for every individual who dies in custody.[3]

In this case, the Mortality Review Committee made five findings to support its conclusion that **the facility "did not provide Mr. Vial's health care within the safe limits of practice."** Among these: The facility did not provide him "appropriate mental health care"; did not document "missed doses of medication"; and "did not locate and use emergency equipment during the medical emergency response."[4] This report was finalized on October 20, 2022, but it was not made public.

A second report was made public in December 2022, the "detainee death review." This subsequent report was issued by ICE's Office of Professional Responsibility. It did not incorporate the Mortality Review's findings; instead, it merely noted two violations of federal standards – concerning medication administration and staff training, and two other "areas of concern" regarding continuity of care and cell change procedures.[5]

ICE's Decision to Resume Transferring People to Torrance

After Mr. Vial's death in August 2022, ICE rightly paused transfers of people to Torrance detention facility pending its investigation into detention conditions. But in December 2022, ICE issued a statement declaring it would resume transfers, on the basis of the detainee death review. (ICE shared the statement with advocacy organizations via

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[3] *Id.*
[4] *Id.*
[5] *See* ICE Office of Professional Responsibility, "Detainee Death Report: Kesley VIAL," Dec. 8, 2022, https://www.ice.gov/doclib/foia/reports/ddrKesleyVial_opr.pdf.

email and it was subsequently reported by journalists, although we can find no record of ICE posting it publicly).[6]

In particular, ICE contended that because the "deficiencies and areas of concern identified in the report were not contributory to the detainee's death, ICE will resume intake at [Torrance] for noncitizens." The statement continued, "ICE remains committed to continuous improvement of its civil detention operations and the health, welfare, and safety of those in its custody remains a top priority." CoreCivic likewise told press, "U.S. Immigration and Customs Enforcement's (ICE) investigation of his death did not identify staffing or access to medical professionals as a contributing factor."[7] However, the previously unknown Mortality Review had identified these and related issues, including health staff failures to document missed doses of medication and failure to communicate pertinent information.[8]

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ICE's December 2022 statement misled the public and members of Congress who have repeatedly expressed concern about the dangerous conditions at Torrance.[9] It made no reference to the Mortality Review's damning findings, and instead used the later Detainee Death report to justify ICE's decision to resume transfers to Torrance.

Next Steps on Torrance

Particularly in this light, Congress and the public deserve transparency and a full accounting of practices at Torrance. We urge you to let the contract for Torrance expire, pending this comprehensive review. The discrepancies and omissions noted above warrant this

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[6] Email to [names withheld] from Francey L Youngberg, "Subject: Torrance update," Dec. 16, 2022; Joshua Bowling, "Inhumane' New Mexico facility will resume locking up migrants," Searchlight New Mexico, Dec. 19, 2022.

[7] Curtis Segarra, "Torrance County Detention Facility faces wrongful death lawsuit," KRQE News, Sept. 27, 2023, https://www.krqe.com/news/new-mexico/torrance-county-detention-facility-faces-wrongful-death-lawsuit/.

[8] *See* ICE Office of Enforcement and Removal Operations, ICE Health Service Corps, "Mortality Review Report of Findings Kelsey VIAL, A240 899 412," Oct. 20, 2022 (attached).

[9] "Members of N.M. delegation call for increased oversight at CoreCivic detention facility in Torrance County after asylum seekers face barriers to legal representation" (Dec. 17, 2021), https://www.heinrich.senate.gov/ newsroom/press-releases/members-of-nm-delegation-call-for-increased-oversight-at-corecivic-detention-facility-in-torrance-county-after-asylum-seekers-face-barriers-to-legal-representation; "N.M. Congressional Democrats condemn inhumane conditions at Torrance County Detention Facility" (Mar. 18, 2022), https://stansbury.house.gov/media/press-releases/nm-congressional-democrats-condemn-inhumane-conditions-torrance-county; "Heinrich leads request for immediate action from ICE to address inhumane, unsafe conditions for migrants at the Torrance County Detention Facility" (Oct. 20, 2022),

step, as does the mounting evidence of dangerous conditions and chronic violations of federal detention standards.[10]

DHS officials reportedly recommended that the facility be closed as a cost-saving measure, as "the daily cost to house a detainee [at Torrance] was more than double the average." [11] Torrance has a guaranteed minimum of 505 beds at a monthly rate of $1,930,957.98, and yet Torrance's average daily ICE population is well below the guaranteed minimum.[12] The FY 2024 average detainee population has been about 361.[13] This unused bed space is a particularly poor use of ICE's resources.

