DEPARTMENT OF HOMELAND SECURITY

REPORT OF INVESTIGATION

HB 4200-01 (37), Special Agent Handbook

1. CASE NUMBER

201207288

PREPARED BY

(b)(6), (b)(7)(c)

2. REPORT NUMBER

002

3. TITLE

Mandza, Evalin Ali/Unknown/0108 Death-Detainee/Alien (Unknown Cause)/AURORA, ADAMS, CO

4. FINAL RESOLUTION

5. STATUS	6. TYPE OF REPORT	7. RELATED CASES
Closing Report	Detainee Death Review	

8. TOPIC

Detainee Death Review of Evalin MANDZA

9. SYNOPSIS

On April 12, 2012, the Joint Intake Center, Washington D.C., received notification regarding the death of U.S. Immigration and Customs Enforcement Detainee Evalin Ali MANDZA. MANDZA, a citizen of Gabon, died on April 12, 2012, at the Aurora Medical Center South, in Aurora, Colorado. The treating physician, Dr. (b)(6), (b)(7)(c) reported MANDZA died of anterior myocardial infarction, and severe left main coronary artery stenosis.

On April 17, 2012, the U.S. Immigration and Customs Enforcement, Office of Professional Responsibility, Office of Detention Oversight, initiated a Detainee Death Review of MANDZA'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 Supervisor	16-OCT-2012	ICE OPR Office of Detention Oversight (ODO)-Houston
12. APPROVED BY(Print Name & Title)	**13. APPROVED DATE**	**15. TELEPHONE NUMBER**
(b)(6), (b)(7)(c) - ICE-OPR Special Agent Supervisor	16-OCT-2012	No Phone Number

DEPARTMENT OF HOMELAND SECURITY	1. CASE NUMBER
	201207288
	PREPARED BY
	(b)(6), (b)(7)(c)
REPORT OF INVESTIGATION CONTINUATION HB 4200-01 (37), Special Agent Handbook	2. REPORT NUMBER 002

10. NARRATIVE

On April 12, 2012, the Joint Intake Center (JIC), Washington, D.C., received notification regarding the death of U.S. Immigration and Customs Enforcement Detainee Evalin Ali MANDZA (Alien Registration Number (b)(6), (b)(7)(c) . MANDZA, a citizen of Gabon who was born on December 5, 1965, died on April 12, 2012, at the Aurora Medical Center South (AMCS), Aurora, Colorado. MANDZA was 46 years old when he died.

At the time of his death, MANDZA was in U.S. Immigration and Customs Enforcement (ICE) custody at the Denver Contract Detention Facility (DCDF) in Aurora, Colorado. DCDF is an ICE contract facility owned and operated by The Geo Group, Inc. (GEO). Detention space at DCDF is solely dedicated to the accommodation of adult ICE male and female detainees of all security classification levels for periods in excess of 72 hours. DCDF has a detainee capacity of 1,116. The average length of stay is 26 days. Medical Care at DCDF is provided by GEO. DCDF is accredited by the American Correctional Association and the National Commission on Correctional Healthcare.

The Office of Enforcement and Removal Operations (ERO), Field Office Director, Denver, Colorado (FOD Denver), is responsible for ensuring DCDF compliance with the ICE Performance Based National Detention Standards (PBNDS). An Assistant Field Office Director (AFOD) is stationed at DCDF and oversees ICE operations at the facility.

On April 17, 2012, Special Agent (SA) (b)(6), (b)(7)(c) and SA (b)(6), (b)(7)(c) , assigned to ICE, Office of Professional Responsibility (OPR), Office of Detention Oversight (ODO), initiated a Detainee Death Review (DDR) regarding the death of Detainee MANDZA. SA (b)(6), (b)(7)(c) and SA (b)(6), (b)(7)(c) were assisted by registered nurse (RN) and subject matter expert, (b)(6), (b)(7)(c) RN (b)(6), (b)(7)(c) is employed by Creative Corrections (CC), a national management and consultant firm, contracted by ICE to provide subject matter expertise in detention management including health care. During the review, ODO interviewed staff from the DCDF and personnel assigned to the ERO office in Centennial, Colorado (ERO Centennial). Additionally, agents reviewed MANDZA's immigration, medical, and detention records.

The following is a chronology of events which occurred while MANDZA was in ICE custody.

On October 16, 2011, MANDZA was arrested by the Aurora Colorado Police Department for the unlawful selling of merchandise and resisting an officer. MANDZA was housed at the Aurora County Jail in Aurora, CO.

On October 17, 2011, MANDZA was convicted in the City of Aurora Municipal Court, Aurora, CO,

DEPARTMENT OF HOMELAND SECURITY

REPORT OF INVESTIGATION CONTINUATION

HB 4200-01 (37), Special Agent Handbook

1. CASE NUMBER

201207288

PREPARED BY

(b)(6), (b)(7)(c)

2. REPORT NUMBER

002

10. NARRATIVE

for the offense of the unlawful selling of merchandise, and sentenced to 60 days in jail, 55 days suspended sentence, with three days to serve. On the same date, Immigration Enforcement Agent (IEA) (b)(6), (b)(7)(c) interviewed MANDZA at the Aurora County Jail (ACJ) in Aurora, CO, pursuant to the Criminal Alien Program. Following the interview, IEA (b)(6), (b)(7)(c) issued a Form I-247, Immigration Detainer Notice, informing ACJ that an investigation had been initiated to determine whether MANDZA is subject to immigration removal proceedings. MANDZA remained at the Aurora County Jail until his release on October 24, 2011.

On October 24, 2011, IEA (b)(6), (b)(7)(c) transported MANDZA from the Aurora County Jail to ERO Centennial (Exhibit 01). At approximately 7:05 a.m., MANDZA arrived at ERO Centennial for processing. Upon arrival at ERO Centennial, IEA (b)(6), (b)(7)(c) arrested and charged MANDZA with immigration violations. At the time of the arrest, IEA (b)(6), (b)(7)(c) completed ICE Form I-213, Record of Deportable/Inadmissible Alien. The I-213 states that IEA (b)(6), (b)(7)(c) issued MANDZA an ICE Form I-862, Notice to Appear, for overstaying his admission as a nonimmigrant in violation of the Immigration and Nationality Act (INA) Section 237(a)(1)(B) (Exhibit 02).

On October 24, 2011, at approximately 4:15 p.m., IEA (b)(6), (b)(7)(c) transported MANDZA from ERO Centennial to the DCDF (refer to Exhibit 01). At approximately 5:05 p.m., MANDZA arrived at the DCDF. MANDZA was processed into the facility by GEO Detention Officer (DO) (b)(6), (b)(7)(c) (b)(6), (b)(7)(c) and GEO DO (b)(6), (b)(7)(c). During processing, MANDZA was issued facility clothing, an identification wrist band, handbooks conveying facility procedures and policies, watched an orientation video, and had his personal property inventoried and stored (Exhibit 03). At the time of admission to DCDF, MANDZA was not in possession of or taking any prescription medication (refer to Exhibit 02). At the conclusion of the initial booking procedure, an intake form was completed.

At approximately 6:45 p.m., an initial medical screening was performed by GEO licensed practical nurse (LPN) (b)(6), (b)(7)(c) (Exhibit 04). During the medical intake screening performed by LPN (b)(6), (b)(7)(c), vital signs (VS) were documented as follows: pulse (P) 81, blood pressure (BP) 101/62, respirations (R) 14, temperature (T) 97.1, all within normal limits (WNL). No chronic care issues were identified, and the form documented negative responses to all health history questions. ODO interviewed LPN (b)(6), (b)(7)(c) on May 21, 2012. LPN (b)(6), (b)(7)(c) stated she always asks more questions than listed on the form and seeks to identify possible signs or symptoms of anything abnormal. LPN (b)(6), (b)(7)(c) stated she found "nothing out of the ordinary" during her screening of MANDZA.

The Nursing Incoming Screen Progress Note form documents there were no medications ordered,

DEPARTMENT OF HOMELAND SECURITY	1. CASE NUMBER
	201207288
	PREPARED BY
	(b)(6), (b)(7)(c)
REPORT OF INVESTIGATION CONTINUATION HB 4200-01 (37), Special Agent Handbook	2. REPORT NUMBER 002

10. NARRATIVE

no special treatments or follow-up referrals, and no work limitations. Additionally, no housing or bunk limitations were ordered for MANDZA (Exhibit 05). This form is designed to focus on chronic conditions requiring follow-up or medication. (b)(6), (b)(7)(c) MD, reviewed and signed the form on October 27, 2011. The Mental Health Intake Screen completed by LPN (b)(6), (b)(7)(c) documents negative responses for all items concerning mental health (Exhibit 06). The form was signed by (b)(6), (b)(7)(c) MD, on the same date. The detainee refused syphilis testing and signed a refusal form (Exhibit 07). A chest x-ray was performed with the results documented as "Negative except for calcified granuloma (small area of inflammation of benign calcification) less than 2 cm" (Exhibit 08). Dr. (b)(6), (b)(7)(c) is no longer employed by DCDF and was not available for an interview.

At the completion of the intake process, GEO DO (b)(6), (b)(7)(c) conducted a classification assessment of MANDZA to determine the appropriate classification level, as determined by previous criminal history and disciplinary issues. GEO DO (b)(6), (b)(7)(c) classified MANDZA at Level II due to his prior convictions and arrests (Exhibit 09). At the completion of the classification process, MANDZA was assigned to DCDF housing unit A2.

GEO DO (b)(6), (b)(7)(c) and GEO DO (b)(6), (b)(7)(c) were the housing unit officers during MANDZA's assignment to housing unit A2. SA (b)(6), (b)(7)(c) SA (b)(6), (b)(7)(c), and RN (b)(6), (b)(7)(c) interviewed GEO DO (b)(6), (b)(7)(c) on May 21, 2012, and DO (b)(6), (b)(7)(c) on May 23, 2012, at the DCDF. GEO DO (b)(6), (b)(7)(c) and GEO DO (b)(6), (b)(7)(c) were shown a photograph of MANDZA as well as a copy of his case file. GEO DO (b)(6), (b)(7)(c) stated he did not recall MANDZA. GEO DO (b)(6), (b)(7)(c) stated he remembered MANDZA and stated that MANDZA spoke French. GEO DO (b)(6), (b)(7)(c) stated he did not remember MANDZA complaining about any health related issues.

On October 25, 2011, MANDZA submitted a sick call request stating he had a "bad movement" (Exhibit 10). On October 26, 2011, at approximately 6:00 p.m., a physical examination and health appraisal were performed by adult nurse practitioner (ANP) (b)(6), (b)(7)(c) (Exhibit 11). All history and vital signs were documented as normal. A Progress Note by Registered Nurse (RN) (b)(6), (b)(7)(c) (b)(6), (b)(7)(c) documents MANDZA was seen for sick call, because he had not had a bowel movement in three to four days (Exhibit 12). RN (b)(6), (b)(7)(c) instructed MANDZA to increase his fluid intake. MANDZA stated he understood and was given Dulcolax and Milk of Magnesia (a laxative to relieve constipation) in accordance with GEO nursing protocols (Exhibit 13).

On October 31, 2011, MANDZA submitted a sick call request for "constipation movement" (Exhibit 14). MANDZA was placed on the sick call list to be seen by Dr (b)(6), (b)(7)(c) on November 3, 2011. During the ODO site visit for this review, RN (b)(6), (b)(7)(c) observed Detainee MANDZA's name was crossed off Dr. (b)(6), (b)(7)(c) sick call list with a crayon.

DEPARTMENT OF HOMELAND SECURITY	1. CASE NUMBER
	201207288
	PREPARED BY
	(b)(6), (b)(7)(c)
REPORT OF INVESTIGATION CONTINUATION HB 4200-01 (37), Special Agent Handbook	2. REPORT NUMBER 002

10. NARRATIVE

SA (b)(6), (b)(7)(c), SA (b)(6), (b)(7)(c), and RN (b)(6), (b)(7)(c) interviewed Acting Health Services Administrator (HSA) RN (b)(6), (b)(7)(c) on May 21, 2012, at DCDF. Acting HSA RN (b)(6), (b)(7)(c) stated names are crossed off sick call lists with crayons to signify the medical record has been removed for the appointment. There was no corresponding Progress Note or other documentation confirming that detainee MANDZA was seen by Dr. (b)(6), (b)(7)(c) on November 3, 2011. RN (b)(6), (b)(7)(c) could not explain why the sick call appointment was missed. No other significant activity occurred regarding MANDZA until November 8, 2011.

On November 8, 2011, MANDZA submitted a sick call request for razor burn (Exhibit 15). On November 9, 2011, at approximately 6:00 a.m., the medical Progress Notes document that MANDZA was seen by LPN (b)(6), (b)(7)(c) for "razor bumps" (Exhibit 16). MANDZA was given triple antibiotic cream to be applied daily for seven days (Exhibit 17).

On November 10, 2011, MANDZA submitted a sick call request for constipation (Exhibit 18). On November 11, 2011, the medical record documents that the sick call request was reviewed by LPN (b)(6), (b)(7)(c). MANDZA was provided Dulcolax and fiber was added to his diet (Exhibit 19).

On November 15, 2011, MANDZA was reassigned from housing unit A2 to housing unit A3. May 21 through 23, 2012, ODO interviewed each GEO DO assigned to housing unit A3 while MANDZA was there: GEO DO (b)(6), (b)(7)(c), GEO DO (b)(6), (b)(7)(c), GEO DO (b)(6), (b)(7)(c), GEO DO (b)(6), (b)(7)(c) (b)(6), (b)(7)(c), GEO DO (b)(6), (b)(7)(c) and GEO DO (b)(6), (b)(7)(c). Each GEO DO stated MANDZA appeared to be in good health, was polite and quiet, and never exhibited any symptoms of illness.

On November 17, 2011, MANDZA submitted a sick call request for a toothache (Exhibit 20). RN (b)(6), (b)(7)(c) provided MANDZA Tylenol (for pain) and scheduled him to see the dentist on November 21, 2011. MANDZA was instructed on proper dental hygiene and advised to return to the clinic if symptoms persisted or worsened (Exhibit 21).

On November 21, 2011, at approximately 3:45 p.m., MANDZA was seen by Dentist (b)(6), (b)(7)(c). According to the dental health record, MANDZA complained of a lower level toothache (Exhibit 22). MANDZA was scheduled for court the following day, so MANDZA requested that his tooth extraction be rescheduled.

On November 27, 2011, MANDZA submitted a sick call request for constipation and razor burn (Exhibit 23). On November 28, 2011, MANDZA was seen by RN (b)(6), (b)(7)(c) for his complaints. RN

DEPARTMENT OF HOMELAND SECURITY	1. CASE NUMBER
	201207288
	PREPARED BY
	(b)(6), (b)(7)(c)
REPORT OF INVESTIGATION CONTINUATION HB 4200-01 (37), Special Agent Handbook	2. REPORT NUMBER 002

10. NARRATIVE

(b)(6), (b)(7)(c) provided MANDZA Milk of Magnesia, Dulcolax, and fiber for the constipation, and triple antibiotic cream for the razor burn rash (Exhibit 24). RN (b)(6), (b)(7)(c) documented MANDZA was instructed to increase fluid consumption, not use triple antibiotic cream around his eyes, and return to the medical unit if symptoms persisted or worsened (refer to Exhibit 23).

On December 2, 2011, at approximately 10:30 a.m., Dr. (b)(6), (b)(7)(c) evaluated MANDZA for constipation and folliculitis (inflammation of hair follicles) (Exhibit 25). For the constipation, MANDZA was prescribed glycerin suppositories, Colace, and advised to increase his fiber intake. MANDZA was provided a triple antibiotic cream for his neck rash.

On December 11, 2011, MANDZA submitted a sick call request for "Dental complaint: need to be cleaned, but not to take out" (Exhibit 26).

On December 12, 2011, at approximately 6:40 a.m., MANDZA was seen by RN (b)(6), (b)(7)(c) (Exhibit 27) and was provided Ibuprofen (Exhibit 28).

On December 14, 2011, MANDZA submitted a sick call request stating he fell from the top bunk and injured his foot (Exhibit 29). On December 15, 2011, Dr. (b)(6), (b)(7)(c) documented an evaluation of Detainee MANDZA. No new orders were issued (Exhibit 30). No significant activity occurred regarding MANDZA until December 20, 2011.

On December 20, 2011, at approximately 1:40 p.m., Dentist (b)(6), (b)(7)(c) documented that MANDZA asked to have his teeth cleaned and complained of pain in his lower level teeth. MANDZA refused a tooth extraction and was given Ibuprofen. During the site visit for this review, ODO found no refusal form in the medical record documenting MANDZA's refusal of a tooth extraction (refer to Exhibit 22).

On December 25, 2011, at approximately 11:40 a.m., a Medical Report on Injuries/Non-Injuries documents MANDZA was evaluated due to his involvement in fighting with other detainees (Exhibit 31). Tiny scratches on his chest and left wrist area were noted by LPN (b)(6), (b)(7)(c). No other injuries were noted. The Pre-Segregation History and Physical form completed by LPN (b)(6), (b)(7)(c) documents clearance for placement in administrative segregation (Exhibit 32). The form was signed by Dr. (b)(6), (b)(7)(c) on December 27, 2011.

On December 25, 2011, at approximately 11:53 a.m., MANDZA was moved to the Special Management Unit for allegedly fighting with another detainee (Exhibit 33). MANDZA was placed in administrative segregation based on an allegation of "horseplay" with another detainee while

DEPARTMENT OF HOMELAND SECURITY	1. CASE NUMBER
	201207288
	PREPARED BY
	(b)(6), (b)(7)(c)
REPORT OF INVESTIGATION CONTINUATION HB 4200-01 (37), Special Agent Handbook	2. REPORT NUMBER 002

10. NARRATIVE

awaiting the outcome of a DCDF investigation (Exhibit 34). On December 27, 2011, MANDZA was released from segregation and returned to housing unit A3 (refer to Exhibit 33). ODO interviewed Lieutenant (b)(6), (b)(7)(c) on May 23, 2012, at the DCDF. Lieutenant (b)(6), (b)(7)(c) investigated the allegations that led to MANDZA being assigned to administrative segregation. Lieutenant (b)(6), (b)(7)(c) stated that the incident on December 25, 2011, was a result of horseplay between MANDZA and another detainee. Although the incident was downgraded from fighting to horseplay, Lieutenant (b)(6), (b)(7)(c) stated MANDZA was held in segregation until the investigation was complete.

On December 30, 2011, at approximately 4:25 p.m., during sick call, RN (b)(6), (b)(7)(c) documented that MANDZA complained of pain in his right big toe resulting from a soccer injury. RN (b)(6), (b)(7)(c) gave MANDZA Ibuprofen and ice packs for his right big toe (Exhibit 35).

On January 3, 2012, Dr. (b)(6), (b)(7)(c) documented that MANDZA complained of a sore foot from striking it against a soccer ball. MANDZA was noted to be in no apparent distress with no swelling, tenderness or gross deformity. MANDZA was prescribed Ibuprofen and assigned to a lower bunk bed (refer to Exhibit 27). No other significant activity occurred regarding MANDZA until January 13, 2012.

On January 13, 2012, MANDZA submitted a sick call request for a toothache (Exhibit 36). The request was reviewed on January 15, 2012, and an appointment was scheduled for January 16, 2012.

On January 15, 2012, MANDZA submitted a sick call request for a toothache and constipation (Exhibit 37). On January 16, 2012, RN (b)(6), (b)(7)(c) documented that MANDZA was seen in medical for his constipation and dental issues. During this appointment, MANDZA was scheduled to see the dentist, Dr. (b)(6), (b)(7)(c), later the same day, as well as Dr. (b)(6), (b)(7)(c) on January 18, 2012 (Exhibit 38). Per a Progress Note by Dr. (b)(6), (b)(7)(c), MANDZA again refused the extraction (refer to Exhibit 22). MANDZA was given Amoxicillin, an antibiotic, and Tylenol for his dental condition. ODO did not find a refusal form for the tooth extraction in the medical record.

On January 18, 2012, MANDZA was removed from housing unit A3 and taken to disciplinary segregation for allegedly refusing to obey a staff member and interfering with the population count. On January 20, 2012, MANDZA was issued a warning, released from segregation, and returned to housing unit A3 (Exhibit 39). The Pre-Segregation History and Physical completed by RN (b)(6), (b)(7)(c) documents medical clearance for housing in Administrative Segregation. "No physical confrontation just arguing" was noted. The form was signed by Dr. (b)(6), (b)(7)(c) but not dated (Exhibit

DEPARTMENT OF HOMELAND SECURITY	1. CASE NUMBER
	201207288
	PREPARED BY
	(b)(6), (b)(7)(c)
REPORT OF INVESTIGATION CONTINUATION HB 4200-01 (37), Special Agent Handbook	2. REPORT NUMBER 002

10. NARRATIVE

40). ODO found that based on the Medical Request dated January 16, MANDZA was to be seen by Dr. (b)(6), (b)(7)(c) on January 18, 2012. There is no documentation confirming this appointment occurred. During her interview, RN (b)(6), (b)(7)(c) could not explain why Dr. (b)(6), (b)(7)(c) did not see MANDZA as scheduled.

During his interview, Lieutenant (b)(6), (b)(7)(c) stated the incident on January 18, 2012, was a result of MANDZA refusing to move to a new cell unless he was allowed to consult with a Lieutenant. Lieutenant (b)(6), (b)(7)(c) stated at the time of the incident, a Lieutenant was unavailable, and MANDZA refused to move, which interfered with the population count. When Lieutenant (b)(6), (b)(7)(c) interviewed MANDZA regarding the incident on January 18, 2012, Lieutenant (b)(6), (b)(7)(c) stated MANDZA exhibited a good attitude and was cooperative. MANDZA stated he had violated DCDF rules violations, and MANDZA was issued a warning. Lieutenant (b)(6), (b)(7)(c) stated he had no further interaction with MANDZA.

GEO DO (b)(6), (b)(7)(c) and GEO DO (b)(6), (b)(7)(c) were assigned to segregation on both occasions MANDZA was housed there: December 25th and January 18th, 2012. ODO interviewed GEO DO (b)(6), (b)(7)(c) and GEO DO (b)(6), (b)(7)(c) on May 23, 2012, at the DCDF. Both GEO DO (b)(6), (b)(7)(c) and GEO DO (b)(6), (b)(7)(c) described MANDZA as very quiet, polite, calm, and in what appeared to be overall good health. GEO DO (b)(6), (b)(7)(c) and GEO DO (b)(6), (b)(7)(c) stated there were no apparent health issues with MANDZA.

GEO DO (b)(6), (b)(7)(c) was assigned to complete secondary classification worksheets on MANDZA each time he was sent to administrative segregation. ODO interviewed GEO DO (b)(6), (b)(7)(c) on May 22, 2012, at the DCDF. GEO DO (b)(6), (b)(7)(c) stated he had no direct contact with MANDZA. GEO DO (b)(6), (b)(7)(c) stated MANDZA was found not guilty of the allegation of fighting lodged on December 25, 2011. MANDZA was released once the investigation was completed. GEO DO (b)(6), (b)(7)(c) stated MANDZA was found guilty of the allegations of refusing to obey a staff member and of interfering with the population count lodged on January 18, 2012. Neither incident had any effect on MANDZA's classification level or housing assignment (Exhibit 41).

On January 27, 2012, at approximately 5:48 p.m., a Progress Note by ANP (b)(6), (b)(7)(c) documents MANDZA complained of constipation, but declined the Colace and the fiber recommended by ANP (b)(6), (b)(7)(c) (Exhibit 42). Glycerin suppositories were renewed for three days, and MANDZA was counseled on taking the prescribed treatment for constipation. ODO found there were no refusal forms for Colace and fiber contained in the record. ANP (b)(6), (b)(7)(c) stated it is not a customary practice to have detainees sign refusal forms for over-the-counter medications.

DEPARTMENT OF HOMELAND SECURITY

1. CASE NUMBER

201207288

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(b)(6), (b)(7)(c)

REPORT OF INVESTIGATION CONTINUATION

HB 4200-01 (37), Special Agent Handbook

2. REPORT NUMBER

002

10. NARRATIVE

On February 9, 2012, a Progress Note by RN (b)(6), (b)(7)(c) documents MANDZA complained of constipation and had not had a bowel movement since February 3, 2012 (refer to Exhibit 42). According to the Progress Note, MANDZA's bowel sounds were decreased and his discomfort was increased. MANDZA was provided Dulcolax and Milk of Magnesia per GEO nursing protocol.

On February 14, 2012, MANDZA submitted a sick call request for a "problem with my teeth" (Exhibit 43). A note (illegible initials) documents MANDZA was scheduled to see the dentist that day. Doctor of Dental Medicine (DMD (b)(6), (b)(7)(c) extracted tooth number 18. MANDZA signed a Consent to Dental Procedures form (Exhibit 44). No other significant activity occurred regarding MANDZA until March 1, 2012.

On March 1, 2012, MANDZA submitted a sick call request complaining of burning eyes and constipation (Exhibit 45). On March 3, 2011, MANDZA was seen by RN (b)(6), (b)(7)(c) and was provided Dulcolax, Milk of Magnesia, and artificial tears (Exhibit 46). MANDZA was instructed to return to the medical unit if symptoms persisted or worsened. MANDZA was placed on the physician sick call list for March 5, 2012.

On March 5, 2012, Physician Assistant (PA) (b)(6), (b)(7)(c) documented the detainee presented with complaints of constipation in the following note as translated by RN (b)(6), (b)(7)(c) "no dumping (when food passes too rapidly from the stomach into the upper intestine), H2O, on meds." Observations: "Lungs clear, heart-no [illegible], abdomen soft, visceromegaly [abnormal enlargement of the soft internal organs];" Assessment: "Constipation, no water;" Plan: "Increase fiber, increase water, increase exercise" (Exhibit 47). PA (b)(6), (b)(7)(c) was not available for interview.

On March 10, 2012, MANDZA was reassigned from housing unit A3 to housing unit A4. GEO DO (b)(6), (b)(7)(c) was assigned as a housing unit officer in housing unit A4 while MANDZA was housed there. ODO interviewed GEO DO (b)(6), (b)(7)(c) on May 22, 2012, at the DCDF. GEO DO (b)(6), (b)(7)(c) stated he saw MANDZA every day and recalled that MANDZA spent almost every day in the law library. GEO DO (b)(6), (b)(7)(c) stated that MANDZA appeared in overall good health, had no known medical problems, was very happy and respectful, and was not considered a problem detainee. GEO DO (b)(6), (b)(7)(c) stated he saw MANDZA the day before he died, and MANDZA showed no signs of pain or distress. GEO DO (b)(6), (b)(7)(c) was surprised to hear that MANDZA had died. No other significant activity occurred regarding MANDZA until March 21, 2012.

On March 21, 2012, MANDZA submitted a sick call request for constipation and razor burn (Exhibit 48). LPN (b)(6), (b)(7)(c) documents MANDZA was seen in the medical unit, scheduled for a medical review, and provided Milk of Magnesia and Dulcolax. Dr. (b)(6), (b)(7)(c) completed a Progress

DEPARTMENT OF HOMELAND SECURITY	1. CASE NUMBER
	201207288
	PREPARED BY
	(b)(6), (b)(7)(c)
REPORT OF INVESTIGATION CONTINUATION HB 4200-01 (37), Special Agent Handbook	2. REPORT NUMBER 002

10. NARRATIVE

Note documenting MANDZA's history of constipation with stress; Colace was ordered (Exhibit 49).

On March 25, 2012, at approximately 9:20 a.m., Dr. (b)(6), (b)(7)(c) completed a Progress Note documenting that the medications were working well, and that MANDZA was not experiencing nausea, vomiting, or diarrhea. Additionally, MANDZA had no complaints, his vital signs were stable, and his medications were to be continued (Exhibit 50).

On March 31, 2012, MANDZA submitted a sick call request for constipation (Exhibit 51). On April 1, 2012, LPN (b)(6), (b)(7)(c) documented in the Health Services Nursing Assessment Protocols that MANDZA was seen in the medical unit, where MANDZA was provided Dulcolax and Milk of Magnesia (Exhibit 52). No other significant activity occurred regarding MANDZA until April 12, 2012.

On April 12, 2012, GEO DO (b)(6), (b)(7)(c) was assigned as the housing unit officer for housing unit A4. ODO interviewed GEO DO (b)(6), (b)(7)(c) on May 22, 2012, at the DCDF. GEO DO (b)(6), (b)(7)(c) stated he worked in housing unit A4 from April 11, 2012, at 7:00 p.m. to April 12, 2012, at 7:00 a.m. GEO DO (b)(6), (b)(7)(c) stated he observed MANDZA at the beginning of his shift and during his rounds. GEO DO (b)(6), (b)(7)(c) stated he had never heard MANDZA complain about any medical conditions, and MANDZA appeared to be in good health. GEO DO (b)(6), (b)(7)(c) stated MANDZA appeared to be fine and expressed excitement regarding his next court date.

On April 12, 2012, at approximately 5:24 a.m., GEO DO (b)(6), (b)(7)(c) was conversing with Lieutenant (b)(6), (b)(7)(c) when a detainee called GEO DO (b)(6), (b)(7)(c) over to MANDZA's cell. GEO DO (b)(6), (b)(7)(c) stated he observed MANDZA lying in bed, holding his chest, rolling back and forth in obvious pain. At that time, GEO DO (b)(6), (b)(7)(c) stated he directed Lieutenant (b)(6), (b)(7)(c) to call a code blue (medical emergency). According to DCDF Logbooks, on April 12, 2012, at approximately 5:25 a.m., a code blue was initiated in housing unit A4 (Exhibit 53). GEO DO (b)(6), (b)(7)(c) stated nursing staff arrived within 3 minutes. GEO DO (b)(6), (b)(7)(c) completed a GEO General Incident Report documenting this event (Exhibit 54).

ODO interviewed Lieutenant (b)(6), (b)(7)(c) on May 22, 2012, at the DCDF. Lieutenant (b)(6), (b)(7)(c) stated that on April 12, 2012, at approximately 5:24 a.m., he was conducting rounds and speaking with GEO DO (b)(6), (b)(7)(c) in housing unit A4, when he heard a detainee call out for GEO DO (b)(6), (b)(7)(c). Lieutenant (b)(6), (b)(7)(c) stated GEO DO (b)(6), (b)(7)(c) entered MANDZA's cell and then instructed him to call a code blue. Lieutenant (b)(6), (b)(7)(c) activated the code blue, began organizing first responders, and ordered side doors to be manned and held open for the medical staff. Lieutenant (b)(6), (b)(7)(c) observed MANDZA holding his hand over his chest and MANDZA appeared

DEPARTMENT OF HOMELAND SECURITY	1. CASE NUMBER
	201207288
	PREPARED BY
	(b)(6), (b)(7)(c)
REPORT OF INVESTIGATION CONTINUATION HB 4200-01 (37), Special Agent Handbook	2. REPORT NUMBER 002

10. NARRATIVE

to be in pain. Lieutenant (b)(6), (b)(7)(c) stated nursing staff arrived within four minutes and began their assessment of MANDZA. Lieutenant (b)(6), (b)(7)(c) completed a GEO Serious Incident Report (Exhibit 55) and a GEO Supervisor Report (Exhibit 56) documenting this event. The nursing staff determined MANDZA had to be moved to the medical unit for further evaluation. Lieutenant (b)(6), (b)(7)(c) stated MANDZA's pain appeared constant, but MANDZA stopped moaning once he arrived at the medical unit.

At approximately 5:28 a.m., GEO medical staff, RN (b)(6), (b)(7)(c), and LPN (b)(6), (b)(7)(c) arrived at housing unit A4 in response to the code blue.

ODO interviewed RN (b)(6), (b)(7)(c) on May 22, 2012, at the DCDF. RN (b)(6), (b)(7)(c) stated she did not recall having any previous contact with MANDZA prior to her response to the code blue on April 12, 2012. According to RN (b)(6), (b)(7)(c), on April 12, 2012, at approximately 5:24 a.m., she was alerted to a code blue in housing unit A4. RN (b)(6), (b)(7)(c) and LPN (b)(6), (b)(7)(c) responded. Upon arrival in housing unit A4, RN (b)(6), (b)(7)(c) found MANDZA in his bed, touching his left side, complaining of chest pain. RN (b)(6), (b)(7)(c) observed MANDZA was calm, alert, and verbal. MANDZA's skin was warm and dry, his color was normal, and he was not short of breath. MANDZA rated his chest pain on a scale of one to ten as an eight to nine. (Agent's note: a pain scale is a way for people to measure their pain so that health professionals can help plan how best to control it. Most pain scales use numbers from zero to ten; zero means no pain, and ten means the worst pain the person has ever known or felt. [www.health.com]) MANDZA's blood pressure was mildly elevated with remaining vital signs within normal limits. MANDZA also stated chest pain worsened upon inspiration (increase pain with breathing) (Exhibit 57). RN (b)(6), (b)(7)(c) recommended the patient be transferred to the DCDF trauma room for further evaluation. RN (b)(6), (b)(7)(c) completed a GEO General Incident Report documenting this event (Exhibit 58).

ODO interviewed LPN (b)(6), (b)(7)(c) on May 22, 2012, at DCDF. LPN (b)(6), (b)(7)(c) stated she had interacted with MANDZA during sick calls when he complained of constipation and razor burn and when he came to the nurses' cart to receive fiber pills. LPN (b)(6), (b)(7)(c) recalled MANDZA was very polite and never exhibited signs or symptoms of a serious medical condition. LPN (b)(6), (b)(7)(c) stated that on April 12, 2012, she and RN (b)(6), (b)(7)(c) responded to a code blue in housing unit A4. Upon arrival, they found MANDZA lying in bed holding his chest. MANDZA was responsive, alert, and described his pain as an eight on a scale of one to ten. LPN (b)(6), (b)(7)(c) completed a GEO General Incident Report documenting this event (Exhibit 59).

On April 12, 2012, at approximately 5:28 a.m., MANDZA was transferred to the DCDF trauma room. At this point, no medications had been administered to the patient in an attempt to relieve

DEPARTMENT OF HOMELAND SECURITY	1. CASE NUMBER
	201207288
	PREPARED BY
	(b)(6), (b)(7)(c)
REPORT OF INVESTIGATION CONTINUATION HB 4200-01 (37), Special Agent Handbook	2. REPORT NUMBER 002

10. NARRATIVE

his chest discomfort. MANDZA was taken to the trauma room where he was placed on oxygen, his vital signs were obtained, and an electrocardiogram (EKG) was performed. In her attempt to diagnose MANDZA, RN (b)(6), (b)(7)(c) used two different EKG machines. RN (b)(6), (b)(7)(c) was unable to get a reading with the first EKG due to her unfamiliarity with the machine, but was able to get a reading utilizing the second EKG machine. When asked if she could interpret the EKG results, RN (b)(6), (b)(7)(c) stated she was not trained on the use of an EKG or in the interpretation of EKG test results. RN (b)(6), (b)(7)(c) stated she relied on "gut instinct" to send MANDZA to the hospital. A Progress Note completed by RN (b)(6), (b)(7)(c) indicated she contacted Dr. (b)(6), (b)(7)(c) and received the verbal order to transport him to the hospital (refer to Exhibit 57).

During her interview, LPN (b)(6), (b)(7)(c) stated MANDZA was moved to the trauma room and placed on oxygen. LPN (b)(6), (b)(7)(c) left MANDZA in the care of RN (b)(6), (b)(7)(c) LPN (b)(6), (b)(7)(c) made the required notifications by phone and began the required paperwork. ODO asked LPN (b)(6), (b)(7)(c) about the use of the EKG machines; LPN (b)(6), (b)(7)(c) stated she had not received any formal training on their use or interpreting the results. LPN (b)(6), (b)(7)(c) stated she called Dr. (b)(6), (b)(7)(c) the Acting HSA (b)(6), (b)(7)(c), ICE ERO AFOD (b)(6), (b)(7)(c), Lieutenant (b)(6), (b)(7)(c) and the AMCS.

ODO interviewed Dr. (b)(6), (b)(7)(c) on May 23, 2012, at the DCDF. Dr. (b)(6), (b)(7)(c) stated that on April 12, 2012, he was contacted by the DCDF nursing staff about MANDZA, who was suffering from chest pains. Dr. (b)(6), (b)(7)(c) stated he never had any contact with MANDZA. ODO provided the EKG results of the test performed by RN (b)(6), (b)(7)(c) to Dr. (b)(6), (b)(7)(c) and asked for his interpretation. Dr. (b)(6), (b)(7)(c) stated the EKG results were not complete and an interpretation could not be made. When asked about the EKG tests performed at the DCDF, Dr. (b)(6), (b)(7)(c) stated it was his opinion that performing the EKG test on MANDZA at DCDF was a waste of time, and the patient needed to be transported immediately to the hospital for further evaluation. Dr. (b)(6), (b)(7)(c) stated that on April 12, 2012, at approximately 5:50 a.m., he authorized the transportation of MANDZA to an off-site medical facility for further evaluation and instructed RN (b)(6), (b)(7)(c) to call 911.

At approximately 6:20 a.m., Lieutenant (b)(6), (b)(7)(c) called the nursing station to check on MANDZA. During this call, he was instructed by LPN (b)(6), (b)(7)(c) to call 911. During his interview with ODO, Lieutenant (b)(6), (b)(7)(c) stated he immediately called 911 for Emergency Medical Services (EMS). Lieutenant (b)(6), (b)(7)(c) expressed concern over the time it took for 911 to be called (refer to Exhibits 55 & 56). During the ODO interview of Dr. (b)(6), (b)(7)(c), Dr. (b)(6), (b)(7)(c) stated he was unaware of any delay that resulted in EMS not being called until approximately 6:21 a.m. Dr. (b)(6), (b)(7)(c) stated EMS should have been contacted immediately, and any GEO protocols that were followed resulting in this delay need to be modified.

DEPARTMENT OF HOMELAND SECURITY	1. CASE NUMBER
	201207288
	PREPARED BY
	(b)(6), (b)(7)(c)
REPORT OF INVESTIGATION CONTINUATION HB 4200-01 (37), Special Agent Handbook	2. REPORT NUMBER 002

10. NARRATIVE

ODO interviewed LPN (b)(6), (b)(7)(c) on May 22, 2012. LPN (b)(6), (b)(7)(c) was questioned about the delay in calling EMS. LPN (b)(6), (b)(7)(c) stated it was her understanding that MANDZA would be transported by GEO personnel in a GEO van. Sometime later, she was told by RN (b)(6), (b)(7) that MANDZA needed to go to the AMCS by ambulance. LPN (b)(6), (b)(7)(c) stated she did not call 911, and she did not instruct the GEO Control Officer to call 911. LPN (b)(6), (b)(7)(c) stated while she continued processing the necessary paperwork to have MANDZA transferred to an off-site medical facility, she received a call from Lieutenant (b)(6), (b)(7)(c). While speaking to Lieutenant (b)(6), (b)(7)(c), LPN (b)(6), (b)(7)(c) asked him to call 911. When asked about the delay in calling 911, LPN (b)(6), (b)(7)(c) stated she needed to get the paperwork concerning MANDZA's medical condition completed before making the call (refer to Exhibit 59).

At approximately 6:26 a.m., Rural/Metro Ambulance personnel arrived at the DCDF and provided medical care to MANDZA. According to EMS records, MANDZA complained of chest pain from his upper abdomen up to his throat (Exhibit 60). EMS treated MANDZA in the DCDF trauma room, and MANDZA denied any previous trauma or illness. MANDZA stated he had eaten soup with hot peppers for dinner on April 11, 2012. EMS noted in their report that the symptoms were indicative of indigestion.

At approximately 6:43 a.m., EMS personnel transported MANDZA from the DCDF to the AMCS Emergency Room (ER). During the transport, MANDZA became uncooperative, would not answer questions, and would not allow the EMS crew to take his vitals. The EMS crew administered aspirin to MANDZA when his pain appeared to intensify, but MANDZA refused to chew the aspirin as instructed. MANDZA vomited, and the aspirin pills were visible in the vomit (refer to Exhibit 60). GEO DO (b)(6), (b)(7)(c) accompanied MANDZA in the ambulance while GEO DO (b)(6), (b)(7)(c) followed in another vehicle.

ODO interviewed GEO DO (b)(6), (b)(7)(c) on May 21, 2012, at the DCDF. GEO DO (b)(6), (b)(7)(c) stated she had no previous contact with MANDZA prior to April 12, 2012. On April 12, 2012, GEO DO (b)(6), (b)(7)(c) was assigned transportation duty, and was alerted to a medical emergency requiring EMS. GEO DO (b)(6), (b)(7)(c) went to the medical unit where she saw MANDZA, who appeared to be "okay." GEO DO (b)(6), (b)(7)(c) stated while riding in the ambulance with MANDZA, his condition changed, and MANDZA appeared to be in a lot of pain, clutched his chest, and would not remain still. GEO DO (b)(6), (b)(7)(c) stated when MANDZA's condition worsened, the EMS crew administered aspirin. GEO DO (b)(6), (b)(7)(c) completed a GEO General Incident Report documenting this event (Exhibit 61).

ODO interviewed GEO DO (b)(6), (b)(7)(c) on May 23, 2012, at the DCDF. GEO DO (b)(6), (b)(7)(c) who was previously listed as a housing unit officer in housing unit A2, was later transferred to transportation

DEPARTMENT OF HOMELAND SECURITY	1. CASE NUMBER
	201207288
	PREPARED BY
	(b)(6), (b)(7)(c)
REPORT OF INVESTIGATION CONTINUATION HB 4200-01 (37), Special Agent Handbook	2. REPORT NUMBER 002

10. NARRATIVE

duty. According to GEO DO (b)(6), (b)(7)(c) on April 12, 2012, while assigned to transportation duty, he responded to a code blue medical emergency requiring transportation to the AMCS. GEO DO (b)(6), (b)(7)(c) stated he followed the ambulance to the AMCS, and his partner, GEO DO (b)(6), (b)(7)(c), rode in the back of the ambulance with MANDZA. GEO DO (b)(6), (b)(7)(c) completed a GEO General Incident Report documenting this event (Exhibit 62).

On April 12, 2012, at approximately 6:58 a.m., MANDZA arrived at the AMCS ER and was received by RN (b)(6), (b)(7)(c) (refer to Exhibit 60). MANDZA was examined initially by AMCS physician (b)(6), (b)(7)(c) During an ODO interview conducted on May 21, 2012, GEO DO (b)(6), (b)(7)(c) stated MANDZA had difficulty speaking to the treating physician upon arrival at the hospital, but was able to point to his chest and say he was in pain. During an ODO interview conducted on May 23, 2012, DO (b)(6), (b)(7)(c) stated, while in the ER, MANDZA was administered baby aspirin and told by the treating physician that he might be having a heart attack. MANDZA either could not, or would not, cooperate and answer questions by medical staff.

According to AMCS medical records, at approximately 7:10 a.m., an electrocardiogram (EKG) was performed on MANDZA in the ER (Exhibit 63). At approximately 7:11 a.m., Dr. (6), (b)(7) received the results of the EKG and asked MANDZA questions. Dr. (6), (b)(7) documented that MANDZA did not answer his questions for several minutes.

On April 12, 2012, at approximately 7:17 a.m., Dr. (6), (b)(7) believed MANDZA was having a heart attack and called a cardiac alert (refer to Exhibit 63). Dr. (6), (b)(7) told MANDZA he needed his cooperation. MANDZA stated that the onset of his chest pains occurred at approximately 4:00 a.m. MANDZA stated he did not have any medical history or family history of heart disease or any contributing factor to heart disease, had not had any previous symptoms of a heart attack, and was not taking any medications.

On April 12, 2012, at approximately 7:28 a.m., MANDZA was admitted to the Cardiac Catheter Laboratory (refer to Exhibit 63). During the catheterization procedure, MANDZA went into cardiac arrest, at which time cardio-pulmonary resuscitation (CPR) was performed. All attempts to revive MANDZA were unsuccessful, and Dr. (6), (b)(7) pronounced MANDZA dead at 8:38 a.m. (refer to Exhibit 63). Dr. (6), (b)(7) cited the cause of death as anterior myocardial infarction (MI), and severe left main coronary artery stenosis.

A State of Colorado Certificate of Death was generated regarding MANDZA. According to the Certificate of Death, MANDZA's immediate cause of death is listed as anterior MI, and severe left

DEPARTMENT OF HOMELAND SECURITY	1. CASE NUMBER
	201207288
	PREPARED BY
	(b)(6), (b)(7)(c)
REPORT OF INVESTIGATION CONTINUATION HB 4200-01 (37), Special Agent Handbook	2. REPORT NUMBER 002

10. NARRATIVE

main coronary artery stenosis (Exhibit 64). Due to MANDZA's death occurring while under the care of AMCS medical staff, Arapahoe County Coroner (b)(6), (b)(7)(c) did not perform an autopsy. MANDZA's body was not claimed by next of kin, and was turned over to the State of Colorado for a pauper's burial.

After MANDZA's death, ERO personnel made appropriate notification to the ICE ERO Assistant Director for Field Operations, the Joint Intake Center, and the Gabon Consulate. According to the ERO Notification and Reporting of Detainee Deaths Individual Incident Checklist, the next of kin notification was made to MANDZA's brother by Supervisory Detention and Deportation Officer (b)(6), (b)(7)(c) (Exhibit 65).

ODO reviewed MANDZA's detention file and HCDF documentation to identify any grievances filed by MANDZA. After a review of MANDZA's detention file and DCDF documentation, and consultation with GEO Grievance Coordinator, it was determined MANDZA did not file any grievances or complaints about medical services during his stay at DCDF.

MEDICAL COMPLIANCE REVIEW

ICE OPR ODO contractor, Creative Corrections (CC), a national management and consulting firm, contracted by ICE to provide subject matter expertise in detention management including health care, conducted a Medical Compliance Review of the medical care provided to MANDZA while in ICE custody. The Medical Compliance Review consists of a timeline of medical encounters documented in MANDZA's medical record and findings with respect to compliance with ICE Performance Based National Detention Standards (PBNDS). The review was performed by RN (b)(6), (b)(7)(c), a CC Health Care Service subject matter expert. RN (b)(6), (b)(7)(c) found the medical care provided by DCDF was deficient in the following areas of the ICE PBNDS: MANDZA's healthcare needs were not met in a timely and efficient manner, MANDZA required health care beyond the facility resources, but was not transferred to an appropriate medical facility in a timely manner, and DCDF medical personnel were not trained in the use and maintenance of available equipment. The CC report is attached to this document (Exhibit 66).

Immigration Health Services Corps (IHSC) reviewed the medical records regarding MANDZA to determine the appropriateness of the medical care he received while in ICE custody. IHSC provided their findings in an IHSC Medical Record Review/Investigation (Exhibit 67). The report cites the cause of MANDZA's death as anterior MI, and severe left main coronary artery stenosis. IHSC determined that MANDZA did not have access to appropriate medical care while detained in the DCDF.

