DETAINEE DEATH REVIEW – Jean Carlos Alfonso JIMENEZ-Joseph
JICMS #201707158

SYNOPSIS

On May 15, 2017, Jean Carlos Alfonso JIMENEZ-Joseph (JIMENEZ), who was a twenty-seven-year-old citizen of Panama, died while in the custody of U.S. Immigration and Customs Enforcement (ICE) at Phoebe Sumter Medical Center (PSMC) in Americus, Georgia (GA). The Stewart County Coroner's Office documented JIMENEZ's cause of death as suicide as the result of hanging.

JIMENEZ was detained at Stewart Detention Center (SDC) in Lumpkin, GA, from March 7, 2017 to May 15, 2017. SDC is an Intergovernmental Service Agreement Facility (IGSA), owned and operated by CoreCivic, and is required to comply with the ICE Performance Based National Detention Center Standards (PBNDS) 2011. At the time of JIMENEZ's death, SDC housed approximately 1,907 male detainees of all classification levels for periods in excess of 72 hours. Medical care at SDC is provided by ICE Health Services Corp (IHSC) and supported by InGenesis, a contract company.

DETAILS OF REVIEW

From June 20 to 22, 2017, ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited SDC to review the circumstances surrounding JIMENEZ's death. ERAU was assisted in its review by contract subject matter experts (SME) in correctional healthcare and security. ERAU's contract SMEs are employed by Creative Corrections, a national management and consulting firm.[1] As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to JIMENEZ, in addition to conducting in-person interviews of individuals employed by CoreCivic, IHSC, InGenesis, and staff from the local ICE Office of Enforcement and Removal Operations (ERO).

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

IMMIGRATION AND CRIMINAL HISTORY

On April 9, 2001, U.S. Customs and Border Protection (CBP) admitted JIMENEZ at the Hartsfield Atlanta International Airport in Atlanta, GA as a nonimmigrant visitor with permission to stay in the United States until October 8, 2001.[2]

On June 21, 2010, JIMENEZ was convicted in Overland Park Municipal Court, in Overland, Kansas, of operating a motor vehicle without a license.

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[1] *See* Exhibit 1: Creative Corrections Medical and Security Compliance Analysis.
[2] *See* U.S. Customs and Border Protection, Non-Immigrant Visa, issued March 9, 2001.

On January 4, 2013, JIMENEZ applied for Consideration of Deferred Action for Childhood Arrival (DACA), Form I-821D, with U.S. Citizenship and Immigration Services (USCIS). [3] USCIS approved JIMENEZ's DACA application with an expiration date of November 24, 2015.[4]

On January 10, 2016, JIMENEZ submitted a second DACA application to USCIS. Because JIMENEZ did not sign the application, USCIS rejected it on January 12, 2016. On January 28, 2016, JIMENEZ submitted a third DACA application to USCIS. JIMENEZ again did not sign the application, and USCIS rejected it on January 28, 2016.[5] On February 24, 2016, JIMENEZ submitted a fourth DACA application to USCIS. The application was approved on May 6, 2016, with an expiration date of May 5, 2018.[6]

On August 24, 2016, Raleigh Police Department (RPD), in Raleigh, North Carolina (NC), arrested JIMENEZ for misdemeanor injury to real property. On this same date, ERO Atlanta 287(g) encountered JIMENEZ in the Wake County Jail, in Raleigh, NC. ERO determined he was not an enforcement priority and took no enforcement action. On October 14, 2016, RPD arrested JIMENEZ for felony larceny of a motor vehicle and misdemeanor larceny. ERO again determined JIMENEZ did not to meet enforcement priority. On November 9, 2016, RPD arrested JIMENEZ for misdemeanor possession of marijuana paraphernalia and municipal ordinance begging. ERO determined JIMENEZ did not to meet enforcement priority.

On November 23, 2016, Wake County District Court, NC, convicted JIMENEZ of misdemeanor possession of marijuana paraphernalia. JIMENEZ was sentenced to 14 days confinement, credited him 14 days for time served, and dismissed the municipal ordinance begging charge. On December 8, 2016, RPD arrested JIMENEZ for misdemeanor assault on a female and failure to appear in court for the October 14, 2016 felony and misdemeanor charges. ERO determined JIMENEZ did not meet enforcement priority.

On January 5, 2017, the Wake County District Court, NC, convicted JIMENEZ of misdemeanor simple assault and misdemeanor larceny. JIMENEZ was sentenced to 28 days confinement, credited 28 days for time served and a fine of $305. The felony larceny of a motor vehicle charge was dismissed without leave.

On February 5, 2017, RPD arrested JIMENEZ on an outstanding bench warrant for misdemeanor possession of marijuana paraphernalia and municipal ordinance begging. On this same date, ERO encountered JIMENEZ and determined he was unlawfully present in the United States. ERO lodged a request for Voluntary Transfer with the Wake County Jail. JIMENEZ was issued

[3] *See* Consideration of Deferred Action for Childhood Arrivals, dated December 27, 2012.
[4] *See* U.S. Citizenship and Immigration Services I-797 Notice of Action DACA Approval Notice, dated November 26, 2013.
[5] *See* U.S. Citizenship and Immigration Services I-797 Notice of Action DACA Rejection Notice, dated February 3, 2016.
[6] *See* U.S. Citizenship and Immigration Services I-797 Notice of Action DACA Approval Notice, dated May 6, 2016.

a Notice to Appear by ERO Atlanta charging him with removability pursuant to section 237(a)(1)(B) of the Immigration and Nationality Act, as an alien present in the United States whose nonimmigrant visa has expired or been revoked.[7] On March 2, 2017, JIMENEZ entered ERO custody at the Wake County Jail in Raleigh, NC.