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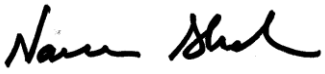
Dangerous conditions at Torrance attract negative publicity and legal liability for ICE. Continued operation of Torrance is undermining ICE's commitments and its mission.

Thank you for your time and attention to this matter. Please contact Naureen Shah (nshah@aclu.org), Deputy Director of Government Affairs for Equality, if we can provide further information.

Sincerely,

Mike Zamore
National Director of Policy & Government Affairs



Naureen Shah
Deputy Director of Government Affairs, Equality

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[10] *See* ACLU and ACLU of New Mexico, letter to ICE Chief of Staff Michael Lumpkin, March 5, 2024, https://www.aclu.org/documents/request-for-meeting-about-closing-the-torrance-county-detention-facility.

[11] Ted Hesson, "Exclusive: Biden officials kept immigration jails despite internal cost concerns," REUTERS (Sept. 27, 2023), https://www.reuters.com/world/us/biden-officials-kept-immigration-jails-despite-internal-cost-concerns-2023-09-27/.

[12] U.S. Dep't of Homeland Sec. Ofc. of Inspector Gen., *Violations of ICE Detention Standards at Torrance County Detention Facility*, No. OIG-22-75, at 19 (Sept. 28, 2022), https://www.oig.dhs.gov/sites/default/files/ assets/2022-09/OIG-22-75-Sep22.pdf.

[13] U.S. Imm. & Customs Enf. *Detention Management*, https://www.ice.gov/detain/detention-management.

Office of Enforcement and Removal Operations
ICE Health Service Corps

U.S. Department of Homeland Security
500 12th Street, SW
Washington, D.C. 20536

U.S. Immigration and Customs Enforcement

October 20, 2022

MEMORANDUM FOR: (b)(6),(b)(7)(C) DHSc, FACHE
Assistant Director
ICE Health Service Corps

THROUGH: (b)(6),(b)(7)(C) MD
Deputy Assistant Director of Clinical Services/Medical Director
ICE Health Service Corps
(b)(6),(b)(7)(C)

(b)(6),(b)(7)(C) MS
Chief of Staff
ICE Health Service Corps
(b)(6),(b)(7)(C)

CDR (b)(6),(b)(7)(C) PA-C
Chief, Investigations Unit
ICE Health Service Corps
(b)(6),(b)(7)(C)

FROM: CAPT (b)(6),(b)(7)(C) PA-C
Investigator, Investigations Unit
ICE Health Service Corps
(b)(6),(b)(7)(C)

SUBJECT: Mortality Review Report of Findings
Kesley VIAL, A240 899 412

Executive Summary:

On August 26, 2022, U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) received notification of the death of ICE detainee Kesley VIAL, A240 899 412. During his detention period, ICE housed Mr. VIAL, a 23-year-old Brazilian male, at Torrance County Detention Facility (TCDF) in Estancia, New Mexico (NM), from April 29 to August 17, 2022, the date he attempted suicide by hanging. On August 24, 2022, a University of New Mexico Hospital (UNMH) physician declared Mr. VIAL deceased due to acute hypoxic respiratory failure (insufficient oxygen leading to failure of lung function) and diffuse anoxic brain injury

(absence of oxygen leading to brain injury). An autopsy report certified Mr. VIAL's cause of death as suicide by hanging. Mr. VIAL's death certificate is pending.

On April 22, 2022, prior to his ICE custody, U.S. Customs and Border Protection (CBP) arrested Mr. VIAL in El Paso, Texas (TX), upon his illegal entry into the United States, and charged him with violating Section 212 (a) (7)(A)(i) of the Immigration and Nationality Act. Mr. VIAL claimed fear of harm and persecution if returned to Brazil. An immigration judge later denied Mr. VIAL's claim, and ICE ordered his removal. From April 29 to August 17, 2022, ICE housed Mr. VIAL at TCDF, except for one week between July 18 to 27, 2022, when ICE transferred Mr. VIAL to El Paso Service Processing Center (ESPC) in El Paso, TX, and Florence Service Processing Center (FSPC) in Florence, Arizona (AZ), for a scheduled charter flight to Brazil.

On April 29, 2022, a TCDF registered nurse (RN) completed Mr. VIAL's intake screening, documented Mr. VIAL denied current or past medical or mental health problems, and cleared him for general population.

On June 15, 2022, a behavioral health provider (BHP) evaluated Mr. VIAL for a self-inflicted injury to his hand (right or left not specified) and referred him to a psychiatrist. The next day, a psychiatrist completed Mr. VIAL's evaluation and documented his history of anxiety, depression, self-injurious behaviors, and two prior suicide attempts. The psychiatrist ordered anti-depressant and anti-anxiety medication, and referred Mr. VIAL to a BHP for counseling.