DEPARTMENT OF HOMELAND SECURITY	1. CASE NUMBER
	201207288
	PREPARED BY
	(b)(6), (b)(7)(c)
REPORT OF INVESTIGATION CONTINUATION HB 4200-01 (37), Special Agent Handbook	2. REPORT NUMBER 002

10. NARRATIVE

MORTALITY REVIEW

CC conducted a Mortality Review as part of the ODO investigation into the death of MANDZA. (b)(6), (b)(7)(c) M.D., CC Chief Medical Officer, conducted the Mortality Review and prepared the report detailing the findings and conclusion. The review is based on available medical and hospital records, and information obtained during on-site interviews. Dr. (b)(6), (b)(7)(c) stated in his report that DCDF medical staff were unfamiliar with the institution's Chest Pain Protocol, appropriate cardiac medication was not administered, and the time it took to transport the patient to a higher level care facility, all may have been contributing factors to the death of the patient.
The CC report is attached to this report (Exhibit 68).

IMMIGRATION AND DETENTION HISTORY

Detainee Evalin Ali MANDZA, a citizen and national of Gabon, was admitted to the United States as a visitor under a B-2 nonimmigrant visa at Newark, NJ, on October 24, 1996. MANDZA was given a period of admission until November 7, 1996.

On June 12, 1997, MANDZA filed an I-485 Application to Adjust Status to Lawful Permanent Resident, based on his marriage to a U.S. citizen spouse.

On May 4, 1998, in Hartford, CT, MANDZA's I-485 was denied for lack of prosecution. (Agent's note: MANDZA failed to respond to a service request for evidence or documentation, which resulted in his application being denied for "lack of prosecution.")

On May 21, 2001, MANDZA filed another I-485 Application to Adjust Status to Lawful Permanent Resident, based on his marriage to a U.S. citizen spouse.

On August 29, 2002, the I-130 Immigrant Visa Petition filed by MANDZA to support his I-485 application was denied for lack of prosecution. MANDZA's I-485 was denied due to the lack of an immediately available immigrant visa.

On October 17, 2011, ERO Centennial encountered and interviewed MANDZA while he was in custody at the Aurora County Jail in Aurora, CO, pursuant to the ICE Criminal Alien Program (CAP). ICE provided a Form I-247, Immigration Detainer-Notice of Action Form, to the Aurora County Jail advising them an investigation is ongoing to determine whether MANDZA is subject to removal from the United States.

DEPARTMENT OF HOMELAND SECURITY	1. CASE NUMBER
	201207288
	PREPARED BY
	(b)(6), (b)(7)(c)
REPORT OF INVESTIGATION CONTINUATION HB 4200-01 (37), Special Agent Handbook	2. REPORT NUMBER 002

10. NARRATIVE

On October 24, 2011, MANDZA was taken into ICE custody and served a Form I-862, Notice to Appear (NTA), for overstaying his admission as a nonimmigrant in violation of the Immigration and Nationality Act (INA), Section 237(a)(1)(B).

MANDZA appeared for immigration removal proceedings before an Immigration Judge on November 22, 2011, December 7, 2011, December 28, 2011, and January 11, 2012. At the time of his death, MANDZA had an immigration removal hearing scheduled for April 12, 2012.

On April 12, 2012, Immigration Judge J. P. Vandello terminated MANDZA's removal proceedings.

CRIMINAL HISTORY

MANDZA was assigned (b)(7)e, State of Colorado SID# (b)(7)e, and State of New York SID# (b)(7)e.

The following criminal history information on MANDZA was recovered from the National Crime Information Center, Superior Court of the State of New York, County of New York, Criminal Court of the City of New York, County of New York, City of Aurora Municipal Court, and his Alien File.

On November 28, 2007, MANDZA was convicted in Superior Court of the State of New York, County of New York, for the offense of possession of a forged instrument, in violation of the New York Penal Law 170.20, for which he was sentenced to 90 days in jail. The case number is 06240-2006.

On April 4, 2008, MANDZA was convicted in the Richmond County Criminal Court, NY, for the offense of patronizing a prostitute, in violation of the New York Penal Law 230.04, for which he was sentenced to time served. The case number is 2008RI003247.

On October 17, 2011, MANDZA was convicted in City of Aurora Municipal Court, Aurora, CO, for the offense of selling of merchandise, for which he was sentenced to 60 days in jail, 55 days suspended sentence, with three days to serve. The case number is J146740.

INVESTIGATIVE FINDINGS

Detainee MANDZA came to ICE custody on October 24, 2011, and was provided an initial medical screening and physical examination in accordance with the ICE PBNDS. During MANDZA's initial medical screening, no medical conditions were identified, and MANDZA was housed in general

DEPARTMENT OF HOMELAND SECURITY	1. CASE NUMBER
	201207288
	PREPARED BY
	(b)(6), (b)(7)(c)
REPORT OF INVESTIGATION CONTINUATION HB 4200-01 (37), Special Agent Handbook	2. REPORT NUMBER 002

10. NARRATIVE

population. On April 12, 2012, MANDZA was found in his cell complaining of chest pains. This review determined that DCDF failed to provide MANDZA access to emergent, urgent, or non-emergent medical care. As a result, his health care needs were not met in a timely and efficient manner in accordance with the ICE PBNDS.

ICE PBNDS Medical Care, section (II)(7), requires that a detainee who needs health care beyond facility resources will be transferred in a timely manner to an appropriate facility where care is available. On April 12, 2012, a code blue emergency was activated at DCDF at approximately 5:24 a.m., and the facility contacted 911 at approximately 6:20 a.m. An approximate total of 56 minutes elapsed between activation of the code blue emergency and the call to 911. Additionally, at approximately 5:50 a.m., Dr. (b)(6), (b)(7)(c) ordered that MANDZA be transferred to the emergency room and that RN (6), (b)(7) call 911. When 911 was contacted by Lieutenant (b)(6), (b)(7)(c) at approximately 6:20 a.m., approximately 30 minutes had elapsed after Dr. (b)(6), (b)(7)(c) order. As a result of the lapse in time between activation of the code blue, Dr. (b)(6), (b)(7)(c) order to contact 911, and the call to 911, CC concludes that on April 12, 2012, DCDF failed to comply with the ICE PBNDS Medical Care, section (II)(7).

ICE PBNDS Medical Care, section (V)(O), requires that medical and safety equipment is available and maintained, and that staff is trained in proper use of the equipment. Because DCDF did not document whether EKG machines were checked daily to determine if they were in working order or for memory capacity, and because neither RN (6), (b)(7) nor LPN b)(6), (b)(7)(c) had documented formal training on use of the EKG at DCDF medical clinic or in recognizing lethal rhythms, CC concluded that the facility was not in compliance with the ICE PBNDS Medical Care, section (V)(O) .

ICE PBNDS Medical Care, section (II)(2), requires that healthcare needs be met in a timely and efficient manner. Because there was no documentation that Dr. (b)(6), (b)(7)(c) evaluated MANDZA for his complaint of constipation on November 3, 2011, and because MANDZA was not seen again by a physician until December 2, 2011, CC concludes that on November 3, 2011, DCDF was not in compliance with ICE PBNDS Medical Care, section (II)(2).

AREAS OF CONCERN

ODO found the nursing staff was unfamiliar with established GEO Nursing Protocol and polices. Nursing staff also lacked proper training on the use and maintenance of supplied medical equipment.

On April 12, 2012, in response to the code blue, RN (6), (b)(7) did not use the assessment criteria in the

DEPARTMENT OF HOMELAND SECURITY	1. CASE NUMBER
	201207288
	PREPARED BY
	(b)(6), (b)(7)(c)
REPORT OF INVESTIGATION CONTINUATION HB 4200-01 (37), Special Agent Handbook	2. REPORT NUMBER 002

10. NARRATIVE

GEO nursing protocol for chest pain. Though she documented "color adequate," she did not note whether MANDZA was pale or cyanotic (bluish discoloration of the skin indicating lack of oxygen). In addition, RN (b)(6), (b)(7)(c) did not address the presence of diaphoresis (perspiring) or the quality of MANDZA's respirations, i.e., whether they were shallow or labored. Although she noted the intensity of the pain and that it worsened with inspiration, she failed to inquire as to the duration of the pain. The only vital sign taken was a pulse oximetry reading. As noted, RN (b)(6), (b)(7)(c) recorded the encounter in a Progress Note, only. There was no completed Chest Pain Protocol form in the medical record.

On April 12, 2012, at approximately 5:28 a.m., RN (b)(6), (b)(7)(c) obtained MANDZA's vital signs, which appeared normal. MANDZA's vital signs were not documented again until 6:20 a.m. GEO nursing protocol for chest pain requires that vital signs be taken every five minutes.

The GEO nursing protocol for chest pain requires a 12-lead EKG. During site visit, ODO learned DCDF has two 12-lead EKG machines made by different manufacturers: a Welch Allen EKG machine and a Schiller AT-102. RN (b)(6), (b)(7)(c) chose the Schiller AT-102 and proceeded to attempt a three-lead rather than 12-lead EKG. A three-lead EKG monitors only two areas of the heart; a 12-lead EKG provides detailed monitoring of all three areas of the heart. During her interview, RN (b)(6), (b)(7)(c) stated she chose to perform a three-lead EKG, because she had not performed a 12-lead EKG "in years." RN (b)(6), (b)(7)(c) further stated she had no formal training in the use of either machine. When RN (b)(6), (b)(7)(c) connected MANDZA to the Schiller AT-102 EKG machine, she realized the memory was full and requested assistance with the machine from LPN (b)(6), (b)(7)(c). When LPN (b)(6), (b)(7)(c) was unsuccessful in erasing the memory, RN (b)(6), (b)(7)(c) detached the Schiller AT-102 and used the Welch Allyn machine instead. RN (b)(6), (b)(7)(c) stated she was unable to interpret the EKG results and relied on her "gut instinct" to ultimately send the detainee to the hospital.

During interviews, both RN (b)(6), (b)(7)(c) and LPN (b)(6), (b)(7)(c) stated they had not received formal training in reading an EKG. They stated that in the past, results from the Schiller AT-102 machine were faxed to the on-call physician or a cardiology practice for interpretation; however, faxing results from the Welch Allyn machine is not possible because the machine is not programmed the same way as the Schiller AT-102. When asked about maintenance of the EKG machines, RN (b)(6), (b)(7)(c) stated she had previously reported the Schiller AT-102 memory issue to Acting HSA (b)(6), (b)(7)(c). According to LPN (b)(6), (b)(7)(c), the EKG machines are checked daily for operability, though the memory is not always checked. Acting HSA (b)(6), (b)(7)(c) was able to produce documentation of checks for the other emergency equipment in the clinic, including oxygen tank, oxygen mask and tubing, Ambu-Bag, pulse oximeter, and automated external defibrillator; however, there was no record documenting a check of either EKG machine.

DEPARTMENT OF HOMELAND SECURITY	1. CASE NUMBER
	201207288
	PREPARED BY
	(b)(6), (b)(7)(c)
REPORT OF INVESTIGATION Exhibit List HB 4200-01 (37), Special Agent Handbook	2. REPORT NUMBER 002

01- Holding Cell and Processing Log
02- Form I-213
03- Property Issuance Form
04- Medical Screening Form
05- Nursing Incoming Screen Progress Note
06- Mental Health Evaluation
07- Medical Release Form
08- Chest X-Ray Results
09- Classification Worksheet
10- Medical Request dated October 25, 2011
11- Medical History and Physical Assessment Form
12- Progress Note dated October 26, 2011
13- GEO Nursing Protocol dated October 26, 2011
14- Medical Request dated October 31, 2011
15- Medical Request dated November 8, 2011
16- Progress Note dated November 9, 2011
17- GEO Nursing Protocol dated November 9, 2011
18- Medical Request dated November 10, 2011
19- GEO Nursing Protocol dated November 11, 2011
20- Medical Request dated November 17, 2011
21- GEO Nursing Protocol dated November 17, 2011
22- Dental Progress Note dated November 21, 2011, December 20, 2011, and January 16, 2012
23- Medical Request dated November 27, 2011
24- GEO Nursing Protocol dated November 28, 2011
25- Progress Note dated December 2, 2011
26- Medical Request dated December 11, 2011
27- Progress Note dated December 12, 2011
28- GEO Nursing Protocol dated December 12, 2011
29- Medical Request dated December 14, 2011
30- GEO Nursing Protocol dated December 15, 2011
31- Medical Report on Injuries/Non-Injuries dated December 25, 2011
32- Pre-Segregation History and Physical Form dated December 27, 2011
33- Special Management Unit Housing Record dated December 25-27, 2011
34- Administrative Segregation Order dated December 25, 2011
35- GEO Nursing Protocol dated December 30, 2011
36- Medical Request dated January 13, 2012
37- Medical Request dated January 15, 2012
38- GEO Nursing Protocol dated January 16, 2012

DEPARTMENT OF HOMELAND SECURITY	1. CASE NUMBER
	201207288
	PREPARED BY
	(b)(6), (b)(7)(c)
REPORT OF INVESTIGATION Exhibit List HB 4200-01 (37), Special Agent Handbook	2. REPORT NUMBER 002

39- Disciplinary Segregation Documents dated January 18, 2012
40- Pre-Segregation History and Physical Form undated
41- Post Segregation Re-Classification Worksheets
42- Progress Note dated January 27, 2012
43- Medical Request dated February 14, 2012
44- Consent to Dental Procedures Form dated February 14, 2012
45- Medical Request dated March 1, 2012
46- GEO Nursing Protocol dated March 3, 2012
47- Progress Note dated March 5, 2012
48- Medical Request dated March 21, 2012
49- Progress Note dated March 21, 2012
50- Progress Note dated March 25, 2012
51- Medical Request dated March 31, 2012
52- GEO Nursing Protocol dated April 1, 2012
53- DCDF Log Books
54- GEO Incident Report from GEO DO (b)(6), (b)(7)(c)
55- GEO Serious Incident Report from Lieutenant (b)(6), (b)(7)(c)
56- GEO Supervisor's Report from Lieutenant (b)(6), (b)(7)(c)
57- Progress Noted dated April 12, 2012
58- GEO Incident Report from RN (6), (b)(7)
59- GEO Incident Report from LPN (b)(6), (b)(7)(c)
60- Rural/Metro EMS records
61- GEO Incident Report from GEO DO (b)(6), (b)(7)(c)
62- GEO Incident Report from GEO DO
63- Aurora Medical Center South Medical Records
64- State of Colorado Certificate of Death
65- ERO Notification and Reporting of Detainee Deaths Individual Incident Checklist
66- Creative Corrections Medical Compliance Review
67- IHSC Medical Record Review Report
68- Creative Corrections Mortality Review

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT
HOLDING CELL AND PROCESSING LOG

6/11/2012

10/24/2011			ALIENS INFORMATION Manifest for dayshift							Duty Desk Agent	Echave / Elliott		HOLDING CELL TIMES				TRANSFERRED INFORMATION		Comments
#	FACILITY RELEASED FROM	TRANSPORTED BY	ALIEN'S NAME	"A" NUMBER	SUBJECT ID	NATIONALITY	DOB	SEX	Med Issues	CASE AGENT	STATUS	I-77 #	ENTRY TIME	TIME FED	TIME FED	OUT TIME	TRANSPORT AGENT	TO	
1	ADAMS CO	(b)(6), (b)(7)(c)	(b)(6), (b)(7)(c)	(b)(6), (b)(7)(c)	(b)(7)e	MEX	(b)(6), (b)(7)(c)	M	NA	(b)(6), (b)(7)(c)	Admin	(b)(7)e	0705	1145	NA	1615	(b)(6), (b)(7)(c)	GEO	(b)(7)e
2	ADAMS CO					MEX		F	NA		NTA		0705	1145	NA	1640		GEO	
3	ADAMS CO					MEX		F	NA		OREC		0705	1145	NA	1530		GEO	
4	ADAMS CO					MEX		M	NA		NTA		0705	1145	NA	1615		GEO	
5	AURORA CITY		MANDZA, EVALIN			GABON	12/5/1985	M	NA		NTA		0705	1145	NA	1615		GEO	
6	DENVER DJC		(b)(6), (b)(7)(c)			MEX	(b)(6), (b)(7)(c)	F	NA		B&B		0845	1145	NA	1640		GEO	
7	DENVER DJC					SUDAN		M	NA		NTA		0845	1145	NA	1615		GEO	
8	DOUGLAS CO					MEX		M	NA		NTA		0735	1145	NA	1615		GEO	
9	DRDC					MEX		M	NA		NTA		0955	1145	NA	1615		GEO	
10	JEFFERSON CO					MEX		M	NA		NTA		0900	1145	NA	1615		GEO	
11	Fug Ops					MEX		M	NA		B&B		0940	1145	NA	1615		GEO	
12	Fug Ops					MEX		M	NA		NTA		1020	1145	NA	1615		GEO	
13	Larimer Count					Guatemala		M	NA		Reinstate		2005	2010	NA	2300		GEO	
14																			
15																			
16																			
17																			
18																			
19																			
20																			
21																			
22																			

ONLY THE SUBJECT ID LISTED ON THE I-213 SHALL BE ENTERED ON THIS FORM

DHS Confidential
JFA

U.S. Department of Homeland Security

Subject ID : (b)(7)e

Record of Deportable/Inadmissible Alien

Family Name (CAPS)	First	Middle
MANDZA, Evalin		

Country of Citizenship	Passport Number and Country of Issue	File Number
GABON		Case No (b)(7)e (b)(6), (b)(7)(c)

U.S. Address: (b)(6), (b)(7)(c) NEW YORK, NEW YORK, 10456,

Date, Place, Time, and Manner of Last Entry	Passenger Boarded at
Unknown Date, Unknown Time, NEW, ADMITTED B-2 VISTOR	

Number, Street, City, Province (State) and Country of Permanent Residence: (b)(6), (b)(7)(c) GABON

Date of Birth	Date of Action	Location Code
12/05/1965 Age: 45	10/24/2011	DEN/DEN

City, Province (State) and Country of Birth	AR [X]	Form : (Type and No.) Lifted ☐ Not Lifted ☐
GABON		

NIV Issuing Post and NIV Number	Social Security Account Name

Date Visa Issued	Social Security Number

Sex	Hair	Eyes	Complxn
M	BLK	BRO	MED

Height	Weight	Occupation
69	180	UNEMPLOYED

Scars and Marks: None Indicated

(b)(7)e ☒ Single ☐ Divorced ☐ Married ☐ Widower ☐ Separated

Method of Location/Apprehension: (b)(7)(E)

At/Near	Date/Hour
CENTENNIAL, COLORADO	10/24/2011

By: (b)(6), (b)(7)(c)

Status at Entry	Status When Found
Non-Immigrant	IN INSTITUTION

Length of Time Illegally in U.S.: OVER 1 YEAR

Immigration Record	Criminal Record
NEGATIVE - See Narrative	None Known

Name , Address, and Nationality of Spouse (Maiden Name, if Appropriate)	Number and Nationality of Minor Children
	See Narrative

Father's Name, Nationality, and Address, if Known	Mother's Present and Maiden Names, Nationality, and Address, if Known
(b)(6), (b)(7)(c) NATIONALITY: GABON	(b)(6), (b)(7)(c) NATIONALITY: GABON

Monies Due/Property in U.S. Not in Immediate Possession	Fingerprinted? ☒ Yes ☐ No	Systems Checks	Charge Code Words(s)
None Claimed		See Narrative	(b)(7)(E)

Name and Address of (Last)(Current) U.S. Employer	Type of Employment	Salary	Employed from/to
UNEMPLOYED		Hr	/ / / /

Narrative (Outline particulars under which alien was located/apprehended. Include details not shown above regarding time, place and manner of last entry, attempted entry, or any other entry, and elements which establish administrative and/or criminal violation. Indicate means and route of travel to interior.)

FINS: 1121982592

Left Index fingerprint

Right Index fingerprint

(b)(7)(E)

OTHER ALIASES KNOWN BY:

MANDZA,ELALIN

MINOR CHILDREN

...(CONTINUED ON I-831)

(b)(6), (b)(7)(c) 0-2411 (Date/Initials)

(b)(6), (b)(7)(c) AGENT

Alien has been advised of communication (Immigration Officer)

Distribution:

file

copy

siea

Receive (Interview)

Officer: (b)(6), (b)(7)(c)

on: October 24, 2011 at 1106 (time)

Disposition: Warrant of Arrest/Notice to Appear

Examining Officer: (b)(6), (b)(7)(c)

Alien's Name	File Number	Date
MANDZA, Evalin	(b)(6), (b)(7)(c) Event No: (b)(7)e	10/24/2011

SUBJECT CLAIMS 3 USC CHILDREN

RECORDS CHECKED

(b)(7)(E)

Record of Deportable/Excludable Alien:

Subject MANDZA was encountered at the Aurora County Jail in Aurora, Colorado on October 17, 2011 during routine CAP operations after being arrested and charged with resisting officer. Disposition of this case is pending. MANDZA was interviewed by IEA (b)(6), (b)(7)(c) and a detainer was placed. On October 17, 2011 MANDZA was transported from Aurora County Jail to Denver Field Office for processing. MANDZA stated that he is a citizen and national of Gabon by virtue of birth. MANDZA stated that his parents are citizens and nationals of Gabon. MANDZA is not in possession of valid immigration documents allowing him to be or remain in the United States legally.

ENTRY DATA
MANDZA stated that he entered the United States at or near Newark, New Jersey, on or about October 24, 1996, with inspection by U.S. Immigration Officers. MANDZA stated this is his first and only entry into the United States.

Subject stated he is a native and citizen of Gabon born on 12/05/1965 in Gabon, to Gabon citizen parents. At no time did the subject make any claim to derivative US citizenship

IMMIGRATION HISTORY
ICE/CIS database checks indicate prior immigration history for MANDZA.
MANDZA entered the United States on/or about October 24,1996 as a B2 visitor and permitted to remain in the United States until November 7, 1996 . ICE has no record of MANZA ever departing the United States on or before the expiration of his admission.

CRIMINAL HISTORY
Criminal history checks for MANDZA were positive.
CHARGES AS FOLLOWS:
11/15/2006
1) FORGERY 2ND : OFFICIAL DOCUMENT CLASS D FELONY
2) UNLAWFUL POSS PERSONAL ID - 3RD CLASS A MISDEMEANOR
3) IDENTITY THEFT 3 OBTAIN GOODS CLASS A MISDEMEANOR
4) GRAND LARCENY-4TH: CREDIT CARD CLASS E FELONY
5) GRAND LARCENY-4TH:PHONE SERV CLASS E FELONY

04/02/2008
1) PATRONIZE A PROSTITUTE- 3RD CLASS A MISDEMEANOR
CONVICTED UPON PLEA OF GUILTY SENT TO TIME SERVED

COURT - POLICE DEPARTMENT NEW YORK
FORGED INSTRUMENT - 3RD
...(CONTINUED ON NEXT PAGE)

Signature	Title
(b)(6), (b)(7)(c)	IMMIGRATION ENFORCEMENT AGENT

U.S. Department of Homeland Security

Continuation Page for Form I213

Alien's Name	File Number	Date
MANDZA, Evalin	(b)(6), (b)(7)(c) Event No: (b)(7)e	10/24/2011

SENTENCE - CONVICTED UPON PLEA OF GUILTY SENT 90 DAYS

(b)(7)(E)

CHARGES
Section 237(a)(1)(B) of the Immigration and Nationality Act (Act), as amended, in that after admission as a nonimmigrant under Section 101(a)(15) of the Act, you have remained in the United States for a time longer than permitted, in violation of this Act or any other law of the United States.

DISPOSITION
MANDZA was advised of his right to speak to a consulate officer from Gabon.
MANDZA states he has fear of persecution or torture if removed to Gabon.
MANDZA has no immigration petitions or applications pending at this time.
MANDZA was offered a Stipulated Removal and he refused a Stipulated Removal.
MANDZA requested to see an immigration judge.
MANDZA was issued a Notice to Appear.

HEALTH, FAMILY WELFARE, AND FUNDS
MANDZA stated he was in good health and taking no medications, and appeared to be in good health.
MANDZA states he has three children which lives in New York with thier mother.
MANDZA has $33.00 in U.S. funds in his possession. Check #3249
MANDZA was provided a copy of the Detainee Handbook.

(b)(7)e

Signature	Title
(b)(6), (b)(7)(c)	IMMIGRATION ENFORCEMENT AGENT

EMEI (b)(6), (b)(7)(c) **'ERTY DISI 'ITION FORM**

MANDZA, EVALIN

DOB: 12/5/1965 Nation: GABON

Arrival Date: 10/24/2011 17:05

Detainee Name: _____ Date: _____ ID# _____

I wish to provide emergency contact/property disposition information: YES NO

Name/Nombre: (b)(6), (b)(7)(c)

Street Address/Direccion: _____

City/Ciudad: _____ State/Estado: _____ Zip Code/Codigo Postal: _____

Telephone/Telefono: 9347-857- (b)(6), (b)(7)(c) Country/Pais: 240-801 (b)(6), (b)(7)(c)

Detainee Signature/Firma del Detenido: _____

By my signature, I authorize the facility to send my personal property to the above designated person in the event of an emergency. / Con mi firma, yo autorizo esta facilidad que mande mis pertenencias personales a la direccion de ariba en caso de una enmergencia.

CLOTHING, BEDDING, LINEN, HYGIENE ISSUE RECEIPT

Shirts 2	L.S. Shirts 1	Toothpaste 1	Comb 1
Pants 2	T-Shirts 2	Toothbrush 1	Soap 1
Shoes 1 pair	Blankets 1	Pillowcase 1	Towel 1
Socks 3 pair	Sheets 2	Radio 1 Headset	Lotion 1
Jumpsuit 2 (Level 3 only)	Gym Shorts 1	Undergarments 3	Shower 1 pair Shoes
Bras 3 (Female only)			

CROSS OUT ITEMS NOT RECEIVED

Discrepancies None

WASH STREET CLOTHES / LAVAR LA ROPA DE LA CALLE? YES (NO)

I verify I have received copy number 384 of the detainee handbook and have been shown the orientation tape in Intake. I understand that I need to return the handbook to staff upon my release from the facility.

Yo verifico que recibi la copia numero 384 del Manual de Detenidos, y que el video de orientacion fue presentado durante mi proceso inicial. Yo entiendo que necesito regresar este manual a los empleados cuando salga de la facilidad.

Officer Signature: (b)(6), (b)(7)(c)

Detainee Signature: _____

SIGNED FORM INDICATES ACTIVATED DETENTION FILE

(b)(6), (b)(7)(c)

ceiving Screening

The GEO Group, Inc.

MANDZA, EVALIN

DOB: 12/5/1965 Nation: GABON

Inmate I Arrival Date: 10/24/2011 17:05

Last _____ MI _____ Sex: _____ Date of Birth: ____/____/____

Inmate Number: _____ Date: 10/25/11 Time: PM 18:45 ☐AM ☐

Previous Commitment? ☑ Yes ☐ No Where? Arizona Co

Interviewed by: (b)(6), (b)(7)(c) Facility Name _____

VITAL SIGNS: Pulse 81 B/P 101/62 Resp 14 Temp 97.1

VISUAL OBSERVATION: ***(Explain any "Yes" answers under "Remarks")***

1. Is inmate unconscious or have obvious pain, bleeding, injuries, illness, or other symptoms suggesting need for emergency medical referral? ☐ Yes ☑ No
2. Is inmate carrying any prescribed medication? If yes, what? _____ ☐ Yes ☑ No
3. Is there obvious fever or other evidence of infection? ☐ Yes ☑ No
4. Is there evidence of infestations, rashes, needle marks, bruises, lesions, jaundice or trauma markings? ☐ Yes ☑ No
5. Does inmate appear to be under the influence of, or withdrawing from drugs, alcohol or an unknown substance? ☐ Yes ☑ No
6. Does inmate exhibit any signs of abnormal behavior, tremors, sweating, persistent cough or lethargy? ☐ Yes ☑ No
7. Does inmate's behavior or physical appearance suggest the risk of suicide or assault on staff or other inmates? ☐ Yes ☑ No
8. Is inmate's mobility restricted in any way or has any body deformities? ☐ Yes ☑ No
   Does inmate have Physical Aids: ☐ Glasses ☐ Hearing Aid ☐ Cane ☐ Crutches ☐ Dentures ☐ Other
9. Is inmate experiencing visual or auditory hallucinations? If yes, Explain _____ ☐ Yes ☑ No

Inmate Questionnaire: ***(Explain any "Yes" answers under "Remarks")***

10. Presently taking medication under a doctor's order? What? _____ How often? _____ ☐ Yes ☑ No
11. Ever had: diabetes, seizures, asthma, ulcers, high blood pressure, heart condition, or a psychiatric disorder? ☐ Yes ☑ No
12. Are you on a special diet prescribed by a physician? _____ ☐ Yes ☑ No
13. Been hospitalized or treated by a psychiatrist or a physician within the past year? ☐ Yes ☑ No
    Why? _____ Where? _____
14. History of or current communicable illnesses: venereal disease, TB infections, hepatitis, HIV or symptoms suggestive of such illness? *(lethargy, cough, spitting up blood, weakness, weight loss, loss of appetite, fever, of appetite, fever, night sweats)* ☐ Yes ☑ No
15. Allergic to anything *(drugs, food plants, etc)?* _____ ☐ Yes ☑ No
16. Ever been treated for a mental disorder or attempted suicide? When? _____ Where? _____ ☐ Yes ☑ No
17. Fainted recently or had a recent head injury? _____ ☐ Yes ☑ No
18. Visualize the mouth, teeth and gums. Are there any dental problems noted? ☐ Yes ☑ No
    If yes, please comment: _____
19. Are there any other medical or mental problems you have not told me about? _____ ☐ Yes ☑ No
20. Use alcohol? ~~Yes~~ No What kind? _____ How often? _____ When was the last time? _____ How much? _____
21. Use drugs? ~~Yes~~ No What kind? _____ How often? _____ When was the last time? _____ How much? _____
22. Ever had problem following withdrawal of alcohol or drug use? _____ What kind of problem? _____ Convulsions? _____
23. Females: Current gynecological problems? _____ Pregnant or on birth control pills? ____ Recently delivered/aborted? ____
24. Language: *(circle one)* English (b)(6), (b)(7)(c) Other _____
25. Placement recommendation: *(circle one)* g emergency treatment next sick call isolation

Remarks: _____

I acknowledge that I have answered all questions truthfully and have been told and shown in writing how to obtain medical, dental psychiatric services. I consent to reasonable and customary medical, dental and psychiatric treatment offered in this facility. ...ave received educational information regarding personal and dental hygiene.

Inmate's Signature X Evalin Mandza Date 10-24-11

The GEO Group, Inc.

Nursing Incoming Screen Progress Notes

[redacted]

Inmate Name: MANDZA, EVALIN **AGE:**

Inmate Number: DOB: 12/5/1965 Nation: GABON **SEX:**

Arrival Date: 10/24/2011 17:05

UNIT: **Date of Birth:** ____/____/____

Date & Time	
	Allergies: NKDA
10-24-11	DATE RECEIVED THIS UNIT:
18 715	IMMUNIZATIONS: DIPHTHERIA/TETANUS Child hood DATES:
	PPD DATE: RESULTS:
	TB CLASS PROPHYLAXIS: YES NO DATE COMPLETED: ____/____/____ DATE TO COMPLETE: / /
	TREATMENT: DATE COMPLETED: IN PROGRESS:
	SEROLOGY DATE: RESULTS:
	CHRONIC ILLNESS/DISABILITIES: ADD TO CHRONIC CLINIC:
	MEDICATION ORDERS:
	1.
	2.
	3.
	4.
	5.
	6.
	7.
	TREATMENT/SPECIAL CARE/FOLLOW-UP/REFERRALS:
	WORK LIMITATION:
	HOUSING & BUNK LIMATIONS:
	NURSE'S SIGNATURE: [redacted]
	PHYSICIAN SIGNATURE: [redacted] OCT 27 2011

[redacted] M.D.

(b)(6), (b)(7)(c)

MANDZA, EVALIN

DOB: 12/5/1965 Nation: GABON

Arrival Date: 10/24/2011 17:05

[AL HEALTH EVALUATION

The GEO Group, Inc.

Inmate Number: _____

Date of Birth: ____/____/____

1. Have you ever been hospitalized for an emotional or nervous problem? ☐ Yes ☑ No If yes, what hospital? When?
2. Have you ever received counseling or outpatient mental health treatment for the above? ☐ Yes ☑ No If yes, when? Where?
3. Are you taking any medication for a nervous condition? ☐ Yes ☑ No If yes, name of medication/dosage _____ How often? Who prescribed it? How long have you been taking it?

4. Do you use any of the follow	Beer?	Wine?	Liquor?
How much?			
How often?			
How long?			

5. Have you ever been treated for alcohol abuse? ☐ Yes ☑ No If yes, how many times? _____ When? Where? How long?
6. Have you ever used illegal drugs? ☐ Yes ☑ No If yes, how many times? _____ What illegal drugs have you used in the last 12 months? _____ When did you start using these drugs?
7. Have you ever been treated for drug abuse? ☐ Yes ☐ No If yes, how many times? _____ When? Where? How long?
8. Have you ever attempted suicide? ☐ Yes ☑ No If yes, how many times? _____ When? _____ Where? Hospitalized? Where?
9. Have you ever thought about suicide? ☐ Yes ☑ No If yes, when was the last time? _____ Do you think of it often? Sometimes? Seldom?
9a. Have you ever hurt yourself without wanting to die? ? ☐ Yes ☐ No If yes, when was the last time? _____ Do you think of it often? Sometimes? Seldom?
10. Have you ever been suspended from school? ☐ Yes ☐ No If yes, how many times?
11. Have you ever lost a job because of a fight? ☐ Yes ☑ No If yes, how many times?
12. Have you ever had a seizure? ☐ Yes ☑ No If yes, when?
13. Have you ever had a head injury? ☐ Yes ☑ No If yes, when?
14. What grade did you complete in school? 10th
15. Were you in any special education classes? ☐ Yes ☑ No If yes, what class?
16. Are you able to read and write English? ☑ Yes ☐ No
17. Have you ever been convicted of a violent crime? ☐ Yes ☑ No If yes, When? _____ Where? _____ What crime? What was your sentence?
18. Have you ever been a victim of a violent crime or sexual abuse? ☐ Yes ☑ No If yes, When? Where?
19. Do people consider you a violent person? ☐ Yes ☑ No If yes, why?
20. Do you have a history of sexual aggression or sexual assault? ☐ Yes ☑ No If yes, When? Where? Have you ever been convicted of a sexual offense? ☐ Yes ☑ No If yes, When? Where?
21. How do you feel about your incarceration?

OK

(b)(6), (b)(7)(c)

Referral: ☐ Mental health ☐ Doctor ☐ Next sick call ☑ General population

(b)(6), (b)(7)(c)

(b)(6), (b)(7)(c)

Intervi

10-25-11

Date

Rev 11/07, 7/11

HS-158

Release of Responsibility for Medical Services

The GEO Group, Inc.

(b)(6), (b)(7)(c)

MANDZA, EVALIN

DOB: 12/5/1965 Nation: GABON
Arrival Date: 10/24/2011 17:05

Inmate Number: _____

Date: 10/24/11 Time: 1845 ☐ AM ☐ PM

This is to certify that I, _____, under the care of the _____
Inmate Name **Facility Name**

and under medical supervision of an attending physician employed by The GEO Group, Inc., am **REFUSING** to accept the following treatment plan:

1. Admission to institutional infirmary
2. Stay in institutional infirmary
3. Medical/Surgical interventions (Specify)
4. Medication (Specify) **Syphilis Testing**
5. Physician's services (Specify)
6. Services in a Hospital Emergency Room
7. Diagnostic Testing
8. Services as an in-patient in a hospital
9. History and Physical including lab tests

*****Write in appropriate plan, which is being refused including risks*****

Undiagnosed Disease Process
Untreated Medical Condition

I acknowledge that I have been informed of the risk involved in refusing the above treatment plan, and hereby release the attending physician and GEO from ALL RESPONSIBILITY for adverse effects resulting from such refusal.

Evalin Ali Mandza
Patients Signature

10-24-11
Date

(b)(6), (b)(7)(c)
Witness *(GEO Employee)*

10-24-11
Date

(b)(6), (b)(7)(c)
Physician Signature

2/22-12
Date

Rev 01/05

DIANAssociates Teleradiology
UNIVERSITY OF MARYLAND RADIOLOGY
CHEST X-RAY TB SCREENING REPORT

Phone: 410-328-3477 Fax: 410-328-0641

DIANAssociates INC.
Severna Park, MD 21146
410-544-7846 Fax: 410-544-5203

SITE: ICE_AURORA

NAME: MANDZA, EVALIN

ALIEN #: (b)(6), (b)(7)(c)

DATE OF X-RAY: 10/24/2011

DATE OF BIRTH: 12/05/1965

STUDY TYPE:

FINDINGS: **Negative except for calcified granuloma (ta) < 2cm.**

SIGNED BY RADIOLOGIST: (b)(6), (b)(7)(c)

SIGNED AT: 2011/10/24 22:19:56 EDT

(b)(6), (b)(7)(c)

DETAINEE CLASS CATION SYSTEM – PRIMARY A. SSMENT FORM

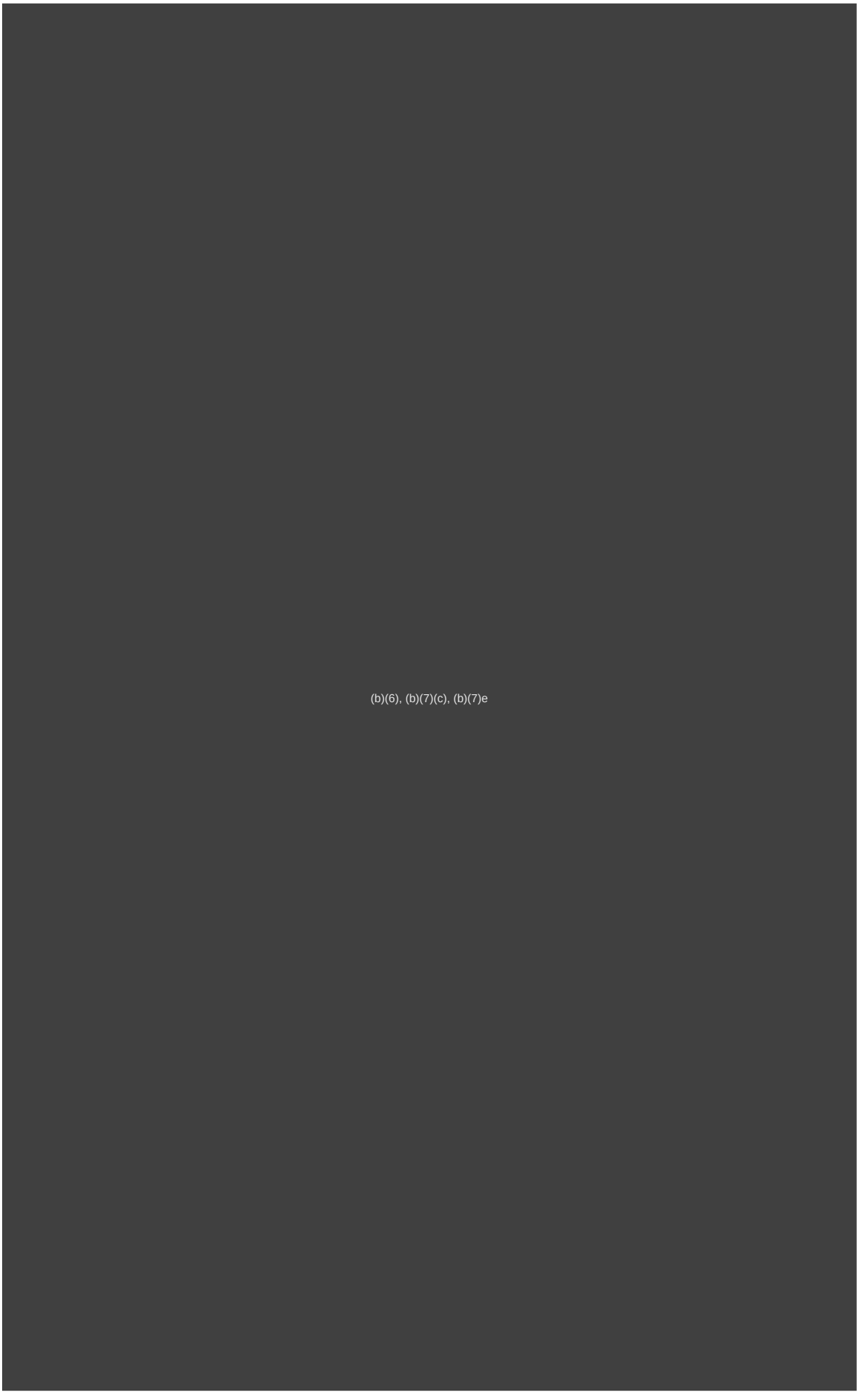
Name: Mandza, Evelin A#: (b)(6), (b)(7)(c)

Date of Birth: 12/05-1(6)- Country of Citizenship: Gabon

Classified By: (b)(6), (b)(7)(c) ID: N/A Date: 10/24/11

Language: (English Ⓨ/ N) Other:

(b)(7)e


(b)(6), (b)(7)(c), (b)(7)e

MENDOZA EVALIN

Medical Request/
Solicated De Asistencia Medica

The GEO Group, I

Date of request: 10 / 23 / 11
Fecha de Solicitud

(Please check one)
(Por favor marque uno)

☐ Medical Complaint
☒ Oueja medica

☐ Dental Complair
☐ Oueja Dental

Print/: Letra-Molde	Inmates Name/ Nombre del Preso	(b)(6), (b)(7)(c) Number/ Numero	Housing Location/ Sitio de Vivienda	Job Assignment/ Asignacion de Trabajo	Duty Hours/ Horas de Trabajo
	Evalin Mendoza		A2 201		

Briefly state the reason for your request; you will receive a response to your request. Please allow several days for your request to be submitted, answered, and returned. A copy of your request will be filed in your records.

Explique brevemente la razon de su solicitud. Permita varios dias para que su solicitud sea procesada. Una copia de su solicitud sera archivada en sus records. Prisioneros de habla hispana pueden solicitar dicha assistençia en espanol.

PROBLEM/QUEJA: BAD MOVEMENT

Inmate's Signature/Firma del Preso

DO NOT WRITE BELOW THIS LINE/NO ESCRIBA DEBAJO DE ESTA LINEA

Date Received: _____ (Stamp Date)

Date Reviewed: _____ ☐ Written Response (see below) ☒ Seen in Medical

ACTION TAKEN: per protocol

☐ Placed on sick call list Date of Appointment: ____/____/____

☐ Placed on Dental list Date of Appointment: ____/____/____

☐ Other (Explain): _____

(b)(6), (b)(7)(c)

Medical History and Physical Assessment

The GEO Group, Inc.

Site:

Mental Health Assessment	N	Abnormal/ comment	Health Assessment
Orientation *(person, place, time)*	✓		Age: 42 Sex: M Race:
General appearance	✓		Height: 5'8 Weight: 141
Motor behavior, mannerisms	✓		Temp: 98.6 Pulse: 78 Resp: 18 B/P 104/64
Affect (mood)	✓		
Content of thought, history of suicide, present thoughts of suicide	✓		

Medical History						NKDA Allergy	N	Abnormal - Comments
Problems	Y	N	Problems	Y	N	General - movement, deformity pain, bleeding, hygiene	✓	
Head trauma		✓	Back/neck problem		✓	Neuro - mental status, intox, withdrawal, tremors, neuro-defects	✓	
Loss of consciousness		✓	Kidney stones/disease		✓	Skin - injury, bruises, trauma, jaundice, diaphoretic, rash, lesions, infestations, needle marks, color, turgor	✓	
Severe headaches		✓	Bladder/kidney infection		✓	Head - normocephalic, hair, scalp	✓	
Vertigo/dizziness		✓	Alcoholism		✓	Eyes - glasses/vision, pupils, sclera, conjunctiva	✓	
Vision problems		✓	Drug abuse		✓	Ears - appearance, canals, TM's, hearing	✓	
Hearing problems		✓	Tobacco abuse		✓	Nose - epistaxsis, sinuses	✓	
Dental problems/dentures		✓	Psychiatric hx		✓	Throat - teeth, gums, dentures, mouth, tongue, tonsils, airway	✓	
Seizures		✓	Suicidal		✓	Neck - C-spine, mobility, veins, carotids, thyroid, lymph nodes	✓	
Strokes		✓	Communicable/ contagious	Y	N	Chest/Breasts - config, ausc/resp., cough/sputum, masses	✓	
Nervous disorders		✓	Tuberculosis		✓	Heart - ausc rate, rhythm, murmurs, ectopy	✓	
DT's		✓	HIV / AIDS		✓			
Heart condition		✓	Hepatitis		✓	Abdomen - bowel sounds, palp, shape, hernia	✓	
Angina/heart attack		✓	V.D. - gonorrhea		✓	GU - flank tenderness, bladder tenderness, distention	✓	
High blood pressure		✓	V.D. - syphilis		✓	Back -ROM, spasm, injury	✓	
Anemia/blood		✓	Lice - crabs - scabies		✓	Extremities - edema, pulse, cyanosis, ROM, injury	✓	
Lung condition		✓	OB/GYN			Genitals - injuries, lesions	✓	
Asthma		✓	LPM date			Rectal-gualac - deferred	✓	
Bronchitis		✓	Duration					
Emphysema		✓	LMP normal					
Pneumonia		✓	Regularity	Y	N			
Diabetes		✓	Gravida/para					
Hay fever/allergies		✓	AB/miscarriage					
Gastritis		✓	Last pap					
Ulcers		✓	Contraception	Y	N			
Bleeding		✓	LAB tests - dates					
Gallbladder/pancreas		✓	RPR					
Liver problems		✓	PPD					
Arthritis		✓	Other:					
Joint/muscle problem		✓						

(b)(6), (b)(7)(c)

MANDZA, EVALIN

DOB: 12/5/1965 Nation: GABON

Arrival Date: 10/24/2011 17:05

Comments: _____

(b)(6), (b)(7)(c)

Inmate Name: _____ Inmate Number: 10/26/11

RN Signature: (b)(6), (b)(7)(c) Date: _____ Physician Signature: (b)(6), (b)(7)(c) Date: 1800

Rev 01/05

Progress Notes

The GEO Group, Inc.

(b)(6), (b)(7)(c)

Site: Aurora / ICE Processing Center

MANDZA, EVALIN
DOB: 12/5/1965 Nation: GABON
Arrival Date: 10/24/2011 17:05

Detainee Name:)B

DATE / TIME	PROGRESS NOTE	ORDERS
10/26/11	Detainee to medical c/o not having found movement 3-4 d. Instructed to increase his fluid intake verbalized understanding — (b)(6), (b)(7)(c)	Ambolax Take 1 x 1 dose MOM 30cc PO x 1 dose
10/26/11	PE Completed (b)(6), (b)(7)(c) NOTED 10/26/11 (b)(6), (b)(7)(c) CPN	

The GEO Group, Inc.