On March 3, 2017, ERO transferred JIMENEZ to the York County Detention Center (YCDC) in York, South Carolina.

On March 7, 2017, ERO transferred JIMENEZ to SDC in Lumpkin, GA.

NARRATIVE

On March 7, 2017, at 5:46 p.m. JIMENEZ was booked into SDC.[8] JIMENEZ signed a personal property receipt showing he arrived with one pair of jeans, one shirt, one jacket, one sweater, one casual item not defined, one wallet and two Visa cards.[9] SDC security staff issued JIMENEZ facility clothing, hygiene supplies, linens, a radio with batteries, a Prison Rape Elimination Act (PREA) pamphlet, and the facility handbook.[10]

An SDC detention officer completed[11] an ICE Custody Classification Worksheet and appropriately classified JIMENEZ as high custody based on the severity of his convictions.[12] A supervisor approved the rating on March 9, 2017.

(b)(6);(b)(7)(C) Licensed Vocational Nurse (LVN), conducted the medical prescreening at 4:25 p.m. LVN (b)(6); noted JIMENEZ spoke fluent English. LVN (b)(6); reviewed the medical summary that accompanied him from YCDC[13] which included diagnoses of psychosis and asthma, and listed his current medications of risperidone[14] 0.5mg at bedtime, and an albuterol aerosol inhaler, as needed for asthma.[15] Neither medication accompanied JIMENEZ to SDC. The transfer summary also noted a positive tuberculosis (TB) test from a March 6, 2017 but documented that JIMENEZ received a follow-up chest x-ray that same day which showed he was negative for an active tuberculosis infection as well as any cardiopulmonary[16] concerns.[17] During the prescreening, JIMENEZ denied pain, fear of being harmed, or a desire to harm

[7] *See* Notice to Appear, dated February 8, 2017.
[8] *See* Stewart Detention Center Inmate/Detainee Commitment Summary, dated March 7, 2017.
[9] *See* Disposition of Non-Allowable Property, dated March 7, 2017.
[10] *See* Receiving and Discharge Check list, dated March 7, 2017.
[11] Name unknown, signature is illegible.
[12] *See* ICE Custody Classification Worksheet, dated March 7, 2017.
[13] *See* York County Sheriff's Office Detention Medical Transfer Report, dated March 7, 2017.
[14] Risperidone is an antipsychotic medication mainly used to treat schizophrenia, bipolar disorder and irritability in people with autism.
[15] Albuterol inhaler is an inhaled bronchodilator used to prevent and treat wheezing and shortness of breath caused by breathing problems such as asthma.
[16] Cardiopulmonary refers to anything pertaining to both the heart and lungs.
[17] *See* York County Sheriff's Office Detention Medical Transfer Report dated March 7, 2017.

himself. LVN (b)(6);(placed JIMENEZ on priority one status.[18] (b)(6);(b)(7)(C) Nurse Practitioner (NP) entered initial orders which included risperidone 0.5mg at bedtime, and an albuterol aerosol inhaler, as needed.

Following the prescreening, Officer (b)(6);(b)(7)(C) completed an Assessment Questionnaire Information form regarding victimization history and risk.[19] JIMENEZ responded with "no" to each question.[20] Officer (b)(6);(b) asked JIMENEZ additional questions concerning detainee risk for self-harm and vulnerability from an untitled form, and when he responded "yes" to a question concerning thoughts of harming himself or others,[21] Officer (b)(6);(b) stopped the interview and notified a nurse.

(b)(6);(b)(7)(C) a Registered Nurse (RN), initiated JIMENEZ's medical intake screening at 9:45 p.m., and documented the following: [22]

- JIMENEZ spoke fluent English and denied any pain.
- JIMENEZ reported taking risperidone 0.5mg at night for psychosis he developed after a skateboard accident in August 2016.
- JIMENEZ reported a suicide attempt in December 2016.
- JIMENEZ admitted to feeling suicidal and having auditory and visual hallucinations at the time of intake.
- JIMINEZ denied a history of alcohol use but stated he used marijuana daily up to one month prior to intake.
- JIMENEZ's vital signs were within normal limits.[23]

Based on the abnormal mental health screening, RN (b)(6);(referred JIMENEZ to a medical provider.

(b)(6);(b)(7)(C) RN, nursing shift supervisor, contacted Lieutenant Commander (LCDR) (b)(6);(b)(7)(C) a Licensed Clinical Social Worker (LCSW) to report JIMENEZ had hallucinations and suicidal ideations. [24] RN (b)(6);(contacted the on-call physician and SDC's Clinical Director, Dr. (b)(6);(b)(7)(C) per LCDR (b)(6);(b)(and the doctor provided a verbal order for a one-time immediate dose of risperidone 1mg for JIMENEZ.[25]

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[18] *See* Prescreening, dated March 7, 2017. Per IHSC Policy 03-08, priority one detainees are those with identified time sensitive medical conditions needing immediate care, to include mental instability, and suicidal ideations.
[19] This form does not specifically reference PREA, however the form is comprised of questions to determine victimization history/risk, to include questions related to sexual assault.
[20] *See* Assessment Questionnaire Information, dated March 7, 2017.
[21] *See* Additional Intake Questions in English and Spanish. Document has no formal title and no date.
[22] *See* Medical Intake, dated March 7, 2017.
[23] Normal temperature is 98.6; normal range for pulse is 60 to 100 beats per minute; normal range for respirations is 12 to 20 breaths per minute; and, normal blood pressure is 120/80, with 90/60 to 139/89 considered within normal range.
[24] *See* Progress Note by LCDR (b)(6);(b)(7)(C) dated March 7, 2017.
[25] *See* Progress Note by (b)(6);(b)(7)(RN, dated March 7, 2017.