Between July 18 to 27, 2022, ICE housed Mr. VIAL at ESPC and FSPC pending his removal flight to Brazil. On July 21, 2022, ICE removed Mr. VIAL from the flight due to overbooking, and he remained at FSPC until July 28, 2022, when ICE returned him to TCDF.

On July 28 and August 4, 2022, a psychiatrist evaluated and treated Mr. VIAL's depression and anxiety. Mr. VIAL denied suicidal ideation. The psychiatrist adjusted Mr. VIAL's antidepressant and antianxiety medications, and scheduled psychiatric follow-up in two to three weeks.

On August 17, 2022, at 6:52 a.m., ICE informed Mr. VIAL his August 16, 2022 deportation flight was rescheduled for September 1, 2022.

- At 1:30 p.m., an RN evaluated Mr. VIAL after he declined to accept shaving razors from a correctional officer (CO). Mr. VIAL denied suicidal ideation; however, the RN referred him immediately to a BHP. A CO escorted Mr. VIAL to the behavioral health clinic, and while walking to his appointment, Mr. VIAL punched the wall in the hallway.

- The BHP completed Mr. VIAL's urgent mental health evaluation and provided him mental health counseling. The BHP noted Mr. VIAL initially presented visibly upset, crying, and shaking, but denied suicidal ideation, and left his appointment calm and hopeful.

- Immediately after his BHP appointment, Mr. VIAL encountered deportation officers (DOs) in the hallway. The DOs documented Mr. VIAL appeared visibly upset, demanded to be deported immediately, and told them he felt like he was given the death penalty or would rather have the death penalty. The DOs subsequently spoke to the BHP and expressed concern about Mr. VIAL working in the kitchen.

- During count time (security process when the facility counts all detainees) (b)(7)(E) (b)(7)(E), Mr. VIAL attempted suicide by hanging. COs responded immediately, called 911, and initiated cardiopulmonary resuscitation (CPR). Three minutes later, health staff responded and continued CPR. At 3:47 p.m. emergency medical services (EMS) arrived, implemented advanced cardiac life support (ACLS), transported Mr. VIAL to Presbyterian Kaseman Hospital (PBH), then transferred Mr. VIAL to UNMH. A UNMH physician admitted Mr. VIAL to the critical care unit with presumed anoxic brain injury. Mr. VIAL's health deteriorated, and on August 24, 2022, a physician pronounced him deceased.

Mortality Finding:

As a result of Mr. VIAL's death, the IHSC Assistant Director requested a mortality review to learn from his death by reviewing the care provided and the circumstances leading up to his death. The goal of the mortality review is to determine the appropriateness of clinical care; ascertain whether changes to policies, procedures or practices are warranted; and identify issues requiring further study.

A mortality review committee (MRC) determined TCDF health staff did not provide Mr. VIAL's health care within the safe limits of practice. Specifically, the MRC determined: 1) TCDF staff did not provide Mr. VIAL appropriate mental health care; 2) TCDF staff and ICE DOs did not communicate pertinent information effectively to the BHP, and the BHPs did not communicate Mr. VIAL's mental health conditions effectively to TCDF staff; 3) ICE transferred Mr. VIAL five times in a one-week period; 4) TCDF health staff did not document Mr. VIAL's missed doses of medication; and, 5) TCDF staff did not locate and use emergency equipment during the medical emergency response.

The MRC convened on October 12, 2022, and it consisted of the following IHSC members: Captain (CAPT) , M.D., Clinical Director, physician reviewer; CAPT , RN, Western Regional Nurse Manager, nurse reviewer; Commander (CDR) , physician assistant, Central Regional Advanced Practice Provider (APP), APP reviewer; and Lieutenant (LT) , psychologist, behavior health reviewer.

The following summary of events was based on: 1) Mr. VIAL's TCDF, FSPC, and ESPC medical records, 2) EMS report and hospital records; 3) incident and notification reports; 4) ICE ENFORCE Alien Removal Module (EARM) and ICE ENFORCE Alien Detention Module (EADM) database records; 5) Mr. VIAL's TCDF detention file; (b)(7)(E)

(b)(7)(E) 7) an on-site review and staff interviews conducted by fact finder CAPT [redacted] nd LT [redacted] 8) applicable TCDF policies and procedures, and ICE Performance-Based National Detention Standards; 9) Mr. VIAL's autopsy report. Mr. VIAL's death certificate is pending.