HEALTH SERVICES
NURSING ASSESSMENT PROTOCOLS

ABDOMINAL PAIN/CONSTIPATION/DIARRHEA/INDIGESTION/VOMITING PROTOCOL

DATE/TIME

10/24/11
0605

S.) CHIEF COMPLAINT: Constipation ALLERGIES: NKDA

History of ulcers / gallbladder disease/ appendicitis / recent abdominal surgeries/ recent weight change (# lbs): no

Time/Activity at onset: 3-4 d After eating, does pain increase / decrease / remain same: —

Pain location: no Radiation: yes/no Duration: Constant or Intermittent:

Current medications: no Alleviating factors:

Circle one: Sick call / walk-in / Self declared ER / true ER

Character: Cramping / stabbing / burning / sharp / dull Flatus: Pain Intensity Scale 1-10:

Last BM: 3-4 days Consistency: Amt: Blood (if yes, red / black/ or maroon, and amt):

Constipation: yes Diarrhea (Frequency/amt): N/A

Nausea/vomiting: no Describe frequency/amt/color:

Heartburn or indigestion: no Frequently / Occasionally / N/A Degree: mild / mod / severe

Urinary frequency: no Burning: no Penile discharge: no Low back pain: no

Dietary habits: Fat intake: just sweets sweet Alcohol intake: 0 Caffeine intake:

Smoking habits:

O.) BP= 109/66 P= 76 Normal/weak/bounding R= 16 T= 97.1 WT. 143 #

Bowel sounds: normal / hypo / hyper / absent Heard in all 4 quadrants: X4 Guarding: no

Rebound tenderness: no Jaundice: N/A If states blood in stool, do hemocult. Results: N/A

Pain location:

Description of observed vomitus/stool: no

More comfortable: lying / sitting / standing — Able to sit still: yes

Skin: normal (warm & dry) / pale / flushed / cyanotic / diaphoretic

Abdomen: soft / rigid Degree: mild / moderate / severe / n/a distended / obese Bladder distended: no

Evidence of dehydration / GI bleeding: no If yes, orthostatic BP= P=

Overall appearance: no acute distress / mild distress / severe distress Obvious anxiety:

A.) Constipation, Unspecified tab, MOM 30cc x 1 dose

P.) The Nurse may offer Patient the choice of Antacid, Milk of Magnesium, Kaopectate, Emetrol, Pepto-bismuth, Duleolax, bulk laxative) Type/dose:

Give according to label instructions.

If vomiting or diarrhea, give clear liquid diet x 24 hrs and lay-in pass, unless otherwise ordered:

If blood in stool, vomiting, or severe diarrhea, place in infirmary/observation, unless otherwise ordered:

If fever above 100.4 F, nausea or vomiting accompanying constipation, absent bowel sounds, blood in stool, dill HIV + inmates with diarrhea, diarrhea that lasts longer than 24 hrs after treatment, or if pt does appear ill, and there is pain upon palpation, the physician must be notified for specific orders.

E.) Instructed to avoid spicy foods, eat small meals, chew slowly & thoroughly, and drink 6-8 glasses water daily:

Instructed not to lie down at least 2 hrs after eating: Caution to quit smoking:

(b)(6), (b)(7)(c)

MANDZA, EVALIN

DOB: 12/5/1965 Nation: GABON

Arrival Date: 10/24/2011 17:05

(b)(6), (b)(7)(c)

MANDZA

Medical Request / Solicated De Asistencia Medica

The GEO Group, Inc.

Date of request: 10 / 31 / 11 (Please check one) Medical Complaint Dental Complain
Fecha de Solicitud (Por favor marque uno) ☒ Queja medica ☐ Queja Dental

Print / : Letra — Molde	Inmates Name / Nombre del Preso	(b)(6), (b)(7)(c)	Number Numero	Housing Location Sitio de Vivienda	Job Assignment Asignacion de Trabajo	Duty Hour Horas de T
	Evalin-Ali Mandza		AZ-201		Medical	

Briefly state the reason for your request; you will receive a response to your request. Please allow several days your request to be submitted, answered, and returned. A copy of your request will be filed in your records.

Explique brevemente la razon de su solicitud. Permita varios dias para que su solocitud sea procesada. Una co su solicitud sear archivada en sus records. Prisioneros de habla hispana pueden solicitar dicha assistencia enes

PROBLEM / QUEJA: Constipation Movement

Evalin Ali Mandza
Inmate's Signature / Firma del Preso

=======DO NOT WRITE BELOW THIS LINE / NO ESCRIBA DEBAJO DE ESTA LINEA=======

Date Received: _____ (Stamp Date)

Date Reviewed: _____ ☐ Written Response (see below) ☒ Seen in Medical

ACTION TAKEN: per protocol / scheduled c Garbikyan

☒ Placed on Sick Call List Date of Appointment: 11 / 3 / 11

☐ Placed on Dental List Date of Appointment: ___ / ___ / ___

☐ Other (Explain) : _____

(b)(6), (b)(7)(c)

Medical Request / Solicated De Asistencia Medica

The GEO Group, Inc.

Date of request: 11 / 08 / 11 (Please check one) Medical Complaint Dental Complai
Fecha de Solicitud (Por favor marque uno) [X] Oueja medica [ ] Oueja Dental

Print / : Letra – Molde	Inmates Name / Nombre del Preso	(b)(6), (b)(7)(c) Number Numero	Housing Location Sitio de Vivienda	Job Assignment Asignacion de Trabajo	Duty Hou Horas de
Evalin Manoza			AZ-261		

Briefly state the reason for your request; you will receive a response to your request. Please allow several day your request to be submitted, answered, and returned. A copy of your request will be filed in your records.

Explique brevemente la razon de su solicitud. Permita varios dias para que su solocitud sea procesada. Una co su solicitud sear archivada en sus reocrds. Prisioneros de habla hispana pueden solicitar dicha assistencia enes

PROBLEM / QUEJA: Bomps shaving, need medical

Evalin Manoza
Inmate's Signature / Firma del Preso

=======DO NOT WRITE BELOW THIS LINE / NO ESCRIBA DEBAJO DE ESTA LINEA=======

Date Received: _____ (Stamp Date)

Date Reviewed: 11/9/11 0600 [ ] Written Response (see below) [X] Seen in Medical

ACTION TAKEN: T.A.O. apply daily X 7 days

[ ] Placed on Sick Call List Date of Appointment: ___/___/___

[ ] Placed on Dental List Date of Appointment: ___/___/___

[ ] Other (Explain) : _____

(b)(6), (b)(7)(c) (b)(6), (b)(7)(c)

Progress Notes

The GEO Group, Inc.

(b)(6), (b)(7)(c)

Site: Aurora MANDZA, EVALIN
DOB: 12/5/1965 Nation: GABON
Arrival Date: 10/24/2011 17:05

Detainee Name:	#	DOB

DATE / TIME	PROGRESS NOTE	ORDERS
11/9/11 0600	Det. C/O razor bumps. See skin protocol. (b)(6), (b)(7)(c)	T.A-D apply daily X 7 days (b)(6), (b)(7)(c)

The GEO Group, Inc.

HEALTH SERVICES
NURSING ASSESSMENT PROTOCOLS

CONTACT DERMATITIS / ECZEMA PROTOCOL / ALLERGIC SKIN RASH

DATE/TIME: 11/9/11 0600

S.) CHIEF COMPLAINT: Razor Bumps — ALLERGIES: NKA

Course and onset of symptoms: ongoing

Where did it start: face — Did it spread (where): all over face + skin strong

Exposure to allergens, poison ivy, poison oak, or chemicals: ☐ Yes ☒ No

circle one: sick call / walk-in / Declared E.R. / true E.R.

Pain Intensity Scale 1-10: 5-6

History of: ☐ Hay fever ☐ Asthma ☐ Eczema ☒ Other Skin Conditions: None

O.) BP= 109/76 P= 71 R= 18 T= 96.9 WT= 144

Location / size of rash/ lesions (face, neck, trunk, folds of skin, behind the knees, elbows, and body):

Color / shape of rash/lesions: none

Describe rash: ☒ Macules ☐ Papules ☐ Pustules ☐ Vesicles ☐ Open excoriation
☐ weeping: ☐ Peeling ☐ Dry/flaking ☐ Crusting lesions ☐ Hives
☒ Burning ☐ Itching

Thickening of Skin: ☐ Yes ☒ No Pigmentation changes: ☒ Yes ☐ No

Are the palms of the hands affected: ☐ Yes ☒ No Are the sole of the feet affected: ☐ Yes ☒ No

Signs of secondary infection: ☐ Purulent drainage ☐ Redness ☐ Edema ☐ Heat no

A.) Razor Bumps

P.) Eliminate contact with allergen, if known: N/A

Wash well with soap and water / dry well: Sy

The Nurse may offer the choice of an anti-itch lotion (Calamine) applied topically qid prn x 2 weeks ☐ Yes ☒ No

or Hydrocortisone cream 1% bid prn x 3 days ☐ Yes ☒ No

The Nurse may also offer Benadryl 25 mg, 2 tabs p.o., t.i.d. x 3 days for itching: ☐ Yes ☒ No

Call physician for specific orders if secondary infection is present, Temp > 100.4, or if lesions are present on the eyes or Genitalia: N/A

TAC apply daily x 7 days

Passes / Referrals given:

E.) Instructed to bathe daily, rinse & dry thoroughly, and use only his own towels / linens/ etc: ☒ Yes ☐ No

Instructed to keep hands off the affected areas and avoid scratching: ☒ Yes ☐ No

Instructed to avoid contact with lotion/ointment in or around the eyes: ☒ Yes ☐ No

Instructed to return to medical if symptoms persist/worsen: ☒ Yes ☐ No

Inmate verbalized understanding of above instructions: ☒ Yes ☐ No

(b)(6), (b)(7)(c)

NAME MANDZA, EVALIN

NUMBER DOB: 12/5/1965 Nation: GABON
Arrival Date: 10/24/2011 17:05

DOB

NURSING SIGNATURE (b)(6), (b)(7)(c)

MANDZA EVALIN

Medical Request / Solicated De Asistencia Medica

The GEO Group, Inc.

Date of request: 11 / 10 / 11 (Please check one) Medical Complaint Dental Complaint
Fecha de Solicitud (Por favor marque uno) ☒ Oueja medica ☐ Oueja Dental

Print / : Evalin Mondoza	(b)(6), (b)(7)(c)	AZ-20		
Letra – Molde Inmates Name / Nombre del Preso	Number Numero	Housing Location Sitio de Vivienda	Job Assignment Asignacion de Trabajo	Duty Hours Hores de Tr

Briefly state the reason for your request; you will receive a response to your request. Please allow several days your request to be submitted, answered, and returned. A copy of your request will be filed in your records.

Explique brevemente la razon de su solicitud. Permita varios dias para que su solocitud sea procesada. Una copi su solicitud sear archivada en sus reocrds. Prisioneros de habla hispana pueden solicitar dicha assistencia enesp

PROBLEM / QUEJA: constipation Movement

Evalin Mandoza
Inmate's Signature / Firma del Preso

==========DO NOT WRITE BELOW THIS LINE / NO ESCRIBA DEBAJO DE ESTA LINEA==========

Date Received: _____ (Stamp Date)

Date Reviewed: 11-11-11 ☐ Written Response (see below) ☒ Seen in Medical

ACTION TAKEN: Per protocal

☐ Placed on Sick Call List Date of Appointment: ____/____/____

☐ Placed on Dental List Date of Appointment: ____/____/____

☐ Other (Explain) : _____

(b)(6), (b)(7)(c)

[redacted]

MANDZA, EVALIN

DOB: 12/5/1965 Nation: GABON

Arrival Date: 10/24/2011 17:05

The GEO Group, Inc.

HEALTH SERVICES
NURSING ASSESSMENT PROTOCOLS

ABDOMINAL PAIN/CONSTIPATION/DIARRHEA/INDIGESTION/VOMITING PROTOCOL

DATE/TIME: 11-11-11 0600

Circle one: Sick call (circled) / Walk-in / Self declared ER / true ER

S.) CHIEF COMPLAINT: Constipation ALLERGIES: NKDA

History of ulcers / gallbladder disease/ appendicitis / recent abdominal surgeries/ recent weight change (# lbs):

Time/Activity at onset: N/A After eating, does pain increase / decrease / remain same: N/A

Pain location: N/A Radiation: yes/no (no circled) Duration: N/A Constant or Intermittent:

Current medications: see MAR Alleviating factors: NO

Character: Cramping / stabbing / burning / sharp / dull NO Flatus: yes Pain Intensity Scale 1-10: N/A

Last BM: 5 days Consistency: Hard Amt: small Blood (if yes, red / black/ or maroon, and amt): NA

Constipation: yes Diarrhea (Frequency/amt): NO

Nausea/vomiting: NO Describe frequency/amt/color: N/A

Heartburn or indigestion: NO Frequently / Occasionally / N/A (N/A circled)

Urinary frequency: NO Burning: NO Penile discharge: NO Degree: mild / mod / severe

Dietary habits: Fat intake: Normal Alcohol intake: NO Low back pain: N/A

Smoking habits: Caffeine intake: NO

O.) BP= 108/71 P= Normal/weak/bounding (Normal circled) R= 18 T= 98.3 WT. 145

Bowel sounds: normal / hypo / hyper / absent (normal circled) Heard in all 4 quadrants: yes Guarding: N/A

Rebound tenderness: NO Jaundice: NO If states blood in stool, do hemocult. Results: N/A

Pain location: NO

Description of observed vomitus/stool: NO

More comfortable: lying / sitting / standing N/A

Skin: normal (warm & dry) / pale / flushed / cyanotic / diaphoretic (normal (warm & dry) circled) Able to sit still: yes

Abdomen: soft / rigid (soft circled) Degree: mild / moderate / severe / n/a Bladder distended: NO

Evidence of dehydration / GI bleeding: NO If yes, orthostatic BP= N/A P= N/A

Overall appearance: no acute distress / mild distress / severe distress (no acute distress circled) Obvious anxiety: N/A

A.)

P.) The Nurse may offer Patient the choice of Antacid, Milk of Magnesium, Kaopectate, Emetrol, Peptobismuth, Dulcolax, bulk laxative (Dulcolax, bulk laxative circled) Type/dose: Dulcolax 15mg PO NO Fiber BID x 10 days

Give according to label instructions.

If vomiting or diarrhea, give clear liquid diet x 24 hrs and lay-in pass, unless otherwise ordered.

If blood in stool, vomiting, or severe diarrhea, place in infirmary/observation, unless otherwise ordered.

If fever above 100.4 F, nausea or vomiting accompanying constipation, absent bowel sounds, blood in stool, all HIV + inmates with diarrhea, diarrhea that lasts longer than 24 hrs after treatment, or if pt does appear ill and there is pain upon palpation, the physician must be notified for specific orders.

E.) Instructed to avoid spicy foods, eat small meals, chew slowly & thoroughly, and drink 6-8 glasses water daily.

Instructed not t[redacted]

Caution to quit smoking: [redacted]

[redacted] 11-11-11

Medical Request /
Solicated De Asistencia Medica

Date of request: Nov / 17 / 11 (Please check one) ☐ Medical Complaint ☒ Dental Complaint
Fecha de Solicitud (Por favor marque uno) ☐ Oueja medica ☒ Oueja Dental

Print / : Evalin Mandza	(b)(6), (b)(7)(c)	AZ		
Letra – Molde Inmates Name / Nombre del Preso	Number Numero	Housing Location Sitio de Vivienda	Job Assignment Asignacion de Trabajo	Duty Hours Horas de Trabajo

Briefly state the reason for your request; you will receive a response to your request. Please allow several days for your request to be submitted, answered, and returned. A copy of your request will be filed in your records.

Explique brevemente la razon de su solicitud. Permita varios dias para que su solocitud sea procesada. Una copia de su solicitud sear archivada en sus reocrds. Prisioneros de habla hispana pueden solicitar dicha assistencia enespanol.

PROBLEM / QUEJA: Dental Hurt, couldn't Go to sleep.

Inmate's Signature / Firma del Preso

=========DO NOT WRITE BELOW THIS LINE / NO ESCRIBA DEBAJO DE ESTA LINEA========

Date Received: _____ (Stamp Date)

Date Reviewed: 11/17/11 ☐ Written Response (see below) ☒ Seen in Medical

ACTION TAKEN: Given Tylenol and scheduled for dentist
instructed on proper oral hygiene. Return to medical if
symptoms persist/worsen (b)(6), (b)(7)(c)

☐ Placed on Sick Call List Date of Appointment: ____/____/____

☒ Placed on Dental List Date of Appointment: 11/21/11

☐ Other (Explain) : _____

The GEO Group, Inc.

HEALTH SERVICES
NURSING ASSESSMENT PROTOCOLS

DENTAL - TOOTHACHE PROTOCOL

DATE/TIME: 11/7/11 0725

S.) CHIEF COMPLAINT: Toothache

ALLERGIES: No

Time of onset: 2 days ago

Pain Intensity Scale 1-10: 9/10

Any trauma or injury: None

Contributing factors related to pain (eating, drinking, chewing, hot, cold, air):

Alleviating factors: Tylenol

Current medications: Fiber

circle one: sick call / walk-in / declared E.R. / true E.R.

Review dental record (chronic condition, recent extraction, etc):

O.) BP= 108/70 P= 74 R=18 99% O2 T= 96.0 WT=

Bleeding: No

Redness or Swelling: Yes

Injury to mouth/ gums/ teeth: No

Identity of the tooth: 2nd to last on bottom (L). Visible signs of decay: Yes Loose: A little

Is tooth positive to percussion: N/A

Oral hygiene: some signs of decay

White patches/ discharge: No

Earache or sore throat (examination if positive): and leads to headache

A.) Toothache

P.) *Notify dentist or physician for specific orders if severe bleeding, facial swelling or pain, if tooth positive to percussion, secondary infection, or temp > 100.4:*

If none of the above symptoms are present: The Nurse may offer Patient the choice of Ibuprofen 200 mg, two tablets p.o. x 3 days

or Tylenol 325 mg, 2 tabs p.o. tid prn pain x 3 days or until seen by dentist:

Schedule for next dental call: Yes 11-21-11

E.) Instruct patient regarding proper oral hygiene: brush and floss properly after each meal. Place toothbrush at an angle against the gumline of your teeth. Scrub teeth with short, back and forth strokes, gently but firmly, at least a dozen times, brush your tongue. Repeat on all teeth inside and out. Scrub the backs of your front teeth with the tip of your toothbrush, finally scrub all chewing surfaces and then rinse mouth. Rinse toothbrush after every use and dry it off. Brush for a total of about 3 minutes: Yes

Instructed to return to medical if symptoms persist/worsen: Yes

Inmate verbalized understanding of above instructions: Yes

(b)(6), (b)(7)(c) RN

(b)(6), (b)(7)(c)

MANDZA, EVALIN

DOB: 12/5/1965 Nation: GABON

Arrival Date: 10/24/2011 17:05

The GEO Group, Inc.

(b)(6), (b)(7)(c)

MANDZA, EVALIN
DOB: 12/5/1965 Nation: GABON
Arrival Date: 10/24/2011 17:05

DENTAL HEALTH RECORD CONTINUATION SHEET

 # = Tooth No.
P = Priority
F = Facility

Date/Time	#	Services Rendered	P	Dentist (Signature)	F
11/21/11 1545		S: Complaint of TA LL. Has court tomorrow so he wants to reschedule O: #18 has deep occlusal caries. (+) percussion A: Irreversible Pulpitis P: Ext #18 RTC next week?		(b)(6), (b)(7)(c) Aurora/ICE Processing Center	
		NOTED 11/21/11 (b)(6), (b)(7)(c) LPN			
12/20/11 1340		S: Wants teeth cleaned and complaint of pain LL. O: #18 still has deep caries. Mobility of 1/2. A: Irreversible pulpitis #18. P: Pt refuses ext. Rx (b)(6), (b)(7)(c) TBP 400 mg Bid X 5 days.		(b)(6), (b)(7)(c) Aurora/ICE Processing Center	
12/20/11 1340		noted (b)(6), (b)(7)(c)			
		24° chart 12/21/11 0420 (b)(6), (b)(7)(c) LPN			
1/16/12 1825		S: Pain LL X 3 days O: #18 is tender to percussion. A: IP #18. P: Refused ext. Rx: Amoxicillin 1000 mg Bid X 7 da Tylenol 1000mg Bid X 7 days DC Tylenol 1000 Bid X 7 days.		(b)(6), (b)(7)(c)	
		orders noted 1/17/12 0650 (b)(6), (b)(7)(c) LPN			
		24° chart ✓ Complete 1/17/12 0610 (b)(6), (b)(7)(c) R.N.			

The GEO Group, Inc.

(b)(6), (b)(7)(c)

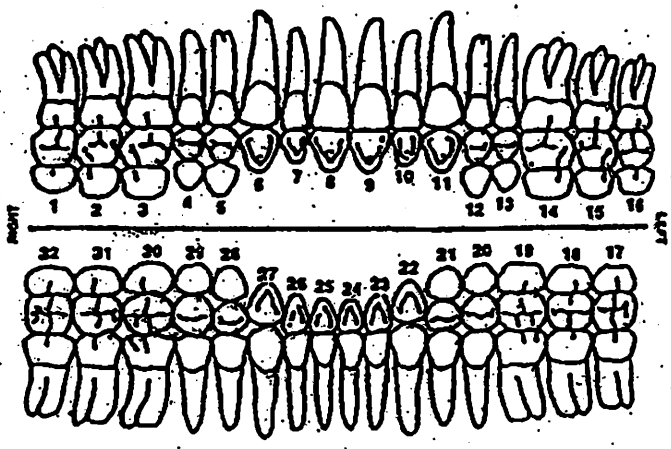
MANDZA, EVALIN
DOB: 12/5/1965 Nation: GABON
Arrival Date: 10/24/2011 17:05

HEALTH SERVICES
DENTAL HEALTH RECORD

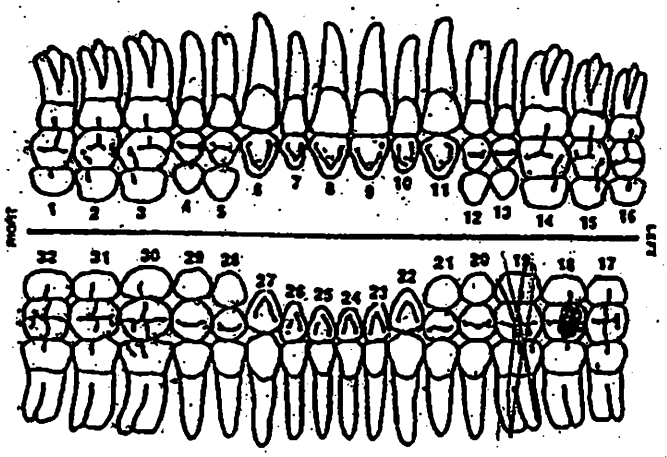
PATIENT IDENTIFICATION

SUBSEQUENT EXAMINATION

RESTORATION & TREATMENT (complete in ink)



DISEASES & ABNORMALITIES (complete in pencil)



REMARKS:

TREATMENT PLAN DATE: _____

Eligibility Date _____ PERIO TYPE _____

DENTAL/MEDICAL HISTORY

Has a doctor ever told you you have:

	Y	N		Y	N		Y	N
1. Heart Problems			6. Artificial Joints/Valves			11. Asthma/Respiratory Problems		
2. Heart Murmur			7. Rheumatic Fever			12. Allergic to Medications		
3. High Blood Pressure			8. Hepatitis/Liver Disease			13. Taking Medications		
4. Diabetes			9. Uncontrolled Bleeding			14. (Women) Pregnant		
5. Epilepsy			10. Stomach Ulcers			15. Other		

REMARKS: (continue on reverse):

Dental/Medical History Updated with each new provider (Dentist/Hygienist) and annually

DATE	INITIALS	DATE	INITIALS	DATE	INITIALS	DATE	INITIALS	DATE	INITIALS	DATE	INITIALS
11/21/11	(b)(6), (b)(7)(c)										

Medical Request /
Solicated De Asistencia Medica

Date of request: 11 / 27 / 11 (Please check one) Medical Complaint Dental Complaint
Fecha de Solicitud (Por favor marque uno) ☒ Oueja medica ☐ Oueja Dental

Print / : Evalin Mandza	(b)(6), (b)(7)(c)	A3-109		
Letra – Molde Inmates Name / Nombre del Preso	Number Numero	Housing Location Sitio de Vivienda	Job Assignment Asignacion de Trabajo	Duty Hours Horas de Trabajo

Briefly state the reason for your request; you will receive a response to your request. Please allow several days for your request to be submitted, answered, and returned. A copy of your request will be filed in your records.

Explique brevemente la razon de su solicitud. Permita varios dias para que su solocitud sea procesada. Una copia de su solicitud sear archivada en sus reocrds. Prisioneros de habla hispana pueden solicitar dicha assistencia enespanol.

PROBLEM / QUEJA: CONSTIPATION MOVEMENT & SHAVING PUMPS MED

Evalin Mandza
Inmate's Signature / Firma del Preso

=========DO NOT WRITE BELOW THIS LINE / NO ESCRIBA DEBAJO DE ESTA LINEA========

Date Received: _____ (Stamp Date)

Date Reviewed: 11/28/11 ☐ Written Response (see below) ☒ Seen in Medical

ACTION TAKEN: Given MOM and Dulcolax x1. Fiber BID x10 days. Also given TAO for razor burn rash on face. Instructed to drink a lot of water, do not use TAO around eyes; and return to medical if symptoms persist/worsen. (b)(6), (b)(7)(c)

☐ Placed on Sick Call List Date of Appointment: ____/____/____

☐ Placed on Dental List Date of Appointment: ____/____/____

☐ Other (Explain) : (b)(6), (b)(7)(c) RN

The GEO Group, Inc.

HEALTH SERVICES
NURSING ASSESSMENT PROTOCOLS
ABDOMINAL PAIN/CONSTIPATION/DIARRHEA/INDIGESTION/VOMITING PROTOCOL

DATE/TIME: 11/28/11 0555

Circle one: (Sick call) walk-in Self declared ER true ER

S.) CHIEF COMPLAINT: Constipation ALLERGIES: NKDA

History of ulcers / gallbladder disease/ appendicitis / recent abdominal surgeries/ recent weight change (# lbs): No

Time/Activity at onset: stress from being here After eating, does pain increase / decrease / remain same:

Pain location: No Radiation: yes/(no) Duration: N/A Constant or Intermittent: N/A

Current medications: Fiber Tab None Alleviating factors:

Character: Cramping / stabbing / burning / sharp / dull None Flatus: Yes Pain Intensity Scale 1-10: None

Last BM: 11/23/11 Consistency: hard Amt: little Blood (if yes, red / black/ or maroon, and amt): No

Constipation: Yes Diarrhea (Frequency/amt): No

Nausea/vomiting: No Describe frequency/amt/color: N/A

Heartburn or indigestion: No Frequently / Occasionally / (N/A) Degree: mild / mod / severe N/A

Urinary frequency: No Burning: No Penile discharge: No Low back pain: No

Dietary habits: Fat intake: normal Alcohol intake: None Caffeine intake: 1-2 cups/2days

Smoking habits: None

O.) BP= 108/72 P= 70 (Normal)/weak/bounding R= 17 T= 97.1 WT. 147 98y.oz

Bowel sounds: (normal) / hypo / hyper / absent Heard in all 4 quadrants: Yes Guarding: No

Rebound tenderness: No Jaundice: No If states blood in stool, do hemocult. Results: N/A

Pain location: Some tenderness on palpation directly under sternum at midline

Description of observed vomitus/stool: N/A

More comfortable: (lying / sitting / standing)

Skin: (normal (warm & dry) / pale / flushed / cyanotic / diaphoretic Able to sit still: Yes

Abdomen: (soft) / rigid Degree: mild / moderate / severe (n/a)

Evidence of dehydration / GI bleeding: No Bladder distended: No

Overall appearance: (no acute distress) / mild distress / severe distress If yes, orthostatic BP= N/A P= N/A

Obvious anxiety: No

A.)

P.) The Nurse may offer Patient the choice of Antacid/ (Milk of Magnesium), Kaopectate, Emetrol,

Peptobismuth, (Dulcolax, bulk laxative) Type/dose: x1 X1

Give according to label instructions.

If vomiting or diarrhea, give clear liquid diet x 24 hrs and lay-in pass, unless otherwise ordered: No

If blood in stool, vomiting, or severe diarrhea, place in infirmary/observation, unless otherwise ordered: No

Fiber PO BID x 10 days

**If fever above 100.4 F, nausea or vomiting accompanying constipation, absent bowel sounds, blood in stool, all HIV + inmates with diarrhea, diarrhea that lasts longer than 24 hrs after treatment, or if pt does appear ill, and there is pain upon palpation, the physician must be notified for specific orders:*

E.) Instructed to avoid spicy foods, eat small meals, chew slowly & thoroughly, and drink 6-8 glasses water daily: Yes

Instructed not to lie down at least 2 hrs after eating: No Caution to quit smoking: No

Instructed on stress relief measures, high fiber diet, and adequate exercise: Yes Return if symptoms persist/worsen: Yes

Inmate verbalized understanding of above instructions: Yes

(b)(6), (b)(7)(c)

MANDZA, EVALIN

DOB: 12/5/1965 Nation: GABON

Arrival Date: 10/24/2011 17:05

(b)(6), (b)(7)(c) EN

The GEO Group, Inc.

HEALTH SERVICES
NURSING ASSESSMENT PROTOCOLS

CONTACT DERMATITIS / ECZEMA PROTOCOL / ALLERGIC SKIN RASH

DATE/TIME 11/28/11 0555

S.) CHIEF COMPLAINT: Razor burn ALLERGIES: NKDA

Course and onset of symptoms: after shaving, get bad bumps

Where did it start: face + neck Did it spread (where): No

Exposure to allergens, poison ivy, poison oak, or chemicals: ☐ Yes ☒ No

circle one: Sick call / walk-in / Declared E.R. / true E.R.

Pain Intensity Scale 1-10: 5/10

History of: ☐ Hay fever No ☐ Asthma No ☐ Eczema No ☐ Other Skin Conditions No

O.) BP= 108/72 P= 70 R= 17 T= 97.1 WT= 147 98/.02

Location / size of rash/ lesions (face, neck, trunk, folds of skin, behind the knees, elbows, and body):

small red bumps

Color / shape of rash/lesions: red, round

Describe rash: ☐ Macules ☐ Papules ☐ Pustules ☐ Vesicles ☐ Open excoriation

☐ weeping: ☒ Peeling ☒ Dry/flaking ☐ Crusting lesions ☐ Hives

☒ Burning ☐ Itching

Thickening of Skin: ☐ Yes ☒ No Pigmentation changes: ☐ Yes ☒ No

Are the palms of the hands affected: ☐ Yes ☒ No Are the sole of the feet affected: ☐ Yes ☒ No

Signs of secondary infection: ☐ Purulent drainage No ☐ Redness No ☐ Edema No ☐ Heat No

A.)

P.) Eliminate contact with allergen, if known: N/A

Wash well with soap and water / dry well: yes

The Nurse may offer the choice of an anti-itch lotion (Calamine) applied topically qid prn x 2 weeks ☐ Yes ☒ No

or Hydrocortisone cream 1% bid prn x 3 days ☐ Yes ☒ No

The Nurse may also offer Benadryl 25 mg, 2 tabs p.o., b.i.d. x 3 days for itching: ☐ Yes ☒ No

Call physician for specific orders if secondary infection is present, Temp > 100.4, or if lesions are present on the eyes or Genitalia:

TAO x 7 days

Passes / Referrals given:

E.) Instructed to bathe daily, rinse & dry thoroughly, and use only his own towels / linens/ etc: ☒ Yes ☐ No

Instructed to keep hands off the affected areas and avoid scratching: ☒ Yes ☐ No

Instructed to avoid contact with lotion/ointment in or around the eyes: ☒ Yes ☐ No

Instructed to return to medical if symptoms persist/worsen: ☒ Yes ☐ No

Inmate verbalized understanding of above instructions: ☒ Yes ☐ No

NAME (b)(6), (b)(7)(c) MANDZA, EVALIN

NUMBER DOB: 12/5/1965 Nation: GABON
Arrival Date: 10/24/2011 17:05

DOB

NURSING SIGNATURE (b)(6), (b)(7)(c) RN

The GEO Group, Inc.

Progress Notes

Site: Aurora / ICE Processing Center

[redacted]
MANDZA, EVALIN
DOB: 12/5/1965 Nation: GABON
Arrival Date: 10/24/2011 17:05

Detainee Name: **DOB**

DATE / TIME	PROGRESS NOTE	ORDERS
12/2/11		
1030		
147#, 97,		
64, 113/69	c/o long hx of constipation	Adult Glycerin Suppository PR BID x 3 days
	c BM 1/wk	
	(-) Abd pain	
	(-) F/c/N/V	
	hx Folliculitis Bumps	↑ Fiber to 60 cc BID x 90 days
	O: VS Noted	
	NAD A to 3	
	Ext: deferred	Colace 100mg ÷ po BID x 90 days
	Assmt: Constipation	
	PL: See orders	
		Triple antibiotic cream to neck BID x 90d
		[redacted]
12/2/11	Noted 1422. Meds to MAR. supp ordered	[redacted] RN
12-03-11	24hr CC @ 0125	[redacted]

Medical Request /
Solicated De Asistencia Medica

Date of request: 12 / 11 / 11 (Please check one) Medical Complaint Dental Complaint
Fecha de Solicitud Mandza (Por favor marque uno) ☐ Oueja medica ☒ Oueja Dental

Print / : Evalin Mandza	(b)(6), (b)(7)(c)	A3-206		
Letra – Molde Inmates Name / Nombre del Preso	Number Numero	Housing Location Sitio de Vivienda	Job Assignment Asignacion de Trabajo	Duty Hours Horas de Trabajo

Briefly state the reason for your request; you will receive a response to your request. Please allow several days for your request to be submitted, answered, and returned. A copy of your request will be filed in your records.

Explique brevemente la razon de su solicitud. Permita varios dias para que su solocitud sea procesada. Una copia de su solicitud sear archivada en sus reocrds. Prisioneros de habla hispana pueden solicitar dicha assistencia enespanol.

PROBLEM / QUEJA: DENTAL complaint. need to be cleaned, but not to take out.

Evalin Mandza
Inmate's Signature / Firma del Preso

=========DO NOT WRITE BELOW THIS LINE / NO ESCRIBA DEBAJO DE ESTA LINEA========

Date Received: _____ (Stamp Date)

Date Reviewed: _____ ☐ Written Response (see below) ☒ Seen in Medical

ACTION TAKEN: See protocol / scheduled c Dr. (b)(6), (b)(7)(c)

☐ Placed on Sick Call List Date of Appointment: ____/____/____

☒ Placed on Dental List Date of Appointment: 12/12/11

☐ Other (Explain) : _____

(b)(6), (b)(7)(c)

The GEO Group, Inc.

Progress Notes

[redacted]

MANDZA, EVALIN
DOB: 12/5/19[illegible] Nation: GABON
Arrival Date: 10/24/2011 17:05

Site: Aurora / ICE Processing Center

Detainee Name: | **DOB**

DATE / TIME	PROGRESS NOTE	ORDERS
12/12/11	Detainee @ medical c/o toothache. (L)	Ibu 400mg po BID x3d
0640	lower tooth with decay, detainee has —	
	been scheduled c̄ Dentist re: tooth —	[redacted]
12/15/11	Lying Standing	
wgt-145	105/70 , 102/66	
70, 18	69 72	
102/65 —	Pt examined by Dr. [redacted] —	
sitting	No new orders made —	[redacted] LPN
	Noted by [redacted] LPN — 12/15/11	—
	24° chart ✓ 12/15/11 @ 2145 — [redacted] LPN	
1-3-12	c/o pain c̄ 1st MP	
	[illegible] Rt Foot [illegible]	
	striking [illegible] against soccer ball	
	O — W Noted NAD	
	Exam: (−) erythema / swelling c̄	
	MP Joint	1) Ibuprofen
	No gross deformity	800 mg ÷ po
	(−) Axial loading pain	BID PRN x 60
	No tenderness c̄ 1st	days
	metatarsal	2) Lower bunk
		bed please
	Assessment: Contusion	[redacted]
1/3/12	1250 Noted med to MAR + bunk Δ'd — [redacted]	RN

24° ✓ 1/4/12 [redacted] LPN

The GEO Group, Inc.

HEALTH SERVICES
NURSING ASSESSMENT PROTOCOLS

DENTAL - TOOTHACHE PROTOCOL

DATE/TIME	
10/24/11 0540	S.) CHIEF COMPLAINT: tooth ache ALLERGIES: NKDA
	Time of onset: x2 wk Pain Intensity Scale 1-10: 7
	Any trauma or injury: no
	Contributing factors related to pain (eating, drinking, chewing, hot, cold, air):
	Alleviating factors:
	Current medications: Lopatine
circle one:	Review dental record (chronic condition, recent extraction, etc):
sick call	
walk-in	O.) BP= 108/68 P= 74 R= 16 T= 97.7 WT= 150 #
declared E.R.	Bleeding: no
true E.R.	Redness or Swelling: no
	Injury to mouth/ gums/ teeth: no
	Identity of the tooth: LLV tooth Visible signs of decay: yes Loose: yes
	Is tooth positive to percussion: yes
	Oral hygiene: fair
	White patches/ discharge: no
	Earache or sore throat (examination if positive): no
	A.) Rx 400 mg PO BID x 3d / tooth ache
	P.) *Notify dentist or physician for specific orders if severe bleeding, facial swelling or pain, if tooth positive to percussion, secondary infection, or temp > 100.4:*
	If none of the above symptoms are present: The Nurse may offer Patient the choice of Ibuprofen 200 mg, two tablets BID p.o. x 3 days:
	or Tylenol 325 mg, 2 tabs p.o., tid prn pain x 3 days or until seen by dentist:
	Schedule for next dental call:
	E.) Instruct patient regarding proper oral hygiene: brush and floss properly after each meal. Place toothbrush at an angle against the gumline of your teeth. Scrub teeth with short, back and forth strokes, gently but firmly, at least a dozen times, brush your tongue. Repeat on all teeth inside and out. Scrub the backs of your front teeth with the tip of your toothbrush, finally scrub all chewing surfaces and then rinse mouth. Rinse toothbrush after every use and dry it off. Brush for a total of about 3 minutes:
	Instructed to return to medical if symptoms persist/worsen:
	Inmate verbalized understanding of above instructions:

(b)(6), (b)(7)(c)

NAME_ MANDZA, EVALIN
DOB: 12/5/1965 Nation: GABON
NUMBEI Arrival Date: 10/24/2011 17:05

DOB___

RSING SIGNATURE (b)(6), (b)(7)(c)

Medical Request /
Solicated De Asistencia Medica

Date of request: 12 / 14 / 11 (Please check one) Medical Complaint Dental Complaint
Fecha de Solicitud (Por favor marque uno) [X] Oueja medica [ ] Oueja Dental

Print / : Letra – Molde	Inmates Name / Nombre del Preso	Number Numero	Housing Location Sitio de Vivienda	Job Assignment Asignacion de Trabajo	Duty Hours Horas de Trabajo
Evelin Mendza AW	(b)(6), (b)(7)(c)		A3-206		

Briefly state the reason for your request; you will receive a response to your request. Please allow several days for your request to be submitted, answered, and returned. A copy of your request will be filed in your records.

Explique brevemente la razon de su solicitud. Permita varios dias para que su solocitud sea procesada. Una copia de su solicitud sear archivada en sus reocrds. Prisioneros de habla hispana pueden solicitar dicha assistencia enespanol.

PROBLEM / QUEJA: I FALL From the TAP bed, HURT My foot

Evelin Mendza
Inmate's Signature / Firma del Preso

=========DO NOT WRITE BELOW THIS LINE / NO ESCRIBA DEBAJO DE ESTA LINEA========

Date Received: 12/15/11 (Stamp Date)

Date Reviewed: 12/15/11 [ ] Written Response (see below) [X] Seen in Medical

ACTION TAKEN: Referred to Dr. (b)(6), (b)(7)(c) for further evaluation

[X] Placed on Sick Call List Date of Appointment: 12/15/11

[ ] Placed on Dental List Date of Appointment: ____/____/____

[X] Other (Explain): Seen by Dr. (b)(6), (b)(7)(c) on 12/15/11 orders made (b)(6), (b)(7)(c) LVN

The GEO Group, Inc.

HEALTH SERVICES
NURSING ASSESSMENT PROTOCOLS

MUSCULOSKELETAL TRAUMA PROTOCOL

DATE/TIME	S.) CHIEF COMPLAINT: Pain to (R) great toe ALLERGIES: NKDA
12/15/11	Time of onset: 0900 Activity at onset: from bed History of ulcers: NO
	Pain location: (R) great toe Constant/intermittent:
Circle one:	Character: cramping / stabbing / burning / sharp / dull Pain Intensity Scale 1-10:
Sick call	Radiation: yes/no History of previous injury to same site: yes/no When:
Walk in	Most comfortable lying / sitting / standing /rocking ? Able to sit still: yes/no
Self ER	Numbness/tingling: yes/no. location: Loss of consciousness: yes/no If so, how long:
True ER	Last tetanus date: (if > 5 yrs & skin broken, notify physician for order for booster).
05:30	Does anything help? yes/no what: Tried OTC medications: yes/no
	O.) Lying BP 105/70 P=69 normal /weak / bounding R 18 T 97.3 WT. 145.5
	Orthostatic (sitting) BP= 102/65 P= 70 (standing) BP= 102/66 P= 72
	Respiratory rhythm: even / uneven Unlabored / labored Shallow / normal /deep
	Heart sounds: regular / irregular
	Gait: steady / slightly unsteady / unable to stand
	Arrived at medical via: walk / wheelchair / stretcher
	Skin: normal /pale / flushed / diaphoretic describe location / degree:
	Abrasions/laceration: location: @ Size:
	Bleeding: yes/no amt: Sign of infection: yes/no describe:
	Swelling: yes/no site: Bruising: yes/no site: Redness: yes/no site:
	Range of motion: full / decreased:
	Capillary refill distal to injury: < 3 sec/sluggish / absent skin temp distal in injury:
	Peripheral pulses distal to injury: strong / weak / unable to palpate
	Overall appearance: no acute distress / mild distress / severe distress
	A.)
	P.) Applied ice x 24 hours (on 45, off 15) yes/no: elevated extremity: yes/no
	Apply warm compress x 48 hrs (after ice x 24) yes/no
	Immobilization: ace wrap applied (sprains only): yes/no If r/o fracture: sturdy splint
	Applied: yes/no type: Steri-strips applied: yes/no Dressing applied: yes/no
	Physician notified: yes/no time: Orders received: yes/no time: List:
	- Ibuprofen given as per orders
	Check q 2 hrs for increased swelling, discoloration, pain, peripheral pulse, R.O.M., numbness: yes/no
	Refer to next physician sick call yes/no 12/15/11
	Passes issued: yes/no type/exp. date:
	Disposition: dorm/infirmary / transfer to E.R. condition: stable / guarded / critical
	E.) Instructed to resume activity gradually: ~B
	If ankle/foot involved: stay off x 48 hrs: yes/no Instructed on use of ice pack/warm:
	Compresses: yes/no instructed to return to medical if symptoms persist/worsen: yes/no
	Inmate verbalized understanding: Y-B

NAME Mandza, Evalin

NUMBER ~~12/5/1965~~ (b)(6), (b)(7)(c)

DOB 12/5/1965

NURSING SIGNATURE (b)(6), (b)(7)(c) LPN

Medical Report on Injuries/Non-Injuries

The GEO Group, Inc.

(b)(6), (b)(7)(c)

Last Name: MANDZA, EVALIN st Name: _____ Middle Name: ____

DOB: 12/5/1965 Nation: GABON

Date of Birtl Arrival Date: 10/24/2011 17:05 nate Number: _____

Date of incident: 12-25-11 Time: 1140 ☒ AM ☐ PM Place: _____

Was it necessary to notify physician? ☐ Yes ☒ No Time of notification: N/A

Name of physician: N/A

Type of incident: ☐ Fighting _____ ☐ Use of Force _____

Other: _____

Injuries/non-injuries: _____

Head Area Examined: NO injury

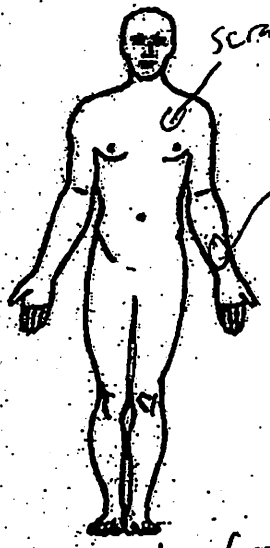
Face Area Examined: NO injury

Chest Area Examined: Tiny Scratches

Back Area Examined: NO injury

Arms Area Examined: Tiny Scratches Lt wrist area

Legs Area Examined: NO injury



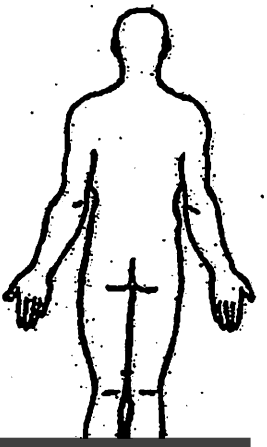
Illustrate on the diagram position or place of injury, if any:

THIS INJURY IS: ~~(CIRCLE ONE)~~

REPORTABLE NON-REPORTABLE

LAY-IN DATE:

START _____ STOP _____



Date of Exam: 12/25/11 Time: 1140 (AM) PM Signed (b)(6), (b)(7)(c)

(b)(6), (b)(7)(c)

IANDZA, EVALIN
DOB: 12/5/1965 Nation: GABON
Arrival Date: 10/24/2011 17:05

(b)(6), (b)(7)(c)

NDZA, EVALIN
B: 12/5/1965 Nation: GABON
ival Date: 10/24/2011 17:05

re-Segregation – History and Physical

The GEO Group, Inc.