Following the call, JIMINEZ signed a patient consent for psychotropic medication, [26] and LCDR (b)(6);(b) assigned JIMENEZ to one-on one constant watch in the medical unit pending a mental health assessment the following morning.[27] Although both the nurse and LCDR (b)(6);(b)(made notations in JIMENEZ's medical record regarding the risperidone order, the Medication Administration Record (MAR) does not contain an entry showing RN (b)(6);(gave him the medication, and ERAU was unable to determine whether he received it as ordered.

On March 8, 2017, at 2:50 a.m, RN (b)(6);(b)(7)(conducted a nursing round and noted JIMENEZ was alert and oriented with good eye contact.[28] She also noted his vital signs were all within normal limits.

At 9:41 a.m., RN (b)(6);(b)(7)(C) conducted a round and documented that JIMENEZ did not express any suicidal ideations or exhibit delusions. She took his vital signs which were within normal limits, with the exception of a low heart rate[29] of 59 beats per minute (bpm).[30]

At 1:33 p.m., LCDR (b)(6);(b) completed JIMENEZ's initial mental health assessment and documented the following:[31]

- JIMENEZ's vital signs were within normal limits with the exception of a low heart rate of 59 bpm.
- JIMENEZ stated he did not receive risperidone for the past day.
- JIMENEZ appeared to be stable and absent of suicidal ideations and auditory hallucinations during the assessment, though he explained his auditory hallucinations were chronic and sometimes commanding in nature.
- JIMENEZ stated he was hospitalized three times for auditory hallucinations in either August or September of 2016. He stated that while hospitalized he was diagnosed with paranoia, schizophrenia, and psychosis.
- JIMENEZ stated his suicidal ideations were infrequent but that he attempted to hang himself in the past. He reported three suicide attempts since the age of 18 due to ineffective coping, alcohol and drug use, or hallucinations commanding him to self-harm.
- JIMENEZ reported taking Abilify[32] and a second medication he could not remember, in the past. As noted on his transfer summary, he was only taking risperidone at this time. JIMENEZ stated he was not compliant with risperidone when he was not in jail or in a psychiatric hospital.
- JIMENEZ stated he had a tendency to decompensate when highly stressed, emotionally triggered, or depressed.

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[26] *See* Consent for Psychotropic Medications for Adults, dated March 7, 2017.
[27] *See* Medical Housing Unit (MHU) Admission dated March 7, 2017. .
[28] *See* Progress Note by (b)(6);(b)(7) RN, dated March 8, 2017.
[29] Although JIMENEZ's heart rate was low on numerous occasions, medical staff never conducted an assessment, i.e. an EKG, to identify whether the detainee had any conditions causing the low heart rate.
[30] *See* Progress Note by (b)(6);(b)(7)(C) RN, dated March 8, 2017.
[31] *See* Progress Note by LCDR (b)(6);(b)(7)(C) dated March 8, 2017.
[32] Abilify is an atypical antipsychotic. It is primarily used to treat schizophrenia and bipolar disorder, as well as major depressive disorders, tic disorders and irritability associated with autism.

- JIMENEZ reported he was incarcerated for approximately one month prior to his transfer to SDC, and was uncertain whether he was currently pending deportation.
- JIMENEZ stated he had no current issues with appetite, energy, motivation, sleep, or fear for his personal safety.

Based on the assessment, LCDR (b)(6);(b) scheduled JIMENEZ for a tele-psychiatry session with Dr. (b)(6);(b)(7)(C) [33] on March 20, 2017. LCDR (b)(6);(b) discharged JIMENEZ from one-on-one observation but directed he remain in medical housing under mental health observation with fifteen minutes checks by security staff, and nursing checks and vital sign monitoring every eight hours. She also noted that she would follow-up with JIMENEZ the following day.

At 1:52 p.m., Dr. (b)(6);(b)(7)(C) completed JIMENEZ's initial physical exam.[34] JIMENEZ reported a history of asthma, depression, severe anxiety, two past suicide attempts, and three past hospitalizations for mental health treatment. JIMENEZ's vital signs were within normal limits with the exception of a low heart rate of 59 bpm. Dr. (b)(6);(b)(7)(C) provided JIMENEZ with extensive patient education on PREA, healthy lifestyle, dental and personal hygiene, and disease prevention and transmission. Dr. (b)(6);(b)(7)(C) ordered that mental health staff follow up with JIMENEZ in one day.

At 5:30 p.m., RN (b)(6);(b)(7)(C) conducted a nursing round and noted JIMENEZ's vital signs were normal, except for a low heart rate of 58 bpm. She noted JIMENEZ voiced no complaints, did not have auditory and visual hallucinations, and had no suicidal ideations.[35]

At 10:00 p.m. RN (b)(6);(b)(7)(C) conducted a nursing round and noted JIMENEZ's vital signs were within normal limits except for a low heart rate of 55 bpm. She also noted JIMENEZ received his albuterol inhaler and took his evening dose of risperidone (0.5mg per NP (b)(6);(b) March 7, 2017 order), without difficulty, and denied visual and auditory hallucinations, and suicidal ideations.[36] JIMENEZ's MAR reflects he received all .5mg doses of risperidone, as ordered.