Summary of Events

On April 29, 2022, an RN completed Mr. VIAL's intake screening using interpreter services in Mr. VIAL's native language (Portuguese). Mr. VIAL denied any current or past medical or mental health problems, prior drug, or alcohol use, or taking medications. The RN documented normal findings, cleared Mr. VIAL for general population, and scheduled him for a routine follow-up.

On May 2, 2022, a BHP completed Mr. VIAL's comprehensive mental health evaluation. Mr. VIAL reported at age 14, he experienced sleep problems, depression, and suicidal ideation, but denied prior suicide attempts and any mental health problems after age 14.

On May 4, 2022, an APP completed Mr. VIAL's intake health assessment. Mr. VIAL denied history of alcohol or drug use, health problems, or medications. The APP documented an indication for psychiatric consultation but did not document a referral to psychiatry.

On May 5, 2022, health staff responded to a medical emergency in Mr. VIAL's dormitory. An RN found Mr. VIAL sitting on the floor holding the left side of his face. Mr. VIAL reported a toothache. The RN documented normal oral exam findings and referred Mr. VIAL to the dentist.

On May 18, 2022, a dentist evaluated Mr. VIAL's toothache and documented normal dental findings.

On June 11, 2022, a licensed practical nurse (LPN) evaluated Mr. VIAL for his reported involvement in an altercation, during which he sustained injury to his right arm. The LPN documented no injuries and cleared him to return to general population.

On June 15, 2022, a BHP completed Mr. VIAL's routine mental health evaluation. Mr. VIAL reported insomnia (difficulty sleeping), crying, and a self-inflicted injury to his hand (right or left not specified). Mr. VIAL denied suicidal ideation. The BHP referred Mr. VIAL to psychiatry.

On June 16, 2022, a psychiatrist completed Mr. VIAL's initial evaluation. Mr. VIAL reported an eight-year history of outpatient treatment for anxiety and depression, self-injurious behaviors, and two prior suicide attempts, once by cutting his wrists and another by attempted drowning. Mr. VIAL reported recent self-mutilation by cutting his hand (right or left not specified), depressed mood, poor appetite, fear of deportation, suicidal ideation by hanging or jumping from the second floor, but stated he did not want to die, and denied suicidal intent or plan. Mr. VIAL stated, "in the case I go back to Brazil, I prefer to die. I won't do anything here." The psychiatrist

diagnosed him with major depressive disorder, severe, without psychotic features, unspecified anxiety disorder, ordered mirtazapine (an anti-depressant medication) 15 mg, by mouth, every night at bedtime, and sertraline (an anti-depressant and anti-anxiety medication) 50 mg, by mouth, once daily, referred Mr. VIAL to the BHP for counseling, and scheduled a psychiatric follow-up in two weeks.

On June 29, 2022, an RN completed Mr. VIAL's sick call evaluation and documented Mr. VIAL's report, "I have troubles." The RN documented normal vital signs and scheduled a BHP follow-up (date/time not specified).

On June 30, 2022, a psychiatrist completed Mr. VIAL's follow-up appointment. Mr. VIAL reported feeling well, improved sleep, mood, and energy but continued anxiety. He denied suicidal ideation or medication side effects. The psychiatrist documented normal exam findings, increased his sertraline dosage to 100 mg, by mouth, once daily, continued mirtazapine 15 mg, by mouth, at bedtime, and scheduled a psychiatric follow-up in three weeks.

On July 13, 2022, a BHP completed Mr. VIAL's routine mental health visit. Mr. VIAL reported feeling sad, denied suicidal ideation or hallucinations, but reported he had been assaulted in his dormitory. The BHP notified a CO who reported to the clinic to address Mr. VIAL's concerns. The BHP documented Mr. VIAL's saddened appearance, absence of depression or psychosis, and scheduled a mental health follow-up in 30 days. The BHP did not document any details about Mr. VIAL's alleged assault or refer him for a medical evaluation.

On July 17, 2022, an RN completed Mr. VIAL's transfer form and documented his history of anxiety, major depressive disorder, insomnia, and current medications, including the following: sertraline 100 mg, by mouth, once daily, and mirtazapine 15 mg, by mouth, every night at bedtime.

On July 18, 2022, ICE transferred Mr. VIAL to ESPC in preparation for his removal flight to Brazil. An ESPC RN completed Mr. VIAL's pre-screen and intake screening, documented his history of major depressive disorder, anxiety, current medications, normal vital signs, normal physical exam, consulted with an APP, and scheduled a follow-up with an APP the next day.

On July 19, 2022, ICE transferred Mr. VIAL to FSPC for his removal flight to Brazil scheduled for July 21, 2022. An FSPC RN completed Mr. VIAL's pre-screen and intake screening, documented his medical and mental health history, current medications, normal vital signs, normal physical exam, and referred him to an APP.