INMATE NAME _____ INMATE NUMBER _____ D.O.B. _____
ALLERGIES: NKDA PRESENTLY ON MEDS: YES / NO
CHRONIC CLINICS: _____

WEIGHT: 151# TEMP: 97.5 PULSE: 89 RESP: 20 B/P: 157/83

CIRCLE APPROPRIATE RESPONSE

PHYSICAL OBSERVATIONS

GENERAL APPEARANCE
Clean Neat Dirty Disheveled

SKIN
- Turgor — Good / Poor
- Lacerations — Yes / No
- Contusions — Yes / No
- Bruises — Yes / No

RESPIRATORY
- Breath Sounds — Clear / Wheezing
- Dyspnea — Yes / No
- Cough/Congestion — Yes / No

CARDIOVASCULAR
- Rhythm — Yes / No
- Edema — Yes / No
- Chest Pain — Yes / No
- Bleeding Tendencies — Yes / No

GASTROINTESTINAL
- Distention — Yes / No
- Constipation/Diarrhea — Yes / No
- Nausea/Vomiting — Yes / No
- Abdominal Pain — Yes / No

GENITOURINARY
- Flank Pain — Yes / No
- Burning/Frequency — Yes / No
- Urination
- Discharge — Yes / No

GYN
- Pregnant
- Menses — N/A — Yes / No

Yes / No

COMMENTS REQUIRED ON ABNORMALITIES:

NEUROLOGICAL
1. Headache/Dizziness — Yes / No
2. Speech — Normal / Slurred
3. Pupils — Equal / Unequal; Reactive / Nonreactive
4. Gait — Normal / Abnormal

PSYCHIATRIC
1. Orientation — Person / Place / Time
2. Coherence of Thought Process — Organized / Disorganized; Logical / Illogical; Obsessive / Delusional
3. Emotional State — Social / Withdrawn; Agitated / Listless; Anxious / Fearful; Negative / Childlike

MUSCULOSKELETAL
1. Range of Motion
2. Upper Extremities — Normal / Limited
3. Lower Extremities — Normal / Limited

CLEARED FOR AD. SEG. Yes / No

REFERRED FOR FURTHER EVALUATION

Psych. Services _____ M.D. _____

EXAMINER: (b)(6), (b)(7)(c) LPN
(b)(6), (b)(7)(c) TITLE: _____

DATE: 12/25/11 TIME: 11:40 A.M./P.M.

ALL FORMS MUST BE COUNTERSIGNED WITHIN SEVENTY-TWO HOURS

PHYSICIAN: (b)(6), (b)(7)(c)

DATE/TIME: 12-27-11

Special Management Unit Housing Record

Name of Detainee: MENDOZA, EVELIN GABRIEL A#: (b)(6), (b)(7)(c) Room# 117

Violation or Reason: 201 FIGHTING / HORSEPLAY Date Received: 12-25-11 Time Received: 1153

Admittance Authorized by: LT. (b)(6), (b)(7)(c) Date Released: 12/27/11 Time Released 2017

Pertinent Information:

Administrative Segregation ☐ Protective Custody/Special Management ☐ Disciplinary Segregation ☐ Medical Observation ☐

Date	Shift	B	L	D	Sh	Rec	Medical*	Housing Officer	Comments- Use Reverse side if required
12/25/11	2nd		N		N	N		(b)(6), (b)(7)(c)	(b)(6), (b)(7)(c)
	3rd			Y	Y	N			
	1st	Y					(b)(6), (b)(7)(c)		
12/26/11	2nd		Y		R	N/A	O/R-S		
	3rd			Y	R	N			
	1st	Y					(b)(6), (b)(7)(c)		
12/27/11	2nd		Y		Y	O/R	O/R-S		
	3rd			Y	N	N			
	1st								
	2nd								
	3rd								
	1st								
	2nd								
	3rd								
	1st								
	2nd								
	3rd								
	1st								
	2nd								
	3rd								
	1st								

Pertinent information - Epileptic, Diabetic, Suicidal, Assaultive, etc.

B (Breakfast) L (Lunch) D (Dinner) **Shower**–Indicate Yes (Y); No (N); Refused (R)
Rec (Recreation) – log in actual time, i.e., 0900/1000

Medical staff will sign the segregation log and the housing unit record each time a detainee is seen. At a minimum, the unit record must be signed at last once each day by a qualified medical staff member.

Comments: i.e., Conduct, Attitide, etc. Additional comments on reverse side must include date, siganture, and titie.

Housing Unit Officer Signature: Assigned officer must sign all record sheets each shift.

MEMORANDUM

The GEO Group, Inc.

Date: Dec 25, 2011

To: Warden

From: Shift Supervisor

RE: ADMINISTRATIVE SEGREGATION ORDER

Mandza, Evalin-Ali (b)(6), (b)(7)(c)
Detainee Name ID#

The above named detainee is to be admitted to **Administrative Segregation** for the following reason(s):

X (A) Is pending an investigation/hearing for the commission of a prohibited act or rule violation and requires pre-hearing detention

_____ (B) Is under medical observation (medical staff must comment and sign this order

_____ (C) Is pending a transfer or release within 24 hours (only required if for security reasons or for the orderly operation of the facility)

_____ (D) Is terminating confinement in Disciplinary Segregation and has been ordered in Administrative Segregation by the Institutional Disciplinary Panel

_____ (E) Is a security risk to him/herself or the security of the facility

_____ (F) Detainee has requested or an order for admission for Protective Custody exists, I hereby request placement in the Administrative Segregation unit for my own protection

_____ (b)(6), (b)(7)(c) _____
Detainee Signature ID# Date

_____ (G) Placed in Administrative Segregation as a result of a Level 3 Classification

Record a brief outline of the circumstances and names of any witnesses to events leading to this placement:
Detainee placed in Administrative Segregation for horseplay with another detainee

Medical Staff Signature: _____ (b)(6), (b)(7)(c) _____ Date: 12/25/11

Supervisor Signature: Lt. _____ Date: 12/25/2011

Admitted by: Lt. (b)(6), (b)(7)(c) Title: WATCH Commander
Admitted: (Date) 12/25/2011 Time: 1129 hours

Released by: _____ (b)(6), (b)(7)(c) Title: _____
Released: (Date) 1/2/14 Time: 0014

Reviewed by: _____ Date: _____
(Facility Administrator or Designee)

I have received a copy of this Administrative Segregation Order X _____ (b)(6), (b)(7)(c) 12-25-04
Detainee Signature / ID# / Date

Detainee Copy

INCIDENT OF PROHIBITED ACTS AND NOTICE OF CHARGES

Detainee Name: Mandza Evalin Ali A-Number: (b)(6), (b)(7)(c)

ID#: _____ Nationality: _____

Date & Time of Incident: 12/25/11 @ 1105 Housing Assignment: A3

Incident Location: A3 - 206 Work Assignment: _____

Classification Level: _____

~~PROHIBITED ACTS:~~

1. Fighting, boxing, wrestling, sparring, and any Code: 201
2. other form of physical encounter including horseplay Code: _____
3. _____ Code: _____
4. _____ Code: _____

Description of Incident:

On 12-25-11 aud approximal 1105 detainee (b)(6), (b)(7)(c) (b)(6), (b)(7)(c) had brought to D/O (b)(6), (b)(7)(c) attention that he is been pushed around in cell 206 by Mandza Evalin Ali. Detainee Mandza Evalin Ali responded that he also been pushed around in the cell 206 by detainee (b)(6), (b)(7)(c) LT. (b)(6), (b)(7)(c) was called by D/O (b)(6), (b)(7)(c) and both detainees were transfered to E1 Segregation. End of the report

Staff Witnesses: Y (N) Evidence Attached: Y N N/A

Supporting Reports: Y N N/A

(b)(6), (b)(7)(c)
Name of Reporting Officer

12-25-11 @ 1230
Date & Time

(b)(6), (b)(7)(c)
Signature

Reviewed for accuracy prior to investigation by: (b)(6), (b)(7)(c)
Supervisor

12/25/2011 1105 hours
Date and Time

Classification Level Change: (Y) N Level change from L2 to L3

The GEO Group, Inc.

HEALTH SERVICES
NURSING ASSESSMENT PROTOCOLS

MUSCULOSKELETAL PAIN PROTOCOL

(b)(6), (b)(7)(c)

DATE/TIME: 12/30/11 1625

S.) CHIEF COMPLAINT: (R) ~~ankle~~ big toe — ALLERGIES: NKDA

Time of onset: 1605 — Activity at onset: playing soccer

Pain location: (R) big toe — Radiation: up foot

Circle one: sick call / walk-in / self ER / true ER

Character/type of pain: sharp pain

~~Constant~~ or intermittent:

Cause or injury: fell playing soccer — Pain Intensity Scale 1-10: 7-8/10

Medications:

Numbness or tingling: NO

O.) BP= 120/81 P= 71 R= 17 T= 96.3 WT= 145

Respiratory rhythm: even, regular — Lung sounds: clear

Method of arrival to medical: walking — Heart sounds: regular rhythm

Gait: limp favoring (R) side — Able to get on and off table: yes

Abrasions/bleeding: No

Bruising: None noted — Swelling: slight

Range of motion: a lot of pain with flexion

Presence of muscle spasms or tightness on palpation: NO

Skin *(distal to injury)*: ~~normal~~ (warm/pink/dry) / pale / flushed / cyanotic / mottled / diaphoretic / cool / dusky:

Capillary refill *distal to injury*: 2 seconds

Peripheral pulses *distal to injury*: N/A

Overall appearance: no acute distress/ mild distress/ moderate distress/ severe distress

A.)

P.) Elevate extremity and Apply cold compresses/ice packs for 24 hrs (on 45 min/ off 15):

Use local heat after acute phase resolution (warm compresses): NO

If sprain: give Ace wrap or splint: No

If leg/foot involved: issue crutches & pass: NO

Give recreation restriction pass to rest affected muscles/joints: NO

The Nurse may offer Patient the choice of Aspirin or Acetaminophen 325 mg, two tablets bid p.o. x 3 days : *or* Ibuprofen 200 mg, two tablets bid p.o. x 3 days:

The Nurse may also offer Patient I small tube of analgesic balm to apply to affected area twice daily.

If severe pain, compartment syndrome, or fracture is suspected, notify physician for specific orders:

E.) Instructed patient to avoid heavy lifting, strenuous work/sports activity until problem resolved, to resume activity *gradually*, and return to medical if problem persists or worsens: yes

Instructed to keep extremity elevated and use cold/warm compresses in dorm: yes

Instructed to avoid contact with balm/ointment in or around the eyes: yes

Instructed on benefits of regular exercise, slowly progressing to 20 minutes QD 3x weekly *after clearance from physician*: yes

(b)(6), (b)(7)(c)

NAME: MANDZA, EVALIN

DOB: 12/5/1965 Nation: GABON

ABE Arrival Date: 10/24/2011 17:05

(b)(6), (b)(7)(c) RN

Evalin Manoza

Medical Request/ Solicated De Asistencia Medica

The GEO Group, Inc.

(b)(6), (b)(7)(c)

Date of request: 01/13/12
Fecha de Solicitud

(Please check one)
(Por favor marque uno)

☐ Medical Complaint
Oueja medica

☒ Dental Complaint
Oueja Dental

Manoza, Evalin-Al'

Print/:

(b)(6), (b)(7)(c)

Letra-Molde Inmates Name/ Nombre del Preso	Number/ Numero	Housing Location/ Sitio de Vivienda	Job Assignment/ Asignacion de Trabajo	Duty Hours/ Horas de Trabajo

Briefly state the reason for your request; you will receive a response to your request. Please allow several days for your request to be submitted, answered, and returned. A copy of your request will be filed in your records.

Explique brevemente la razon de su solicitud. Permita varios dias para que su solicitud sea procesada. Una copia de su solicitud sera archivada en sus records. Prisioneros de habla hispana pueden solicitar dicha assistencia en espanol.

PROBLEM/QUEJA: Dental problem

Inmate's Signature/Firma del Preso

DO NOT WRITE BELOW THIS LINE/NO ESCRIBA DEBAJO DE ESTA LINEA

Date Received: _____ (Stamp Date)

Date Reviewed: 1/15/12 ☐ Written Response (see below) ☒ Seen in Medical

ACTION TAKEN: Referred to Dental 1/16/12

☐ Placed on sick call list Date of Appointment: ____/____/____

☐ Placed on Dental list Date of Appointment: ____/____/____

☐ Other (Explain): _____

(b)(6), (b)(7)(c)

Medical Staff Signature

1/15/12
Date

The GEO Group, Inc.

Medical Request/
Solicated De Asistencia Medica

Date of request: 01 / 15 / 12 (Please check one) Medical Complaint ☒ Dental Complaint ☒
Fecha de Solicitud (Por favor marque uno) Oueja medica Oueja Dental

Print/: Letra-Molde	Inmates Name/ Nombre del Preso	Number/ Numero	Housing Location/ Sitio de Vivienda	Job Assignment/ Asignacion de Trabajo	Duty Hours/ Horas de Trabajo
	Evalin Mandza	(b)(6), (b)(7)(c)	A3-105		

Briefly state the reason for your request; you will receive a response to your request. Please allow several days for your request to be submitted, answered, and returned. A copy of your request will be filed in your records.

Explique brevemente la razon de su solicitud. Permita varios dias para que su solicitud sea procesada. Una copia de su solicitud sera archivada en sus records. Prisioneros de habla hispana pueden solicitar dicha assistencia en espanol.

PROBLEM/QUEJA: Dental Problem. / I need to Keeping taking the constipation suppo. that help. thanks

Inmate's Signature/Firma del Preso

DO NOT WRITE BELOW THIS LINE/NO ESCRIBA DEBAJO DE ESTA LINEA

Date Received: _____ **(Stamp Date)**

Date Reviewed: 1/16/12 ☐ **Written Response (see below)** ☒ **Seen in Medical**

ACTION TAKEN: Not given anything for dental b/c already on Ibuprofen 800mg prn. Scheduled to see Dr (b)(6), (b)(7)(c) 1-18-12 to discuss glycerine supp. Scheduled to see Dr (b)(6), (b)(7)(c) 1/16/12 to discuss dental problem (b)(6), (b)(7)(c) RN

☒ **Placed on sick call list** (b)(6), (b)(7)(c) **Date of Appointment:** 1 / 18 / 12

☒ **Placed on Dental list** **Date of Appointment:** 1 / 16 / 12

☐ **Other (Explain):** _____

(b)(6), (b)(7)(c) RN 1/16/12

Medical Staff Signature **Date**

The GEO Group, Inc.

HEALTH SERVICES
NURSING ASSESSMENT PROTOCOLS

ABDOMINAL PAIN/CONSTIPATION/DIARRHEA/INDIGESTION/VOMITING PROTOCOL

DATE/TIME	
1/16/12	S.) CHIEF COMPLAINT: Constipation ALLERGIES: N/A
0902	History of ulcers / gallbladder disease/ appendicitis / recent abdominal surgeries/ recent weight change (# lbs): No
	Time/Activity at onset: unsure After eating, does pain increase / decrease / ~~remain same~~:
	Pain location: Abd , Radiation: yes/no Duration: couple days Constant or Intermittent:
	Current medications: Motrin, Colace, Fiber Alleviating factors: None
Circle one:	Character: Cramping / stabbing / burning / sharp / dull Flatus: yes Pain Intensity Scale 1-10: 3/10
Sick call	Last BM: 1/14/12 Consistency: hard Amt: little Blood (if yes, red / black/ or maroon, and amt): None
walk-in	Constipation: Yes Diarrhea (Frequency/amt): No
Self declared ER	Nausea/vomiting: No Describe frequency/amt/color: N/A
true ER	Heartburn or indigestion: No Frequently / Occasionally / N/A Degree: mild / mod / severe
	Urinary frequency: No Burning: No Penile discharge: No Low back pain: No
	Dietary habits: Fat intake: Nothing from commissary Alcohol intake: No Caffeine intake: 1 cup/day
	Smoking habits: None
	O.) BP= 104/64 P= 75 Normal/weak/bounding 97% R= 17 T= 96.5 WT. 156.
	Bowel sounds: normal / hypo / hyper / absent Heard in all 4 quadrants: yes Guarding: No
	Rebound tenderness: No Jaundice: No If states blood in stool, do hemocult. Results: N/A
	Pain location: None
	Description of observed vomitus/stool: N/A
	More comfortable: lying / sitting / standing N/A Able to sit still: yes
	Skin: normal (warm & dry) / pale / flushed / cyanotic / diaphoretic
	Abdomen: soft / rigid Degree: mild / moderate / severe / n/a Bladder distended: No
	Evidence of dehydration / GI bleeding: No If yes, orthostatic BP= N/A P= N/A
	Overall appearance: no acute distress / mild distress / severe distress Obvious anxiety: No
	A.)
	P.) The Nurse may offer Patient the choice of Antacid, Milk of Magnesium, Kaopectate, Emetrol,
	Peptobismuth, Dulcolax, bulk laxative) Type/dose: No
	Give according to label instructions.
	If vomiting or diarrhea, give clear liquid diet x 24 hrs and lay-in pass, unless otherwise ordered: No
	If blood in stool, vomiting, or severe diarrhea, place in infirmary/observation, unless otherwise ordered: No
	If fever above 100.4 F, nausea or vomiting accompanying constipation, absent bowel sounds, blood in stool, all HIV + inmates with diarrhea, diarrhea that lasts longer than 24 hrs after treatment, or if pt does appear ill, and there is pain upon palpation, the physician must be notified for specific orders:
	Scheduled to see Dr (b)(6), (b)(7)(c) 1/19/12. Dct requesting glycerine supp.
	E.) Instructed to avoid spicy foods, eat small meals, chew slowly & thoroughly, and drink 6-8 glasses water daily: Yes
	Instructed not to lie down at least 2 hrs after eating: No Caution to quit smoking: No
	Instructed on stress relief measures, high fiber diet, and adequate exercise: Yes Return if symptoms persist/worsen: Yes
	Inmate verbalized understanding of above instructions: Yes

NAME (b)(6), (b)(7)(c) MANDZA, EVALIN

NUMBER DOB: 12/5/1965 Nation: GABON

DOB Arrival Date: 10/24/2011 17:05

NURSING SIGNATURE (b)(6), (b)(7)(c) RN

INVESTIGATION REPORT

Detainee Name: Manoza-Evalin-Ali A#: (b)(6), (b)(7)(c)

Date & Time of Incident: 1/18/12 0620 Place of Incident: A3-unit

Housing Assignment: A3-105 Date of Investigation: 01-18-12 Code(s): 307-314

Name of Investigating Officer: Lt. (b)(6), (b)(7)(c) advised

(b)(6), (b)(7)(c) (Detainee A#) that he/she has the right to remain silent at stages of the disciplinary process, but, that silence may be used to draw an adverse inference against him/her at any stage of the disciplinary process. However, silence alone may not be used to support a finding that he/she committed a prohibited act:

Detainee Statement and Attitude during the Interview: Detainee Manoza-Evalin stated I wanted to talk with the Lieutenant before I moved from my cell. I wanted to know why I was being moved from my cell. Attitude was good during interview

Other Facts About the Incident (i.e. witness statements, disposition of evidence, etc.): Detainee Manoza-Evalin admitted he refused to move unless he spoke with the Lieutenant.

Investigator's Comments and Conclusions: Detainee guilty of codes 307 and 314 based on his own self admission to charges. Refer to UDC.

Date and Time Investigation Began: 1-18-12 1105 hours

Date and Time Investigation Ended: 1-18-12 1110 hours

Lt. (b)(6), (b)(7)(c)

Signature of Investigating Officer

Reviewed for Accuracy by Supervisor

INSTITUTION DISCIPLINARY PANEL REPORT

Detainee Name: Mandza, Evelin-Ali A-Number: (b)(6), (b)(7)(c)

Date of Incident: 1/18/2012 Code(s): 307, 314

I. Notice of Charge(s):

A. Advance written notice of charge(s) (copy of Incident Report) was given to the detainee on _____ (Date) at _____ (Time).

B. The IDP hearing was held on _____ (Date) at _____ (Time).

C. The detainee was advised of his/her rights before this IDP by _____ (Officer) on _____ (Date) and a copy of the advisement of rights form is attached.

II. Staff Representative:

A. Detainee waived his/her rights to staff representative: _____

B. Detainee requested staff representative and _____ (Staff Representative) appeared.

C. Requested staff representative declined or could not appear but detainee was advised of option to postpone hearing to obtain an alternative staff representative with the following result :_____

III. Presentation of Evidence:

A. Detainee has been advised of his/her right to present a statement or to remain silent, to present documents, including written statements of unavailable witnesses, and for relevant and material witnesses to appear on his/her behalf.

B. Summary of detainee's statement: _____

C. Witnesses:

1. The following persons were called as witnesses at this hearing and appeared: _____
2. A summary of testimony of each witness is attached.
3. The following persons requested were not called for the reason(s) given: _____
4. Unavailable witnesses were requested to submit written statements and those statements received were considered (statements attached).
5. Documentary Evidence: In addition to the incident report and investigation, the panel considered the following documents: _____
6. Confidential information was considered by the IDP and was not provided to the detainee on _____ (Date)

IV. Findings:

_____ a. The Act was Committed as Charged
_____ b. The Following Act was Committed: _____
_____ c. No Prohibited Act was Committed

V. Specific Evidence Relied on to Support Findings :

_____
_____
_____

VI. Sanctions or Action Taken: Offense Severity:

_____
_____
_____

VII. Reason for Sanction or Action Taken:

_____
_____
_____

_____ _____
Hearing Board Chairperson Date

_____ _____
Hearing Board Member Date

_____ _____
Hearing Board Member Date

VIII. Review and Concur:

A. Concur with findings: _____
B. Proceedings terminated: _____
C. Discipline Imposed: _____

Findings Administrator's Signature: _____ Date/Time: _____

Copy delivered to detainee by: _____ on _____
(Signature and Title) (Date)

The GEO Group, Inc.

Incident of Prohibited Acts and Notice of Charges

Aurora/I.C.E. Processing Center

Detainee Name: Mandza Evalin-Ali
A-Number: (b)(6), (b)(7)(c)
ID#: N/A
Nationality: Gabon
Date & Time of Incident: 1-18-12 0620
Housing Assignment: A-3
Incident Location: Cell 105
Work Assignment: none
Classification Level: level 2

Prohibited Acts:

1. Refusing to obey a staff member	code: 307
2. Interfering with count	code: 314
3.	code:
4.	code:

Description of Incident:

Please Print – who, what, when, where, how, & why. You must state facts (absolutely no editorializing)

On 1-18-12 at about 0600. Detainee (b)(6), (b)(7)(c) approached me D/O (b)(6), (b)(7)(c) and asked to speak with the Lt. about detainee Mandza Evalin-Ali (b)(6), (b)(7)(c) Lt. (b)(6), (b)(7)(c) gave orders to move Mr Mandza to another cell. At about 0620 I D/O (b)(6), (b)(7)(c) gave Mr. Mandza a direct order several times to pack his belongings but he refused and said that he needed to speak with Lt. (b)(6), (b)(7)(c) I then explained to him that we were starting count and he was interfering with count. Mr. Mandza sat outside the cell in the day area during count. Lt. (b)(6), (b)(7)(c) came to A-3 at 0635 and ordered him to medical via Segregation. Lt. (b)(6), (b)(7)(c) advised me to do a charge packet for refusing to obey a direct order and interfering with count. END OF REPORT

SUPERVISOR'S REMARKS:
N/A

Evidence Attached?: ☐ Yes No ☒ N/A Supporting Reports?: ☒ Yes ☐ No ☐ N/A

Staff Witnesses?: ☒ Yes ☒ No

Reporting Officer: Date & Time: 1-18-12 0734 D/O (b)(6), (b)(7)(c)

Signature

Reviewed for accuracy prior to investigation by: (b)(6), (b)(7)(c)

Supervisor Signature

Classification Level Change?: ☒ Yes ☐ No

Level change from level 2 to level 3.

X Ellen Mankin
1/19/2012

NOTICE OF INSTITUTION DISCIPLINARY PANEL HEARING

AVISO DE LA AUDIENCIA DISCIPLINARIA DEL PANEL DE LA INSTITUCION

Detainee Name: Mandza, Evelin-Ali A-Number: [redacted]

Date: 1/19/12 Alleged Disciplinary Violation(s): 307, 314 Date of Offense: 1/18/12

You are being referred to the Institution Disciplinary Panel for the above-mentioned charge(s).

Le están refiriendo el panel disciplinario de la institución para las cargas.

The hearing will be held on the next available business day (within prescribed times), at 0730-1600 hours (time) at the following location The GEO Group Inc. I.C.E. Processing Center.

La audiencia será llevada a cabo en el día laboral disponible próximo (dentro de épocas prescritas), en 0730-1600 horas (tiempo) en la localización siguiente Los GEO Group, Inc. I.C.E. Proceso del centro.

You are entitled to have a full time staff member represent you at the hearing. Please indicate below if you desire to have a staff member assist you, and if so, his or her name.

Le dan derecho a hacer que un miembro a tiempo completo del personal le represente en la audiencia. Indique por favor abajo si usted desea tener una ayuda del miembro del personal usted, y si es así su nombre.

I (do) _____ (do not) _____ wish to have a staff representative.

If so, the staff representative's name is: _____

You also have the right to call witnesses at the hearing ant to present documentary evidence on your behalf; provided, that calling your witnesses will not jeopardize facility security. Names of witnesses you wish to call should be listed below. State below what each proposed witness would be able to testify to **(be specific)**

Usted también tiene la derecha de llamar testigos en la audiencia y de presentar certificado justificativo en su favor; con tal que, eso que llama sus testigos no comprometa seguridad de facilidad. Los nombres de testigos que usted desea llamar se deben enumerar abajo. El estado debajo de cual podría cada testigo propuesto atestiguar **(sea especifico)**:

Name: _____ A-Number: _____ Can testify to: _____

Name: _____ A-Number: _____ Can testify to: _____

Name: _____ A-Number: _____ Can testify to: _____

The chairperson of the Institution Disciplinary Panel will call those listed above as witnesses (staff or detainee) who are reasonably available, and who are determined by the chairperson to be necessary for an appreciation of all the circumstances surrounding the charge(s). Representative witnesses need not be called. Unavailable witnesses may be asked to submit written statements. If additional space is required, use the reverse side of this form.

El presidente del panel disciplinario de la institución llamara esos enumerados arriba como testigos (personal o detainee) que estén razonablemente disponibles, y que son determinados por el presidente para ser necesarios para un aprecio de todas las circunstancias que rodean las cargas. Los testigos repetidores no necesitan ser llamados. Los testigos inasequibles se pueden someter declaraciones escritas. Si se requiere el espacio adicional, utilice el dorso de est.

DETAIEE RIGHTS AT THE INSTITUTIONAL DICIPLINARY PANEL HEARING (IDP)

EL DETAINEE ENDEREZA EN LA AUDIENCIA DISCIPLINARIA INSTITUCIONAL del PANEL (IDP)

1. The right to have a written copy of the charge(s) against you at least 24 hours prior to appearing before the IDP.
2. The right to have a full time member of staff who is reasonably available to assist you before the IDP.
3. The right to call witnesses and present documentary evidence in your behalf, provided institutional safety would not be jeopardized.
4. The right to remain silent. Your silence may be used to draw an adverse inference against you. However, your silence alone may not be used to support a finding that you committed a prohibited act.
5. The right to be present throughout the IDP decision, except during committee deliberations and where institutional safety would be jeopardized.
6. The right to be advised of the IDP decision in writing and the facts supporting the panel's decision, except where institutional safety would be jeopardized.
7. The right to appeal the decision of the IDP by means of the Detainee Grievance Procedure to the Facility Administrator within 15 days of the notice of the panel's decision and disposition.

Como un detainee cargó con un acto prohibido, usted se ha referido el panel disciplinario de la institución para la disposición. Mientras que en la audiencia de IDP, usted tiene las derechas siguientes:

1. El derecho de tener una copia escrita de las cargas contra usted por lo menos 24 horas antes de aparecer antes del IDP.
2. El derecho de tener un miembro a tiempo completo del personal que está razonablemente disponible para asistirle antes del IDP.
3. El derecho de llamar testigos y de presentar certificado justificativo en su favor, con tal que la seguridad institucional no fuera comprometida.
4. El derecho de seguir siendo silencioso. Su silencio se puede utilizar para dibujar una inferencia adversa contra usted. Sin embargo, su silencio solamente no se puede utilizar para apoyar encontrar que usted cometió un acto prohibido.
5. El derecho de estar presente a través de la decisión de IDP, excepto durante deliberaciones del comité y donde estaría la seguridad institucional en peligro.
6. El derecho de ser aconsejado de la decisión de IDP en la escritura y de los hechos que apoyan la decisión del panel, a menos que cuando sea institucional la seguridad fuera comprometida.
7. El derecho de abrogar la decisión del IDP por medio del procedimiento del agravio del Detainee al administrador de la facilidad en el plazo de 15 días del aviso de la decisión y de la disposición del panel.

I hereby acknowledge that I have been advised of and understand the rights afforded me at the Institution Disciplinary Panel Hearing.

Reconozco que me han aconsejado de y entiendo por este medio que las derechas me produjeron en la audiencia disciplinaria del panel de la institución.

Signed: _____ A#: (b)(6), (b)(7)(c) Date: 1/19/2012

Notice of Rights given to detainee by: (b)(6), (b)(7)(c) _____

Refusal to Sign

I have personally advised _____ of the rights afforded detainees at the Institution Disciplinary Panel hearing. The detainee refused to sign the acknowledgement.

Staff Member and Date: _____

Waiver of 24 hours Notice

I have been advised that I have at least a 24-hour notice prior to appearing before the IDP. At this time I wish to waive this right and proceed with the IDP hearing.

Me han aconsejado que tenga por lo menos 24 avisos de la hora antes de aparecer antes del IDP. En este tiempo deseo renunciar a esta derecha y proceder con la audiencia de IDP.

Detainee Signature/Date and Time: _____

UNIT DISCIPLINARY COMMITTEE REPORT OF FINDINGS AND ACTIONS

Detainee Name: Mandza. Evalin-Ali A-Number: (b)(6), (b)(7)(c)

Date of Incident: 01/18/2012

Incident Location: A-3 Housing Unit Prohibited Code(s): 307. 314

Committee Action: Comments to Committee from Detainee regarding the above Incident: Interviewed Detainee Mandza (b)(6), (b)(7)(c) stated under his own admittance that he refused to move unless he spoke with the lieutenant.

It is the Finding of the Unit Disciplinary Committee that:

1. You committed the Prohibited Ac as Charged: Code(s): 307. 314
2. You committed the following Prohibited Act: Code(s): 307. 314
3. You did not commit a Prohibited Act as charged: N/A

Committee Findings are based on the Following Information (witnesses, confidential information, etc. NOT officer's reports): Detainee Mandza was found guilty of the above codes and given a warning.

Committee Action:

[ ] Refer to IDP Date & Time: January 19, 2012 / 1310

[ ] Loss of Privileges [ ] Loss of Job [ ] Housing Changes

[ ] Restrict to Dorm [ ] Remove from Program [ ] Reprimand

[X] Warning [ ] Confiscate Contraband [ ] Impound Personal Property

Comments: Detainee Mandza was found guilty and given a warning and to be moved back to the housing unit.

UDC Chairperson's Signature (b)(6), (b)(7)(c) Date/Time: 01/19/2012/1330

UDC Member's Signature: (b)(6), (b)(7)(c) Date/Time: N/A

Copy delivered to detainee by n 1/30/12 (Date)

Rev. 3/05

Pre-S [redacted] ysical

The GEO Group, Inc.

MANDZA, EVALIN

INMATE NAME _____ DOB: 12/5/1965 Nation: GABON
ALLERGIES: NKDA Arrival Date: 10/24/2011 17:05
CHRONIC CLINICS: NO

_____ D.O.B. _____
ON MEDS: YES / NO

WEIGHT: 155 TEMP: 98.6 PULSE: 102 RESP: 16 B/P: 147/83

CIRCLE APPROPRIATE RESPONSE

PHYSICAL OBSERVATIONS

GENERAL APPEARANCE
(Clean) Neat Dirty Disheveled

SKIN
- Turgor — (Good) / Poor
- Lacerations — Yes / (No)
- Contusions — Yes / (No)
- Bruises — Yes / (No)

RESPIRATORY
- Breath Sounds — (Clear) / Wheezing
- Dyspnea — Yes / (No)
- Cough/Congestion — Yes / (No)

CARDIOVASCULAR
- Rhythm — reg/WNL
- Edema — (Yes) / No
- Chest Pain — Yes / (No)
- Bleeding Tendencies — Yes / (No)

GASTROINTESTINAL
- Distention — Yes / (No)
- Constipation/Diarrhea — Yes / (No)
- Nausea/Vomiting — Yes / (No)
- Abdominal Pain — Yes / (No)

GENITOURINARY
- Flank Pain — Yes / (No)
- Burning/Frequency — Yes / (No)
- Urination — Yes / (No)
- Discharge — Yes / (No)

GYN
- Pregnant — Yes / No
- Menses — N/A — Yes / No

COMMENTS REQUIRED ON ABNORMALITIES:

No physical confirmation, just allegiance

NEUROLOGICAL

1. Headache/Dizziness — Yes / (No)
2. Speech — (Normal) / Slurred
3. Pupils — (Equal) / Unequal; (Reactive) / Nonreactive
4. Gait — (Normal) / Abnormal

PSYCHIATRIC

1. Orientation — (Person) / (Place) / (Time)
2. Coherence of Thought Process — (Organized) / Disorganized; (Logical) / Illogical
3. Emotional State — Obsessive / Delusional; Social / (Withdrawn); (Agitated) / Listless; Anxious / (Fearful); Negative / Childlike

MUSCULOSKELETAL

1. Range of Motion
2. Upper Extremities — (Normal) / Limited
3. Lower Extremities — (Normal) / Limited

CLEARED FOR AD. SEG. (Yes) / No

REFERRED FOR FURTHER EVALUATION

Psych. Services _____ M.D. _____

EXAMINER: [redacted] TITLE: RN

DATE: _____ TIME: __ : __ A.M./P.M.

ALL FORMS MUST BE COUNTERSIGNED WITHIN SEVENTY-TWO HOUR[redacted]

PHYSICIAN: [redacted]

DATE/TIME: [redacted]

DETAINEE CLASSIFICATION SYSTEM – SECONDARY ASSESSMENT FORM

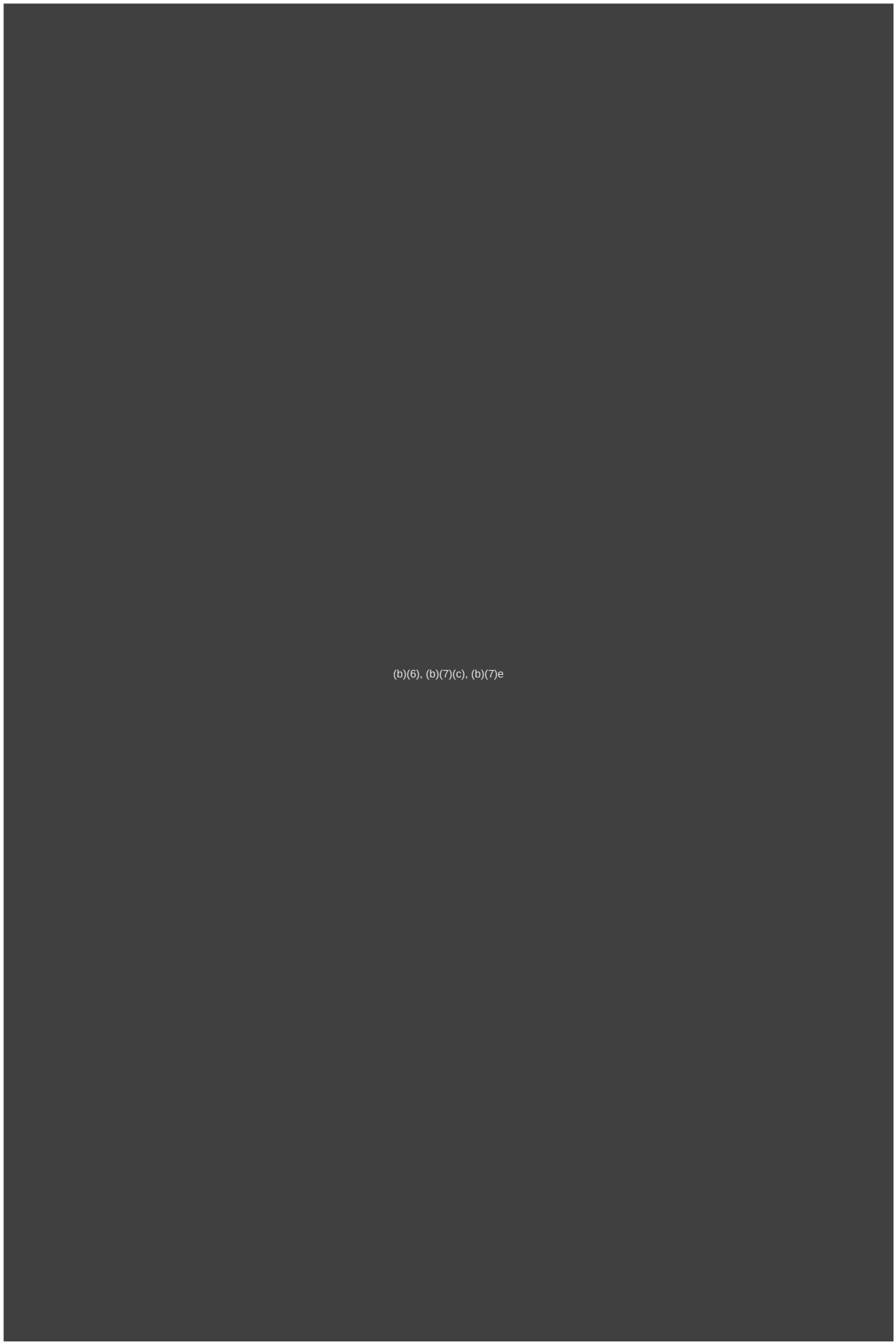
Name: MANZA, EVALIN-ALI A#: (b)(6), (b)(7)(c)

Date of Birth: 12/05/65 Country of Citizenship: GAB

Classified By: (b)(6), (b)(7)(c) ID#: — Date: 12-26-2011

Language: (English (Y) / N) Other: _____

(b)(7)e


(b)(6), (b)(7)(c), (b)(7)e

DETAINEE CLASSIFICATION SYSTEM – SECONDARY ASSESSMENT FORM

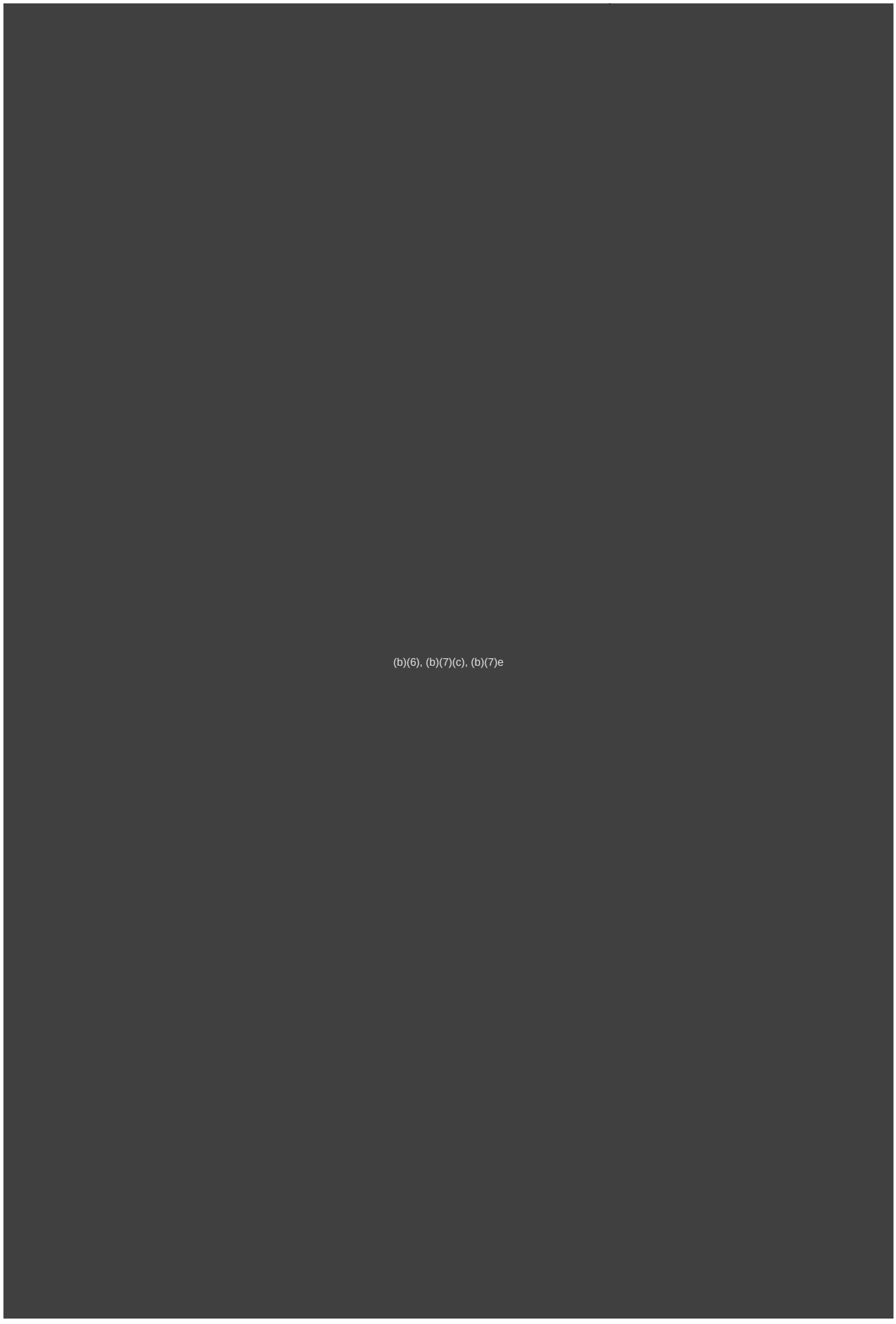
Name: Manchez-Eval A#: (b)(6), (b)(7)(c)

Date of Birth: 12/5/85 Country of Citizenship: Gabon

Classified By: (b)(6), (b)(7)(c) ID#: _____ Date: 1/20/12

Language: (English Y / N) Other: _____

(b)(7)e


(b)(6), (b)(7)(c), (b)(7)e

(b)(6), (b)(7)(c)

From: (b)(6), (b)(7)(c)
Sent: Tuesday, May 22, 2012 5:33 PM
To: (b)(6), (b)(7)(c)
Subject: FW: mandza

From (b)(6), (b)(7)(c)
Sent: Mon 5/7/2012 4:08 PM
To: (b)(6), (b)(7)(c)
Subject: mandza

Unit	Floor	Block	Cell	Bed	Assigned	Removed	Updated By
A4	NA	A	110	2HC	04/11/2012 14:48:00	04/12/2012 08:33:00	(b)(6), (b)(7)(c)
HOLDING UNIT	NA	02	NA	02	04/11/2012 13:34:00	04/11/2012 14:48:00	(b)(6), (b)(7)(c)
A4	NA	A	110	2HC	03/10/2012 00:39:00	04/11/2012 13:34:00	
A3	NA	A	110	2HC	01/20/2012 10:48:00	03/10/2012 00:39:00	
E1	NA	E	106	01	01/18/2012 06:47:00	01/20/2012 10:48:00	
A3	NA	A	207	02	01/18/2012 06:25:00	01/18/2012 06:47:00	
A3	NA	A	105	02	01/03/2012 13:06:00	01/18/2012 06:25:00	
A3	NA	A	105	01	12/29/2011 04:00:00	01/03/2012 13:06:00	
A3	NA	A	110	1HC	12/29/2011 03:43:00	12/29/2011 04:00:00	
A3	NA	A	109	01	12/27/2011 17:17:00	12/29/2011 03:43:00	
E1	NA	E	117	01	12/25/2011 13:00:00	12/27/2011 17:17:00	
A3	NA	A	206	01	11/28/2011 16:05:00	12/25/2011 13:00:00	
A3	NA	A	109	03	11/15/2011 19:06:00	11/28/2011 16:05:00	
A2	NA	A	201	03	10/24/2011 18:41:00	11/15/2011 19:06:00	

(b)(6), (b)(7)(c)

Progress Notes

The GEO Group, Inc.

Site: Aurora / ICE Processing Center

(b)(6), (b)(7)(c)

MANDZA, EVALIN
DOB: 12/5/1965 Nation: GABON
Arrival Date: 10/24/2011 17:05

Detainee Name: | **#**

DATE / TIME	PROGRESS NOTE	ORDERS
1/27/12 1748	S: C/o Constipation	Glycerine Supp. rectally BID
WT: 156.2lb	Nurse ordine, detainee has	x3d
96.5, 16	declined Colace + fiber -	(b)(6), (b)(7)(c)
112/68, 67	O: WDWN AAO	
	Abd Soft, NTTP	
	A: Constipation non Compliant	noted 1/28/12 (b)(6), (b)(7)(c)
	c TX	at 0200
	P: Glycerine Suppos rectally	
	BID x3d	
	Counseled on Tx prescribed	
	TX for Constipation.	
	(b)(6), (b)(7)(c)	
	24° chart ✓ 1/30/12 0700 (b)(6), (b)(7)(c)	
2/9/12	0900. Det c/o constipation. Last BM	
	was 2/3/12. ↓ Bowel sounds	
	↑ discomfort. Given Dulcolax 10mg	
	po 1x dose, mom 30cc po 1x dose	
	and discharged back to dorm (b)(6), (b)(7)(c) RN	

Medical Request /
Solicated De Asistencia Medica

Date of request: 2/14/12 (Please check one) ☐ Medical Complaint ☒ Dental Complaint
Fecha de Solicitud (Por favor marque uno) ☐ Oueja medica ☒ Queja Dental

Print / : Letra – Molde	Inmates Name / Nombre del Preso	Number Numero	Housing Location Sitio de Vivienda	Job Assignment Asignacion de Trabajo	Duty Hours Horas de Trabajo
	Evelin Mandza	(b)(6), (b)(7)(c)	A3-110		

Briefly state the reason for your request; you will receive a response to your request. Please allow several days for your request to be submitted, answered, and returned. A copy of your request will be filed in your records.

Explique brevemente la razon de su solicitud. Permita varios dias para que su solocitud sea procesada. Una copia de su solicitud sear archivada en sus reocrds. Prisioneros de habla hispana pueden solicitar dicha assistencia enespanol.

PROBLEM / QUEJA: A Problem with my teeth

Inmate's Signature / Firma del Preso

=========DO NOT WRITE BELOW THIS LINE / NO ESCRIBA DEBAJO DE ESTA LINEA========

Date Received: _____ (Stamp Date)

Date Reviewed: _____ ☒ Written Response (see below) ☐ Seen in Medical

ACTION TAKEN: you see dentist 2/14/12

(b)(6), (b)(7)(c)

☐ Placed on Sick Call List Date of Appointment: ____/____/____

☐ Placed on Dental List Date of Appointment: ____/____/____

☐ Other (Explain) : _____

The GEO Group, Inc.

Consent to Dental Procedures

Inmate Name: Evalin Mandza Inmate Number: (b)(6), (b)(7)(c)

Date of Birth: 12/5/65 Date of Procedure: 2/14/12 Time: ☐ AM ☒ PM

I hereby authorize The GEO Group, Inc. and Dr. (b)(6), (b)(7)(c) (*Print Dentists' Name*), his/ her assistant(s) to treat me as is necessary in his/ her judgment.