On March 9, 2017, at 6:40 a.m., Dr. (b)(6);(b)(7)(C) completed a mental health observation assessment noting JIMENEZ was upbeat and positive.[37] JIMENEZ's vital signs were within normal limits except for a low heart rate of 56 bpm. During interview, Dr. (b)(6);(b)(7)(C) explained that he was not concerned with the low heart rate since JIMENEZ was athletic.[38] Dr. (b)(6);(b)(7)(C) noted JIMENEZ had mild anxiety and a moderately depressed mood. He scheduled a mental health observation follow-up for the following day.

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[33] Dr. (b)(6);(b)(7)(C) is an IHSC psychiatrist working out of Krome North Service Processing Center. In the absence of a full-time psychiatrist, SDC uses tele-psychiatry with Dr. (b)(6);(b) whose normally scheduled times for SDC referrals are from 8:00 a.m. to 11:00 a.m. two days per week.
[34] *See* Progress Note by Dr. (b)(6);(b)(7)(C) dated March 8, 2017, regarding JIMENEZ's physical exam.
[35] *See* Progress Note by (b)(6);(b)(7)(C) RN, dated March 8, 2017.
[36] *See* Progress Note by (b)(6);(b)(7)(C) RN, dated March 8, 2017.
[37] *See* Progress Note by Dr. (b)(6);(b)(7)(C) dated March 9, 2017.
[38] ERAU Interview with Dr. (b)(6);(b)(7)(C) date June 21, 2017.

At 11:45 a.m. LCDR (b)(6);(b) completed a mental health evaluation during which she determined JIMENEZ did not have current suicidal ideations and hallucinations.[39] JIMENEZ stated he last heard voices a few weeks prior,[40] that he was sleeping and eating fine, and that he wanted to move to general population. She noted JIMENEZ continued to be compliant with his medication and had no other medical issues.[41] She recorded his mental health diagnoses as schizoaffective disorder bipolar type,[42] and cannabis abuse uncomplicated.[43] Based on her evaluation, LCDR (b)(6);(b) decided to discharge JIMENEZ from mental health observation, and at 5:04 p.m., security staff moved him to general population.[44] JIMENEZ's record shows that although medical staff completed a special needs form for him to be housed in low bunk on a low tier prior to his move to general population,[45] security staff assigned him to an upper bunk.[46]

On March 14, 2017, LCDR (b)(6);(b) saw JIMENEZ for a mental health follow-up during which the detainee denied any current thoughts of suicide.[47] LCDR (b)(6);(b) noted JIMENEZ's vital signs were within normal limits except for a low heart rate of 45 bpm and an elevated blood pressure of 142/75. JIMENEZ told LCDR (b)(6);(b) that he experienced auditory hallucinations since childhood, but that they were not constant. He denied current hallucinations and any intent to self-harm but requested a consult with a psychiatrist to discuss a possible medication change. JIMENEZ completed an IHSC Authorization for Release of Confidential Health Information from WakeBrook[48] and WakeMed[49] medical facilities to receive his medical records.[50] LCDR reminded JIMENEZ he had a tele-psychiatry appointment scheduled for March 20, 2017. During the encounter, LCDR (b)(6);(b) noted JIMENEZ stated he was moved to another dorm shortly after his discharge from medical housing on March 9, 2018, due to inappropriate behavior after he exited the shower without being properly clothed. JIMENEZ told LCDR (b)(6);(b) he did not intend to expose himself.[51] Housing documentation shows JIMENEZ was first housed in Unit 6A after his discharge from medical housing, and then moved to Unit 6B approximately four hours later. Security staff did not document the reason for this move or anything regarding JIMENEZ exposing himself.

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[39] *See* Progress Note by LCDR (b)(6);(b)(7)(C) dated March 9, 2017.
[40] This statement contradicts his report during his intake screening that he experienced auditory hallucinations at the time of intake.
[41] JIMENEZ's received all medication as ordered throughout his detention.
[42] Schizoaffective disorder bipolar type is a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and major depression.
[43] Uncomplicated cannabis abuse refers to excessive use of marijuana without associated psychologic symptoms and impairment in social or occupational functioning.
[44] *See* Progress Note by LCDR (b)(6);(b)(7)(C) dated March 9, 2017, regarding MHU discharge.
[45] *See* Special Needs Form Lower Bunk/Lower Tier, dated March 08, 2017 through June 07, 2017.
[46] *See* Stewart Detention Center Inmate Housing History Report, dated May 24, 2017.
[47] Exhibit 2: Progress Note by LCDR (b)(6);(b)(7)(C) dated March 14, 2017.
[48] *See* IHSC Authorization for Release of Confidential Health Information WakeBrook, dated March 14, 2017.
[49] *See* IHSC Authorization for Release of Confidential Health Information WakeMed, dated March 14, 2017.
[50] WakeBrook is a behavioral health facility in Raleigh, North Carolina (NC). It is a part of the UNC Medical Health Care Center. WakeMed is a hospital also located in Raleigh, NC.
[51] There was no documentation from security staff that this incident happened.