On July 20, 2022, an FSPC APP completed Mr. VIAL's intake health assessment. Mr. VIAL reported a history of anxiety and depression, alcohol use, mental health hospitalization, auditory hallucinations, suicidal ideation within the past 12 months, and previous self-injurious behaviors. Mr. VIAL denied current suicidal ideation or thoughts of self-harm. The APP documented normal exam findings, except for bilateral ear inflammation, diagnosed Mr. VIAL with

adjustment disorder, ordered continuation of his previous medications, and referred him to a BHP.

On July 21, 2022, an FSPC RN completed Mr. VIAL's transfer form, documented his history of anxiety, depression, ear infection, and current medications.

On July 22, 2022, an FSPC RN documented, "kickback from Brazil flight," completed Mr. VIAL's pre-screen, and documented his anxiety, depression, and current list of medication.

- An FSPC psychologist completed Mr. VIAL's mental health evaluation. Mr. VIAL reported he wanted to return to Brazil, felt depressed, denied suicidal ideation, and requested an increase in his medication dosage. The psychologist diagnosed him with adjustment disorder and scheduled a mental health follow-up in two weeks.

- An FSPC psychiatric APP (psych-APP) completed Mr. VIAL's initial evaluation. Mr. VIAL reported an eight-year history of psychiatric treatment, self-injurious behavior, auditory hallucinations, regular use of alcohol, cocaine, marijuana, hallucinogens, methamphetamines, and a history of suicide attempt at age 16 or 17. Mr. VIAL reported current auditory hallucinations, anxiety, depression, but denied current suicidal ideation. The psych-APP diagnosed Mr. VIAL with depression and anxiety disorder. In addition to Mr. VIAL's current medications, the psych-APP ordered hydroxyzine (treatment for anxiety) 25 mg, by mouth, twice daily, diphenhydramine (sleep aid) 25 mg, by mouth, once daily, and scheduled a psychiatric follow-up in two weeks.

On July 26, 2022, ICE transferred Mr. VIAL to ESPC and rescheduled his deportation flight to September 1, 2022.

- An ESPC RN completed Mr. VIAL's pre-screen, intake screening, and documented his past medical and mental health history and current medications. Mr. VIAL reported feeling well. The RN documented Mr. VIAL's abnormal intake screening and referred him to an APP.

On July 27, 2022, an ESPC RN evaluated Mr. VIAL for segregation clearance, documented normal vital signs, normal exam findings, and referred Mr. VIAL to a BHP the next day. The RN did not document the reason for Mr. VIAL's segregation clearance.

On July 28, 2022, ICE transferred Mr. VIAL to TCDF.

- A TCDF LPN completed Mr. VIAL's intake screening, documented Mr. VIAL's request for mental health treatment, and his report of not receiving medication for the past three days. Mr. VIAL denied thoughts of self-harm. The medical documentation did not

include a reason for Mr. VIAL's missed medications; however, the LPN referred Mr. VIAL to the psychiatrist on the same day.

- A psychiatrist completed Mr. VIAL's evaluation and documented his frustration, sadness, and anxiety about his cancelled deportation flight. Mr. VIAL denied suicidal ideation and requested to re-start his medications. The psychiatrist ordered sertraline 100 mg, by mouth, once daily, and hydroxyzine 50 mg, by mouth, each night at bedtime, and scheduled a psychiatric follow-up in two to three weeks.

On July 31, 2022, a CO referred Mr. VIAL to a BHP after he expressed intent to harm himself prompting the BHP to complete a self-harm/suicide risk assessment. Mr. VIAL reported anxiety, denied suicidal ideation, denied intent to self-harm, and explained he expressed (to the CO) intent to harm himself to avoid changes to his current room location. The BHP noted Mr. VIAL's depressed and anxious mood, released him to his dormitory, and scheduled a follow-up appointment with psychiatry (date and time not specified).

On August 4, 2022, a psychiatrist completed Mr. VIAL's routine mental health follow-up appointment. Mr. VIAL reported insomnia, anxiety about leaving the facility and returning to Brazil, but denied suicidal ideation. The psychiatrist documented Mr. VIAL appeared anxious but an otherwise normal exam, and increased his sertraline dosage to 150 mg, by mouth, once daily, hydroxyzine to 100 mg, by mouth, each night, at bedtime, added aripiprazole 2 mg, by mouth, once daily, and scheduled a psychiatric follow-up in two weeks.