The procedure(s), Ext tooth # 18 (*Layman's terms*),

necessary to treat my condition has been fully explained to me by Dr. (b)(6), (b)(7)(c),

and I understand the nature of, and risks associated with, this procedure(s). Briefly stated, they are:

(Benefits)

Possible Risks:

A. Infection, discomfort, or swelling after tooth removal.
B. Heavy bleeding that may be prolonged.
C. Injury or tenderness of adjacent teeth.
D. Stretching of the corners of the mouth with resultant cracking and/or bruising.
E. Limited or painful opening of the mouth for several days or weeks.
F. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
G. Breakage of the jaw.
H. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side; this may persist for several weeks, months, or in remote instances, permanently.
I. Opening of the sinus (a normal cavity situated above the upper teeth), to the mouth requiring additional surgery.
J. Other:

I am aware that the practice of the medical sciences is not exact and I acknowledge that no guarantees have been made to me as to the results of this procedure(s). Alternate treatment methods and their consequences as well as the risks of refusing the described treatment(s) (if applicable) have been fully explained to me.

Evalin Ali Mandza (b)(6), (b)(7)(c)

Signature of Inmate W

(b)(6), (b)(7)(c) DMD

Rev 01

HS

The GEO Group, Inc.

Medical Request/
Solicated De Asistencia Medica

Date of request: 3/1/12
Fecha de Solicitud

(Please check one)
(Por favor marque uno)

☒ Medical Complaint
Oueja medica

☐ Dental Complaint
Oueja Dental

Print/: Letra-Molde Inmates Name/ Nombre del Preso	Number/ Numero	Housing Location/ Sitio de Vivienda	Job Assignment/. Asignacion de Trabajo	Duty Hours/ Horas de Trabajo
Evalin Mendez	A3-110	(b)(6), (b)(7)(c)		

Briefly state the reason for your request; you will receive a response to your request. Please allow several days for your request to be submitted, answered, and returned. A copy of your request will be filed in your records.

Explique brevemente la razon de su solicitud. Permita varios dias para que su solicitud sea procesada. Una copia de su solicitud sera archivada en sus records. Prisioneros de habla hispana pueden solicitar dicha assistencia en espanol.

PROBLEM/QUEJA: Eyes problem, burning / constipation

evalin mendez
Inmate's Signature/Firma del Preso

DO NOT WRITE BELOW THIS LINE/NO ESCRIBA DEBAJO DE ESTA LINEA

Date Received: _____ **(Stamp Date)**

Date Reviewed: 3/3/12 ☐ **Written Response (see below)** ☒ **Seen in Medical**

ACTION TAKEN: Given Dulcolax, milk of magnesia, and artificial tears. Return to medical if symptoms persist/worsen (b)(6), (b)(7)(c) RN

☒ **Placed on sick call list** **Date of Appointment:** 3/5/12

☐ **Placed on Dental list** **Date of Appointment:** ___/___/___

☐ **Other (Explain):** _____

(b)(6), (b)(7)(c) RN
Medical Staff Signature

3/3/12
Date

The GEO Group, Inc.

HEALTH SERVICES
NURSING ASSESSMENT PROTOCOLS

ABDOMINAL PAIN/CONSTIPATION/DIARRHEA/INDIGESTION/VOMITING PROTOCOL

DATE/TIME	
3/3/12 0530	S.) CHIEF COMPLAINT: Constipation ALLERGIES: NKDA
	History of ulcers / gallbladder disease/ appendicitis / recent abdominal surgeries/ recent weight change (# lbs): No
	Time/Activity at onset: N/A After eating, does pain increase / decrease / remain same:
	Pain location: Abd uncomfortable Radiation: yes/no Duration: hour Constant or Intermittent:
	Current medications: colace Alleviating factors: using bathroom
Circle one:	Character: Cramping / stabbing / burning / sharp / dull Flatus: Yes Pain Intensity Scale 1-10: 2/10
Sick call	Last BM: last Friday Consistency: hard Amt: sm Blood (if yes, red / black/ or maroon, and amt): No
walk-in	Constipation: Yes Diarrhea (Frequency/amt): No
Self declared ER	Nausea/vomiting: No Describe frequency/amt/color: N/A
true ER	Heartburn or indigestion: No Frequently / Occasionally N/A Degree: mild / mod / severe N/A
	Urinary frequency: No Burning: No Penile discharge: No Low back pain: No
	Dietary habits: Fat intake: No more than usual Alcohol intake: No Caffeine intake: 2 cup/day
	Smoking habits: None
	O.) BP= 103/67 P= 107 Normal/weak/bounding 99% R= 17 T=96.3 WT. 157
	Bowel sounds: normal / hypo / hyper / absent Heard in all 4 quadrants: Yes Guarding: No
	Rebound tenderness: No Jaundice: No If states blood in stool, do hemocult. Results: N/A
	Pain location: abd-not now
	Description of observed vomitus/stool: N/A
	More comfortable: lying / sitting / standing N/A Able to sit still: Yes
	Skin: normal (warm & dry) / pale / flushed / cyanotic / diaphoretic
	Abdomen soft / rigid Degree: mild / moderate / severe n/a Bladder distended: No
	Evidence of dehydration / GI bleeding: No If yes, orthostatic BP=N/A P= N/A
	Overall appearance: no acute distress / mild distress / severe distress Obvious anxiety: No
	A.)
	P.) The Nurse may offer Patient the choice of Antacid, Milk of Magnesium, Kaopectate, Emetrol,
	Peptobismuth, Dulcolax, bulk laxative) Type/dose:
	Give according to label instructions.
	If vomiting or diarrhea, give clear liquid diet x 24 hrs and lay-in pass, unless otherwise ordered: No
	If blood in stool, vomiting, or severe diarrhea, place in infirmary/observation, unless otherwise ordered: No
	*If fever above 100.4 F, nausea or vomiting accompanying constipation, absent bowel sounds, blood in stool, all HIV + inmates with diarrhea, diarrhea that lasts longer than 24 hrs after treatment, or if pt does appear ill, and there is pain upon palpation, the physician must be notified for specific orders:
	E.) Instructed to avoid spicy foods, eat small meals, chew slowly & thoroughly, and drink 6-8 glasses water daily: Yes
	Instructed not to lie down at least 2 hrs after eating: No Caution to quit smoking: No
	Instructed on stress relief measures, high fiber diet, and adequate exercise: Yes Return if symptoms persist/worsen: Yes
	Inmate verbalized understanding of above instructions: Yes

NAME (b)(6), (b)(7)(c) MANDZA, EVALIN

NUMBER DOB: 12/5/1965 Nation: GABON

Arrival Date: 10/24/2011 17:05

DOB

NURSING SIGNATURE (b)(6), (b)(7)(c) RN

![GEO The GEO Group, Inc.]

Progress Notes

[redacted]

Site: Aurora / ICE Processing Center

MANDZA, EVALIN
DOB: 12/5/1965 Nation: GABON
Arrival Date: 10/24/2011 17:05

Detainee Name: | **DOB**

DATE / TIME	PROGRESS NOTE	ORDERS
3/3/12	0530 Det c/o eyes burning. They are red with brown spots underneath the iris'. that he says have grown bigger. Pupils 2-3 mm in size, equal and reactive to light. No vision changes. Given Artificial Tears KOP Return to medical if symptoms persist/worsen ______	[redacted] RN
3/5/12	4) Fiber 60cc po BID (R) (D/C) X 90 5) Colase 100mg po BID (R) (D/C) X 90 6) ______ (R) (D/C) X ______	
	[redacted] 3/7/12 MD Signature Date	Noted 3/7/12 [redacted]
3/5/12 B/P 106/68 P 72 R 18 T 97.8 Wt 153# Ht 5'8"	S-> Pt seen at the clinic c/o constipation No dumping H2O — on meds. O-> General [illegible] Lungs clear x2 [illegible] Heart no [illegible] Abdomen — soft rounded [illegible] visceromegaly A-> Constipation No water	P: ① ↑ Fiber (90) days ② ↑ water [redacted] ③ Exercise Noted 3/11/12 ⑪ 1030 [redacted] [redacted] Noted 3/5/12 @ 1645 [redacted]

[redacted]

Rev 01/05 HS-166

The GEO Group, Inc.

Medical Request/
Solicated De Asistencia Medica

Date of request: 3 / 21 / 12
Fecha de Solicitud

(Please check one)
(Por favor marque uno)

☒ Medical Complaint / Oueja medica

☐ Dental Complaint / Oueja Dental

Print/: Letra-Molde Inmates Name/ Nombre del Preso	(b)(6), (b)(7)(c) Number/ Numero	Housing Location/ Sitio de Vivienda	Job Assignment/ Asignacion de Trabajo	Duty Hours/ Horas de Trabajo
Evalin Mandza	(b)(6), (b)(7)(c)	A4-110		

Briefly state the reason for your request; you will receive a response to your request. Please allow several days for your request to be submitted, answered, and returned. A copy of your request will be filed in your records.

Explique brevemente la razon de su solicitud. Permita varios dias para que su solicitud sea procesada. Una copia de su solicitud sera archivada en sus records. Prisioneros de habla hispana pueden solicitar dicha assistencia en espanol.

PROBLEM/QUEJA: bad Move problems / bumps shaver Problems

Evalin Mandza
Inmate's Signature/Firma del Preso

DO NOT WRITE BELOW THIS LINE/NO ESCRIBA DEBAJO DE ESTA LINEA

Date Received: _____ **(Stamp Date)**

Date Reviewed: 3/22/12 0615 ☐ **Written Response (see below)** ☒ **Seen in Medical**

ACTION TAKEN: M.O.M. 30 cc po now X1 dose Bisacodyl tabs 10 mg po now X1 dose. M.O.M. 30cc po q h.s. X3 days prn (start 3/22/12) Pt. scheduled for med. review

☐ **Placed on sick call list** **Date of Appointment:** ____/____/____

☐ **Placed on Dental list** **Date of Appointment:** ____/____/____

☐ **Other (Explain):** _____

(b)(6), (b)(7)(c)
Medical Staff Signature

3/21/12
Date

Progress Notes

The GEO Group, Inc.

(b)(6), (b)(7)(c)

Site: Aurora MANDZA, EVALIN

DOB: 12/5/1965 Nation: GABON
Arrival Date: 10/24/2011 17:05

Detainee Name:	#	DOB

DATE / TIME	PROGRESS NOTE	ORDERS
3/21/12 0615	Dct. C/O "constipation". See Abd pain protocol. Dct. currently on meds for constipation. (b)(6), (b)(7)(c) (b)(6), (b)(7)(c)	M.O.M. 30cc po now X1 dose Dulcolax tabs-ii po now X1 dose M.O.M. 30cc po q d-s. X3days pm. Schedule to M.D. for med. review. (b)(6), (b)(7)(c) (b)(6), (b)(7)(c) T.A.O. apply Bid X7days. (b)(6), (b)(7)(c)
3/21/12 WT 158 BP 109/59 P 83 T 97.5	Hx constipation & Stress Rx worked, Bud Only "So so" C/O ABD PAIN @ N/V C/O Blood Stools @ Gen WNAD AAOx3 ABD SNT (+)BS x4 (A)(I) Constipation & ath pain Tried Cd Ace Chart ✓ 3-22-12 JA (b)(6), (b)(7)(c)	Cd Ace 100 mg T.P.O. @ HS x 7 DAys then 1-ti P.O. @ HS PRN 30 days (b)(6), (b)(7)(c)
	Orders noted 3/21/12 @ 0240 (b)(6), (b)(7)(c) RN LPN	

Rev 01/05

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The GEO Group, Inc.

Progress Notes

[redacted]

Site: Aurora / ICE Processing Center

MANDZA, EVALIN
DOB: 12/5/1965 Nation: GABON
Arrival Date: 10/24/2011 17:05

Detainee Name: **DOB**

DATE / TIME	PROGRESS NOTE	ORDERS
3/25/12	(S) meds works well ∅ complaints	
0920	normal B.M. ∅ N/V/D	
93/60	VSS	
75	A/P cont Rx PRN hx of	
96%	problems	
97.5		
	[redacted]	
3/25/12	1205 Noted — [redacted] RN	[redacted] R.N.
3-26-12	01[20] noted [redacted] [redacted] LPN Aurora/ICE Processing Center	

Medical Request/
Solicated De Asistencia Medica

The GEO Group, Inc.

Date of request: 3/31/12
Fecha de Solicitud

(Please check one)
(Por favor marque uno)

☒ Medical Complaint
Oueja medica

☐ Dental Complaint
Oueja Dental

Print/: Evalin Manoza
Letra-Molde Inmates Name/
Nombre del Preso

(b)(6), (b)(7)(c)
Number/
Numero

4Y-110
Housing Location/
Sitio de Vivienda

Job Assignment/.
Asignacion de Trabajo

Duty Hours/
Horas de Trabajo

Briefly state the reason for your request; you will receive a response to your request. Please allow several days for your request to be submitted, answered, and returned. A copy of your request will be filed in your records.

Explique brevemente la razon de su solicitud. Permita varios dias para que su solicitud sea procesada. Una copia de su solicitud sera archivada en sus records. Prisioneros de habla hispana pueden solicitar dicha assistencia en espanol.

PROBLEM/QUEJA: NO Movemant all weak, cont.

Evalin Manoza
Inmate's Signature/Firma del Preso

DO NOT WRITE BELOW THIS LINE/NO ESCRIBA DEBAJO DE ESTA LINEA

Date Received: _____ **(Stamp Date)**

Date Reviewed: _____ ☐ **Written Response (see below)** ☒ **Seen in Medical**

ACTION TAKEN: Dulcolax tabs 15mg PO QHS x 1. MOM 30cc PO QD PRN x

☐ **Placed on sick call list** **Date of Appointment:** ____/____/____

☐ **Placed on Dental list** **Date of Appointment:** ____/____/____

☐ **Other (Explain):** _____

Medical Staff Signature

Date

The GEO Group, Inc.

HEALTH SERVICES
NURSING ASSESSMENT PROTOCOLS

ABDOMINAL PAIN/CONSTIPATION/DIARRHEA/INDIGESTION/VOMITING PROTOCOL

DATE/TIME: 4/1/12 0500

S.) CHIEF COMPLAINT: [illegible] ALLERGIES: NKDA

History of ulcers / gallbladder disease/ appendicitis / recent abdominal surgeries/ recent weight change (# lbs):

Time/Activity at onset: N/A After eating, does pain increase / decrease / remain same:

Pain location: N/A Radiation: yes/no Duration: N/A Constant or Intermittent: N/A

Current medications: Alleviating factors:

Circle one: Sick call / walk-in / Self declared ER / true ER

Character: Cramping / stabbing / burning / sharp / dull N/A Flatus: yes Pain Intensity Scale 1-10:

Last BM: 4 days Consistency: Normal Amt: Sm Blood (if yes, red / black/ or maroon, and amt): N/A

Constipation: yes Diarrhea (Frequency/amt): N/A

Nausea/vomiting: N/A Describe frequency/amt/color: N/A

Heartburn or indigestion: N/A Frequently / Occasionally / N/A

Urinary frequency: No Burning: No Penile discharge: N/A Degree: mild / mod / severe N/A

Dietary habits: Fat intake: Normal Alcohol intake: N/A Low back pain: N/A

Smoking habits: N/A Caffeine intake: N/A

O.) BP= 130/62 P= 68 Normal/weak/bounding R= 18 T= 98 WT. 157

Bowel sounds: normal / hypo / hyper / absent Heard in all 4 quadrants: yes Guarding: No

Rebound tenderness: No Jaundice: N/A If states blood in stool, do heamocult. Results: No

Pain location: N/A

Description of observed vomitus/stool: N/A

More comfortable: lying / sitting / standing N/A

Skin: normal (warm & dry) / pale / flushed / cyanotic / diaphoretic Able to sit still: yes

Abdomen: soft / rigid Degree: mild / moderate / severe / n/a

Evidence of dehydration / GI bleeding: No Bladder distended: N/A

Overall appearance: no acute distress / mild distress / severe distress If yes, orthostatic BP: N/A P= N/A

Obvious anxiety: N/A

A.) [illegible]

P.) The Nurse may offer Patient the choice of Antacid, Milk of Magnesium, Kaopectate, Ensure,
Peptobismuth, Dulcolax, bulk laxative) Type/dose:

Give according to label instructions: N/A

If vomiting or diarrhea, give clear liquid diet x 24 hrs and lay-in pass, unless otherwise ordered:

If blood in stool, vomiting, or severe diarrhea, place in infirmary/observation, unless otherwise ordered:

If fever above 100.4 F, nausea or vomiting accompanying constipation, absent bowel sounds, blood in stool, all HIV + inmates with diarrhea, diarrhea that lasts longer than 24 hrs after treatment, or if pt does appear ill, and there is pain upon palpation, the physician must be notified for specific orders:

E.) Instructed to avoid spicy foods, eat small meals, chew slowly & thoroughly, and drink 6-8 glasses water daily: N/A

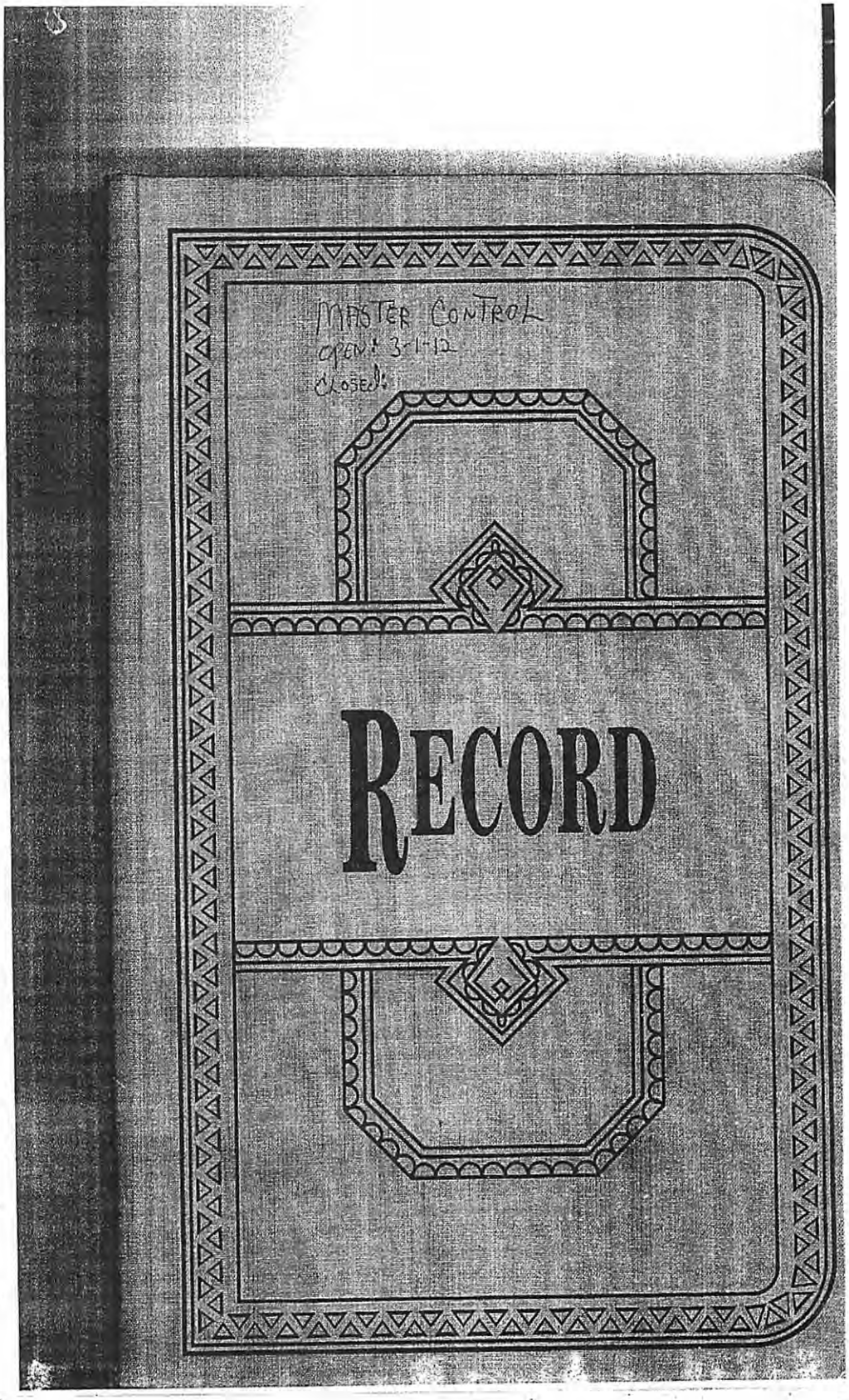
Instructed not to lie down at least 2 hrs after eating: N/A Caution to quit smoking: N/A

[illegible] 4/1/12

(b)(6), (b)(7)(c)

MANDZA, EVALIN
DOB: 12/5/1965 Nation: GABON
Arrival Date: 10/24/2011 17:05

(b)(6), (b)(7)(c)


MASTER CONTROL
OPEN: 3-1-12
CLOSED:
RECORD

2300-0700 4/11/12 1st Shift [redacted]

2300 D/O [redacted] on duty in Control w/420 S

/ D.O.S

post

A' - [redacted] medical - [redacted]

A⁴ - Seg -

B' - Utility Rover [redacted]

B² - Utility Rover

B³ - perimeter -

B⁴. perimeter -

B⁵ Intake. [redacted]

Classy - [redacted]

Transport - [redacted]

Rovers - [redacted] - Nurse [redacted]

2320 Moving 2 from E' to B'

2334 Moving N from Intake to A & B pod

2340 perimeter lights Outside of building

2344 lights on outside building

1344 L.T. [redacted] — Rounds —

0058 Census sent to Corp.

0100 Formal Count

0116 Formal Count Clears w/420 D.O.S

0138 Code greens completed

0222 GTI On-Site

0243 GTI OFF SITE LEFT 2. NEW COUNT 422

0250 NEW PAPER ON SITE

0259 3 FROM A TO INTAKE PENDING F/R

0302 2 FROM B TO INTAKE PENDING F/R

0316 Lunches Completed

0333 Kitchen Supr [redacted] on-site

0457 Code greens completed.

0501 GTI off-site took 5 New Ct - 417

0524 Major [redacted] on-s

0524 Code Blue A⁴ pod

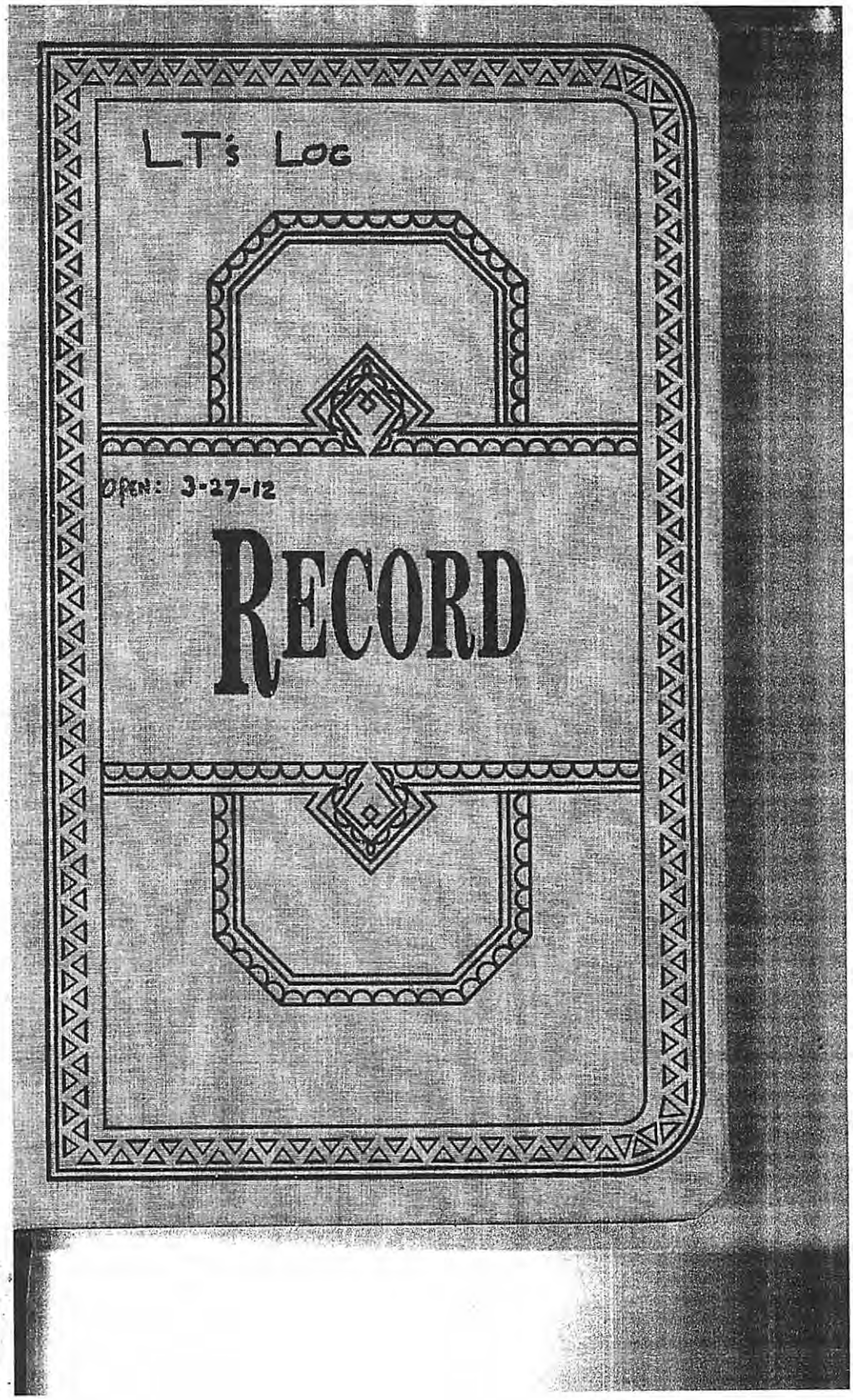
0528 Medical on-site

w/c (b)(6), (b)(7)(c)

170

Control

2300/00	4/12/12	1st Shift Thursday
0532	Shandown Code Blue	
054	Moving 2 / A's & B from Intake	
0626	EMT on-site	
0643	EMT ~~off~~ site -	
0658	(1) A4 to Borrow Out Count remains the same 417	


LT's Log
OPEN: 3-27-12
RECORD

16 LT. (b)(6), (b)(7)(c) "1ST WATCH" WEDNESDAY 2nd Shift

11 APRIL 12 2245-0715 4-12-12

2131 LT. (b)(6), (b)(7)(c) ON DUTY, BRIEF BY LT. (b)(6), (b)(7)(c)
CAMERA, CAM-CORDER IN LT'S OFFICE
AND READY FOR USE.

2145 ROSTER & POST ASSIGNMENT ADDRESSED.

2220 VP-VERIFIED AT-9

2230 SCHEDULE POSTED

2245 BRIEFING HELD IN STAFF LOUNGE
ALL STAFF REMINDED TO PAT DOWN
ALL DETAINEE ESCORTS.

2254 STAFF REPORT TO THEIR POST

2300 SHIFT CHANGE CONDUCTED

2303 LT. (b)(6), (b)(7)(c) IN ARMORY DUTIES

2342 INTERIOR CHECKS CONDUCTED.

0058 CENSUS E-MAILED TO HQ'S-420

0100 COUNT TIME

0116 FACILITY COUNT CLEARS-420

0250 NEWS PAPERS ON SITE

0138 HRS. ALL FIRST BREAKS CLEARED

0316 ALL LUNCHES FOR STAFF CLEARED

0333 KITCHEN STAFF ON SITE, MS. (b)(6), (b)(7)(c)

0352 TWO MINUTE DRILL CONDUCTED

0415 ALL FIRE CODE GREENS CLEAR

0520 MAJOR (b)(6), (b)(7)(c) ON SITE

0525 CODE-BLUE A-4 UNIT, CHEST PAINS

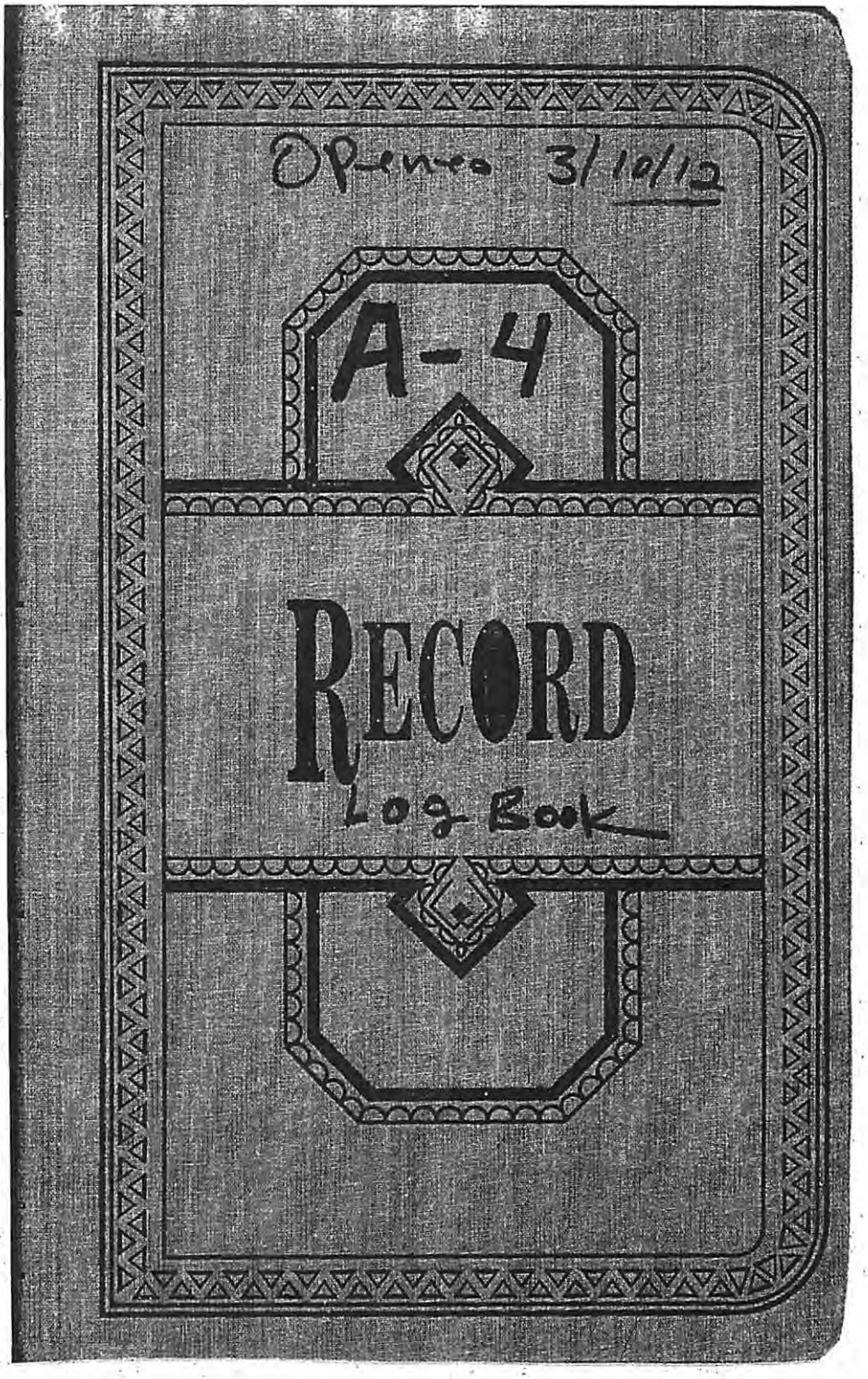
0633 STAND DOWN ISSUED

0638 MEAL SERVICE STARTED

0620 911 CALLED, REQUEST BY MEDICAL

0644 EMS OFF SITE TO HOSPITAL
AT UNIVERSITY HOSPITAL-ER
CHANGE TO AURORA-SOUTH

[redacted]


Opened 3/10/12
A-4
RECORD
Log Book

1st 4/11/12

2300-0700

2300 D/O (b)(6), (b)(7)(c) Assumes Duties of A-4 with 63 Detainees Assigned and 63 Detainees Present — (63)/63

2309 5 Detainees out of Dorm for clean up — (58)/63

2330 Security check All Appears Safe & Secure (58)/63

2340 6 New Bookings from Intake 109-2 / 202-3 / 203-4 207-1 / 207-7 / 210-2 New count — (64)/64

0000 Security check All Appears Safe & Secure — 64/69

0014 D/O (b)(6), (b)(7)(c) IN FOR CODE GREEN, ALL SECURED

0027 5 Detainees Back in dorm from clean up — (69)/69

0031 Security check All Appears Safe & Secure — (69)/69

0100 Count time

0111 called count into control for A-4 — (69)/69

0116 Count clear — 420 D.O.S.

0130 Security check All Appears Safe & Secure — (69)/69

0145 Safety check all safe and Secure

0203 Security Check All Appears Safe & Secure — (69)/69

0230 Security Check All Appears Safe & Secure — (69)/69

0256 2 Detainees out of Dorm to intake "FR" — (67)/67

0300 Security Check All Appears Safe & Secure — (67)/67

0330 Security Check All Appears Safe & Secure — (67)/67

0400 Security Check All Appears Safe & Secure — (67)/67

0407 3 Detainees out of Dorm to Medical — (64)/67

0420 D/O (b)(6), (b)(7)(c) IN FOR CODE GREEN

0435 (3) BACK FROM MEDICAL (67)/67

0436 Security check All Appears Safe & Secure — (67)/67

0500 Security check All Appears Safe & Secure — (67)/67

0517 LT (b)(6), (b)(7)(c) — Rank

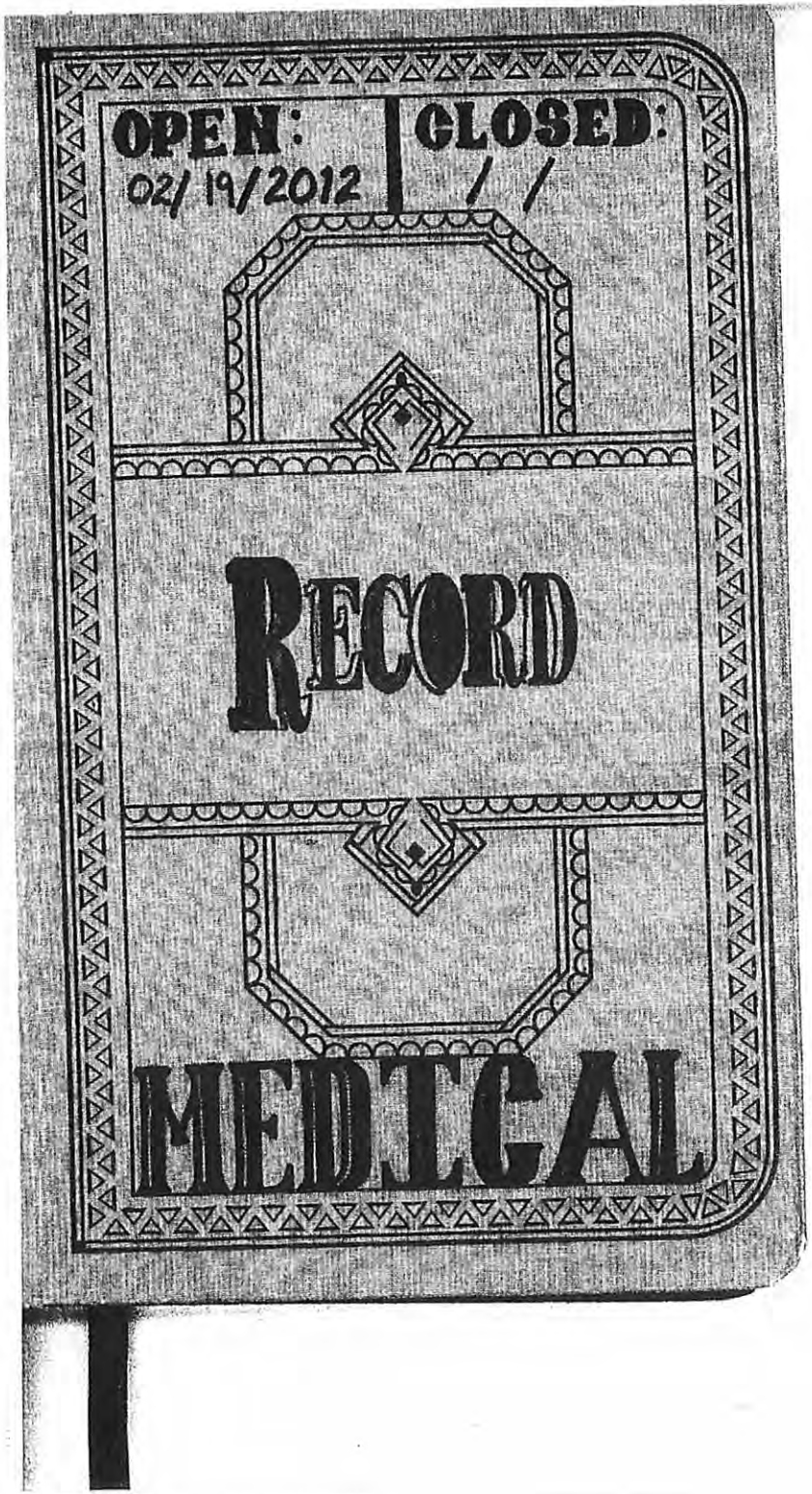
0525 Code Blue A4-110/2 (b)(6), (b)(7)(c) complaint of chest pains

0528 Medical Arrives / MaJor (b)(6), (b)(7)(c)

0533 medical Departs with Detainee mendez to medical

0537 Security check All Appears Safe & Secure — (66)/67

* continued on page 162 *


OPEN:
02/19/2012
CLOSED:
/ /
RECORD
MEDICAL

LT (b)(6), (b)(7)(c) Medical/Med-Iso Thursday 261
4-11-12
2300-0700

2300 D/O (b)(6), (b)(7)(c) relieves D/O (b)(6), (b)(7) with 2 assigned and 2 present 2
2330 Security check-All appears Safe
2351 Shakedown conducted and logged 2
0003 Security check-all appears safe 2
0030 Security check-All appears safe 2
0037 LT (b)(6), (b)(7)(c)
0055 D/O (b)(6), (b)(7)(in to assist with count 2
0100 Count and Security check-all appears safe 2
0116 Count clears with 420 2
0145 T.O (b)(6), (b)(7)(c) in to relieve for lunch break 2
0155 D/C (b)(6), (b)(7)(c) exits medical 2
0200 Security Check all safe and secure 2
0215 Security Check all Safe and Secure 2
0230 Security Check-all Safe and secure
0233 T.O (b)(6), (b)(7)(c)
0300 Security check-All appears safe 2
0330 Security check-all appears Safe 2
0400 Security check-All appears Safe 2
0410 13 in for BR-BS+Mess
0430 Security check-all appears safe
0433 13 back to pods 2
0500 Security check-All appears safe 2
0524 Code blue in A4 2
0530 Security check-all appears Safe 2
0532 Stand down on code blue 2
0545 Security check-All appears safe 2
0545 approx Mandza, Evelin-Ali (b)(6), (b)(7)(c) 2
0510 9 in from B1+B2 for sick call 2
0600 Security check-All appears Safe 2
0625 8 returns to B1+B2 2
0645 Mandza Out to Hospital 2
0653 Count clears 2
0700 D/O (b)(6), (b)(7)(c) relieved by D/O (b)(6), (b)(7)(c) 2

General Incident Report

The GEO Group, Inc. – Aurora/I.C.E. Processing Center

Subject: *Please check one of the appropriate boxes*

☐	Security Breach	☐	Rules Violation	☐	Detainee on Detainee Assault	☐	Detainee on Staff Assault
☐	Major Fire	☐	Minor Fire	☐	Self Harm	☐	Detainee Injury
☒	Med. Emergency	☐	Maintenance	☐	Major Disturbance	☐	Minor Disturbance
☐	Contraband	☐	Hunger Strike	☐	Other:		

To: Major (b)(6), (b)(7)(c) **Title:** Major **Date:** 4/12/12 **Time:** 0525

From: D/O (b)(6), (b)(7)(c) **Title:** D/O **Location:** A4 - 110/2

Detainee: MenDZA, EVALin-ALI (b)(6), (b)(7)(c)
Print Name ID# Dorm

Detainee:
Print Name ID# Dorm

Print Name ID# Dorm

Print Name ID# Dorm

Details of Incident

(Please Print - Who, What, When, Where, How &Why. You Must State Facts And Absolutely No Editorializing)

I D/O (b)(6), (b)(7)(c) was talking with Lt. (b)(6), (b)(7)(c) while he was making his Rounds and the other Detainees in A4-110 Got My attention that inmate MenDZA, EVALin-ALI (A# (b)(6), (b)(7)(c)) needed Help when I Arrived at Room 110 ALI was complaining of Chest pains I instructed Lt. (b)(6), (b)(7)(c) to call the code Blue.

Code Blue called at 0525
Medical Arrived at 0528
Stand down from Code Blue 0533
Medical Departs with Detence Mendza 0534

Supervisor's Assessment

(Please Print and Include: Date/Time, if AOD was notified, when and by whom)

REFER TO SUPERVISOR'S REPORT

Use of force Report submitted?: ☐ Yes ☒ No

D/O (b)(6), (b)(7)(c)
Staff Signature And Printed Name and Title

(b)(6), (b)(7)(c) 4-12-12
Supervisor's Signature, Printed Name and Title, Date And Time

SERIOUS INCIDENT REPORT

04/12/2012 - 04/12/2012

Incident Date / Time: 4/12/2012 7:00:09AM
Facility: Aurora/ICE Processing Center
Region: Western Region
Incident number: 120412061198

Law Enforcement Notified: No
Local Law Enforcement Notified: No
State Law Enforcement Notified: No
Federal Law Enforcement Notified: No

Assaults
- [ ] A1: Inmate/Staff
- [ ] A2: Inmate/Inmate
- [ ] A3: Minor Fight

Escapes
- [ ] E1: Escape
- [ ] E2: Attempted Escape
- [ ] E3: Failure To Return
- [ ] E4: Walk Away

Use Of Force
- [ ] U1: Major Use Of Force
- [ ] U2: Minor Use Of Force

Disturbances
- [ ] D1: Major Disturbance
- [ ] D2: Organized Inmate Resistance
- [ ] D3: Inmate Hunger Strike
- [ ] D4: Minor Disturbance

Fire
- [ ] F1: Major Fire
- [ ] F2: Minor Fire

Other
- [ ] O1: Weapon Discharge
- [ ] O2: Serious Contraband
- [x] EMERGENCY MEDICAL TRANSPORT

Health Services
- [ ] H1: Death
- [ ] H2: Inmate Suicide
- [ ] H3: Attempted Suicide
- [ ] H4: Inmate Self Harm
- [ ] H5: Acute Illness - Inmate
- [ ] H6: Serious Injury - Staff
- [ ] H7: Serious Injury - Inmate
- [ ] H8: Inmate Hospitalization
- [ ] H9: Inmate ER

Number of Staff Involved: 5
Staff: LT (b)(6), (b)(7)(c)
RN, (b)(6), (b)(7)(c)
LPN
D/O
D/O

Number of Inmates Involved: 1
Inmates: MANDZA, EVALIN-ALI
Inmates: (b)(6), (b)(7)(c)

Incident Description: At about 0525 hours, a Code Blue (medical emergency) was called by Lt. (b)(6), (b)(7)(c) at A-4 Unit due to Idetainee Mandaz, Evalin-Ali (b)(6), (b)(7)(c) complaining of chest pains. Medical staff responded transporting detainee Mandaz, Evalin-Ali # (b)(6), (b)(7)(c) via wheel chair to medical. Nurse (b)(6), (b)(7)(advised the detainee needed to be transported to the Aurora South Hospital for further medical examination.

Immediate Action Taken: Upon arrival in the medical department an assessment by RN (b)(6), (b)(7) and LPN (b)(6), (b)(7) was conducted. The determination to call 911 (ambulance) was requested and EMS arrived on site at about 0625 hours. Detainee was taken to the Aurora South Hospital ER for additional treatment.

Follow-Up Information:

Report Created By: Lt. (b)(6), (b)(7)(c)
Reviewed By: Warden (b)(6), (b)(7)(c)

Report Transmitted On: 4/12/2012 12:02:03PM

SUPERVISOR REPORT

The GEO Group, Inc.
GEO Corrections
Aurora ICE Processing Center
3130 N. Oakland Street
Aurora, CO 80010
www.geogroup.com

Date: April 12, 2012

To: (b)(6), (b)(7)(c) Major
cc: Warden
(b)(6), (b)(7)(c) AFA
ICE Officials
From: (b)(6), (b)(7)(c) Lieutenant (b)(6), (b)(7)(c)

RE: CODE BLUE , IN A-4 UNIT

Detainee: Mandza, Evalin-Ali
A # : (b)(6), (b)(7)(c)
DOB : 12-05-65
Country : GAB
Received Date: 10-24-11

At about 0525 hours a Code Blue (medical emergency) at A-4 Unit due to above listed detainee complaining of chest pains that would not stop.

Upon medical and additional staff support on scene, detainee was secured and moved to the medical unit via wheel chair for additional assessment by nurses.

At 0620 hours medical informed that 911 needed to be call in order to have detainee taken to Aurora South Hospital ER for additional treatment.

GEO Nurses (b)(6), (b)(7)(c) attended to the detainees treatment.
EMS departed to hospital from the facility at 0644 hours.

ICE notifications were made by Nurses (b)(6), (b)(7)(c) to inform them of the emergency details.

GEO notifications were made by Lt. (b)(6), (b)(7)(c)

This report generated and S.I.R. filed by me.

ANDZA, EVALIN

(b)(6), (b)(7)(c)

Progress Notes

The GEO Group, Inc.

Site: Aurora / ICE Processing Center

Detainee Name:	#	DOB

DATE / TIME	PROGRESS NOTE	ORDERS
4/12/12 0525	Responded to Code blue at housing unit 4A, found detainee lying on back (in bed) touching left chest area. Detainee alert and oriented, answers all questions appropriately. Skin w/d, color adequate, no respiratory distress noted. Reports chest pain 8-9/10, pain worse c inspiration. Pulse ox on RA 94%. Assisted to w/c for transfer to medical unit.	
VS 154/84-68-18 T 97	0528 Transfer to Trauma room. On assessment skin w/d, color adequate, Bilateral breath sound clear to ause. All peripheral pulses palpable. O2 placed at 4L pulse ox 92-94%. Abdomen soft flat c hyperactive bowel sounds. Reports last BM was on 4/8/10. ~~12 lead EKG done~~ error mb Chest pain remains unchanged. B/P 144/85-71-rr 18. 3 lead & EKG done.	
0550	Dr. (b)(6), (b)(7)(c) notified of Detainee status. Orders received	V.O. Dr. (b)(6), (b)(7)(c) 1. Send Detainee to hosp. for Chest pain eval.
0602	Ms. (b)(6), (b)(7)(c) HSA. Notified of Detainee status.	(b)(6), (b)(7)(c)
	Cont.	(b)(6), (b)(7)(c)

(b)(6), (b)(7)(c)

NAMDZA Evalin

(b)(6), (b)(7)(c)

Progress Notes

The GEO Group, Inc.