On March 20, 2017, at 10:05 a.m., Dr. (b)(6);(b)(conducted JIMENEZ's initial tele-psychiatry assessment[52] with assistance from (b)(6);(b)(7)(C) LCSW who was on site at SDC during the appointment.[53] Prior to the appointment with Dr. (b)(6);(b)(at 6:05 a.m, LVN (b)(6);(b)(7)(C) took JIMENEZ's vital signs, which were within normal limits except for a low heart rate of 51 bpm. During the appointment, JIMENEZ discussed his past medical history including head trauma he suffered during a skateboarding accident in 2016, after which he was prescribed the antipsychotic drugs aripiprazole[54] and quetiapine[55] to treat disorganized thinking and auditory and visual hallucinations. He stated these medications were later discontinued, and he was prescribed risperidone. Dr. (b)(6);(b)(noted JIMENEZ had no current suicidal or homicidal ideations, that his psychiatric diagnosis and medication treatment remained unchanged. Dr. (b)(6);(b ordered laboratory testing for lipid panel,[56] comprehensive metabolic panel,[57] prolactin,[58] complete blood count (CBC) with differential/platelet[59] and hemoglobin A1c.[60] He also ordered a tele-psychiatry follow-up in three to four weeks. Dr. (b)(6);(b)(noted that JIMENEZ was vulnerable to stress while going through the immigration process and being detained for an undetermined amount of time, and stated that JIMENEZ's psychological care would focus on maintaining his psychological stability, and providing treatment in the form of psychotherapy, as needed, as well as medication. [61]

On March 27, 2017, JIMENEZ failed to show up for a scheduled sick call appointment with RN (b)(6);(b)(7)(C) [62] According to RN (b)(6);(b)(because the sick call process at SDC requires detainees to just sign up for sick call with the nurse on their unit and does not require that they specify a reason, she could not determine the reason for JIMENEZ's sick call request on this date.[63]

On April 6, 2017, at 8:16 a.m., RN (b)(6);(b)(7)(C) conducted a sick call assessment for blisters on JIMENEZ's feet which resulted from his playing basketball without shoes on.[64] RN (b)(6);(b)(noted JIMENEZ's vital signs were within normal range except for a low heart rate of 51

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[52] *See* Progress Note by Dr. (b)(6);(b)(7)(C) dated March 20,2017.
[53] (b)(6);(b)(7)(C) was on maternity leave when ERAU conducted this review and was unable to be interviewed.
[54] Aripiprazole is the generic name for Abilify.
[55] Quetiapine is the generic name for Seroquel. It is an atypical antipsychotic used to treat schizophrenia, bipolar disorder and major depressive disorders.
[56] A lipid panel is a panel of blood test that serves as an initial broad medical screening tool for abnormalities in lipids, such as cholesterol and triglycerides.
[57] A comprehensive metabolic panel is a blood test that measures your sugar level, electrolyte and fluid balance, kidney function and liver function.
[58] Prolactin is a hormone made in your pituitary gland. A prolactin test measures how much of the hormone you have in your blood. Prolactin levels can increase due to medications such as those used for psychosis.
[59] A complete blood count (CBC) with Differential/Platelets is a blood test that measures the cells that make up your blood to include red blood cells, white blood cells and platelets.
[60] A hemoglobin A1c test reflects your average blood sugar level for the past two to three months. Specifically, this test measures what percentage of your hemoglobin, a protein in red blood cells that carries oxygen, is coated with sugar.
[61] *See* Progress Note by Dr. (b)(6);(b)(7)(C) dated March 20,2017.
[62] *See* Progress Note by (b)(6);(b)(7)(C) RN, dated March 27, 2017.
[63] ERAU Interview with (b)(6);(b)(7)(C) RN dated June 21, 2017.
[64] *See* Progress Note by (b)(6);(b)(7)(C) RN, dated April 6, 2017.

bpm. She noted he had blisters on his right great toe and the ball of this foot but had no redness, swelling or drainage. She counseled JIMENEZ on the risk for infection and pain management, and advised him to wear shoes and not to participate in basketball until the blisters healed. During the assessment, JIMENEZ requested an update on the medical records for WakeMed and WakeBrook. RN (b)(6);(b informed JIMENEZ he had a pending appointment with LCDR (b)(6);(b)(and could follow up on his medical records at that time.

On April 10, 2017, JIMENEZ submitted a detainee information request form to go to the law library. This request was responded to on April 14, 2017 by an unknown staff member who only wrote "segregation."[65] When JIMENEZ submitted the request, he was not in segregation, however, by the time it was answered he was. As discussed below, on April 13, 2017, JIMENEZ was placed in administrative segregation after being involved in a physical altercation with another detainee. He remained in administrative segregation until April 18, 2017. JIMENEZ's record contains no documentation indicating SDC fulfilled this request to use the law library.

On April 11, 2017, LCDR (b)(6);(b) completed a mental health follow-up with JIMENEZ.[66] The detainee reported he was taking his medication but asked that his medication be reviewed as he was hearing voices almost daily. JIMENEZ stated the voices were not commanding in nature but admitted they sometimes encouraged him to act impulsively, like walking out of the shower without clothing. JIMENEZ stated that the voices made him uncomfortable. During the encounter, JIMENEZ requested clarification of his diagnosis and stated he was skeptical of his diagnosis of schizoaffective disorder. JIMENEZ stated that his previous medications, Abilify and Seroquel,[67] were more effective in treating his symptoms. LCDR (b)(6);(b)(noted that SDC had not yet received JIMENEZ's medical records from Wakemed or Wakebrook medical facilities. She also noted JIMENEZ's next tele-psychiatry appointment was scheduled for April 24, 2017 and that she would conduct a follow-up mental health appointment, although she did not note the date. She maintained his diagnosis of cannabis abuse but modified the diagnosis of schizoaffective disorder, bipolar type to paranoid schizophrenia.[68] JIMENEZ's vital signs on this date were within normal limits except for a low heart rate of 56 bpm.