On August 5, 2022, an APP completed Mr. VIAL's intake health assessment and documented his history of anxiety, depression, drug, and alcohol use. The APP documented normal physical exam findings, diagnosed him with anxiety and insomnia, and referred Mr. VIAL to a BHP.

On August 10, 2022, a BHP completed Mr. VIAL's routine mental health evaluation and documented Mr. VIAL's report of anxiety, insomnia, and denial of suicidal ideation. The BHP documented mental health education and scheduled a BHP follow-up in 30 days.

On August 15 and 16, 2022, an RN completed Mr. VIAL's transfer form and documented his current diagnoses, medications, and a coronavirus 2019 rapid test, which showed negative results.

On August 17, 2022, at 6:52 a.m., ICE sent Mr. VIAL an electronic message informing him of his rescheduled flight from August 16 to September 1, 2022.

- At 8:29 a.m., a CO observed Mr. VIAL's ill appearance and escorted him to the health clinic. An RN evaluated Mr. VIAL, and he reported feeling hungry and dizzy. The RN documented normal vital signs, normal physical exam, and released Mr. VIAL back to the dormitory.

- A CO reported Mr. VIAL requested a room change from 210, where he had a roommate, to 206, where he did not have a roommate. The CO reported the room change occurred during the morning hours; however, according to the facility roster, Mr. VIAL's assigned room remained 210. The CO also reported detainees were permitted to change rooms when they became vacant.

- At 1:30 p.m., an RN evaluated Mr. VIAL after he declined to accept his shaving razors from a CO. The RN documented Mr. VIAL's agitated appearance and his request to move to a room in the medical clinic. Mr. VIAL denied suicidal ideation; however, the RN referred him immediately to a BHP.

    - A CO escorted Mr. VIAL to his BHP appointment, and while in the hallway, Mr. VIAL punched the wall. An RN briefly evaluated Mr. VIAL's hand injury in the behavioral health clinic and requested Mr. VIAL report to the medical clinic after his BHP appointment. The CO was not aware of the RN's request for Mr. VIAL to return to the medical clinic.

    - The BHP completed Mr. VIAL's urgent mental health evaluation and provided him mental health counseling. The BHP noted Mr. VIAL initially presented visibly upset, crying, and shaking, but denied suicidal ideation, and left his appointment calm and hopeful. The BHP did not review Mr. VIAL's prior health records, or discuss his history of self-injury or prior suicide attempts with him. The BHP did not know Mr. VIAL declined shaving razors, requested a room in the medical clinic, or of the RN's intent for Mr. VIAL to return to the medical clinic.

    - Immediately after his BHP appointment, a CO escorted Mr. VIAL to meet with ICE DOs, and Mr. VIAL encountered the DOs in the hallway. The DOs documented Mr. VIAL appeared visibly upset, demanded to be deported immediately, and told them he felt like he was given the death penalty or would rather have the death penalty. Mr. VIAL walked away from the DOs toward his dormitory.

    - The DOs subsequently spoke to the BHP and expressed their concern about Mr. VIAL's emotional state and working in the kitchen; however, it is not clear whether the DOs mentioned Mr. VIAL's comments about the death penalty.

- At 2:45 p.m., Mr. VIAL entered his dormitory and walked to room 206, where he communicated briefly with another detainee who checked on Mr. VIAL because he seemed upset. Mr. VIAL reassured the detainee, and they both walked out of room 206. Mr. VIAL walked to room 210, asked the CO to unlock the door, and Mr. VIAL entered briefly to obtain his sheet and blanket. Mr. VIAL dragged his sheet and blanket into room 206 and closed the door.

- At 2:50 p.m., a CO looked inside Mr. VIAL's room (206) and pulled on the door handle to verify it was locked.

- At 3:18 p.m. two COs entered Mr. VIAL's dormitory. While conducting the count, a CO stopped at Mr. VIAL's room, saw him with a sheet around his neck hanging from a shelf, and immediately called for assistance on the radio. A second CO ran up the stairs to assist, followed by three detainees who were cleaning the dormitory during count. The detainees assisted lifting Mr. VIAL, while a CO untied the sheet from his neck. Both COs initiated and continued CPR until medical staff arrived.

- At 3:19 p.m., the chief of security entered Mr. VIAL's dormitory, and via radio transmission, alerted central control to call 911. He told the three detainees assisting in Mr. VIAL's room to return to their rooms.

- At 3:21 p.m., two RNs entered the dormitory and ran to Mr. VIAL's room with the automated external defibrillator (AED). One minute later, three more RNs arrived.

- At 3:22 p.m., an RN applied the AED to Mr. VIAL's chest, which advised to continue CPR.