Site: Aurora / ICE Processing Center

Detainee Name:	#	DOB

DATE / TIME	PROGRESS NOTE	ORDERS
4/12/12	0610 Report called to (b)(6), (b)(7)(C) Charge nurse at Medical Center of Aurora Medical Center E.R.	
	0620 VS 139/81 - ~~HR 102~~ MB HR 67 pulse ox 100% @ 4L, O2 ↓ to 1L/NC.	
	0630 EMS arrived report given, EKG done by Emt. Transfer care to EMS.	
	0633 Detainee Transfer to MCA (E.R.) on EMS.	
	0633-0644 Nurse CDR (b)(6), (b)(7)(c) Ist (b)(6), (b)(7)(c) notified by (b)(6), (b)(7)(c) LPN, U Hale agrees to Notify the (b)(6), (b)(7)(c)	

General Incident Report

The GEO Group, Inc. – Aurora/I.C.E. Processing Center

Subject: *Please check one of the appropriate boxes*

☐ Security Breach	☐ Rules Violation	☐ Detainee on Detainee Assault	☐ Detainee on Staff Assault
☐ Major Fire	☐ Minor Fire	☐ Self Harm	☐ Detainee Injury
☒ Med. Emergency	☐ Maintenance	☐ Major Disturbance	☐ Minor Disturbance
☐ Contraband	☐ Hunger Strike	☐ Other:	

To: Warden **Title:** _____ **Date:** 4/12/12 **Time:** 0936

From: (b)(6), (b)(7)(c) **Title:** RN **Location:** MEDICAL

Detainee: MANDZA, Evalin (b)(6), (b)(7)(c) A4 **Detainee:** _____

Print Name ID# Dorm Print Name ID# Dorm

Print Name ID# Dorm Print Name ID# Dorm

Details of Incident

(Please Print - Who, What, When, Where, How &Why. You Must State Facts And Absolutely No Editorializing)

I nurse (b)(6), (b)(7)(c) RN responded to A4 dorm housing unit @0525. Detainee was found in bed, touching his left chest area. Detainee was AlertandOriented complaining of chest pain 8/10. Pulse ox on room air was 94%. This Nurse requested detainee to be transfer to medical unit for further evaluation. 0528 Detainee was transfer to Trauma room. He was placed on gurney. On assement his skin was dry and intact, B/L breath sounds clear, all pulses palpable placed on oxygen - O2 sat 92-94%. His Abdomen is soft non tender with hyperactive bowel sounds reports his last BM was on 4/8/12 ~~Lead EKG done~~ Chest pain remains at 8/10 B/P 144/75 HR 71 - RR 18. 3 Lead EKG done 0550 Dr (b)(6), (b)(7)(c) was notified of Detainee condition Orders received to send detainee to hospital for chest pain. NO (b)(6), (b)(7)(c) LPN instructed to get all transfer forms ready and to call EMS. (b)(6), (b)(7)(c)

Cont.

Supervisor's Assessment

(Please Print and Include: Date/Time, if AOD was notified, when and by whom)

Use of force Report submitted?: ☐ Yes ☐ No

General Incident Report ☐ Continuation ☐ Supplemental

The GEO Group, Inc. – Aurora/I.C.E. Processing Center

Subject: MANZA, Evalin A (b)(6), (b)(7)(c)

Date: 4/12/12 **Time:** 0930

Details of Incident (Continued)

(Please Print - Who, What, When, Where, How &Why. You Must State Facts And Absolutely No Editorializing)

Cont

0600 hrs. (b)(6), (b)(7)(c) HSA notified of Detainee Status. Report called to (b)(6), (b)(7)(c) Charge Nurse at Medical Center of Aurora ER. 0620 VS 139/31-HR67 pulse ox 100% on 2L decrease to 1L/NC. 0632 EMS arrived. Report given. EMS Done their assessment EKG done by EMT. All care Transfer to EMS. 0632 Detainee Transfer to MCA ER by EMS.

Between 0633-0644. (b)(6), (b)(7)(c), CDR (b)(6), (b)(7)(c) (b)(6), (b)(7)(c) (b)(6), (b)(7)(c) (b)(6), (b)(7)(c) (b)(6), (b)(7)(c) All were notified by HS. (b)(6), (b)(7)(c) (b)(6), (b)(7)(c)

Supervisor's Assessment (Continued)

(Please Print and Include: Date/Time, if AOD was notified, when and by whom)

Staff Signature, Printed Name and Title, Date And Time

Supervisor's Signature, Printed Name and Title, Date And Time

General Incident Report

The GEO Group, Inc. – Aurora/I.C.E. Processing Center

Subject: *Please check one of the appropriate boxes*

☐ Security Breach	☐ Rules Violation	☐ Detainee on Detainee Assault	☐ Detainee on Staff Assault
☐ Major Fire	☐ Minor Fire	☐ Self Harm	☐ Detainee Injury
☒ Med. Emergency	☐ Maintenance	☐ Major Disturbance	☐ Minor Disturbance
☐ Contraband	☐ Hunger Strike	☐ Other:	

To: (b)(6), (b)(7)(c) **Title:** WARDEN **Date:** 4-12-12 **Time:** 0930

From: (b)(6), (b)(7)(c) **Title:** L.P.N. **Location:** MEDICAL Dept.

Detainee: MANDZA EVALIN A (b)(6), (b)(7)(c) **Detainee:**

Print Name ID# Dorm Print Name ID# Dorm

Print Name ID# Dorm Print Name ID# Dorm

Details of Incident

(Please Print - Who, What, When, Where, How &Why. You Must State Facts And Absolutely No Editorializing)

This writer Nurse (b)(6), (b)(7)(c) LPN responded to Code Blue in housing unit A-4. Det. # (b)(6), (b)(7)(c) was laying in bed on back holding left chest area with complaints of chest pain. Detainee was Alert & oriented. Pulse ox 94% on room air at that time (0525)

0528 Detainee # (b)(6), (b)(7)(c) was transferred by w/c to Medical unit trauma room for assessment. Respiratory assessment done by Nurse (b)(6), (b)(7)(c) R.N. det. then started on 4L per nasal cannula at 4 Liters. EKG done by Nurse (b)(6), (b)(7)(c) R.N. Detainee # (b)(6), (b)(7)(c) voiced chest pain 8/10 Dr. (b)(6), (b)(7)(c) called. Report on detainee's status given - Orders received per MD (b)(6), (b)(7)(c) to send to hosp. At this time I nurse (b)(6), (b)(7)(c) completed transfer form & notified watch Commander (b)(6), (b)(7)(c) of transfer to hosp. per M.D. orders.

0620 V.S. 139/81 Heart rate 67 pulse ox 100% @ 4 Liters

cont.

Supervisor's Assessment

(Please Print and Include: Date/Time, if AOD was notified, when and by whom)

Use of force Report submitted?: ☐ Yes ☐ No

General Incident Report ☐ Continuation ☐ Supplemental

The GEO Group, Inc. – Aurora/I.C.E. Processing Center

Subject: MANDZA, ENALIN (b)(6), (b)(7)(c)

Date: 4/12/12 **Time:** 0930

Details of Incident (Continued)

(Please Print - Who, What, When, Where, How &Why. You Must State Facts And Absolutely No Editorializing)

per NASAL CANNULA - 02 then ↓ to 1 liter per nasal cannula.
0630 EMS arrived - Report given on detainee # (b)(6), (b)(7)(c)
status. Detainee care done by EMS onsight
0632 detainee # (b)(6), (b)(7)(c) transferred by EMS per stretcher
to Medical Center of Aurora ER. ✓
0633-0644 MR (b)(6), (b)(7)(c) CDR (b)(6), (b)(7)(c) ART (b)(6), (b)(7)(c)
(b)(6), (b)(7)(c) was notified. Major (b)(6), (b)(7)(c)
will notify Warden (b)(6), (b)(7)(c)

Supervisor's Assessment (Continued)

(Please Print and Include: Date/Time, if AOD was notified, when and by whom)

(b)(6), (b)(7)(c)

Staff Signature, Printed Name and Title, Date And Time

Supervisor's Signature, Printed Name and Title, Date And Time

(b)(6), (b)(7)(c) LPN

ICE/ERO/IHSC
CDR (b)(6), (b)(7)(c)
Field Medical Coordinator – Denver Field Office
12445 E. Caley Avenue
Centennial, CO 80111
720-873 (b)(6), (b)(7)(c) *(office)*
202-321 *(BB)*
8-66-311-0973 (Secure Fax)
(b)(6), (b)(7)(c)

fax

TO:	Rural/Metro	**FROM:**	CDR (b)(6), (b)(7)(c)
FAX:		**PAGES:**	2
PHONE:	303-3 (b)(6), (b)(7)	**DATE:**	5/14/2012
RE:	**Mandza, Evalin-Ali**	**DOB:**	12/05/1965

☐ Urgent ☐ For Review ☐ Please Comment Please Reply ☐ Please Recycle

Comments: Please provide copies of the ambulance report. Transport took place 4/12/2012. Thanks

AMBULANCE SERVICE PATIENT INVOICE

RURAL/METRO OF CNTRL COLORADO
P O BOX 2812
SCOTTSDALE AZ 85252-2812

PLEASE MAKE CHECKS PAYABLE TO:

MAKE SURE THIS ADDRESS APPEARS IN RETURN ENVELOPE WINDOW

RURAL/METRO OF CNTRL COLORADO
P O BOX 52202
PHOENIX AZ 85072-2202

PATIENT			
MANDVA, EVELYN			SD8611189 1009126
ID #	INVOICE NO	DATE OF SERVICE	TIME OF CALL
8611189	1009126869	4/12/12	6:23:
TOTAL CHARGES	TOTAL PAID	AMOUNT DUE	
$1,316.31	$.00	$1,316.31	

AMOUNT ENCLOSED $

FROM: 3130 OAKLAND ST
TO: AURORA SOUTH CAMPUS

SD8611189

EVALIN MANZA
1419 DETROIT ST APT 24
DENVER CO 80206-2441

Federal Employer ID (b)(6), (b)(7)(c)

TO RECEIVE PROPER CREDIT, PLEASE RETURN THIS PART WITH YOUR PAYMENT
NOTE: SHOULD YOU WISH TO PAY BY CREDIT CARD, SEE AUTHORIZATION NOTICE ON THE BACK

PLEASE KEEP THIS PART FOR YOUR FILES
PATIENT INVOICE

PATIENT MANDVA, EVELYN
ID # SD8611189 INV: 0001009126869

INVOICE DATE: 5/14/12

REFER TO INVOICE NO. ON ALL INQUIRIES OR CORRESPONDENCE

INVOICE NO.	DATE OF SERVICE	TIME OF CALL	INCIDENT NO.
1009126869	4/12/12	6:23:32	1009309973

CALL SOURCE: AURORA FIRE DEPARTMENT
FROM: 3130 OAKLAND ST
TO: AURORA SOUTH CAMPUS

DATE OF SERVICE	PAYMENT AMOUNT DATE	DESCRIPTION	QTY / UNITS	CHARGE RATE	AMOUNT
4/12/12		ALS EMERGENCY	1	947.67	947.67
4/12/12		MILEAGE	7	17.51	122.57
4/12/12		INFECTION CONTROL SUPPLIE	1	13.95	13.95
4/12/12		OXYGEN W SUPPLIES	1	105.88	105.88
4/12/13		EKG & CARDIAC SUPPLIES	1	111.72	111.72
4/12/12		PULSE OXIMETER PROBE	1	14.52	14.52

TOTAL PAID	TOTAL CHARGES
$.00	$1,316.31
	AMOUNT DUE
	$1,316.31

INQUIRIES CALL: 303/367-(b)(6), (b)(7)(c) Or 888/876-(b)(6), (b)(7)(c)

Federal Employer ID (b)(6), (b)(7)(c)

13-427 REV. 10/10

NOTE: PLEASE READ FINANCIAL POLICY ON BACK

FINAL — **Patient Care Report**

Rural/Metro Ambulance

Rural/Metro Ambulance
3350 Peoria Street, Suite 100
Aurora, CO 80010
303 34[redacted]
Pridemark Paramedic Service
6100 W 54th Ave
Arvada, CO 80002
303 4[redacted]

Run Number: 29253
Date of Service: 04/12/2012
Patient Name: Evelin Manza
Triage Tag #:

CREW INFO	RESPONSE INFO	DISPOSITION	TIMES
Vehicle: 101 Crew #1: [redacted] Crew #2: Doc'd By: Assisted By: 19, 0, 0 # of patients on scene: 1	Location: [redacted] Call Source: Aurora Fire Department Call Type: ALS Response Priority: 1-Emergent - Lights/Sirens Nature Of Call: Chest Pain Med/Trauma: Medical Resp. with: Police Officer: Case: Resp. Delay: <None> <None> <None> Trans. Delay: <None> <None> <None>	Outcome: Treated, Tx by this unit Destination: Aurora South Campus, Dept: ER, 1501 S POTOMAC ST, AURORA, CO 80012 Transport Priority: 2-Urgent - No Lights/Sirens Content to Care: None, None, None Pt. Found: In Bed Pt. Transported: - Main Stretcher Condition at Dest.: Worse Chief Complaint: RH, Cardiac	Dispatch: 06:23 04-12-12 En route: 06:23 04-12-12 At scene: 06:29 04-12-12 At patient: 06:27 04-12-12 Transport: 06:48 04-12-12 At dest.: 06:58 04-12-12 @Scene mileage: 1,000.0 @Dest. mileage: 1,005.1

PATIENT INFORMATION

Name: Evelin Manza
Phone: (303) [redacted]
Medical Record #: [illegible]
SSN: [redacted]
DOB: 12/[illegible] ([illegible] yrs)
Weight: 180 lbs
Sex: Male
Home Addr.: [redacted]
Mailing Addr.: [redacted]
Race: African American
Personal Meds: None
Comments:
Auth Billing: 11[illegible]

NEXT OF KIN

Name:
Phone:
Relationship:
SSN:
DOB:
Sex:
Home Addr.:

CAD

Payer Notes: 11358
Comments:

INSURANCE

Work Related: No

Provider Info.

Company: Self Pay
Policy #:
Group #:

HISTORY

Allergies
Denied by Patient

Cause of Injury
Denied by Patient

FINAL

Patient Care Report

Rural/Metro Ambulance

Rural/Metro Ambulance
3350 Peoria Street, Suite 100
Aurora, CO 80010
303 343(6), (b)(7)(

Pridemark Paramedic Service
6100 W 54th Ave
Arvada, CO 80002
303 432(6), (b)(7)

Run Number: 29253
Date of Service: 04/12/2012
Patient Name: Evelin Manza
Triage Tag #:

Chief Complaint

Chest Pain

Note: Pt describes burning sensation from his mid chest that goes into his throat. Pain is reproducible on palpation. Pt states he has increased pain when swallowing.

Medications

Other - Not Listed -

Note: Laxative

Past Medical History

Other

Note: Constipation.

ASSESSMENTS

Body Area	Assessment	Body Area	Assessment
Airway	Patent	Breathing	Normal Respirations
Circulation	Pulses - Radial - Normal (2+)	LOC	A & O to Event, A & O to Person, A & O to Place, A & O to Time
Central Nervous System	Neuro Sensory and Motorfunction Normal	Blood/Fluid Loss	None Noted
ALS Assessment	ALS Assessment Performed For - Chest Pain/Discomfort		

IMPRESSIONS

Primary Impression: Chest Pain/Discomfort
Pain travels from upper abd through the chest into the throat. Possible indigestion.

TRAUMA

No Trauma Assessed

VITAL SIGNS

Time	PTA	BP	Pulse	Respiratory	SPO2	ETCO2	Glucose	GCS
06:30		140/90 Auscultated	72, Normal, Regular	22, Normal				E4 + V5 + M6 = 15

Skin Temp=Normal Skin Color=Normal Skin Moisture=Normal Lung Sounds Left=Normal / Clear Lung Sounds Right=Normal / Clear Cap. Refill=Normal
Pupil size: Left=4, Right=4 Pupil Reacts: Left=Reactive, Right=Reactive Pupil Dilation: Left=Normal, Right=Normal
Level of Consciousness: Alert; Pain Scale=7; Arm Movement: Left=Spontaneous, Right=Spontaneous; Leg Movement: Left=Spontaneous, Right=Spontaneous

Completed By: Aurora Fire

Time	PTA	BP	Pulse	Respiratory	SPO2	ETCO2	Glucose	GCS
06:44		142/90 NIBP Machine	78, Normal, Regular	30, Normal	100%, Source: Supplemental			E4 + V5 + M6 = 15

Skin Temp=Normal Skin Color=Normal Skin Moisture=Normal Lung Sounds Left=Normal / Clear Lung Sounds Right=Normal / Clear Cap. Refill=Normal
Pupil size: Left=4, Right=4 Pupil Reacts: Left=Reactive, Right=Reactive Pupil Dilation: Left=Normal, Right=Normal
Level of Consciousness: Alert; Pain Scale=10; Arm Movement: Left=Spontaneous, Right=Spontaneous; Leg Movement: Left=Spontaneous, Right=Spontaneous
ECG=Normal Sinus Rhythm

Completed By: (b)(6), (b)(7)(c)

FINAL

Patient Care Report

Rural/Metro Ambulance

Rural/Metro Ambulance
3350 Peoria Street, Suite 100
Aurora, CO 80010
303 3[illegible](6), (b)(7)
Pridemark Paramedic Service
6100 W 54th Ave
Arvada, CO 80002
303 43[illegible](6), (b)(7)

Run Number: 29253
Date of Service: 04/12/2012
Patient Name: Evelin Manza
Triage Tag # :

SCORES

no trauma scores entered

TREATMENT SUMMARY

Time	PTA	Treatment	Who performed	Comments
06:30		Oxygen	Aurora Fire	
		Device=Adult Cannula	Indications=Related to chief complaint	Rate=3 LPM
		Result=No Change	Did pt tx w/ own portable O2?=No	Could pt self administer O2?=No
		Reason pt could not administer=None-N/A		
06:31		Cardiac Monitor	(b)(6), (b)(7)(c)	
		Interp=Sinus Rhythm	Ectopy=Artifact	Indications=Chest Pain
		12-Lead Performed=Yes	Interp By=AFD medic.	
06:31		SpO2 Monitor	(b)(6), (b)(7)(c)	
		SpO2 Monitor=Related to chief complaint		
06:47		Aspirin	(b)(6), (b)(7)(c)	
		Dosage=FOUR 81 mg chewable ASA	Result=No Change	
06:55		Cardiac Monitor	(b)(6), (b)(7)(c)	
		Interp=Sinus Rhythm	Ectopy=Artifact	Indications=Chest Pain
		12-Lead Performed=Yes	Interp By=Detachig	

NARRATIVE

M101 Dispatch to chest pain. UA pt found lying supine on exam table in facility clinic. Pt CC chest pain.

Pt states he awoke c the pain this morning. Pt describes this pain as a burning sensation that travels from his upper abd through his chest and up into his throat. Pt states that he did eat soup c hot peppers last night. Pt denies any recent trauma or illness. Pt denies any drug or alcohol use.

Pt AAOx4 (person, place, time, event). CMEx4. Breath sounds clear and equal bilaterally. Chest wall intact. Increased pain on palpation of chest. No trauma noted. HEENT clear and intact. Pupils 4, PEARL. Skin WPD. Abd non distended or rigid, increased pain on palpation of bilateral upper quadrants. No trauma noted.

Pt placed on 3L oxygen via NC. SpO2 monitor applied, 12 lead acquired– sinus rhythm c artifact. Pt escorted to pram by own power. Pt secured to pram c straps. Pt began hyperventilating en route. Pt would not talk c crew but appeared as if the pain had become worse. Pt given 324mg ASA PO. Pt would not follow directions to chew the pills so they sit in his mouth for a few minutes. Pt would not cooperate to get a third set of vitals en route. Pt vomited UA to ED. ASA pills present in vomit. Pt care transferred to nurse at receiving facility.

CHARGES

Units	Description
2	EKG & Cardiac Supplies-1150000
1	Oxygen Supplies- 1110505
1	Pulse Ox Monitor- 1184753

FINAL

Patient Care Report

Rural/Metro Ambulance

Rural/Metro Ambulance
3350 Peoria Street, Suite 100
Aurora, CO 80010
303 3[illegible](6), (b)(7)

Pridemark Paramedic Service
6100 W 54th Ave
Arvada, CO 80002
303 432[illegible](6), (b)(7)

Run Number: 28253
Date of Service: 04/12/2012
Patient Name: Evalin Manza
Triage Tag # :

MEDICAL NECESSITY

Specific Injury/Injury for Amb Tx:	Upper abd and chest pain.	Pt moved from Stretcher/WC via:	Patient assisted on own power
Treatments/Fees Not Avail @ Send Fac:	Doctor Evaluation	Patient Placed in:	Bed
Pt moved to Stretcher/WC via:	Assisted under own power		

SIGNATURES

Time	Type	Who signed	Why patient did not sign
04/12/2012 07:00	Facility Acceptance	RN - RN, (b)(6), (b)(7)	<Not applicable>

The above-named patient, Evalin Manza was received by this facility at the date and time indicated above.

Receiving Facility Representative Signature (b)(6), (b)(7) RN

X (b)(6), (b)(7)(c)

04/12/2012 07:13	Patient Unable to Sign-CREW-No Auth Rep	Crew Member #1	(b)(6), (b)(7)(c)	Refused

My signature below indicates that, at the time of service, the patient, Evalin Manza was physically or mentally incapable of signing, and no authorized representative was available or willing to sign on the patient's behalf.

Crew Name (b)(6), (b)(7)(c)

X (b)(6), (b)(7)(c)

CREW INFORMATION

Start Date/Time : 04/11/2012 07:00

Crew #	Name	Crew #	Name
000072029 -Paramedic	(b)(6), (b)(7)(c)	000059603 -EMT	(b)(6), (b)(7)(c)

X (b)(6), (b)(7)(c)

X (b)(6), (b)(7)(c)

Incident Number 00001-2012-011559-00
Patient Number 1
Patient Name Mandza, Evalin

EMS Patient Care Report
Aurora Fire Department

Incident Information

Incident Location 3130 N Oakland Street (80011)

Incident Date 04/12/2012
Time of Call 06:21:46
Shift B Shift

Incident Time Log

Unit	Dispatched	Responding	On Scene	To Hospital	At Hospital	In Service
Engine 3	06:22:20	06:23:16	06:25:04			06:43:29
Medic 101	06:22:28	06:24:39	06:25:39	06:43:16		06:56:03

Patient Information

Age 46 Years
Gender Male
Ethnicity Black, non-Hispanic

Patient Hx

History Source Patient
Patient Weight 150 Pounds (Approx)

Current Medications
The patient denies taking any medications currently.

Allergies
The patient denies having any known allergies.

Medical History
The patient has a history of constipation.

Barriers to Patient Care
None

Advance Directives
None

Alcohol / Drug Use Indicators
None

This Encounter

Classification Medical
Onset of Symptoms 2 Hours
1st Patient Contact 04/12/2012 06:28

Cardiac Arrest No

Provider's Impression
Chest pain and Heartburn / Indigestion

Disposition Transported by Rural/Metro, no AFD
Initial Condition Green (Good)

Transported By	Rural/Metro
Transported To	TMCA (The Medical Center of Aurora)
Reason	Diversion
Destination Condition	Unknown

Starting Miles

Ending Miles

Treatments & Assessments

Time	Treatments & Assessments
06:29	Position: Supine; Blood Pressure: 135/85; Pulse: 80 (Regular); Respirations: 20 (Increased, not labored); Perceived Pain: 9/10; Pulse Oximetry: 100 (On Oxygen); Movement of Extremities: x4; Level of Conciousness: 15 (4+5+6); EKG Interpretation: Normal sinus rhythm ; Taken by automated device;
~06:30	Oxygen, 4 l/m - nasal canula; Response: No change; Authorization: Protocol (standing order); administered by Rural/Metro Employee
06:32	12 Lead Cardiac Monitor; Authorization: Protocol (standing order); performed by (b)(6), (b)(7)(c) COMMENT: NSR, no ST segment elevation, no ectopic beats observed

Signatures

HIPAA Information

HIPAA information given to patient	Information wa:
Signature obtained	No
Reason that signature was not obtained	Patient transported by other agency

Transfer of Care

Care Transferred To

Reason that signature was not obtained

PPE / Exposures

Provider was exposed to body fluids or stuck with a needle No

Narrative

PE3 was dispatched to chest pain.

C-- U/a at the immigration detention facility, we located the Pt in an examination room lying supine on an examination table. Scene secure. Pt is a 46 y/o male who is conscious and alert. Pt states a CC of midline chest pain.

H-- Pt states medical hx, no current medications and nkda's. Pt states he hasn't had a bowel movement in the past four days. Pt states he ate a bowl of soup last night, that contained a large amount of hot chili peppers. O- Two hours ago, Pt woke up from sleep with current pain. P- pain is reproducible upon movement, and chest wall palpation. Q- Pt states it is a burning sensation. R- Pt states the burning travels from his upper abd, to his esophagus. S- 9 out of 10. Pt denies nausea/vomiting. Pt states no diaphoresis.

A-- General Impression: Pt is conscious and is responsive to verbal questioning. Pt is showing no

signs of pain or respiratory distress. ABC's open/patent, increased/unassisted, skin warm and dry, radial pulse strong and regular, heent clear, chest wall stable rise and fall equal, breath sounds clear and equal bilateral, abd soft non-tender, pelvis stable, moex4, gcs=15, vitals as recorded. Pt was placed onto 4 lpm O2 prior to our arrival by facility nurse. 12 lead ECG revealed a Sinus Rhythm, no ST segment elevation or ectopic beats observed. Pt was packaged onto the pram and removed from the facility. Pt was secured into RM 101 for non- emergent transport to TMCA South due to AIP diversion. Immigration detention officer accompanied RM 101. Pt states no further complaints.

R-- See Treatment.

T-- See Encounter. Upon release of care Pt's condition had remained unchanged.

--END OF STATEMENT--

Submitted by:

Fire Medic [redacted]

OIC:

Capt. [redacted]

Report completed by: [redacted] on 04/12/2012 at 08:24:48

Incident Number: 00001-2012-011559-00

Incident Time Log

Primary Jurisdiction	Aurora Fire Department
Incident Type	Emergency medical incident [321]
Location	3130 N Oakland Street
Location Continued	
Station District	Aurora Station 3
City	Aurora
County	Adams
Zip Code	80011
Response Zone	
Map Number	
Latitude	3,182,497.0
Longitude	1,702,465.

Day of Week: Thursday
Shift: B Shift

Benchmark Times

Alarm Received	04/12/2012 06:21:46
First Unit Arrived	04/12/2012 06:25:04
Last Unit Cleared	04/12/2012 06:56:03

Apparatus and Personnel Summary

	Apparatus	Personnel
Suppression	1	4
EMS	0	0
Other	1	0

Responding Units

Unit Name	Capability	Dispatched	Responding	On Scene	To Hospital	At Hospital	In Service
Engine 3	ALS Engine	06:22:20	06:23:18	06:25:04			06:43:29
Medic 101	Ambulance (ALS)	06:22:28	06:24:39	06:25:39	06:43:16		06:56:03

Responding Personnel

Name	Primary Function	Start Time	End Time	Hours	EMT Level	Actions Taken
Engine 3						
(b)(6), (b)(7)(c)	Captain	06:22:20	06:43:29	0.35	EMT Basic	
	Engineer	06:22:20	06:43:29	0.35	EMT Basic	
	Rescue Technician	06:22:20	06:43:29	0.35	EMT Paramedic	
	Rescue Technician	06:22:20	06:43:29	0.35	EMT Paramedic	

Total Person Hours: 1.40

1.40

Dispatcher Notes (Unmodified)

Incident Initiated By: AP/MUSIC, (b)(6), (b)(7)(c) CHEST PAINS Original Location : GEO GROUP INC THE 120565 C/B...NO HX AFD TO THE BACK GATE

Printed on 05/04/2012 at 15:01:11

C:\Program Files (x86)\High Plains\FireManager\Reports\IncidentTimeLog2.rpt

The GEO Group, Inc.

General Incident Report

Aurora/I.C.E. Processing Center

Subject: *Please check one of the appropriate boxes*

☐ Security Breach	☐ Rules Violation	☐ Hunger Strike	☐ Detainee on Detainee Assault
☐ Major Fire	☐ Contraband	☐ Self Harm	☐ Detainee on Staff Assault
☐ Minor Fire	☐ Maintenance	☐ Detainee Injury	☐ Medical Emergency
☐ Major Disturbance	☐ Minor Disturbance	☒ Other _____	

To: (b)(6), (b)(7)(c) **Title: Major** **Date: 04/12/12** **Time: 0633**

From: (b)(6), (b)(7)(c) **Title: Transport Officer** **Location: The Medical Center of Aurora**

Detainee: Mandza, Evalin A (b)(6), (b)(7)(c) — Name / ID / Dorm

Detainee: _____ — Name / ID / Dorm

Detainee: _____ — Name / ID / Dorm

Detainee: _____ — Name / ID / Dorm

Details of Incident

Please Print – who, what, when, where, how, & why. You must state facts (absolutely no editorializing).

On the above date and approximate time this Transport Officer (b)(6), (b)(7)(c) and Transport Officer (b)(6), (b)(7)(c) were notified by Lt. (b)(6), (b)(7)(c) to go on a emergency medical transport for detainee#A (b)(6), (b)(7)(c) Mandza Evalin. I rode in the ambulance (Aurora Metro) with detainee Mandza Evalin. Transport Officer (b)(6), (b)(7)(c) followed the ambualnce in vehicle 69806. At approximate 0657 hours, we arraived at The Medical Center of Aurora. Detainee mandza was moved to emergency room #17. Detainee Mandza was examined by medical staff and Dr. (b)(6), (b)(7)(c) At approximately 0735 hours, detainee Mandza was moved to Cath Lab #4 for a Cardiac Catheterization procedure. At 0755 hours medical staff started giving Mandza chest compressions with negaitive results. At 0833 hours, nurse (b)(6), (b)(7)(c) and Dr. (6), (b)(7) pronounced detainee Mandza Evalin dead. At 0940 hours, detainee Mandza Evalin was moved to the mortuary of the hospital. End of report.

Supervisor's Assessment

Please Print and Include: Date/Time, whether AOD was notified, when, and by whom.

Use of Force Report submitted?: ☐ Yes ☒ No

(b)(6), (b)(7)(c)

Staff Signature and Printed Name and Title

Supervisor's Signature, Printed Name and Title, Date & Time

The GEO Group, Inc.

General Incident Report

Aurora/I.C.E. Processing Center

Subject: *Please check one of the appropriate boxes*

☐ Security Breach	☐ Rules Violation	☐ Hunger Strike	☐ Detainee on Detainee Assault
☐ Major Fire	☐ Contraband	☐ Self Harm	☐ Detainee on Staff Assault
☐ Minor Fire	☐ Maintenance	☐ Detainee Injury	☒ Medical Emergency
☐ Major Disturbance	☐ Minor Disturbance	☐ Other _____	

To: (b)(6), (b)(7)(c) **Title: Major** **Date: 4/12/12** **Time: 0633**

FROM: (b)(6), (b)(7)(c) **Title: T/O** **Location: The Medical Center of Aurora**

Detainee: Mandza, Evalin (b)(6), (b)(7)(c) A3 **Detainee:** _____

Name ID Dorm Name ID Dorm

Detainee: _____ **Detainee:** _____

Name ID Dorm Name ID Dorm

Details of Incident

Please Print – who, what, when, where, how, & why. You must state facts (absolutely no editorializing).

On 04/12/12 at approximately 0633 myself and T/O (b)(6), (b)(7)(c) where notified by Lt (b)(6), (b)(7)(c) of an emergency medical transport to The Medical Center of Aurora for detainee Mandza, Evalin (b)(6), (b)(7)(c). Detainee was transported via ambulance (Aurora Metro). Officer (b)(6), (b)(7)(c) rode in the ambulance with him, while I followed in vehicle 69806. Upon arraival at the hospital detainee was moved to emergency room #17. Dr. (b)(6), (b)(7)(c) conducted several medical evaluations and moved detainee Mandza to Cardiac Cath Lab #4 for a Cardiac Catheterization. While being worked on at approximately 0755 hours, a team of medical staff began to conduct chest compressions with negative results. At 0833 hours detainee Mandza, Evalin was pronounced dead by medical personel (Nurse (b)(6), (b)(7)(c) and Dr. (b)(6), (b)(7)). At 0940 the body of detainee Mandza was moved to the mortuary of the hospital. ///End of Report///.

Supervisor's Assessment

Please Print and Include: Date/Time, whether AOD was notified, when, and by whom.

(b)(6), (b)(7)(c)

Use of Force Report submitted?: ☐ Yes ☒ No

Transport Officer

Staff Signature and Printed Name and Title *Supervisor's Signature, Printed Name and Title, Date & Time*

HealthONE®
The Medical Center of Aurora
North Suburban Medical Center
Presbyterian/St. Luke's Medical Center
Rose Medical Center
Sky Ridge Medical Center
Spalding Rehabilitation Hospital
Swedish Medical Center

LEADING HOSPITALS. TRUSTED CARE.

RELEASE OF INFORMATION

303-695-(b)(6), (b)(7)(c)- MEDICAL CENTER OF AURORA
303-450-(b)(6), (b)(7)(c)- NORTH SUBURBAN
303-839-(b)(6), (b)(7)(c)- PRESBYTERIAN/ST LUKES
303-320-(b)(6), (b)(7)(c)- ROSE MEDICAL CENTER
720-225-(b)(6), (b)(7)(c)- SKY RIDGE
303-363-(b)(6), (b)(7)(c)- SPALDING REHAB
303-788-(b)(6), (b)(7)(c)- SWEDISH/SOUTHWEST ER
720-279-6593-FAX

FACSIMILE TRANSMITTAL SHEET

TO: CDR (b)(6), (b)(7)(c)	FROM: (b)(6), (b)(7)(c)
COMPANY:	DATE: 05/04/2012 11:38
FAX NUMBER: 18663110973	TOTAL NO. OF PAGES INCLUDING COVER:
RE:	SENDER'S REFERENCE NUMBER:

NOTES/COMMENTS:

☐ **REQUESTOR VERIFIED**

☐ **PATIENT VERIFIED**

☐ **FAX NUMBER VERIFIED**

This information has been disclosed to you from records protected by Federal Confidentiality rules. Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains to as otherwise permitted by 42 C.F.R part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

THE MEDICAL CENTER OF AURORA

South Campus
1501 South Potomac
Aurora, CO 80012

North Campus
700 Potomac
Aurora, CO 80011

Centennial Medical Plaza
14200 East Arapahoe Road
Englewood, CO 80112

PATIENT NAME: MANDZA,EVALIN
ACCT #: E40000734489 MR #: E001113503
LOCATION: E.SURGIN

ATTENDING PHY: (b)(6), (b)(7)(c)
ADMITTING PHY:

CARDIAC CATH LAB

Case No.: 42299

ADMISSION DATE: 04/12/2012
PROCEDURE DATE: 04/12/2012

CARDIOLOGIST: (b)(6), (b)(7)(c), MD

PROCEDURE:
Coronary catheter insertion, coronary cineangiogram, drug-eluting stent to the left main coronary artery and PTCA of the left anterior descending artery.

INDICATION:
Acute anterior myocardial infarction.

Procedure as an emergency.

DESCRIPTION OF PROCEDURE:
The patient was brought to the cardiac catheterization laboratory and quickly prepped and draped in the usual sterile fashion. A 6-French sheath was placed in the right femoral artery, a 6-French XB 3.5 guiding catheter was positioned. A Prowater flex guidewire was positioned down the left anterior descending artery. A 2.5 x 12 mm TREK angioplasty catheter was positioned across the total occlusion and inflated to 12 atmospheres for 10 seconds. The angioplasty catheter was then removed. The patient then went into ventricular tachycardia and then a PEA arrest. ACLS protocol was begun, including CPR cardioversion. Of note is that the patient had received an Angiomax bolus and infusion prior to the balloon inflation. The patient received 3 mg of epinephrine IV. The guiding catheter was pulled back. The patient then developed a blood pressure of close to 200 and a heart rate of at least 140. This was transient. The guiding catheter was then removed and a 6-French JL4 guiding catheter was positioned in an effort to try and not have the guiding catheter into the left main as it was realized this was the source of the embolus to the left anterior descending artery and there was a severe stenosis there. We were not able to visualize the left main with this catheter and this had to be removed. An aortic root shot injection was performed which still did not show any filling into the left coronary artery. This guiding catheter was then removed and an XB 3.5, 6-French guiding catheter was then repositioned. During this time, the patient received continued CPR. He required multiple defibrillations at 360 joules in an attempt to revive him.

Also of note is that a 7-French sheath was placed in the left femoral vein in an attempt to access the artery and place a balloon pump. The artery was never able to be accessed on that side and the balloon pump was unable to be placed. A temporary pacemaker wire was positioned.

A second 6-French XB 3.5 guiding catheter was then positioned to replace the Judkins catheter, and the Prowater flex guidewire was positioned down the left anterior descending artery, and a Runthrough guidewire was positioned down the circumflex artery which now also had an embolus in it, presumed from the left main ostium. A Xience 3.5 x 12 mm stent was positioned across the ostium with restoration of patency; however, by this point the distal arteries had at best TIMI 1 flow and ultimately had TIMI 0 flow. No further interventional maneuvers were then able to be performed. The patient received a final defibrillation of 360 joules but had no electrical activity. Because of the embolization into 2 arteries and now the TIMI 0 flow throughout the whole left coronary system despite a patent left main coronary artery, it was felt he had microvascular thrombosis and there was no hope for resuscitation. The patient was then pronounced dead at 8:38 am on 04/12/2012.

Procedure time: 52 minutes
Fluoro time: 11.5 minutes
Contrast: 100 mL Isovue
Fluids: 1000 mL normal saline

MEDICATIONS ADMINISTERED:
Fentanyl 50 mcg IV
Versed 1 mg IV
Benadryl 25 mg PO
Epinephrine 1 mg IV x6
Angiomax bolus 11 mL, plus drip 250 mg/50 mL NS @ 26 mL/hr
Solium Bicarbonate 1 mEq x2
Calcium Chloride 1 mg IV
Amiodarone 150 mg IV

FINAL DIAGNOSES:
1. Successful stent placement to the left main coronary artery.
2. Unsuccessful percutaneous intervention of the left anterior descending artery, which was felt to have been occluded from an embolization from the left main.
3. Unsuccessful resuscitation of the patient due to no flow into the entire left coronary circulation due to a combination of embolization from the left main and thrombosis of the microcirculation due to no flow and prolonged CPR.

(b)(6), (b)(7)(c)
D: 04/13/2012 08:25:48 / T: 04/13/2012 09:08:32
Job #: 761752/509640304

PATIENT NAME: MANDZA,EVALIN ACCOUNT #:E40000734489

(b)(6), (b)(7)(c)

Electronically Signed by (b)(6), (b)(7)(c) on 05/02/12 at 1439

PATIENT NAME: MANDZA,EVALIN ACCOUNT #:E40000734489

Denver Patient Care Inquiry (PCI: OE Database COCAA)

Run: 05/04/12-11:35 by (b)(6), (b)(7)(c)

THE MEDICAL CENTER OF AURORA

South Campus
1501 South Potomac
Aurora, CO 80012

North Campus
700 Potomac
Aurora, CO 80011

Centennial Medical Plaza
14200 East Arapahoe Road
Englewood, CO 80112

PATIENT NAME: MANDZA,EVALIN
ACCT #: E40000734489 MR #: E001113503
LOCATION: E.ERHOLD

ATTENDING PHY:
ADMITTING PHY: (b)(6), (b)(7)(c)

HISTORY & PHYSICAL REPORT

ADMISSION DATE: 04/12/2012

REASON FOR ADMISSION:
Acute anterior MI.

HISTORY OF PRESENT ILLNESS:
The patient is a 46-year-old gentleman whose history was limited as the patient was in severe pain and not very communicative. He apparently had chest pain starting at 4 o'clock this morning while he was in the detention center. The pain was obviously severe and an EKG was eventually done there at 5:45. He was transported here because of ongoing pain. Upon arrival here, he was found to have evidence of an acute anterior MI and a cardiac alert was called.

The patient's history again is very limited. He denies having similar chest pain or any heart problems. He denies any medical problems.

MEDICATIONS:
He takes no medications.

ALLERGIES:
NONE.

REVIEW OF SYSTEMS:
Cannot be done.

PHYSICAL EXAMINATION:
GENERAL: He is a well-nourished gentleman. He is in extreme chest pain.
VITAL SIGNS: 149/97, pulse is 53 plus metoprolol.
HEENT: Normal.
SKIN: Warm and dry. JVP is 5.
CHEST: Clear to auscultation.
CARDIAC EXAM: Revealed a 4th heart sound, without murmurs or gallops.
ABDOMINAL: With no masses, tenderness or organomegaly.
NEURO: Good pulses in his feet, groin and hands. They were all equal.

LABORATORIES:
Potassium of 3, BUN of 7, creatinine 1.

IMPRESSION:
The patient is a 46-year-old gentleman with no apparent risk factors. He is having an acute anterior myocardial infarction. He will report to the Cath Lab. We will treat it with beta blockers, aspirin, statin and a platelet inhibitor.

CONDITION AT THE TIME OF ADMISSION:
Guarded.

(b)(6), (b)(7)(c)
D: 04/12/2012 07:40:04 / T: 04/12/2012 08:19:23
Job #: 863240/509465129

(b)(6), (b)(7)(c)

Electronically Signed by (b)(6), (b)(7)(c) on 04/20/12 at 0656

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PATIENT NAME: MANDZA,EVALIN
ACCT #: E40000734489 MR #: E001113503
LOCATION: E.SURGIN

ATTENDING PHY: (b)(6), (b)(7)(c)
ADMITTING PHY:

ED TSYSTEMS DOCUMENTATION

Patient: MANDZA, EVALIN Clinical Report - Physicians/Mid Levels
MRN: E001113503 The Medical Center of Aurora
VisitID: E40000734489 1501 South Potomac St., Aurora, CO 80012 303-695-2628
46y, M Arrival Date/Time: 04/12/2012 6:58
DOB: 12/05/1965

Arrived- By private vehicle. Historian- patient.

HISTORY OF PRESENT ILLNESS
CHEST PAIN. This started 4:00 and is still present. It was abrupt in onset. Onset during light activity. It is described as "pain" and it is described as located in the central chest area. No radiation. At its maximum, severity described as 10 / 10. When seen in the E.D., severity described as 10 / 10. Modifying factors- Not worsened by anything. Not relieved by anything. He has had difficulty breathing. No nausea, vomiting or diaphoresis.

Similar symptoms previously: None.

Recent medical care: Not recently seen/assessed.

REVIEW OF SYSTEMS
No chills, fever, decreased vision, hearing loss or nasal congestion. No runny nose, sore throat, calf pain, chest pain or cough.

PAST HISTORY
Negative.

Denies the following risk factors for heart disease - hypertension, smoking, diabetes, elevated cholesterol and family history of heart disease. Denies the following risk factors for DVT/PE - history of DVT and pulmonary embolism and recent surgery.

Medications:
None..
Allergies:
No Known Drug Allergy..

Denver Patient Care Inquiry (PCI: OE Database COCAA)

Run: 05/04/12-11:35 by (b)(6), (b)(7)(c)

SOCIAL HISTORY
Never smoked. No alcohol use or drug use.

ADDITIONAL NOTES
The nursing notes have been reviewed.
Weight: 79.3 kg estimated. Height: 72 inches Estimated. BMI: 23.7.

PHYSICAL EXAM
Appearance: Alert. Appears to be in pain.
Eyes: Pupils equal, round and reactive to light.
ENT: Pharynx normal.
Neck: Neck supple.
CVS: Normal heart rate and rhythm. Heart sounds normal.
Respiratory: No respiratory distress. Breath sounds normal.
Abdomen: Soft and nontender.
Back: Normal external inspection.
Skin: Skin warm and dry. Normal skin color.
Extremities: Extremities exhibit normal ROM.
Neuro: Oriented X 3. No motor deficit. No sensory deficit.

LABS, X-RAYS, AND EKG
EKG: EKG time (7:10). Rate: 96. Normal P waves. Normal QRS complex. ST elevation in lead V2, V3, V4 and V5. The study has been interpreted contemporaneously by me. The study has been independently viewed by me. The EKG appears to be a good tracing.
Laboratory Tests: 0412:AA:BG00055R: (COLL: 04/12/2012 07:21) (MsgRcvd 04/12/2012 07:34) Final results

Laboratory Test	Value
POINT OF CARE TROPONIN I	0.03

0412:AA:BG00054R: (COLL: 04/12/2012 07:26) (MsgRcvd 04/12/2012 07:29) Final results

Laboratory Test	Value
POC TOTAL CARBON DIOXIDE	20
POINT OF CARE SODIUM	142
POINT OF CARE POTASSIUM	3.0
POINT OF CARE CHLORIDE	107
POINT OF CARE BUN	7
POINT OF CARE IONIZED CALCIUM	1.13
POINT OF CARE CREATININE	1.0
POINT OF CARE ANION GAP	19
POINT OF CARE HGB	15.6
POINT OF CARE HEMATOCRIT	46
POINT OF CARE GLUCOSE	170
GFR AFRICAN AMERICAN PATIENT	>60
GFR NON-AFRICAN AMER. PATIENT	>60

0412:AA:CG00059S: (COLL: 04/12/2012 07:15) (MsgRcvd 04/12/2012 07:42) Final results

Laboratory Test	Value

PROTHROMBIN TIME PATIENT	10.9
INTERNATIONAL NORMAL RATIO	1.0
PARTIAL THROMBOPLASTIN TIME	22

0412:AA:H00140R: (COLL: 04/12/2012 07:15) (MsgRcvd 04/12/2012 07:28)
Final results

Laboratory Test	Value
SPECIMENS REC'D-NO ORDERS	

.

PROGRESS AND PROCEDURES
Course of Care: Pt arrived by EMS as abdominal pain, neg EKG in ICE detention. EKG done at facility reported as neg..

7:11 EKG shown to me by Nursing staff. I immediately go to the bedside. Pt is not answeing questions. Is writhing in pain, pointing to his chest. After several minutes of questions pt is still not asnsering questions. There are no language barrriers.

Cardiac aler called by me at 7:17. Pt is finally answering questions after I told him that he is having a heart attack, and I need him to anser my questions in order for me to help him. At this time pt is prividing minimal history. Pt has received ASA and metoprolol. Discussed with Dr. (b)(6), (b)(7)(c), (b)(6), (b)(7)(c) One of his partners will see PT in ER.