On April 13, 2017, at approximately 3:58 p.m., JIMENEZ was involved in a physical altercation with another detainee.[69] As seen in video surveillance footage, no officers were on the unit during the altercation. Per SDC Housing Unit Post Orders, an officer is never to leave their post for any reason unless properly relieved by an assigned officer or the shift supervisor/unit manager.[70] When a Core Civic counselor entered the unit at approximately 3:59 p.m., after the altercation ended, a detainee informed him of the altercation, and the counselor escorted

[65] *See* Detainee Information Request, dated April 10, 2017.
[66] Exhibit 3: Progress Note by LCDR (b)(6);(b)(7)(C) dated April 11, 2017.
[67] Seroquel is the brand name for quetiapine.
[68] The basis for the diagnosis change was not documented.
[69] *See* Video Surveillance of Unit 6B.
[70] *See* Housing Unit Post Orders, dated May 20, 2016.

JIMENEZ from the housing unit to medical.[71] It is unknown when an officer returned to the unit.

RN (b)(6);(b)(7)(C) assessed JIMENEZ at 4:50 p.m.[72] JIMENEZ complained of level five pain to the left side of his upper and lower lip and to his left cheekbone, and RN (b)(6);(b)(7)(C noted minor swelling and blood from a laceration in that area. RN (b)(6);(b)(7)(C documented that JIMENEZ's neurology assessment[73] was normal, and that he denied blurred vision, dizziness, or confusion. She noted JIMENEZ also denied hallucinations or suicidal and homicidal ideations and did not have active psychosis or mania. RN (b)(6);(b)(7)(C gave JIMENEZ 400 mg of ibuprofen to help with pain and swelling and advised him to request sick call or notify an officer or nurse if the pain or swelling worsened. Because JIMENEZ's blood pressure was elevated at 166/95 during the encounter (all other vital signs were normal), RN (b)(6);(b)(7)(C contacted Dr. (b)(6);(b)(7)(C) who ordered 2 mg of clonidine[74] for the detainee, and RN (b)(6);(b)(7)(gave JIMENEZ the clonidine. RN (b)(6);(b)(7)(C cleared JIMENEZ for segregation, noting he had no acute or unresolved medical conditions that would worsen in segregation, and at 5:34 p.m. he was placed in administrative segregation in the Special Management Unit (SMU) pending a hearing for fighting.

While JIMENEZ was in medical for segregation clearance, UM (b)(6);(reviewed video footage of the altercation, prepared an Administrative Segregation (AS) Order, and provided a copy of the order to JIMENEZ as required by the PBNDS 2011. In his written report, UM (b)(6);(b documented that the video footage showed JIMENEZ engaging in a detainee-on-detainee fight.[75] That same afternoon, an officer interviewed JIMENEZ, and JIMENEZ stated that the other detainee approached him and initiated an altercation. JIMENEZ stated he responded verbally to the other detainee but never physically touched him. The officer prepared an Investigation Report based on interviews with both detainees and sent it to the Unit Disciplinary Committee (UDC) for review.

On April 14, 2017, the UDC reviewed the incident, determined the altercation resulted from verbal insults by both detainees, and referred the incident to SDC's Institution Disciplinary Panel (IDP).[76] SDC completed an IDP notification that JIMENEZ would receive a hearing on April 18, 2017.[77]

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[71] Per an incident report completed by Unit Manager (UM) (b)(6);(b)(7)(C, SDC staff escorted both JIMENEZ and the other detainee involved in the altercation to medical for pre-segregation medical clearance.
[72] *See* Progress Note by (b)(6);(b)(7)(C) RN, dated April 13, 2017.
[73] A neurology assessment is the evaluation of the patient's nervous system. This includes checking motor and sensory skills, balance and coordination, mental status, reflexes, and functioning of the nerves.
[74] Clonidine is a drug used to treat high blood pressure, attention deficit hyper activity disorder, anxiety disorders, tic disorders, withdrawal, migraine, menopausal flushing, diarrhea, and certain pain conditions.
[75] As noted below, Officer (b)(6);(b reviewed the footage and did not find that JIMENEZ engaged physically with the other detainee. ERAU was unable to determine how UM (b)(6) came to an inconsistent conclusion based on review of the same footage.
[76] *See* Investigative Report, dated April 13, 2017.
[77] *See* Notice of Institution Disciplinary Panel Hearing, dated April 17, 2017.

While JIMENEZ was held in the SMU from April 14 to April 18, 2017, regular nursing rounds were documented, though his vital signs were not taken at any point, and the nursing notations appeared to contain standard observations with little deviation. The following observations of JIMENEZ were consistently recorded in the nursing notes:[78]

- JIMENEZ had no medical needs or concerns.
- JIMENEZ denied suicidal ideations.
- JIMENEZ's behavior, affect, and cognitive functioning were normal.
- JIMENEZ's behavior did not appear to show active psychosis, mania, suicidal ideal or homicidal ideation.

Several nurses interviewed reported that segregation nursing round typically include face-to-face encounters with detainees during which they ask specific questions to determine the detainee's thought process and the potential presence of suicidal ideations.

While JIMENEZ was in the SMU, LCDR (b)(6);(b) received his medical records from University of North Carolina (UNC) Health Care.[79] The records documented JIMENEZ was admitted as a psychiatric patient, and had a history of psychosis, cannabis abuse, and aggressive and impulsive behavior. LCDR (b)(6);(b) revised JIMENEZ's diagnosis back to schizoaffective disorder, bipolar type.[80] LCDR (b)(6);(b)(documented that JIMENEZ's treatment plan would remain the same and that she would see him monthly or as needed.