- At 3:30 p.m., the AED delivered one shock to Mr. VIAL.

- At 3:47 p.m., EMS arrived, administered naloxone (opioid reversal) intranasally, attached a cardiac monitor, and performed ACLS measures including endotracheal intubation (an insertion of a tube through the mouth into the trachea to secure the airway). EMS documented Mr. VIAL was unconscious, unresponsive, pulseless, apneic, had fixed and dilated pupils, cool extremities, and a Glasgow coma scale (standardized method to evaluate level of consciousness; score ranges from 3 to 15) score equal to 3 (a score of 15 is normal and a score of 3 indicates severe neurological deficit). Upon return of Mr. VIAL's spontaneous circulation, EMS directed TCDF staff to continue bag-valve mask respirations and assist carrying Mr. VIAL on a backboard down the stairs to the EMS stretcher.

- At 4:12 p.m., EMS left the dormitory with Mr. VIAL, returned to their ambulance, and transported Mr. VIAL to the Presbyterian Kaseman Hospital (PKH) in Albuquerque, New Mexico (NM), with subsequent transfer to UNMH in Albuquerque, NM. PKH records are pending.

- At 8:00 p.m., the UNMH physician evaluated Mr. VIAL as a level one trauma emergency (highest level of acuity requiring immediate multispecialty critical care) and ordered Mr. VIAL's laboratory and radiologic studies. The physician admitted Mr. VIAL to the critical care unit and documented the following:

- Multisystem organ failure (failure of internal organs such as heart, lungs, kidney, liver, pancreas, and bowels due to severe injury or infection);
- suspected anoxic brain injury (absence of oxygen leading to brain injury);
- cardiac arrest (sudden stop of the heartbeat and blood flow) with return of spontaneous circulation after CPR; cardiac irregularities of rhythm and function;
- hemopericardium (blood surrounding the outside of the heart);
- hypovolemic shock (organ dysfunction due to inadequate flow of blood to tissues);
- acute liver and kidney injury due to cardiac arrest and hypotension (low blood pressure);
- irregularities of right and left carotid arteries (main arterial flow to the brain);
- traumatic internal injuries due to prolonged CPR as follows: 1) nondisplaced sternal (middle chest bone) fracture; 2)retrosternal hemorrhage (bleeding underneath the middle chest bone); 3) bilateral rib fractures (broken ribs on both sides); 4) small right hemopneumothorax (air and blood in the space outside of the lung); 5) pulmonary edema (fluid in the lungs); 6) left lower lobe aspiration (stomach contents inside the lungs); and 7)left hepatic lobe contusions (bruising of the left side of the liver).

On August 18, 2022, Mr. VIAL's repeat CT scan of the head showed no changes and the radiologist recommended further evaluation with magnetic resonance imaging (MRI).

On August 19, 2022, a physician documented Mr. VIAL's MRI of his brain results and confirmed diffuse anoxic brain injury.

Between August 20 and 24, 2022, Mr. VIAL's condition remained unchanged.

On August 24, 2022, at 11:38 a.m., a UNMH physician documented brain death testing, declared Mr. VIAL neurologically deceased, and provided the following diagnoses: cardiac arrest, after hanging, unclear downtime, acute hypoxic respiratory failure, diffuse anoxic brain injury, hypovolemic shock, kidney failure, left hepatic lobe contusions, and bilateral rib fractures. The physician referred Mr. VIAL to the New Mexico Donor Services (NMDS).

On August 26, 2022, NMDS staff contacted Mr. VIAL's family and obtained consent for organ donation.

On August 28, 2022, the NMDS performed Mr. VIAL's organ donation surgery.

The final autopsy report noted Mr. VIAL's cause of death was suicide by hanging.

LT Brett Dodd performed Mr. VIAL's psychological autopsy (procedure for analyzing the cause of death by reconstructing what the person thought, felt, and did before death, based on gathered information).

ICE detention standards used for this review: Performance-Based National Detention Standards (PBNDS), 2011 with 2016 revisions, and the National Commission on Correctional Health Care (NCCHC) Standards, 2018.The following are identified program strengths, weaknesses, and recommendations found during this review.

Strengths

Strengths identified during this investigation were: 1) COs and nursing staff responded promptly to Mr. VIAL's statements and behaviors and referred him to the BHP; 2) Medical staff responded to the emergency within three minutes; 3) COs initiated immediate life saving measures and called 911; 4) TCDF staff proactively made changes after Mr. VIAL's death, including increased responsiveness to risks for self-harm and removal of the shelves in the dormitory rooms; 5) TCDF leadership completed post suicide debriefing for staff and detainees.