Dr. (b)(6), (b)(7)(c) at bedside. i-stat noted,not hyperkalemic.

Pt to cath lab..

Critical care performed (35 minutes). Time is exclusive of separately billable procedures. Time includes: direct patient care, patient reassessment, interpretation of data (chest xrays), review of patient's medical records, medical consultation and documentation of patient care- see progress notes.

Clinical Review This patient definitively has Acute Coronary Syndrome.
ECG interpretation documented.
Antiplatelet medications administered.
Reperfusion therapy initiated.
Consultation obtained from cardiologist.
Chest pain precautions provided to patient.

Disposition: Admitted.

CLINICAL IMPRESSION
Acute myocardial infarction with ST elevation (STEMI). Aspirin administered in ED.

(Electronically signed by (b)(6), (b)(7)(c), MD 04/12/2012 7:44)

Any laboratory data incorporated in this document has been entered by the emergency clinician and may have been summarized or otherwise modified. The original full report is available in Meditech. Please refer to PCI for the Performing site information.

Patient: MANDZA, EVALIN Clinical Report - Nurses
MRN: E001113503 The Medical Center of Aurora
VisitID: E40000734489 1501 South Potomac St., Aurora, CO 80012 303-695-(b)(6), (b)(7)(c)
46y, M Arrival Date/Time: 04/12/2012 6:58
DOB: 12/05/1965

TRIAGE

Triage time 0659. Acuity: LEVEL 2.
Chief Complaint: ABDOMINAL PAIN and NAUSEA and (chest pain).
BP: 150/81. HR: 97. RR: 40. Temp: 96.8. O2 saturation: -95 percent on room air. Alert. Pain level now: 10/10. --07:23 (b)(6), (b)(7)(c), RN

Pain level now: 10/10. --07:40 (b)(6), (b)(7)(c), RN.
Weight: 79.3 kg estimated. Height: 72 inches Estimated. BMI: 23.7. --07:23 04/12/2012 (b)(6), (b)(7)(c).

Medications
None. --0720 (04/12/12) (b)(6), (b)(7)(c).

Allergies
No Known Drug Allergy. --0720 (04/12/12) (b)(6), (b)(7)(c).

History
This started last night. (based on pt writhing in pain in bed).

Treatment PTA:
EMS treatment PTA verbally communicated. Oxygen administered by nasal cannula. BP: 140/90. HR: 80. RR: 30. O2 saturation: 100 % (nasal cannula at 3 liters/minute).

PAST MEDICAL HX: Immunizations: status is unknown.

SURGERY HX: No history of previous surgery.
SOCIAL HX: Unknown if ever smoked. No alcohol use (unknown). No drug use (unknown). A self harm assessment was performed (uta d/t condtion). A suicide risk assessment was performed (uta d/t condition). Functional assessment: no impairments noted. The nutritional risk assessment revealed no deficiencies. The learning needs assessment revealed no barriers. No report of abuse. No infectious disease exposure.
Arrived by EMS. --07:23 (b)(6), (b)(7)(c) RN

PATIENT NAME: MANDZA,EVALIN ACCOUNT #:E40000734489

The patient has had vomiting (green bile looking on arrival to unit).
--07:24 (b)(6), (b)(7)(c) RN

SOCIAL HX: (Is at ICE facility). --07:24 (b)(6), (b)(7)(c) RN

Treatment PTA:
ASA 325 mg chewed given by EMS. --07:25 (b)(6), (b)(7)(c) RN

06:59 late entry -. (Uta assess full level of complaints. Pt will not answer any ?s will only thrash around in bed in pain). --07:49 (b)(6), (b)(7)(c) RN.

ADDITIONAL PROBLEMS:
None. --07:20 (b)(6), (b)(7)(c).

ADDITIONAL SURGERIES:
None. --07:20 (b)(6), (b)(7)(c).

Assessment
The patient states feels the same. --07:23 (b)(6), (b)(7)(c) RN.

Interventions
ID band on patient. --07:23 (b)(6), (b)(7)(c), RN.

PHYSICAL ASSESSMENT
To room via stretcher. Alert. Oriented X 4. Appears in pain and in distress. Respirations not labored. Breath sounds within normal limits. Abdomen soft and nontender. Bowel sounds within normal limits. Capillary refill less than 2 seconds. Mucous membranes are pink. Skin is warm and dry. --07:25 (b)(6), (b)(7)(c), RN.

NURSING PROGRESS NOTES
Patient identifiers checked. The initial plan of care for this patient includes an assessment with efforts to address the presence of pain. Call light placed in reach. Side rails up x 2. Bed placed in lowest position. Brakes of bed on. --07:25 (b)(6), (b)(7)(c), RN

Care transferred and report given (RN). --07:26 (b)(6), (b)(7)(c), RN

EKG time (0710). EKG was performed by a nurse and shown to the ED physician. Dr (b)(6), (b)(7)(c) --07:26 (b)(6), (b)(7)(c) RN

(cardiac alert called at 0717). --07:26 (b)(6), (b)(7)(c) RN

07:18. IV access: site #1, left antecubital space, 18g angiocath, with aseptic technique and good blood return; blood drawn: rainbow set. Sent to the lab. Lock flushed with 5 mL saline. --07:27 (b)(6), (b)(7)(c) R.N.

07:20. BP: 131/86. HR: 91. RR: 38. O2 saturation: -100 percent on nasal cannula at 2 liter/minute. --07:28 (b)(6), (b)(7)(c) R.N.

METOPROLOL 5 mg slow IVP over 1 minute. IV patency established. IV site checked: no pain, redness, or swelling. IV flushed thoroughly pre- and post-medication administration. --07:28 (b)(6), (b)(7)(c) R.N.

PATIENT NAME: MANDZA,EVALIN ACCOUNT #:E40000734489

BP: 136/94. HR: 94. RR: 36. O2 saturation: room air -94 percent. --07:28 (b)(6), (b)(7)(c), R.N.

07:20 late entry -. IV access: site #2, right antecubital space, 18g angiocath, with aseptic technique and good blood return; one attempt. Lock flushed with 5 mL saline. --07:46 (b)(6), (b)(7)(c), R.N..

DISPOSITION / DISCHARGE
07:28. BP: 145/89. HR: 90. RR: 28. O2 saturation: -100 percent on nasal cannula at 2 liter/minute. FLACC pain scale; face: 2-frequent to constant frown, clenched jaw, quivering chin; legs: 2-kicking or legs drawn up; activity: 2-arched, rigid or jerking; cry: 2-crying steadily, screams or sobs, frequent complaints; consolability: 2-difficult to console or comfort. Condition at departure: critical. Transported via stretcher by tech and nurse with defibrillator, IV and O2. Admitted to the Cath Lab. Patient has no belongings. --07:47 (b)(6), (b)(7)(c) R.N.

Departure time: 0728. --07:47 (b)(6), (b)(7)(c) R.N..

Locked/Released at 04/12/2012 15:35 by (b)(6), (b)(7)(c) R.N.

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PATIENT NAME: MANDZA,EVALIN
ACCT #: E40000734489 MR #: E001113503
LOCATION: E.SURGIN

ATTENDING PHY:
ADMITTING PHY: (b)(6), (b)(7)(c)

ELECTROCARDIOGRAM

Test Reason : 28
Blood Pressure : ***/*** mmHG
Vent. Rate : 096 BPM Atrial Rate : 096 BPM
P-R Int : 182 ms QRS Dur : 098 ms
QT Int : 378 ms P-R-T Axes : 081 052 071 degrees
QTc Int : 477 ms

Normal sinus rhythm
Right atrial enlargement
ST elevation consider anterolateral injury or acute infarct
ST elevation consider inferior injury or acute infarct
** ** ** ** * ACUTE MI * ** ** ** **
Abnormal ECG
No previous ECGs available
Confirmed by (b)(6), (b)(7)(c) (121) on 4/13/2012 7:44:11 AM

Referred By: SELF REFERRED Overread By: (b)(6), (b)(7)(c) MD

(b)(6), (b)(7)(c)

PATIENT NAME: MANDZA,EVALIN ACCOUNT #:E40000734489

Denver Patient Care Inquiry (PCI: OE Database COCAA)

Run: 05/04/12-11:35 by (b)(6), (b)(7)(c)

PATIENT NAME: MANDZA,EVALIN
UNIT NO: E001113503

EXAMS:	**REASON FOR EXAM:**	**CPT CODE:**
002432047 CHEST SNGLE VW PORT AP	CP - CHEST PAIN	

CHEST SINGLE VIEW RADIOGRAPH
VIEWS: One POSITION: Upright

EXAM DATE AND TIME: 4/12/2012 7:31 AM

INDICATION: Chest pain.

COMPARISON: None.

FINDINGS:
Lungs: The lungs are well-expanded and clear. There is no consolidation or effusion.

Heart: The cardiac silhouette is normal in size. The thoracic aorta is normal in caliber.

Osseous Structures: The osseous structures are unremarkable.

Support Catheters: None.

There is no pneumothorax.

IMPRESSION:
1. No radiographic evidence for acute cardiopulmonary disease.

** Electronically Signed by (b)(6), (b)(7)(c) MD **
** on 04/12/2012 at 0743 **
Reported and signed by: (b)(6), (b)(7)(c) MD

CC:

TECHNOLOGIST: (b)(6), (b)(7)(c) BATCH NO:
TRANS: DR (b)(6), (b)(7)(c) SYS D/TM: 05/04/2012 (1136)
ELECTRONIC SIGNATURE DATE/TIME: 04/12/2012 (0743)

PAGE 1 **Signed Report Printed From PCI**

South ED
Medical Center of Aurora
1501 S. Potomac
Aurora,CO 80012
PHONE #: 303-695-(b)(6), (b)(7)(c)
FAX #: 303-873-5592

NAME: MANDZA,EVALIN
HP: (303)361-(b)(6), (b)(7)(c) AGE: 46 S:M
DOB: 12/05/1965 LOC: E.CCL A
PHYS: (b)(6), (b)(7)(c)
EXAM DATE: 04/12/2012 STATUS: DIS IN
A#: E40000734489 U#: E001113503

RUN DATE: 05/04/12 The Medical Center-Aurora LAB *LIVE* PAGE 1
RUN TIME: 1136 Specimen Inquiry
RUN USER: (b)(6), (b)(7)(c) PCI User: (b)(6), (b)(7)(c) Lab Database: LAB.COCAA

PATIENT: MANDZA,EVALIN **ACCT #:** E40000734489 **LOC:** E.SURGIN **U #:** E001113503
DOCTOR: (b)(6), (b)(7)(c) **AGE/SX:** 46/M **ROOM:** E.CCL **REG:** 04/12/12
PHONE: (303)750-(b)(6), (b)(7)(**STATUS:** DIS INx **BED:** A **DIS:** 04/12/12

Specimen: 0412:AA:BG00087R **Collected:** 04/12/12-0718 **Status:** COMP **Req#:** 05215267
Received: 04/12/12-0846 **Sub Dr:** (b)(6), (b)(7)(c)
Verified: 04/12/12-0846
Patient Id:
Ordered: ABGPOC

Test	Result	Flag	Reference	Site
ABGPOC				
POC PH	7.16	LC	7.35-7.45	POC
POC PCO2	27.2	L	32-38 mmHg	POC
POC PO2	87	H	65-75 mmHg	POC
POC HCO3	9.6	L	22-26 mmol/L	POC
TCO2POC	10	L	22-32 mmol/L	POC
POC BE	-19	L	-2.5-2.5 mmol/L	POC
POC O2 SAT	94		92-94 %	POC
POC SITE	ARTERIAL			POC

POC - POINT OF CARE TESTING

RUN DATE: 05/04/12 The Medical Center-Aurora LAB *LIVE* PAGE 1
RUN TIME: 1136 Specimen Inquiry
RUN USER: (b)(6), (b)(7)(c) PCI User: (b)(6), (b)(7)(c) Lab Database: LAB.COCAA

PATIENT: MANDZA,EVALIN **ACCT #:** E40000734489 **LOC:** E.SURGIN **U #:** E001113503
DOCTOR: (b)(6), (b)(7)(c) **AGE/SX:** 46/M **ROOM:** E.CCL **REG:** 04/12/12
PHONE: (303)750-(b)(6), (b)(7)(**STATUS:** DIS INx **BED:** A **DIS:** 04/12/12

Specimen: 0412:AA:BG00055R **Collected:** 04/12/12-0721 **Status:** COMP **Req#:** 05215191
Received: 04/12/12-0734 **Sub Dr:** Carepoint,Physician
Verified: 04/12/12-0734
Patient Id:
Ordered: TROPONIN ISTAT

Test	Result	Flag	Reference	Site
TROPONIN ISTAT	0.03		0.00-0.08 ng/mL	POC
	ISTAT Troponin I Interpretation:			
	I-STAT results greater than 0.08 ng/mL should be considered Positive for Myocardial Injury.			
	Interpretation of Cardiac Troponin I results should be done only in the context of the overall clinical picture, e.g. clinical history, EkG, and other laboratory tests indicative of cardiac damage.			

POC - POINT OF CARE TESTING

RUN DATE: 05/04/12 The Medical Center-Aurora LAB *LIVE* PAGE 1
RUN TIME: 1136 Specimen Inquiry
RUN USER: (b)(6), (b)(7)(c) PCI User: (b)(6), (b)(7)(c) Lab Database: LAB.COCAA

PATIENT: MANDZA,EVALIN **ACCT #:** E40000734489 **LOC:** E.SURGIN **U #:** E001113503
DOCTOR: (b)(6), (b)(7)(c) **AGE/SX:** 46/M **ROOM:** E.CCL **REG:** 04/12/12
PHONE: (303)750-(b)(6), (b)(7)(**STATUS:** DIS INx **BED:** A **DIS:** 04/12/12

Specimen: 0412:AA:CG00059S **Collected:** 04/12/12-0715 **Status:** COMP **Req#:** 05215186
Received: 04/12/12-0730 **Sub Dr:** (b)(6), (b)(7)(c)
Verified: 04/12/12-0741

Patient Id:
Ordered: PT, PTT
Comments: Campus: S
DISCHARGE PENDING? N

Test	Result	Flag	Reference	Site
PT				
PT PATIENT	10.9		9.5-12.0 SEC	AR
INR	1.0			AR
	~THE INR TARGET RANGE FOR ORAL ANTICOAGULANTS:			
	VENOUS THROMBOSIS: 2.0-3.0			
	ARTERIAL THROMBOSIS & HEART VALVE PROPHYLAXIS: 2.5-3.5			
	ATRIAL FIBRILLATION: 2.0-3.0			
PTT	22		22-30 SECONDS	AR
	**** NEW PTT THERAPEUTIC RANGE FOR HEPARINIZED PATIENTS ****			
	EFFECTIVE 6/27/2011			
	The therapeutic range is 38 - 62 seconds for unfractionated heparin, as measured by the aPTT, which roughly corresponds to the recommended heparin concentrations of 0.3 - 0.7 U/mL as measured by the activated factor X assay. If the patient's clinical situation warrants greater accuracy in the monitoring of the anticoaguation, consider measuring the actual heparin level.			
	VERIFIED 6/10/2011 - NEW REFERENCE RANGE FOR HEPARININZED PATIENTS			

AR - THE MED CTR OF AURORA, SOUTH CAMPUS
1501 S. POTOMAC, AURORA, CO. 80012

RUN DATE: 05/04/12 The Medical Center-Aurora LAB *LIVE* PAGE 1
RUN TIME: 1136 Specimen Inquiry
RUN USER: (b)(6), (b)(7)(c) PCI User: (b)(6), (b)(7)(c) Lab Database: LAB.COCAA

PATIENT: MANDZA,EVALIN **ACCT #:** E40000734489 **LOC:** E.SURGIN **U #:** E001113503
DOCTOR: (b)(6), (b)(7)(c) **AGE/SX:** 46/M **ROOM:** E.CCL **REG:** 04/12/12
PHONE: (303)750-(b)(6), (b)(7) **STATUS:** DIS INx **BED:** A **DIS:** 04/12/12

Specimen: 0412:AA:H00141S **Collected:** 04/12/12-0715 **Status:** COMP **Req#:** 05215186
Received: 04/12/12-0730 **Sub Dr:** (b)(6), (b)(7)(c)
Verified: 04/12/12-0742

Patient Id:
Ordered: CBC W/AUTO DIFF
Comments: Campus: S
DISCHARGE PENDING? N

Test	Result	Flag	Reference	Site
CBC W/AUTO DIFF				
WBC	6.7		3.4-11.2 10*3uL	AR
RBC	5.38		4.20-5.40 10*6/uL	AR
HGB	15.2		13.7-18.3 g/dL	AR
HCT	45.8		41.0-55.0 %	AR
MCV	85.1		79.0-98.0 fL	AR
MCH	28.2		26.0-33.0 pg	AR
MCHC	33.2		31.0-36.0 g/dL	AR
RDW	12.4		11.5-14.5 %	AR
PLT	268		150-375 10*3/uL	AR
MPV	7.5		7.4-10.4 fL	AR
NE%	52.5		45.0-75.0 %	AR
LYMPH %	35.7		20.0-50.0 %	AR
MONO %	10.6		2.8-13.0 %	AR
EOS %	0.8		0.7-5.2 %	AR
BASO %	0.4		0.0-1.5 %	AR
NE#	3.5		1.7-6.0 10*3/uL	AR
LYMPH #	2.4		1.1-3.3 10*3/uL	AR
MONO #	0.7		0.2-0.9 10*3/uL	AR
EOS #	0.1		0.1-0.4 10*3/uL	AR
BASO #	0.0		0.0-0.1 10*3/uL	AR

AR - THE MED CTR OF AURORA, SOUTH CAMPUS
1501 S. POTOMAC, AURORA, CO. 80012

CERTIFICATION OF VITAL RECORD

STATE OF COLORADO

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

HOLD TO LIGHT TO VIEW WATERMARK

AMENDED

STATE OF COLORADO
CERTIFICATE OF DEATH

STATE FILE NUMBER

FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Evalin MANDZA		2. SEX: Male	3. DATE OF DEATH (Month, Day, Year): April 12, 2012
4. SOCIAL SECURITY NUMBER: (b)(6), (b)(7)(c)	5a. AGE - (Years): 46	5b. UNDER 1 YEAR: Mos / Days	5c. UNDER 1 DAY: Hrs / Mins
6. DATE OF BIRTH: Month December, Day 5, Year 1965		7. BIRTHPLACE (City and State or Foreign Country): Unknown	
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ Yes ☑ No	9a. PLACE OF DEATH (Check only one): HOSPITAL* ☐ Inpatient ☑ ER/Outpatient ☐ DOA; OTHER: ☐ Assisted Living/Nursing Home ☐ Hospice ☐ Decedent's Residence ☐ Other (Specify)		
9b. FACILITY NAME (If not institution, give street and number): Aurora Medical Center South	9c. CITY, TOWN, OR LOCATION OF DEATH: Aurora	9d. COUNTY OF DEATH: Arapahoe	
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired): Unknown	10b. KIND OF BUSINESS/INDUSTRY: Unknown	11. MARITAL STATUS: ☐ Married ☐ Never Married ☐ Widowed ☐ Divorced ☑ Unknown	12. SPOUSE (If wife, give maiden name): Unknown
13a. RESIDENCE - STATE: Colorado	13b. COUNTY: Aurora	13c. CITY, TOWN, OR LOCATION: Adams	13d. STREET AND NUMBER: (b)(6), (b)(7)(c)
13e. INSIDE CITY LIMITS? ☑ Yes ☐ No	13f. ZIP CODE: 80010	14. WAS DECEDENT OF HISPANIC ORIGIN? (If "Yes", specify Cuban, Mexican, Puerto Rican, etc.) ☐ No ☐ Yes Specify: Unknown	15. RACE: American Indian, Black, White, etc. (Specify): African American
16. EDUCATION: (Specify only highest grade completed) Elementary or secondary (0 - 12) College (13-16 or 17+): Unknown			
17. FATHER - NAME (First, Middle, Last): Unknown	18. MOTHER - NAME (First, Middle, Maiden): Unknown	19. INFORMANT - NAME and relationship to deceased: (b)(6), (b)(7)(c) Human Services	
20a. METHOD OF DISPOSITION: ☑ Burial/Entombment ☐ Cremation ☐ Resomation ☐ Removal from State ☐ Donation ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Mount Olivet Cemetery	20c. LOCATION - City or Town, State: Wheat Ridge, Colorado	
21a. SIGNATURE OF FUNERAL DIRECTOR OR PERSON ACTING AS SUCH: Signature (b)(6), (b)(7)(c)	21b. NAME AND ADDRESS OF FACILITY: Archdiocese of Denver Mortuary, 12801 W. 44th Ave., Wheat Ridge, CO 80033		
22a. REGISTRAR'S SIGNATURE: Signature (b)(6), (b)(7)(c) Deputy	22b. DATE FILED (Month, Day, Year): MAY 17 2012		

PHYSICIAN/CORONER

23. TIME OF DEATH: 8:33 ☑ AM ☐ PM ☐ Mil	24. DATE AND TIME PRONOUNCED DEAD: Month April, Day 12, Year 2012, Time 8:33 ☑ AM ☐ PM ☐ Mil	25. WAS CORONER NOTIFIED? ☑ Yes ☐ No	
TO BE COMPLETED BY SIGNING PHYSICIAN: 26a. To the best of my knowledge, death occurred at the time, date and place, and due Signature (b)(6), (b)(7)(c) ☒ MD ☐ DO		TO BE COMPLETED BY CORONER: 27a. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature ☐ Coroner ☐ Assoc/Deputy Coroner	
26b. DATE SIGNED (Month, Day, Year): 5/17/12		27b. DATE SIGNED (Month, Day, Year)	
26c. NAME AND MAILING ADDRESS OF SIGNING PHYSICIAN: (b)(6), (b)(7)(c) Aurora, Co 80012		27c. NAME AND COUNTY	
		28. NAME OF ATTENDING PHYSICIAN IF OTHER THAN SIGNING PHYSICIAN	
29. MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Undetermined	30. DID TOBACCO USE CONTRIBUTE TO DEATH: ☐ Yes ☐ No ☐ Probably ☒ Unknown	31. IF FEMALE: ☐ Not pregnant within last year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within the past year	
32a. DATE OF INJURY (Month, Day, Year)	32b. TIME OF INJURY: ☐ AM ☐ PM ☐ Mil	32c. INJURY AT WORK? ☐ Yes ☐ No	32d. DESCRIBE HOW INJURY OCCURRED
32e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)	32f. LOCATION INJURED (Street and Number or Rural Route Number, City, County, State)		

33. IMMEDIATE CAUSE - enter only one cause per line for (a), (b), and (c). Do not enter mode of dying (e.g. Cardiac or Respiratory Arrest) alone.

		Interval between onset and death
Part 1. Conditions if any which gave rise to immediate cause stating the underlying cause last (c).	(a) Anemia M.I. DUE TO OR AS A CONSEQUENCE OF:	Hours / NOT known
	(b) Severe Left Main Coronary Artery Stenosis DUE TO OR AS A CONSEQUENCE OF:	Interval between onset and death
	(c)	Interval between onset and death

Part 2. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause in Part 1

34. AUTOPSY: ☐ Yes ☒ No

35. If YES, were findings considered in determining cause of death? ☐ Yes ☐ No

MAY 24 2012

DATE ISSUED

(b)(6), (b)(7)(c)

STATE REGISTRAR

THIS IS A TRUE CERTIFICATION OF NAME AND FACTS AS RECORDED IN THIS OFFICE. Do not accept unless prepared on security paper with engraved border displaying the Colorado state seal and signature of the Registrar. PENALTY BY LAW, Section 25-2-118, Colorado Revised Statutes, 1982, if a person alters, uses, attempts to use or furnishes to another for deceptive use any vital statistics record. NOT VALID IF PHOTOCOPIED.

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REV 01/07

American Bank Note Company

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

STATE OF COLORADO 1876

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT

DIRECTIVE TITLE: NOTIFICATION AND REPORTING OF DETAINEE DEATHS
INDIVIDUAL INCIDENT CHECKLIST

Field Office:	**Denver**
Detainee Name:	**Evalin-Ali MANDZA**
A#:	(b)(6), (b)(7)(c)
Date of Death:	**Thursday, April 12, 2012**

a) **Immediately following the death** of a detainee:
i) Enforcement and Removal Operations (ERO) Field Office Director ***(FOD)*** *shall:*

Status:		Date:	Time:	Time Zone:	Person making Notification:	Person Notified:	Manner:
COMPLETED	❖Contact the ERO Assistant Director for Field Operations.	4/12/2012	0915	MST	FOD (b)(6), (b)(7)(c)	AD (b)(6), (b)(7)(c)	Telephonic
COMPLETED	❖Joint Intake Center (JIC) by telephone to report the death.	4/12/2012	1015	MST	DFOD (b)(6), (b)(7)(c)	JIC; (b)(6), (b)(7)((b)(6), (b)(7)(c)	Telephonic
N/A	❖The Assistant Director for Field Operations shall notify the Executive Associate Director by telephone.						
COMPLETED	❖Report the detainee death as a "significant incident" to the ICE Reporting and Operations Center (IROC) using the electronic ICE Significant Event Notification (SEN) system.	4/12/2012	1200	MST	AFOD (b)(6), (b)(7)(c	SEN Notification System	via Email
N/A	❖The Executive Associate Director shall provide telephonic notification to the Office of the Director.						
N/A	❖The **JIC**, upon being notified, shall provide telephonic notification to the DHS Office of the Inspector General (OIG).						

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT

DIRECTIVE TITLE: NOTIFICATION AND REPORTING OF DETAINEE DEATHS
INDIVIDUAL INCIDENT CHECKLIST

b) **Within 24 hours** of the death of a detainee:
*i) The **FOD** shall provide email, telephonic, or in person notification to:*

Status:		Date:	Time:	Time Zone:	Person making Notification:	Person Notified:	Manner:
COMPLETED	❖The appropriate Chief Counsel Office (who will notify the alien's attorney of record, EOIR, BIA and Circuit Court officials).	4/12/2012	1025	MST	DFOD (b)(6), (b)(7)(c)	Chief Counsel (b)(6), (b)(7)(c)	In Person
COMPLETED	❖Attorney of Record notification.	4/12/2012	1050	MST	Senior Attorney (b)(6), (b)(7)(c)	Supervisory Legal Assistant (b)(6), (b)(7)(c)	Telephonic
COMPLETED	❖The appropriate state agency(ies), in states that require notification.	4/12/2012	unknown	MST	GEO Medical Staff	(b)(6), (b)(7)(c) Adams County Coroner's Office	Telephonic
COMPLETED	❖The local ICE public affairs officer.	4/12/2012	1333	MST	DFOD (b)(6), (b)(7)(c)	(b)(6), (b)(7)(c)	via Email
COMPLETED	❖The ICE Health Service Corp (IHSC).	4/12/2012	0630	MST	GEO Medical Staff	Unknown	Telephonic

*ii) **The Executive Associate Director of ERO shall** :*

Status:		Date:	Time:	Time Zone:	Person making Notification:	Person Notified:	Manner:
N/A	❖Provide email or telephonic notification to the DHS Office of Health Affairs.						
N/A	❖Provide email or telephonic notification to the Civil Rights and Civil Liberties.						
N/A	❖Provide written notification to OAD via a Director's Note.						
N/A	❖Provide written notification to the Office of Professional Responsibility via a Director's Note.						

	❖Provide written notification to the Office of Public Affairs via a Director's Note.						
N/A	❖Provide written notification to the Office of Congressional Relations via a Director's Note.						
N/A	❖Provide written notification to the Office of ICE Policy, via a Director's Note.						

c) **Within 48 hours** of the death of a detainee, the **Executive Associate Director of ERO** shall:

► Ensure that copies of all available medical reports are provided to the DHS Office of Health Affairs (OHA) in order to provide OHA the ability to initiate a proper mortality review. **(All other relevant documents shall be provided to OHA in accordance with section 8.)**

NOTE: All notifications provided in accordance with this section, along with an acknowledgment that the notification was received (if possible), shall be documented and maintained in the decedent's alien file (A-file).

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT

DIRECTIVE TITLE: NOTIFICATION AND REPORTING OF DETAINEE DEATHS
INDIVIDUAL INCIDENT CHECKLIST

7.2 Notification to Consulate and Detainee's Next-of-Kin.

a) **Within 24 hours** of the death of a detainee:

Status:		Date:	Time:	Time Zone:	Person making Notification:	Person Notified:	Manner:
COMPLETED	❖The **FOD** shall telephonically notify the applicable consulate of the death and coordinate with consular officials, as necessary, to locate the next-of-kin.	4/12/2012	1027	MST	SDDO (b)(6), (b)(7)(c)	(b)(6), (b)(7)(c) Embassy of Gabon	Telephonic
N/A	❖The **FOD** shall ensure that, unless consular officials are unwilling to do so, all notifications to next-of-kin are made by consular officials.						
COMPLETED	❖If consular officials are unwilling to notify next-of-kin, the **FOD** shall telephone the person named as the next-of-kin to inform them of the death in a language they can understand.	4/12/2012	0937	MST	SDDO (b)(6), (b)(7)(c)	(b)(6), (b)(7)(c) Carter (203) 424 (b)(6), (b)(7)(c)	Telephonic

b) **Within 48 hours** of the next-of-kin being notified:

	Date:	Time:	Time Zone:	Person making Notification:	Person Notified:	Manner:
❖The **FOD** shall send a condolence letter to the next-of-kin (see attached template), with a copy to the applicable consulate.	4/17/2012	0730	MST	SDDO (b)(6), (b)(7)(c)	(b)(6), (b)(7)(c)	USPS mail

Name of Next-of Kin:	
Address:	(b)(6), (b)(7)(c) Aurora, CO 80016
Relation:	Brother

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT

DIRECTIVE TITLE: NOTIFICATION AND REPORTING OF DETAINEE DEATHS
INDIVIDUAL INCIDENT CHECKLIST

7.3. Notification to Congress, the Media and Nongovernmental Organizations.

a) **Within 24 hours** of the death of a detainee, the ICE Office of Congressional Relations shall provide e-mail notification to the Chair and Ranking member of the following Committees:

Status:		Date:	Time:	Time Zone:	Person making Notification:	Person Notified:	Manner:
N/A	❖Those House and Senate members who have jurisdiction over where the death occurred						
N/A	❖Senate Judiciary Committee.						
N/A	❖House Judiciary Committee.						
N/A	❖Senate Judiciary Committee, Subcommittee on Immigration, Refugees and Border Security.						
N/A	❖House Judiciary Committee, Subcommittee on Immigration, Citizenship, Refugees, Border Security and International Law.						
N/A	❖Senate Homeland Security and Governmental Affairs Committee.						
N/A	❖House Homeland Security Committee.						
N/A	❖Senate Appropriations Committee.						
N/A	❖House Appropriations Committee.						

NOTE: OCR shall coordinate with the ICE Office of the Chief Financial Officer before sending notifications to House and Senate Appropriations Committee staff.

	COMMENTS:
►The Office of Public Affairs shall provide a media release to the local press and the Associated Press, and post the media release on ICE's Internet website. (After notification of the next-of-kin, or when the next-of-kin cannot be located but reasonable efforts have been made by DRO (in coordination with the consulate) to locate the next-of-kin.)	

▶The ICE Office of Policy shall provide a copy of the media release to nongovernmental organizations (NGOs) via the ICE/NGO working group co-chairs.	
▶In instances where the consulate has been notified of a detainee's death but the next-of-kin have not been located yet efforts to locate them continue, notifications to Congress, the media or NGOs shall include information that efforts to reach next-of-kin are ongoing.	

8 ONGOING REPORTING REQUIREMENTS.

8.2. Detention Management Division.

Upon the death of a detainee in a detention facility, the ERO Assistant Director for Management (ADM) shall require:

Status:		Date:	Time:	Time Zone:	Person making Notification:	Person Notified:	Manner:
N/A	❖In coordination with OPR, an internal review of all facility inspection records for the detention facility at which the death occurred.						
N/A	❖A review of all contract documentation for the detention facility where the death occurred.						
N/A	❖If the death occurs at a medical facility or while the detainee is in transit, the ADM shall require such review at the facility where the decedent was last held in custody.						

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT

DIRECTIVE TITLE: NOTIFICATION AND REPORTING OF DETAINEE DEATHS
INDIVIDUAL INCIDENT CHECKLIST

b) The ADM shall submit the records **within 14 calendar days** of the death of the detainee to:

Status:		Date:	Time:	Time Zone:	Person making Notification:	Person Notified:	Manner:
N/A	✓ ICE senior management						
N/A	✓ OPR						
N/A	✓ OHA for inclusion in OHA's mortality review						
N/A	✓ CRCL						
N/A	✓ OIG (if the investigation is being conducted by the OIG).						

c) The ADM shall provide autopsy and toxicology results (if applicable), a copy of all treatment authorization requests (TAR), a copy of the death certificate and all other relevant documents (ie., state and local law enforcement investigatory information), as soon as they become available to:

Status:		Date:	Time:	Time Zone:	Person making Notification:	Person Notified:	Manner:
N/A	✓ OHA for inclusion in OHA's mortality review						
N/A	✓ CRCL						
N/A	✓ OIG (if the investigation is being conducted by the OIG).						

Detainee Death Review
Medical Record Review
MANDZA, Evalin Ali, A # (b)(6), (b)(7)(c)
Denver Contract Detention Facility, Denver, CO

Section 1: Medical Compliance Review

As requested by the ICE Office of Professional Responsibility, Office of Detention Oversight, Creative Corrections (CC) participated in a review of detainee Evalin Ali MANDZA's death at the Denver Contract Detention Facility (DCDF) in Denver, CO. CC accompanied Special Agents (b)(6), (b)(7)(c) and (b)(6), (b)(7)(c) on a site visit May 21-23, 2012, and participated in interviews of ICE, correctional and medical staff. Additionally, CC reviewed the medical record of detainee MANDZA, and relevant policies and procedures. CC's participation was requested to determine compliance with the ICE Performance Based National Detention Standards governing medical services.

The following chronicles detainee MANDZA's period of detention at DCDF based on documented and reported information. CC's observations and compliance findings appear in commentary. Medical terminology is defined in parentheses and brackets.

Medical Encounters Timeline

October 17, 2011

Record of Deportable/Inadmissible Alien Form I 213 completed by Immigration Enforcement Officer (b)(6), (b)(7)(c) documents detainee MANDZA, 46 years old, was arrested and charged with resisting an officer and detained at the Aurora County Jail. The form further documents the detainee "states he is in good health and is taking no medications;" further, "appears to be in good health." He was subsequently transferred to the Denver Enforcement & Removal Operations (ERO) Field Office for processing.

October 24, 2011
5:05 pm

The detainee arrived at the DCDF. The Order to Detain listed his nationality as Gabon, a country in west central Africa.

6:45 pm

Intake Screening was conducted by (b)(6), (b)(7)(c), Licensed Practical Nurse (LPN). Vital signs (VS) were documented as follows: pulse (P) 81, blood pressure (BP) 101/62, respirations (R) 14, temperature (T) 97.1, all within normal limits (WNL). No chronic care issues were identified, and the form documented negative responses to all health history questions. His placement recommendation was recorded as "General Population." A consent for treatment form was signed and dated. On interview LPN (b)(6), (b)(7)(c) stated she always asks more questions than listed on the form and seeks to identify possible signs or symptoms of anything abnormal. She stated she found "nothing out of the ordinary."

The Nursing Incoming Screen Progress Note form documents no medications were ordered, no special treatments or follow-up referrals, no work limitations, and no housing or bunk limitations. CC was informed this form is designed to focus on chronic conditions requiring follow up and/or medications. (b)(6), (b)(7)(c), MD reviewed and signed the form on October 27, 2011.

The Mental Health Intake Screen completed by LPN (b)(6), (b)(7)(c) documents negative responses for all items. The form was signed by (b)(6), (b)(7)(c), MD on the same date.

The detainee refused syphilis testing and signed a refusal form.

A chest x-ray was performed with the results documented as "Negative except for calcified granuloma *[small area of inflammation of benign calcification]* less than 2 cm."

October 25, 2011
Detainee MANDZA submitted a sick call request stating he had "bad movement."

October 26, 2011
6:00 pm
A physical examination and health appraisal was performed by (b)(6), (b)(7)(c) Adult Nurse Practitioner (ANP). Height: 5 feet 8 inches; weight: 141 pounds. VS: T 98.6, P 78, R 18, BP 104/64, and all WNL. All history and systems items were documented as normal. Dr. (b)(6), (b)(7)(c) signed the physical examination on October 27, 2011.

Progress Note by (b)(6), (b)(7)(c), Registered Nurse (RN) documents detainee MANDZA was seen for sick call complaining of not having a bowel movement in three to four days. He was instructed to increase his fluid intake. The detainee verbalized understanding and was given Ducolax and Milk of Magnesia (MOM) *(laxatives to relieve constipation)* in accordance with GEO nursing protocols.

October 31, 2011
Detainee MANDZA submitted a sick call request for "constipation movement." He was placed on the sick call list to be seen by Dr. (b)(6), (b)(7)(c) on November 3, 2011.

During site visit, CC learned Detainee MANDZA's name was crossed off Dr. (b)(6), (b)(7)(c) sick call list with a crayon. Acting HSA RN (b)(6), (b)(7)(c) stated names are crossed off sick call lists with crayons to signify the medical record has been pulled for the appointment. There was no corresponding Progress Note or other documentation supporting detainee MANDZA was seen by Dr. (b)(6), (b)(7)(c) on November 3, 2011; in fact, he was not seen by a physician until December 2, 2011. RN (b)(6), (b)(7)(c) could not explain why the sick call appointment was missed.

> **COMMENT**: CC cites non-compliance with ICE PBNDS, Medical Care, section (II)(2), requiring that health care needs be met in a timely and efficient manner.

November 8, 2011
Detainee MANDZA submitted a sick call request for, "bumps shaving, need medical."

November 9, 2011
The medical record documents the sick call request was reviewed and the detainee was seen by LPN (b)(6), (b)(7)(c). Per GEO nursing protocol, he was given TAO *(triple antibiotic cream)* to be applied daily for seven days.

November 10, 2011
Detainee MANDZA submitted a sick call request for "constipation movement."

November 11, 2011
The medical record documents the sick call request was reviewed by LPN (b)(6), (b)(7)(c) Per GEO nursing protocol he was given Ducolax again and fiber was added.

November 17, 2011
Detainee MANDZA submitted a sick call request for "dental hurt, couldn't go to sleep." RN (b)(6), (b)(7)(c) gave him Tylenol *(for pain)* and scheduled him to see the dentist on November 21, 2011. He was instructed on proper dental hygiene and advised to return to the clinic if symptoms persisted or worsened.

November 21, 2011
Detainee MANDZA was seen by (b)(6), (b)(7)(c) DDS. Per Progress Note, detainee complained of lower level toothache. "The tooth has deep cavities and needs to be extracted. The detainee has court tomorrow, so will reschedule the extraction."

COMMENT: The record includes no documentation the extraction was rescheduled.

November 27, 2011
Detainee MANDZA submitted a sick call request for "constipation movement with shaving bumps."

November 28, 2011
RN (b)(6), (b)(7)(gave detainee MANDZA MOM, Ducolax, and fiber for the constipation and TAO for razor burn rash. RN (b)(6), (b)(7)(documented he was instructed to "drink a lot of water, don't use TAO around the eyes, and return to medical if symptoms persist or worsen."

December 2, 2011
Dr. (b)(6), (b)(7)(c evaluated detainee MANDZA for constipation and folliculitis *(inflammation of hair follicles)*. He prescribed glycerin suppositories, increased fiber, and Colace for the constipation, and a triple antibiotic cream for his neck rash.

December 11, 2011
Detainee MANDZA submitted a sick call request for "dental complaint, need to be cleaned but not to take out."

December 12, 2011
Detainee MANDZA was seen by RN (b)(6), (b)(7)(c) and was given Ibuprofen per GEO nursing protocol. A dental appointment was scheduled for December 20, 2011.

December 14, 2011
Detainee MANDZA submitted a sick call request stating "I fall from top bed hurt my foot."

December 15, 2011
Dr. (b)(6), (b)(7)(c) documented he evaluated detainee MANDZA; no new orders were issued.

December 20, 2011
Dr. (b)(6), (b)(7)(c) (DDS) documented the detainee asked to have his teeth cleaned and complained of pain in his lower level. He refused extraction and was given Ibuprofen.

COMMENT: No refusal form was found in the medical record.

December 25, 2011
11:40 am
Medical Report on Injuries/Non-Injuries documents detainee MANDZA was evaluated due to his involvement in "horseplay" with other detainees. Tiny scratches on his chest and left wrist area were noted by LPN (b)(6), (b)(7)(c) No other apparent injuries.

The Pre-Segregation History and Physical by LPN (b)(6), (b)(7)(c) documents clearance for placement in administrative segregation. The form was signed by Dr. (b)(6), (b)(7)(c) on December 27, 2011.

December 30, 2011
RN (b)(6), (b)(7)(c) documented detainee "fell playing soccer." She gave him Ibuprofen and ice packs for his left big toe.

January 3, 2012
Dr. (b)(6), (b)(7)(c) documented the detainee complained of a sore foot from striking it against a soccer ball. He was noted to be in no apparent distress with any swelling, tenderness or gross deformity. He was prescribed Ibuprofen and a lower bunk was ordered.

January 13, 2012
Detainee MANDZA submitted a sick call request for a "dental problem." The request was reviewed on January 15, 2011 and an appointment was scheduled for January16, 2012.

January 15, 2012
Detainee MANDZA submitted a sick call request for a "dental problem/I need to keeping taking the constipation suppositories that help. Thanks." The request was reviewed and LPN (b)(6), (b)(7)(c) saw the detainee. He was reminded of his dental appointment on January 16, 2012.

January 16, 2012
RN)(6), (b)(7)(documented the detainee was seen in medical for his constipation and dental issues. He was scheduled to see the dentist the same day and to see Dr.)(6), (b)(7)(on January 18, 2012.

Per Progress Note by Dr. (b)(6), (b)(7)(c) the detainee again refused the extraction. He was given Amoxicillin *(antibiotic)* and Tylenol.

> **COMMENT**: No refusal form was found in the medical record.

January 18, 2012
7:08 am
An entry in the Segregation/Special Management Unit (SMU) log book documents detainee MANDZA was "escorted to seg/SMU."

The Pre-Segregation History and Physical completed by RN (b)(6), (b)(7)(c) documents medical clearance for housing in Administrative Segregation. "[N]o physical confrontation just arguing" was noted. The form was signed by (b)(6), (b)(7)(c) MD, but not dated.

> **COMMENT**: Per January 16 Progress Note, detainee MANDZA was to be seen by Dr.)(6), (b)(7)(this date. There is no documentation this appointment occurred. RN)(6), (b)(7)((could not explain why Dr.)(6), (b)(7)(did not see the detainee.

January 27, 2012
Progress Note by ANP)(6), (b)(7)(documents the detainee was complaining of constipation and was declining the Colace and fiber. The glycerin suppositories were renewed for three days, and he was counseled on taking the prescribed treatment for constipation.

> **COMMENT**: There were no refusal forms for Colace and fiber in the record. CC was informed it is not customary practice to have detainees sign refusal forms for over-the-counter medications.

February 9, 2012
Progress Note by RN)(6), (b)(7)(documented the detainee complained of constipation and had not had a bowel movement since February 3, 2012. His bowel signs were decreased and discomfort was increased. He was given Ducolax and MOM per GEO nursing protocol.

February 14, 2012
Detainee MANDZA submitted a sick call request for a "problem with my teeth." A note (illegible initials) documents he was to see the dentist that day.

DMD (b)(6), (b)(7)(c) extracted tooth number 18. A consent form was signed and dated.

March 1, 2012
The detainee submitted a sick call request complaining of burning eyes and constipation. RN (b)(6), (b)(7)(c) reviewed the request, saw the detainee and gave him Ducolax, MOM and artificial tears per GEO nursing protocol. He was to return to medical if symptoms persisted or worsened. He was placed on the physician sick call list for March 5, 2012.

March 5, 2012
Physician Assistant (PA) (b)(6), (b)(7)(c) documented the detainee presented with complaints of constipation; "no dumping *(when food passes too rapidly from the stomach into the upper intestine)*, H2O, on meds." Observations: "Lungs clear, heart-no *[illegible]*, abdomen soft, visceromegaly*[abnormal enlargement of the soft internal organs]*;" Assessment: "Constipation, no water;" Plan: "Increase fiber, increase water, increase exercise."

March 21, 2012
Detainee MANDZA submitted a sick call request for "bad move problems/bumps shaver problems." LPN (b)(6), (b)(7)(c) documents he was seen in medical and given MOM, Ducolax and was scheduled for a medical review.

Progress Note by Dr. (b)(6), (b)(7)(c) documents the detainee has a history of constipation and a stress fracture; Colace ordered again.

March 25, 2012
Progress Note by Dr. (b)(6), (b)(7)(c) documents medications are working well, no nausea, vomiting, diarrhea; no complaints; vital signs stable; continue medications. Detainee to submit a sick call request if problems.

March 31, 2012
Detainee MANDZA submitted a sick call request for "no movement all week."

April 1, 2012
LPN (b)(6), (b)(7)(c) documents the detainee was seen in medical and given Ducolax and MOM per GEO nursing protocol.

April 12, 2012
5:24 am
Per Medical Correctional Log book, "Code Blue in A-4."

5:25 am
Per A-4 Log book, "Code Blue A-4 110/2, Mandza Evalin-Ali complaining of chest pains."

Per General Incident Report authored by (b)(6), (b)(7)(c) Detention Officer (DO), "I D/O (b)(6), (b)(7)(c) was talking with Lt. (b)(6), (b)(7)(c) while he was making rounds on unit A-4 when the other detainees got my attention that detainee Mandza Evalin-Ali needed help. When I arrived at A-110, Ali was complaining of chest pains. I instructed Lt. (b)(6), (b)(7)(c) to call Code Blue." DO (b)(6), (b)(7)(c) documented on the report Code Blue was called at 05:25, Medical arrived at 05:28, "Stand down from Code Blue" at 05:33, "Medical departs with detainee Mandza" at 05:34. On interview, DO (b)(6), (b)(7)(c) stated he normally makes rounds every 30 minutes and that during his 5:00 a.m. round, "everything was fine." When he was summoned by the other detainees and went over to detainee MANDZA's bed, he found the detainee "rocking and rolling" in bed with his hands on his chest complaining of chest pain. He also stated nursing staff who responded had a wheelchair, crash bag *(containing ammonia, a manual breathing bag, gloves, spill kit),* and a pulse oximeter *(measures the oxygen level in the blood).* He did not remember an AED automated external defibrillator (AED) being brought to the housing unit.