On April 16, 2017, Chief of Security (b)(6);(b)(7)(C) completed a 72 hour confinement review. While it was completed within 72 hours, there was no indication that JIMENEZ was interviewed.[81]

The morning of April 17, 2017, LCDR (b)(6);(b)(conducted a weekly mental health segregation round. JIMENEZ stated he did not like segregation but was staying busy by drawing, reading, and exercising. LCDR (b)(6);(b) noted segregation logs documented JIMENEZ was eating and showering regularly, and using the telephone often. JIMENEZ stated he was taking his medication as ordered and denied thoughts of harming himself. LCDR (b)(6);(b) described JIMENEZ as pleasant and cooperative and determined he was in no acute medical or emotional distress.[82]

[78] *See* Daily Segregation Nursing Rounds, dated April 14 through April 18, 2017.
[79] *See* Progress Note by LCDR (b)(6);(b)(7)(C) dated April 14, 2017.
[80] As noted on April 11, 2017, LCDR (b)(6);(modified JIMENEZ's diagnosis from schizoaffective disorder, bipolar type to paranoid schizophrenia. The modification back to the original diagnosis on April 14, 2017 is not documented; however, it was modified after LCDR (b)(6);(reviewed information in the UNC Health Care records.
[81] Exhibit 4: Confinement Review, dated April 16, 2017.
[82] *See* Progress Note by LCDR (b)(6);(b)(7)(C) dated April 17, 2017.

Sergeant (b)(6);(b)(7)(C) who was the segregation and disciplinary sergeant at the time, conducted JIMENEZ's IDP hearing, on April 18, 2017.[83] Based on her review of video footage prior to the hearing, Officer (b)(6);(b)(determined JIMENEZ was physically assaulted by the other detainee and did not physically engage in the altercation himself. She found JIMENEZ not guilty of fighting and directed his release from the SMU.[84] At approximately 6:20 p.m., SDC transferred JIMENEZ from the SMU back to general population. SDC staff did not complete a Special Reclassification Assessment for JIMENEZ upon his release from the SMU, as required by the PBNDS 2011.

On April 19, 2017, (b)(6);(b)(7)(C) NP, conducted an emergency assessment[85] of JIMENEZ after he complained of abdominal pain, nausea and dizziness.[86] During the encounter, JIMENEZ complained of nasal congestion, and straining during bowel movement, and asked for his room to be cleaned due to it having a strong smell of urine. JIMENEZ's vital signs were within normal limits except for a mildly low heart rate of 59 bpm. NP (b)(6);(b)(7)(C) ordered JIMENEZ an injectable antihistamine,[87] and an injectable anti-nausea medication,[88] both administered by LPN (b)(6);(b)(7)(C) at the time of the appointment. She also prescribed docusate sodium[89]100 mg as needed for constipation, and flunisolid for seasonal allergies.[90] NP (b)(6);(b)(7)(C) asked the medical officer to coordinate cleaning of JIMENEZ's room prior to his return and noted the officer complied.

On April 24, 2017, Dr. (b)(6);(b)(postponed JIMENEZ's scheduled tele-psychiatry appointment due to needing to see a detainee with more acute psychiatric needs.[91] LCDR (b)(6);(b)(documented on April 25, 2017, that she moved JIMENEZ's rescheduled appointment with Dr. (b)(6);(b)(from June 13, 2017, to May 15, 2017.

On April 25, 2017, at 1:08 p.m., JIMENEZ had a monthly psychiatric medication check-up appointment with NP (b)(6);(NP (b)(6); noted that while waiting for the appointment, JIMENEZ jumped out of his seat repeatedly and declared he was Julius Ceasar. He reported hearing voices telling him to commit suicide but stated he did not have a desire to harm himself or anyone else. JIMENEZ stated his risperidone was not strong enough and asked for stronger medication.[92] NP

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[83] Exhibit 5: Institution Disciplinary Panel, dated April 18, 2017. As noted in the Findings section of this report, April 18, 2017, fell outside the hearing timeframe prescribed by both the PBNDS 2011 and SDC Policy. Additionally, although JIMENEZ requested in advance that another detainee serve as a witness during the hearing, Officer (b)(6);(b) did not have another detainee present.

[84] *See* Institution Disciplinary Panel Report dated April 18, 2017.

[85] While the medical assessment note referenced an emergency assessment, there is no documentation of a medical emergency being called.

[86] *See* Progress Note by (b)(6);(b)(7)(C) NP, dated April 19, 2017.

[87] Diphenhydramine is an antihistamine used to relived symptoms of allergy, hay fever and the common cold.

[88] Promethazine is used to prevent and treat nausea and vomiting related to certain conditions, such as before and after surgery, and motion sickness.

[89] Docusate Sodium is a medication used to treat occasional constipation.

[90] Flunisolide is a medication used to prevent and treat seasonal and year-round allergy symptoms.

[91] *See* Progress Note by Dr. (b)(6);(b)(7)(C) dated April 24, 2017.

[92] Exhibit 6: Progress Note by NP (b)(6);(b)(7)(dated April 25, 2017.

(b)(6);(completed an Abnormal Involuntary Movement Scale assessment[93] to determine whether JIMENEZ had tardive dyskinesia,[94] and the score was zero. NP (b)(6); ordered labs to be completed on May 1, 2017, to include urinalysis, lipid panel, comprehensive metabolic panel, prolactin,[95] and CBC with differential. She also included an order that medical staff schedule JIMENEZ for a follow-up in four weeks. NP (b)(6); stated that immediately following the assessment, she notified LCDR (b)(6);(b) of JIMENEZ's complaint of hearing voices directing him to commit suicide.