Weaknesses

1) Inappropriate mental health care.

- On August 17, 2022, Mr. VIAL made statements and displayed behaviors that warranted a suicide risk assessment [(SRA) standard tool to measure risk of suicide]; however, the BHP did not complete an SRA.
- On May 2, June 15, June 16, and July 31, 2022, behavioral health staff documented Mr. VIAL's history of self-injury and prior suicide attempts; however, on August 17, 2022, the BHP did not review Mr. VIAL's prior health records or discuss his history of self-injury or prior suicide attempts with him.
- A BHP circulated a weekly mental health watch list; however, 1) TCDF does not have a policy that governs this document; 2) medical staff reported no awareness of names on the list; 3) medical and behavioral health staff did not discuss the patients on the list; 4) health staff reported no awareness of Mr. VIAL's prior suicide attempts; and 5) the BHP did not include Mr. VIAL's name on the list.
- TCDF health staff documented indications for Mr. VIAL's referral to behavioral health but did not document written referrals in his medical record.

Applicable standards of care for this finding:

- PBNDS 2011 with 2016 Revisions: Part 4.6, Significant Self Harm and Suicide Prevention and Intervention; section C. *Referrals*.
- NCCHC 2018: J-B-05, *Suicide Prevention and Intervention*.

2) Communication.

- On August 17, 2022, no single TCDF staff person knew about Mr. VIAL's mental health history, statements, and behaviors: he declined shaving razors, he requested a room in the medical clinic, he punched the wall, and he spoke about the death penalty.
- On August 17, 2022, after Mr. VIAL punched the wall, an RN requested Mr. VIAL return to the medical clinic for further assessment, but he did not return.
- TCDF health staff did not complete a medical/psychiatric alert for Mr. VIAL, and his health conditions required one. The medical/psychiatric alert is a continuity of care document to notify the ICE Field Office Director of detainee health needs that may affect detainee transfer or facility activities.
- IHSC staff had difficulty obtaining timely information from UNMH. On August 24, 2022, UNMH declared Mr. VIAL neurologically deceased, however, UNMH did not notify IHSC until August 26, 2022.

Applicable standards of care for this finding:

- PBNDS 2011 with 2016 Revisions: Part 4.6, Significant Self Harm and Suicide Prevention and Intervention; section G. *Communication.*
- PBNDS 2011 with 2016 Revisions: Part 4.7, Terminal Illness, Advance Directives, and Death; section E. *Death of a Detainee in ICE/ERO Custody.*
- NCCHC 2018: J-B-07, *Communication on Patient's Health Needs*.

3) Transition of care:

- ICE transferred Mr. VIAL five times, to three facilities, and once to the flight line, during a one-week period.

  Applicable standards of care for this finding:

- PBNDS 2011 with 2016 Revisions: Part 4.3 Medical Care, section Z. *Continuity of Care.*
- PBNDS 2011 with 2016 Revisions: Part 7.4 Detainee Transfers, section II *Expected Outcomes.*

4) Medications:

- Between July 28 and August 16, 2022, TCDF health staff did not document Mr. VIAL's missed doses of medication. Mr. VIAL's medication administration record (MAR) had blank spaces or areas documenting "no-show," but did not include any documentation to justify reason for blank spaces or documenting "no show," and, the LPN/RNs did not

refer him to a higher-lever provider after his missed doses of medication. Health staff continued to document "no-show" on Mr. VIAL's MAR during his hospitalization.

Applicable standards of care for this finding:

- PBNDS 2011 with 2016 Revisions: Part 4.3, Medical Care; section G. *Pharmaceutical Management*
- NCCHC 2018: J-D-02, *Medication Services*.

5) Training:

- TCDF documented emergency medical response and hanging drills; however, during the emergency response, an RN did not locate the bag-valve mask in the emergency bag, and COs did not obtain and use the cut-down tool.

Applicable standards of care for this finding:

- PBNDS 2011 with 2016 Revisions: Part 4.3, Medical Care; section II. *Expected Outcomes.*
- NCCHC 2018: J-D-07, *Emergency Services and Response Plan.*
- Core Civic: 9-19 Suicide Prevention/Risk Reduction, 2021: Section F, *Suicide Attempt*.

Recommendations

- Forward these findings to the IHSC Deputy Assistant Director of Health Care Compliance (DAD-HCC).
- The IHSC DAD of HCC will share these findings through appropriate communication channels to ICE, TCDF's administrator and health authority, for review and any action(s) deemed appropriate.
- The respective IHSC HCC unit and ICE will ensure the corrective action plan, if applicable, is implemented and sustained.

End of report.