Per GEO Serious Incident Report, Incident Description, written by Lt (b)(6), (b)(7)(c), he called a Code Blue due to the detainee "complaining of chest pains." On interview, Lt. (b)(6), (b)(7)(c) stated he found the detainee in a "fetal position grasping his chest and groaning." He called the "Code Blue" over the radio and proceeded to open the side door to expedite medical staff's arrival. He stated nursing staff brought with them a wheelchair, crash bag, and oxygen tank, but no AED.

Medical record Progress Note by RN (b)(6), (b)(7)(c) documented, "Responded to Code Blue at housing unit 4A. Found detainee lying on back (in bed) touching left chest area. Detainee alert and oriented, answers all questions appropriately. Skin w/d *[warm/dry]*, color adequate, no respiratory distress noted. Reports chest pain 8-9/10 *[8-9 on a pain scale of 0 to 10, with 10 being worst]*, pain worse with inspiration, pulse ox: *[level of oxygen in the blood]* on RA *[room air]* 94%. Assisted to wheelchair for transfer to medical unit."

> **COMMENT**: RN (b)(6), (b)(7)(c) did not utilize the assessment criteria in the GEO nursing protocol for chest pain. Though she documented "color adequate," she did not note whether or he was pale or cyanotic *(bluish discoloration of the skin indicating lack of oxygen).* In addition, she did not address the presence of diaphoresis *(perspiring)* or quality of his respirations, i.e., whether they were shallow or labored. Although she noted the intensity of the pain and that it was worse with inspiration, she failed to inquire as to the duration of the pain. The only vital sign taken was a pulse oximetry reading. As noted, she recorded the encounter in a Progress Note, only. There was no completed "Chest Pain Protocol" form in the medical record.

RN (b)(6), (b)(7)(c) stated during interview she responded immediately to the Code Blue, taking with her the wheelchair, oxygen tank, crash bag and the AED. LPN (b)(6), (b)(7)(c) did not document in the medical record, however, on interview, she stated she responded with RN (b)(6), (b)(7)(c) to the "Code Blue" with a wheelchair, crash bag, oxygen tank and AED. As noted, DO (b)(6), (b)(7)(c) and Lt. (b)(6), (b)(7)(c) reported that they did not observe an AED.

COMMENT: Whether an AED was brought to the scene cannot be confirmed. While use of an AED on detainee MANDZA would not have been appropriate because he was found alert, responsive, breathing and with a pulse, code blue response equipment should always include an AED in the event it is needed.

COMMENT: CC verified current CPR certification for all responding correctional and medical staff.

5:28 am
Per Progress Note by RN (6), (b)(7) "Transfer to trauma room. VS 154/84 -68-18; On assessment skin (warm and dry) color adequate, bilateral breath sounds clear to auscultation. All peripheral *[areas of the arm, wrist, legs and feet]* pulses palpable. O2 *[oxygen]* placed at 4 L*[liters]*, pulse ox 92-94%, abdomen soft, flat with hypoactive bowel sounds *[normal during sleep, but can also indicate constipation]*. Reports last [bowel movement] was on 4-8. Chest pain remains unchanged. BP 144/85, 71*[pulse]* rr *[regular rhythm]* 18 *[respirations]*. 3 lead EKG *[electrocardiogram]* done."

COMMENT: VS were not documented again until 6:20 am. Per GEO nursing protocol for chest pain, VS are to be taken every five minutes.

The GEO nursing protocol for chest pain requires a 12-lead EKG. During site visit, CC learned DCDF has two 12-lead EKG machines made by different manufacturers: a Welch Allen EKG machine and a Schiller AT-102. RN (6), (b)(7) chose the Schiller AT-102 and proceeded to attempt a three-lead rather than 12-lead EKG. A three-lead EKG monitors only two areas of the heart; a 12-lead EKG provides detailed monitoring of all three areas of the heart. On interview RN (6), (b)(7) stated she chose to perform a three-lead EKG because she had not performed a 12-lead EKG "in years." She further stated she had no formal training in the use of either machine. When RN (6), (b)(7) completed hooking detainee MANDZA up to the Schiller AT-102 EKG machine, she realized the memory was full and requested LPN (6), (b)(7)(assistance. LPN (6), (b)(7)(was unsuccessful in erasing the memory, therefore, the Schiller AT-102 was detached and the Welch Allyn machine was used. RN (6), (b)(7) stated she was unable to interpret the EKG results and relied on her "gut instinct" to ultimately send the detainee to the hospital.

During interviews, both RN (6), (b)(7) and LPN (6), (b)(7)(stated they had not received formal training in reading EKGs. They stated in the past, results from the Schiller AT-102 machine were faxed to the on-call physician or a cardiology practice for interpretation; however, faxing results from the Welch Allyn machine was not possible because the machine has not been programmed the same way as the Schiller AT-102. Asked about maintenance of the EKG machines, RN (6), (b)(7) indicated she had previously reported the Schiller AT-102 memory issue to Acting HSA (b)(6), (b)(7)(c). According to LPN (6), (b)(7)(the EKG machines are checked daily for operability, though the memory is not always checked. HSA (b)(6), (b)(7)(c) was able to produce documentation of checks for the clinic's other emergency equipment, including oxygen tank, oxygen mask and tubing, Ambu-Bag, pulse oximeter, and AED; however, there was no record documenting EKGs are checked.

COMMENT: ODO cites non-compliance with ICE PBNDS, Medical Care, section (V)(O) requiring that medical and safety equipment be available and maintained, and that staff be trained in proper use of the equipment.

.

Per interview with DCDF's new physician, Doctor of Osteopathy (b)(6), (b)(7)(c) he supports documentation by RN (b)(6), (b)(7). However, after reviewing the GEO nursing protocol for chest pain, he stated it is flawed because the EKG should not be used as an "acute tool" in this setting; further, that this may have delayed sending the detainee to the hospital up to "ten minutes." He would like to see the protocol revised to call for an immediate 911/EMS response to chest pain along with the administration of aspirin. He stated, "We are putting the facility at risk" by not sending detainees to the hospital in this situation. He further stated he does not need to be contacted for an order to do so.

During interview, LPN (b)(6), (b)(7)(stated RN (b)(6), (b)(7) instructed her to "get the paperwork started" when detainee MANDZA was in the trauma room. She stated this instruction meant the physician was to be called for an order, the HSA was to be notified, and the Shift Commander (Lt (b)(6), (b)(7)(c) was to be contacted for an "order for transport." She indicated she was under the impression the detainee would be transported by GEO transport van rather than ambulance because she thought at the time the detainee "wasn't in dire distress."

5:50 am

Per medical record documentation by RN (b)(6), (b)(7) "Dr. (b)(6), (b)(7)(c) notified of detainee status. Orders received." A verbal order was given to "transfer the detainee to hospital for chest pain evaluation." On interview, RN (b)(6), (b)(7 stated it was her understanding a doctor's order was required to send a detainee to an outside hospital. However, RN (b)(6), (b)(7)(c) stated during interview she would use her "nursing discretion" to send a detainee to an outside hospital if needed and notify the physician later. In addition, as noted, Dr. (b)(6), (b)(7)(c) stated it was not necessary to obtain a physician's order in this situation. CC notes that according to GEO policy "Emergency Services," 4-Triage,(a), Immediate Life Threatening Emergency, dated 6/13/2011, "If the Response Team Leader determines a life threatening emergency exists, Emergency Medical Services (EMS) will be summoned immediately."

COMMENT: CC cites non-compliance with ICE PBNDS, Medical Care, section (II)(7) requiring that detainees who need health care beyond facility resources to be transferred in a timely manner to an appropriate facility where care is available.

RN (b)(6), (b)(7) stated she instructed LPN (b)(6), (b)(7)(to call EMS, however, she did not document this instruction. It is further noted Lt. (b)(6), (b)(7)(c) Supervisor's Report and the Aurora Fire Department EMS Patient Care Report (see below) document the time as 6:20 am and 6:21am, respectively. During interview, LPN (b)(6), (b)(7)(stated that she was still under the impression detainee MANDZA would be going to the hospital via GEO transport van. In her General Incident Report, LPN (b)(6), (b)(7)(writes "orders received per Dr. (b)(6), (b)(7)(c) to send to hosp. At this time I Nurse (b)(6), (b)(7)(completed transfer form and notified watch commander (b)(6), (b)(7)(c) of transfer to hosp per MD orders."

Per GEO Serious Incident Report authored by Lt. (b)(6), (b)(7)(c) LPN (b)(6), (b)(7)(c) "advised the detainee needed to be transported to the Aurora South Hospital for further medical examination."

6:00 am
Per Progress Note authored by RN (b)(6), (b)(7)(c) "Ms. (b)(6), (b)(7)(c) notified of detainee status."

6:20 am
Per Serious Incident Report by LPN (b)(6), (b)(7)(c) detainee Evalin Ali MANDZA "VS-*[BP]* 139/81, *[P]* 67, pulse ox 100% on 4 liters."

Per Supervisor Report by Lt. (b)(6), (b)(7)(c), "At 0620 hours medical informed that 911 needed to be call in order to have detainee taken to Aurora South Hospital ER for additional treatment." On interview, he stated this direction was given when he called the nursing station to get a status update on the transport of detainee MANDZA to the ER. He stated he spoke with LPN (b)(6), (b)(7)(c) who instructed him to call 911. This was 30 minutes after an order was obtained from Dr. (b)(6), (b)(7)(c) to send the detainee to the emergency room and approximately 50 minutes after the detainee arrived in the trauma room. Lt. (b)(6), (b)(7)(c) stated in retrospect it "bothered" him it took so long to send the detainee out.

Per GEO Serious Incident Report, Immediate Action Taken, by Lt. (b)(6), (b)(7)(c), "Upon arrival in the medical department an assessment by RN (b)(6), (b)(7)(c) and LPN (b)(6), (b)(7)(c) was conducted. The determination to call 911 (ambulance) was requested and detainee was taken to the Aurora South Hospital ER for additional treatment." The report by Lt. (b)(6), (b)(7)(c) does not state who made the determination to call 911, when 911 was called, nor by whom.

> **COMMENT**: The decision to call EMS versus transport the detainee by van is not documented in the medical record. Interviews with staff point to poor communication resulting in a delay in getting him to the ER. CC cites a second deficiency in the ICE PBNDS, Medical Care, section (II)(7) requiring timely transfer to off-site care facilities.

6:21 am
Per the Aurora Fire Department EMS Patient Care Report, a call came in from DCDF for emergency response.

6:25 am
Per GEO Serious Incident Report by Lt. (b)(6), (b)(7)(c) "EMS arrived on site about 0625 hours." The Aurora Fire Department EMS Patient Care Report confirms this time.

6:29 am
Per the Aurora Fire Department EMS Patient Care Report, VS were "BP 135/85, P 80-regular, R 20-increased but not labored, perceived pain 9/10, O2 level 100 %, movement of extremities X 4*[is able to move all four extremities]*, level of consciousness 15 *[out of 15]*, EKG interpretation –normal sinus rhythm taken by automated device."

6:30 am
Per the Transport/Escort Log, "EKG done by EMT."

Aurora Fire Department EMS Patient Care Report documents impression as "Chest pain and Heartburn/Indigestion;" Cardiac Arrest was answered as "No." "The patient is conscious and alert" and complains of "midline chest pain." The EMS report further documents:

> "History: Pt *[patient]* states no medical history, no current medications, no nkdas*[no known drug allergies]*. Pt states he hasn't had a bowel movement in the last 4 days. Pt states he ate a bowl of soup last night that contained a large amount of hot chili peppers. Onset: Two hours ago pt awoke with current pain. Provocation *[Does anything make the pain worse?]:* Pain is reproduce able upon movement and chest wall palpitation. Quality of Pain: Pt states it is a burning sensation. Region and radiation: Pt states the pain travels from his upper abdomen to his esophagus. Severity: 9/10; pt denies nausea and vomiting; pt states no diaphoresis.
>
> Assessment: General Impression-Pt is conscious and is responding to verbal questioning. Pt is showing no signs of pain or respiratory distress. **ABC's** *[airway, breathing, circulation]* open/patent, increased/unassisted, skin warm and dry, radial pulse strong and regular, heent *[head, ears, eyes, nose, throat]*clear, chest wall stable rise and fall equal, breath sounds clear and equal bilateral, abd *[abdomen]*soft non-tender, pelvis stable, vitals as recorded. Pt was placed onto 4 L O2 prior to our arrival by facility nurse. 12 lead ECG revealed a Sinus Rhythm, no ST segment elevation or ectopic beats observed *[indications of an abnormal EKG]*." Pt was packaged onto the pram and removed from the facility. Pt was secured into RM 101 for non-emergent transport to TMCA South. Pt states no further complaints.
>
> Upon release of care pt's condition remained unchanged."

6:35 am
Per the Transport/Escort Log, Commander (b)(6), (b)(7)(c) (Immigration Health Services Corps) and Warden (b)(6), (b)(7)(c) notified.

6:43 am
Per Control Emergency Log book, EMT offsite.

6:57 am
General Incident Report authored by (b)(6), (b)(7)(c), DCDF Medical Transport Officer, documents arrival at Aurora South Medical Center. Officer (b)(6), (b)(7)(c) accompanied the ambulance to the ER.

> **COMMENT:** The detainee was transported as a non-emergent case, therefore, it took 14 minutes to get to the hospital.

Per Aurora H&P *[history and physical]*, "The patient is a 46 year old gentleman with no apparent risk factors. He is having an acute anterior myocardial infarction. He will report to the Cath Lab. Condition at time of admission: guarded"

7:35 am
Per General Incident Report detainee moved to the "Cath Lab for Cardiac Catheterization."

Per Aurora Hospital Cardiac Catheterization Report "Ventricular tachycardia *[fast heart rhythm that originates in the ventricles of the heart]* and PEA arrest (pulseless electrical activity), *[there is electrical activity, but the heart does not contract. The heart rhythm observed on EKG looks like the heart is producing a pulse, but is not]*; CPR cardioversion *[procedure to restore normal heart rhythm]*; continued CPR and multiple defibrillations."

7:55 am
Per General Incident Report "*[hospital]* medical staff started giving Mandza chest compressions with negative results."

> **COMMENT:** On interview with Transport Officer (b)(6), (b)(7)(c) who remained with the detainee at the hospital, "The whole cardio department was here to try to save his life."

8:38 am
Per the Cardiac Catheterization Report Detainee Evalin Ali MANDZA expired due to "unsuccessful resuscitation of the patient."

12:49 pm
GEO Serious Incident Report transmitted by Warden (b)(6), (b)(7)(c)

1:00 pm
ICE Removal proceeding hearing scheduled.

Per Serious Incident Report authored by (b)(6), (b)(7)(c), Warden, "In compliance with current ICE standards the onsite staff is handling the details of the autopsy."

May 24, 2012
Per the Death Certificate, Immediate Cause of Death was listed as "Anterior MI *[myocardial infarction or heart attack]* due to or as a consequence of "Severe left main coronary artery stenosis *[abnormal narrowing]*.

MEDICAL COMPLIANCE REVIEW CONCLUSIONS

The ICE PBNDS, Medical Care, requires that detainees have access to emergent, urgent, or non-emergent medical care so that their health care needs are met in a timely and efficient manner. . As discussed in the above timeline, deficiencies were found in the following:

- ICE PBNDS Medical Care, section (II)(2) requiring detainees to have healthcare needs met in a timely and efficient manner.
    - There was no documentation to support Dr. (b)(6), (b)(7)(c) evaluated the detainee for his complaint of constipation as scheduled on November 3, 2011. He was not seen by the physician until December 2, 2011.
- ICE PBNDS Medical Care, section (II)(7) requiring a detainee who needs health care beyond facility resources will be transferred in a timely manner to an appropriate facility where care is available.
    - A total of 56 minutes elapsed between the Code Blue emergency and activation of 911. Thirty minutes elapsed after Dr. (b)(6), (b)(7)(c) ordered transfer to the ER.
- ICE PBNDS Medical Care, section (V)(O) requiring medical and safety equipment to be available and maintained and staff to be trained in proper use of the equipment.
    - There was no documentation EKG machines were checked daily to determine if they were in working order and for memory capacity.
    - Neither RN (b)(6), (b)(7) nor LPN (b)(6), (b)(7)(had documented formal training on the EKG machines used at DCDF medical clinic, or in recognizing lethal rhythms.

Submitted:

(b)(6), (b)(7)(c)

Creative Corrections, LLC

U.S. Immigration and Customs Enforcement

ADDENDUM

IHSC MEDICAL RECORD REVIEW/INVESTIGATION

Detainee: MANDZA, Evalin-Ali

Alien Number: (b)(6), (b)(7)(c) **DOB: 12-05-1965**

EXECUTIVE SUMMARY

On 04-12-2012, U.S. Immigration and Customs Enforcement (ICE), Health Service Corps (IHSC) received notification of the death of Evalin-Ali MANDZA, A (b)(6), (b)(7)(c), an individual in the custody of ICE at the Denver Contract Detention Facility, Aurora, Colorado. The Assistant Director for IHSC requested a review of MANDZA's medical records to determine the appropriateness of the medical care he received while in ICE custody.

Cause of Death: Anterior myocardial infarction
Severe left main coronary artery stenosis

Conclusion: This additional information does alter the initial observations, conclusions and recommendations that appeared in the 05-09-2012 report.

MANDZA did not have access to appropriate medical care while detained in the Denver Contract Detention Facility (DCDF). On 04-12-2012 he received appropriate emergent medical care at the DCDF; however, there was an approximate 30 minute delay from when the physician ordered MANDZA transferred to the hospital for evaluation of chest pain, to when EMS received a call to respond to the facility. At present, IHSC has not received a death certificate; however, based upon a review of the hospital records, MANDZA apparently had an acute myocardial infarction (heart attack) and expired as a result of an inherent potential complication of a lifesaving procedure called emergency angioplasty. Prior to the morning of 04-12-2012, MANDZA did not have a history of any significant medical problems, nor did he complain of any symptoms that demonstrated an increased risk for cardiac problems.

DETAILS OF INQUIRY

ISSUE

On 04-12-2012, U.S. Immigration and Customs Enforcement (ICE), Health Service Corps (IHSC) received notification of the death of Evalin-Ali MANDZA, A (b)(6), (b)(7)(c) an individual in the custody of ICE at the Denver Contract Detention Facility, Aurora, Colorado. The Assistant Director for IHSC requested a review of MANDZA's medical records to determine the appropriateness of the medical care he received while in ICE custody.

PURPOSE

Review MANDZA's medical records and prepare a formal statement regarding the standard of health care he received while in ICE custody.

BACKGROUND

MANDZA was a 46 year old male from Gabon, on the date he expired.

ICE Custody History

- 10-24-2011 to 04-12-2012 Denver Contract Detention Facility, CO
- 04-12-2012 Expired

Medical and Mental Health Conditions:

- No medical diagnoses
- Irreversible pulpitis tooth #18 – extracted
- Acute anterior myocardial infarction

ADDITIONAL INFORMATION RECEIVED

Aurora Fire Department (04-12-2012)

"**C**-- U/a at the immigration detention facility, we located the Pt in an examination room lying supine on an examination table. Scene secure. Pt is a 46 y/o male who is conscious and alert. Pt states a CC of midline chest pain.

H—Pt states medical hx, no current medications and nkda's. Pt states he hasn't had a bowel movement in the past four days. Pt states he ate a bowl of soup last night, that contained a large amount of hot chili peppers. **O**—Two hours ago, Pt woke up from sleep with current pain. **P**- pain is reproducible upon movement, and chest wall palpation. **Q**- Pt states it is a burning sensation. **R**- Pt states the burning travels from his upper abd, to his esophagus. **S**- 9 out of 10. Pt denies nausea/vomiting. Pt states no diaphoresis.

A- General Impression: Pt is conscious and is responsive to verbal questioning. Pt is showing no signs of pain or respiratory distress. **ABC's** open/patent, increased/unassisted, skin warm and dry, radial pulse strong and regular, heent clear, chest wall stable rise and fall equal, breth sounds clear and equal bilateral, abd soft non-tender, pelvis stable, moex4, gcs=15, vitals as recorded. Pt was placed onto 4lpm O2 prior to our arrival by facility nurse. 12 lead ECG revealed a Sinus

Rhythm, no ST segment elevation or ectopic beats observed. Pt was packaged onto the pram and removed from the facility. Pt was secured into RM 101 for non-emergent transport to TMCA South due to AIP diversion. Immigration detention officer accompanied RM 101. Pt states no further complaints.

R- See Treatment

T- See Encounter. Upon release of care Pt's condition had remained unchanged."

0621 Time call received.

0628 Patient contact.

0629 (Paramedic) "Position: Supine; Blood Pressure: 135/85; Pulse: 80 (Regular); Respirations: 20(Increased, not labored); Perceived Pain: 9/10; Pulse Oximetry: 100 (On Oxygen); Movement of Extremities: x4; Level of Consciousness: 15 (4+5+6); EKG Interpretation: Normal Sinus Rhythm; Taken by automated device."

~0630 "Oxygen, 4 l/m – nasal cannula; Response: No change; Authorization: Protocol (standing order); administered by Rural/Metro Employee"

0632 "12 Lead Cardiac Monitor; Authorization: Protocol (standing order); performed by [paramedic] COMMENT: NSR, no ST segment elevation, no ectopic beats observed"

Rural Metro Ambulance (04-12-2012)

Crew: #1 Paramedic, #2 EMT
"Dispatch to chest pain. UA pt found lying supine on exam table in facility clinic. Pt CC chest pain.

Pt states he awoke c the pain this morning. Pt describes that pain as a burning sensation that travels from his upper abd through his chest and up into his throat. Pt state that he did eat soup c hot peppers last night. Pt denies any recent trauma or illness. Pt denies any drug or alcohol use.

Pt AAOx4 (person, place, time, event). CMSx4. Breath sounds clear and equal bilaterally. Chest wall intact. Increased pain on palpation of chest. No trauma noted. HEENT clear and intact. Pupils 4, PEARL. Skin WPD. Abd non distended or rigid, increased pain on palpation of bilateral upper quadrants. No trauma noted.

Pt placed on 3L via NC. SpO2 monitor applied, 12 lead acquired – sinus rhythm c artifact. Pt scooted to pram by own power. Pt secured to pram with straps. Pt began hyperventilating en route. Pt would not talk c crew but appeared as if the pain had become worse. Pt given 324mg ASA PO. Pt would not follow directions to chew the pills so they sat in his mouth for a few minutes. Pt would not cooperate to get a third set of vitals en route. Pt vomited UA to ED. ASA pills present in vomit. Pt care transferred to nurse at receiving facility."

0627 At patient.

0630 O2 3L nasal cannula applied by Aurora Fire Department (AFD)

0631 Cardiac monitor and 12 lead EKG performed by Rural Metro Paramedic; interpreted by AFD as sinus rhythm with ectopy and artifact.

0631 SpO2 monitor applied by Rural Metro Paramedic.

0643 Transport to ED.

0647 Four 81mg chewable ASA administered by Rural Metro Paramedic.

0655 Cardiac monitor and 12 lead EKG; interpreted by Rural Metro Paramedic as sinus rhythm with ectopy and artifact.

0700 Arrived ED and transferred care.

Death Certificate

Cause of Death: Anterior myocardial infarction
Severe left main coronary artery stenosis

Autopsy

Coroner did not perform an autopsy.

OBSERVATIONS

The Denver Contract Detention Facility nurse received a physician's order at 0550 to transfer MANDZA to the hospital for evaluation of chest pain. The Aurora County Fire Department did not receive a call until 0621.

CONCLUSIONS

This additional information does alter the initial observations, conclusions and recommendations that appeared in the 05-09-2012 report.

MANDZA did not have access to appropriate medical care while detained in the Denver Contract Detention Facility (DCDF). On 04-12-2012 he received appropriate emergent medical care at the DCDF; however, there was an approximate 30 minute delay from when the physician ordered MANDZA transferred to the hospital for evaluation of chest pain, to when EMS received a call to respond to the facility. At present, IHSC has not received a death certificate; however, based upon a review of the hospital records, MANDZA apparently had an acute myocardial infarction (heart attack) and expired as a result of an inherent potential complication of a lifesaving procedure called emergency angioplasty. Prior to the morning of 04-12-2012,

MANDZA did not have a history of any significant medical problems, nor did he complain of any symptoms that demonstrated an increased risk for cardiac problems.

RECOMMENDATIONS

- The findings of this review should be forwarded to the DCDF Health Authority for review, comment and corrective action plan(s) as indicated.
- During the next scheduled NDS/PBNDS review of the DCDF, the reviewers should focus on the length of time it takes the facility to arrange for emergent transport of detainees.

NOTE: recommendations applicable to non-IHSC staffed facilities will be shared with the facility by the appropriate Field Office. Follow-up on implementation of the recommendations will be conducted by the appropriate IHSC Field Medical Coordinator.

RECORDS REVIEWED

Other Information Received/Reviewed:

- 04-12-2012 Aurora Fire Department EMS report
- 04-12-2012 Rural Metro Ambulance report
- State of Colorado Certificate of Death

Note: The information and conclusions conveyed in this report are based upon the medical records and other sources of information made available to the reviewers as of 05-14-2012.

Date of Report: 05-24-2012

End of report

Reviewers:

(b)(6), (b)(7)(c) M.D.
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Deputy Assistant Director Clinical Services/Medical Director (A)
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Detainee Death Review
Medical Record Review
MANDZA, EVALIN ALI A (b)(6), (b)(7)(c)
Denver Contract Detention Facility, Denver, CO

Section 2: Mortality Review
This mortality review was prepared by (b)(6), (b)(7)(c) MD, Creative Corrections' Chief Medical Officer, based on medical records from the Denver Contract Detention Facility (DCDF) and information obtained during on-site interviews by (b)(6), (b)(7)(c), RN, Health Care Subject Matter Expert.

AUTOPSY FINDINGS
None. Autopsy not conducted.

CHRONOLOGICAL SUMMARY
October 17, 2011
Patient was processed at the Denver Field Office and Form 1213 documents the patient "states he is in good health and is taking no medication" and "appears to be in good health." He was 46 years old.

October 24, 2011
Patient arrived at the Denver Contract Detention Facility (DCDF) and listed his nationality as Gabon, a country in west central Africa.

Intake screening was conducted by (b)(6), (b)(7)(c) Licensed Practical Nurse (LPN). Vital signs were all within normal limits. Patient denied having any chronic care problems and it was documented he was not currently taking any prescribed medication. Spanish was documented as his primary language, as circled on the Receiving Screening Form, Line # 24. It was not documented whether he spoke and understood English. Patient was recommended to be placed in the general population. (b)(6), (b)(7)(c) MD reviewed and signed the form on October 27, 2011. Patient had no significant mental health problems/issues as documented by LPN (b)(6), (b)(7)(c) Document was signed by (b)(6), (b)(7)(c) MD on this date.

A chest x-ray was performed with the results documented as "Negative except for calcified granuloma (small area of inflammation that has calcified) less than 2cm." The location of the granuloma in the lungs was not documented by the radiologist.

October 25, 2011
Patient complained of having "bad movement," which could be referred to as difficulty with movement of his bowels.

October 26, 2011
Physical examination was performed by (b)(6), (b)(7)(c), Adult Nurse Practitioner (ANP). The progress note documented physical examination was completed, however, it did not confirm if

there were any significant findings on exam. Patient complained of having difficulty with movement of his bowels for several days in duration as stated on the progress note. Patient was prescribed Milk of Magnesia (MOM, laxative to relieve constipation) and was instructed to increase his fluid intake. Patient was also given Ducolax (a stool softener). This was the patient's second complaint for having difficulty with movement of his bowels. The patient initially complained of difficulty with movement of his bowels on October 25, 2011.

October 31, 2011
Patient submitted a Sick Call Request complaining of constipation. This was patient's third complaint of constipation. Patient was scheduled to be seen by Dr. (b)(6), (b)(7)(c) on November 3, 2011. However, the appointment did not occur. Patient was not evaluated by Dr. (b)(6), (b)(7)(c) until December 2, 2011 for this complaint of constipation. Patient should have been scheduled to be evaluated earlier by a physician for this complaint.

November 8, 2011
Patient submitted a Sick Call Request complaint requesting to be seen with a complaint of bumps (on his face, secondary to shaving). Patient was given topical antibiotic ointment to be applied to his face daily for seven days.

November 10, 2011
Patient submitted a Sick Call Request continuing to complain of constipation. This was the fourth complaint for this malady. Patient was evaluated by (b)(6), (b)(7)(c), LPN, for this complaint. Patient was given Ducolax and recommended to add fiber to his diet. Patient should have been evaluated by a physician since this has been a persistent complaint.

November 17, 2011
Patient submitted a Sick Call Request, complaining of dental pain. Patient was scheduled to be seen by the dentist on November 21, 2011 and was instructed to take Tylenol as needed for pain.

November 21, 2011
Patient was evaluated by the dentist who recommended a tooth extraction.

November 27, 2011
Patient continued to complain of having constipation. This was the fifth complaint for this ongoing problem. Despite the recommendations given by the nurses, there was no improvement in his condition.

November 28, 2011
Patient was evaluated by an RN (medical staff's signature was illegible) and was given MOM, Ducolax and fiber. Patient had been given these same recommendations in the past, without an effective resolution. Patient was also instructed to return to health services if his symptoms worsened.

December 2, 2011
Patient was evaluated by Dr. (b)(6), (b)(7)(c) for constipation, as well as having a rash involving his neck. Physical examination was deferred by Dr. (b)(6), (b)(7)(c). Dr. (b)(6), (b)(7)(c) recommended the following for treatment: (1) adult glycerin suppositories (medication used to stimulate the bowels) to be administered rectally twice a day for 3 days. (2) add fiber to his diet twice a day for 90 days (60 cc) (3) Colace **(**stool softener) twice a day for 90 days. Stool softener and fiber had been previously recommended by other clinical providers. This treatment had proven to be ineffective. (4) Triple antibiotic ointment cream to the neck area twice a day for 90 days.

Dr. (b)(6), (b)(7)(c) progress note documented the patient was having abdominal pain. The examination of the abdomen was deferred by Dr. (b)(6), (b)(7)(c). The physician should have ordered abdominal x-rays, labs, and performed an abdominal exam, as well as rectal exam for this chronic complaint.

December 11, 2011
Patient submitted a Sick Call Request with a complaint of having dental pain.

December 12, 2011
Patient was seen by RN (b)(6), (b)(7)(c) for this dental complaint, and was given Ibuprofen and scheduled to be evaluated by the dentist on December 20, 2011.

December 14, 2011
Patient submitted a Sick Call Request complaining of pain involving his right great toe secondary to falling off the top bunk.

December 15, 2011
Patient was evaluated by Dr. (b)(6), (b)(7)(c); however, his progress note did not indicate a physical examination was performed for an injury involving his right great toe. In addition, no x-rays of his right great toe were ordered. No recommendations and/or orders were given by the physician.

December 20, 2011
Patient was seen by Dr. (b)(6), (b)(7)(c) (dentist) and it was recommended to extract the tooth. Patient refused the extraction; however, there was no refusal form documented in patient's medical record. The provider should always complete a refusal form if the patient refuses the recommended treatment.

December 25, 2011
An injury report was completed by (b)(6), (b)(7)(c) LPN, for evaluation of abrasions on the patient's chest and left wrist due to a physical altercation described as "horseplay" with other detainees. Patient was cleared to be placed in administrative segregation. The History and Physical exam performed by LPN (b)(6), (b)(7)(c) was signed by Dr. (b)(6), (b)(7)(c) on December 27, 2011.

December 30, 2011
Patient was evaluated by RN (b)(6), (b)(7)(c), with a complaint of an injury involving his right great toe. Patient stated he "fell playing soccer." The health assessment performed by RN (b)(6), (b)(7)(c) indicated injury to his right great toe. Ice packs and Ibuprofen were recommended.

January 3, 2012
Patient was examined for injury to his right great toe (secondary to playing soccer). Author's signature on progress note was illegible. The physical exam was negative. Patient was prescribed Ibuprofen as well as authorized to have a lower bunk. The duration of patient requiring to have a lower bunk was not documented by author. In addition, a diagnosis of the injury was not documented by the author. During site visit for this review, the author was determined to be Dr. (b)(6), (b)(7)(c)

January 13, 2012
A Sick Call Request was submitted for complaint of a "dental problem." Patient was scheduled to be seen by the dentist on January 16, 2012.

January 15, 2012
Patient submitted a Sick Call Request, continuing to complain of constipation. This was the sixth complaint of patient informing health services of this problem. Per patient, the suppositories were helping with this condition. Patient also continues to complain of dental problem and as previously advised his appointment for the dentist was scheduled for January 16, 2012.

January 16, 2012
Patient was seen by Dr. (b)(6), (b)(7)(c) (dentist) and was prescribed Amoxicillin (antibiotic) and Tylenol. Dr. (b)(6), (b)(7)(c) recommended an extraction of the involved tooth; however, patient refused. No refusal form was found in the patient's health record. Patient was scheduled to be evaluated by Dr. (b)(6), (b)(7)(c) on January 18, 2012 to discuss the use of glycerin suppositories.

January 18, 2012
Patient was "escorted to seg/SMU." History and Physical form was completed by RN (b)(6), (b)(7)(c) which cleared the patient to be admitted in Administrative Segregation. Patient voiced having no physical complaints to RN (b)(6), (b)(7)(c). Physical examination was performed by RN (b)(6), (b)(7)(c) was unremarkable. It was signed by (b)(6), (b)(7)(c) MD., but not dated. The date of the signature should have been documented by the Practitioner. The patient was scheduled to be seen by Dr. (b)(6), (b)(7)(c) however, this appointment did not occur.

January 27, 2012
Patient continued to complain of constipation and refused to take Colace and fiber. This was the patient's seventh complaint of this issue. ANP (b)(6), (b)(7)(c) renewed patient's treatment of Glycerin suppositories for three days and the patient was counseled to take the previously prescribed treatment for constipation. According to the progress note, (b)(6), (b)(7)(c) documented that the patient was noncompliant with the full prescribed treatment for constipation.

February 9, 2012
Progress note by RN (b)(6), (b)(7)(documented the eighth complaint of patient complaining of constipation. Patient stated his last bowel movement was on January 23, 2012. Patient also had generalized abdominal discomfort associated with decreased bowel sounds. Decreased bowel sounds upon examination could have indicated a bowel obstruction was ensuing and could have necessitated a medical emergency. Patient was given a Ducolax and MOM, 30cc, one dose. It was imperative that the patient be seen immediately by a physician.

February 14, 2012
Patient submitted a Sick Call Request complaining of dental pain. Patient was seen by (b)(6), (b)(7)(c) (b)(6), (b)(7)(c), DMD (doctor of medical dentistry) and tooth # 18 was extracted.

March 1, 2012
A Sick Call Request was submitted by the patient with his ninth complaint of constipation. Patient also complained of his eyes burning.

March 3, 2012
RN (b)(6), (b)(7)(reviewed the request and gave Ducolax and artificial tears. Patient was placed on the physician's sick call list for March 5, 2012. Patient was instructed to "return if symptoms persisted/worsened."

March 5, 2012
Patient was evaluated by (b)(6), (b)(7)(c) PA (physician's assistant) with his tenth complaint of having constipation. The progress note was written by (b)(6), (b)(7)(c) (penmanship was illegible). The PA documented on examination visceromegaly (abnormal enlargement of the soft internal organs). It was difficult to ascertain which internal organs were enlarged, by the provider's progress note. The provider documented "no water." Increased water consumption is recommended for a patient who complains of being constipated. Again, the patient should have been scheduled to be evaluated by a physician for this chronic complaint. In addition, due to the chronicity of this complaint, a gastroenterology consult should have been considered for evaluation of this condition with appropriate treatment.

March 7, 2012
Patient was seen by a provider; however, the note was illegible.

March 21, 2012
Patient submitted a Sick Call Request complaining of "bad move problems/bumps shaver problems." This was the patient's eleventh complaint of being constipated. Patient denied having abdominal pain. RN (b)(6), (b)(7)(reiterated to the patient that he needed to continue the same treatment as previously prescribed. It was quite obvious that this treatment was ineffective. At this time, the patient should have been scheduled to be evaluated by the physician and/or a referral submitted for a gastroenterology consult. Topical antibiotic ointment was prescribed to be applied twice a day for seven days to the facial area for his rash.

A progress note by (b)(6), (b)(7)(c) (LPN) documented the patient had a stress fracture. The progress note did not indicate location of fracture, or how the diagnosis was determined. In addition, there was no evidence that x-rays were taken of the involved area.

March 25, 2012
The author (illegible signature) of the progress note stated previously prescribed medications for treatment of constipation was working. Patient stated he had normal bowel movements. Patient was instructed to continue prescribed treatment for constipation as needed. During site visit for this review, the author was determined to be Dr. (b)(6), (b)(7)(c).

March 31, 2012
A Sick Call Request was submitted by the patient for "no movement all week." This was the patient's twelfth complaint of constipation. Ducolax was prescribed one dose twice a day and MOM was prescribed, one dose per day as needed for constipation. Signature of provider was not documented on the Sick Call Request.

April 1, 2012
The patient was evaluated by LPN (b)(6), (b)(7)(c) and was given Ducolax and MOM.

April 12, 2012
(b)(6), (b)(7)(c) Detention Officer (DO), was making rounds on the A-4 Unit at 05:25 and was informed by other detainees that Evalin Mandza Ali was complaining of chest pains. (b)(6), (b)(7)(c) (DO) instructed Lt. (b)(6), (b)(7)(c) to "call Code Blue." The Code Blue was called at 05:25. (b)(6), (b)(7)(c) stated the patient was "rocking and rolling" in bed with his hands on his chest complaining of chest pain. The nurses on duty, RN (b)(6), (b)(7)(c) and LPN (b)(6), (b)(7)(c), responded with a wheelchair, and a crash bag, which contained various medical equipment. It was unclear whether an AED (automated external defibrillator) was brought to the housing unit by the nurse. An AED should be taken to the housing unit when the patient is complaining of chest pain, because a cardiac arrest (abnormal rhythm of the heart muscle) may ensue. This equipment is necessary in an attempt to restore the normal function of the heart muscle.

Patient rated his chest pain, on a scale of 1 to 10, as an 8-9/10. Blood pressure was mildly elevated with remaining vital signs within normal limits. Patient also stated chest pain worsened upon inspiration (increase pain with breathing). RN (6), (b)(7) recommended the patient be transferred to the institution's trauma room for further evaluation. Patient was transferred to the trauma room within the institution at 05:28. At this point, no medications were administered to the patient in an attempt to relieve his chest discomfort. It is standard protocol to administer Nitroglycerin (medication given to relieve chest discomfort) and Aspirin (medication used to dilate the heart arteries). EMS (Emergency Medical Services) should have been activated immediately when nurses became aware that the patient was complaining of chest pain. RN (6), (b)(7) attempted to perform an EKG using the Schiller AT-102 machine (an EKG is used as a standard assessment to determine if there is any injury to the patient's heart muscle); however she realized the memory of the machine was full, thus the machine was inoperable. There should be a log book in the trauma room which documents that the EKG machine has been checked on a daily

basis by clinical staff which insures the equipment is functional. Also, the memory should be cleared after each use.

RN (6), (b)(7) stated she had not performed a "12 lead EKG in years;" therefore, a 3 lead EKG was performed using the Welch Allyn EKG machine. A 3 lead EKG monitors only two areas of the heart. A 12 lead EKG assesses the entire function of the patient's heart to determine if there was any direct injury to the heart muscle, which could cause a myocardial infarction (death of the heart muscle, hence a heart attack). RN (6), (b)(7) also stated she had not had any formal training from the institution on the use of the two EKG machines available in the trauma unit. This is not medically acceptable, especially since she is a clinical health services provider.

RN (6), (b)(7) stated she could not interpret the findings on the EKG performed on the Welch Allyn machine. Clinical health services staff should be able to interpret any abnormalities on the tracing of the EKG which could identify a patient was having an acute heart attack. RN (6), (b)(7) also stated in the past the EKG could be faxed to the institution's physician on call and/or a cardiologist for interpretation of the EKG. RN (6), (b)(7) stated that presently no provision had been made to proceed with this process of faxing the EKG. Therefore, RN (6), (b)(7) stated she just relied on her "gut instinct" to send the patient to the hospital. Dr. (b)(6), (b)(7)(c) DO (doctor of osteopathic medicine) stated he would like to revise "Chest Pain Protocol" to reflect an immediate EMS response to chest pain along with administration of Aspirin. This is a very good recommendation made by Dr (b)(6), (b)(7)(c) to revise the "Chest Pain Protocol."

At 05:50, Dr. (b)(6), (b)(7)(c) was notified that the patient was complaining of chest pain. Dr. (b)(6), (b)(7)(c) recommended the patient be transferred to the local community hospital for further evaluation. It is also noted that LPN (6), (b)(7) stated the patient "wasn't in dire distress," and they didn't "need to rush" (unclear who LPN (6), (b)(7)(was referring to as "they"). LPN (6), (b)(7)(recommended the patient be transported to the local community hospital by GEO van. A complaint of chest pain from a patient requires emergent evaluation and if necessary immediate transport to a higher level medical facility for evaluation and treatment. This transport to this higher level medical facility should occur expeditiously, by an ambulance. The decision to transport a patient via institutional van with a complaint of having severe chest pain was medically inappropriate.

It is so noted RN (6), (b)(7) failed to follow the institution's "Chest Pain Protocol." Vital signs were taken twice during this encounter and not documented between 5:50 and 06:20 am. Per Institution's "Chest Pain Protocol," vital signs are to be taken every five minutes. In addition, no completed Chest Pain Protocol Form was located in the patient's health record.

RN (6), (b)(7 instructed LPN (6), (b)(7)(to "get the paper work started." When an emergency exists within the detention center, there should be a protocol whereby having to notify various staff should not cause a delay in transporting the patient to a hospital. LPN (6), (b)(7)(advised Lt. (b)(6), (b)(7)(c) that "the Patient needed to be transported to Aurora South Hospital for further medical examination." There was confusion as to who activated the EMS (Emergency Medical Services). The staff designated in orchestrating the emergency should be the individual notifying the custodial staff in charge of activating EMS. EMS was activated at 06:21. EMS arrived at the institution at 06:30. Patient continued to complain of chest discomfort, rating pain as 9 out of 10. A 12 lead

EKG was performed by EMS, which revealed the patient had "normal sinus rhythm taken by automated device." Normal sinus rhythm means the patient's heart beat was beating at a normal rate. There were no acute findings seen on the EKG tracing which indicated the patient was having an acute heart attack. Upon departure from the institution, patient continued to rate his chest pain as a 9 out of 10.

At 06:57, patient arrived at Aurora South Medical Center. Per Aurora H & P (history and physical), "The patient is a 46 year old gentleman with no apparent cardiac risk factors. He is having acute anterior myocardial infarction. He will report to the Catherization Lab. Condition at time of admission was "guarded." Patient was diagnosed with having an acute heart attack. During the cardiac catheterization (a procedure used to identify if there was blockage of the heart arteries), patient went into cardiac arrest (no contraction of the heart muscles). Advanced Cardiac Life Support Measures (medication used in an attempt to restore function of the heart) was unsuccessful. Patient expired at 08:38 on April 12, 2012.

May 24, 2012
Per the Death Certificate, Immediate Cause of Death was listed as "Anterior MI (myocardial infarction or heart attack) due to or as a consequence of "Severe left main coronary artery stenosis (abnormal narrowing)."

FINDINGS
Based on documentation in the medical record as summarized above, the reviewer finds the following:

Timeliness of Care

A. **Evaluation of chest pain**
It took approximately 50 minutes from the onset of the patient's complaint of chest pain for the patient to be transferred to a higher level facility for further evaluation. A complaint of chest pain requires emergent evaluation and immediate transport to a hospital. This delay in deciding to transport patient to a higher level care facility can be deleterious to patient's condition. EMS should have been activated immediately when medical staff was notified that the patient was having chest pain. The institution's "Chest Pain Protocol" should be revised to include the immediate administration of Nitroglycerin and Aspirin provided patient has no contraindications for these medications.

B. **Notification of appropriate staff**
There was a delay in transporting the patient to the hospital because various staff, as well as signatures had to be obtained. The clinical staff should be familiar with the protocol for "Emergency Services," which mandates which staff should be notified in a medical emergency.

D. **Scheduling of patients**

Frequently there were instances wherein the patient was not scheduled for the physician and/or dentist due to the lack of proper scheduling procedures. Procedures should be in place for scheduling patients to be seen by the clinical staff in a timely manner.

E. **Persistent complaint of constipation**

Patient submitted numerous Sick Call Requests for being constipated. The same treatment was offered repeatedly without an effective resolution. Patient was seen by the physician; however, no physical examination was performed for this ongoing complaint. In addition, there were no labs, x-rays or documentation of consideration for a specialty consult (gastroenterology) to be placed for further evaluation for this condition. Patient also complained of having abdominal pain and decreased bowel sounds were detected. This could have indicated an obstruction of his intestinal tract.

Quality of Care

A. **Use of medical equipment**

The two nurses on duty at the time of the medical emergency were unable to operate the EKG machine. Medical staff should be comfortable and knowledge in the operation of various medical equipment, i.e. EKG machines. Training should be performed with documentation that the clinical staff are familiar with the use of the medical equipment.

B. **Chest Pain Protocol**

Nitroglycerin and Aspirin is standard medical practice to be administered immediately to any patient when the chest pain appears to be cardiac in origin. Dr. (b)(6), (b)(7)(c) stated that the "Chest Pain Protocol" would need to be revised to include this measure. Also, chest pain should necessitate emergent transport outside the institution if the pain appears to be cardiac in nature.

C. **Legibility of progress notes**

It was difficult to read the progress notes due to poor penmanship of the providers. The date and signature of the provider should be legible.

D. **In house training**

It was quite evident with this patient that the nurses were not trained properly to understand the nature and seriousness of this medical emergency. Interpretation and recognition of an acute myocardial infarction (heart attack) on an EKG tracing should be recognizable to the clinical staff. Continuing medical education should be a consideration in educating the clinical staff on the latest updates in the assessment and treatment of medical emergencies. Training by the staff physicians should be conducted on a regular basis to familiarize the medical staff in dealing appropriately with medical emergencies.

E. **Diagnostic Screening**

A drug screen should have been considered by the physician(s) in determining a possible cause for patient's persistent complaint of constipation. For example, if the patient had

been taking non-prescribed narcotics/substances, this could have been a cause for his being constipated.

CONCLUSION

It was obvious the medical staff was unfamiliar with the institution's "Chest Pain Protocol." Appropriate cardiac medication was not administered to this patient. This medication was critical in reducing the workload of the heart as well as preventing the death of the muscle of the heart (hence a heart attack). Also, time was of the essence in transporting the patient to a higher level care facility for prevention of further destruction of the heart wall muscle which could have contributed to the patient's demise.

An autopsy was not ordered; reasons not documented. An autopsy would have been helpful to ascertain the pathology (abnormality) of the patient's heart arteries. Toxicology was not ordered, which would have been beneficial in determining if the patient was taking any illicit/ recreational drugs which could have also contributed to his demise.

Submitted:
(b)(6), (b)(7)(c) *MD*
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