At 2:15 p.m., LCDR (b)(6);(b) assessed JIMENEZ.[96] JIMENEZ stated he experienced auditory hallucinations around 3:00 or 4:00 a.m. that morning and that the voices told him he was Julius Ceasar. He stated the voices also told him he should kill himself. JIMENEZ denied active suicidal or homicidal ideations. JIMENEZ stated he was working on his immigration case, but expressed doubt about winning due to his past misdemeanor convictions. JIMENEZ asked LCDR (b)(6);(b)(for an increase in his dosage of risperidone, stated he felt he needed something stronger, and that he took a higher dose of risperidone in the past. LCDR (b)(6);(b)(documented JIMENEZ had depression and anxiety, but no thoughts of self-harm or harming others, and that he was compliant with his medications.

On April 27, 2017, at approximately 4:09 p.m., Officer (b)(6);(b)(7)(C) the housing unit officer assigned to Unit 4, Pod B, where JIMNEZ was housed, left the housing unit. At approximately 4:34 p.m., JIMENEZ climbed over the railing on the second tier of the unit and jumped approximately nine feet to the first tier, landing on his feet.[97] After landing, JIMENEZ walked to a table in the dayroom, took his shirt off, and then pulled his pants down and back up. At approximately 4:38 p.m., Officer (b)(6);(b)(7)(C reentered the pod,[98] and a detainee informed him JIMENEZ jumped from the top tier of the unit while he was gone. Officer (b)(6);(b)(7)(C) reported the incident to Unit Manager (b)(6);(b)(7)(C) Unit Manager (b)(6);(b)(7)(watched the surveillance video of JIMENEZ jumping, reported the incident to her shift captain, and requested officer assistance in escorting JIMENEZ to the medical unit to be medically cleared prior to being placed in segregation. Unit Manager (b)(6);(b)(7)(C) issued a report charging JIMENEZ with an act that could endanger persons(s) or property.[99] Unit Manager (b)(6);(b)(7)(C noted during interview that Officer (b)(6);(b)(7)(C) should not have left the pod unsupervised.

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[93] The AIMS test is used to detect and follow the severity of a patient's tardive dyskinesia over time.
[94] Tardive Dyskinesia is a side effect which causes stiff, jerky movements of the face and body that cannot be controlled. Antipsychotics can cause this side effect.
[95] NP (b)(6) ordered prolactin testing due to JIMENEZ having elevated prolactin levels in his March 23, 2017 lab work. During interview, NP (b)(6) stated the elevated prolactin was likely a side effect of JIMENEZ's risperidone. Prolactin is a hormone produced by the pituitary gland in the brain which is important for male and female reproductive health.
[96] *See* Progress Note by LCDR (b)(6);(dated April 25, 2017
[97] *See* Surveillance Video from Unit 4B. The video surveillance footage shows JIMENEZ walked up the stairs to the second tier at approximately 4:30 p.m. and practiced jumping several times between approximately 4:32 p.m. and 4:34 p.m.
[98] *See* Surveillance video from Unit 4B, April 27, 2017.
[99] UM (b)(6);(b)(inaccurately documented the time of the incident as 9:40 a.m.

At approximately 4:52 p.m., two officers escorted JIMENEZ to the medical unit where he was medically cleared by RN (b)(6);(b for placement in segregation.[100] RN (b)(6);(b documented JIMENEZ's vital signs were within normal limits and that she cleared him for special housing.[101] RN (b)(6);(did not make any notations regarding the jumping incident. Following the medical encounter, security staff escorted JIMENEZ to the Special Management Unit (Unit 7, Pod A), where he was housed in AS in cell 102.[102] During interview, LCDR (b)(6);(b) stated she was not informed of the incident in a timely matter.[103]

Nurses conducted regular daily rounds of the SMU while JIMENEZ was housed there from April 27, 2017 until his death on May 14, 2017. Nursing notes from those rounds were substantially the same in content, and none noted any distress, complaints, pain, or suicidal or homicidal intent from JIMENEZ. Nurses noted JIMENEZ's breathing was unlabored, he demonstrated appropriate responses, and his behavior, affect, and cognitive functioning appeared to be normal. Nurses did not obtain JIMENEZ's vital signs during any of the rounds.[104] RN (b)(6);(b stated she typically just knocks on the cell door and asks the detainee to verbally acknowledge her presence, and stated that if the detainee does not proactively ask a question or raise an issue, she moves to the next cell.[105] Creative Corrections notes this practice contravenes IHSC Directive 03-06, *Health Evaluation of Detainees in Special Management Units*, which requires the medical provider or nurse to make face-to-face visits with detainees in the SMU and to document those visits in both detainee's health record and in the SMU Log Book. RN (b)(6);(b also admitted to erroneously documenting a full encounter for these abbreviated visits, to include direct face-to-face questioning of the detainee's behavior and thought process.[106] Each full week JIMENEZ was in segregation, LCDR (b)(6);(b) conducted one mental health segregation round.[107]

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[100] *See* Surveillance video from Unit 4B, April 27, 2017.

[101] *See* Report of Detainee Incident/Segregation Review, dated April 27, 2017

[102] Unit 7, Pod A of the Special Management Unit (SMU) is a 39-single cell unit for detainees in a segregated status. Cell 102 has a metal bunk along the back wall. A stainless-steel toilet/sink combination is on the left-hand side with a mirror above the sink. To the right of the mirror is a stainless-steel sprinkler head. The door is steel with a viewing window at both the top and bottom of the door. The door handle is on the right-hand side and opens out to the dayroom.

[103] LCDR (b)(6);(stated during interview that she was not informed in a timely manner and never received a mental health referral for JIMENEZ following the incident. (b)(6);(b)(7)(a CoreCivic employee (title unknown), emailed multiple ICE recipients, including LCDR (b)(6);(HSA (b)(6);(b)(7) and Assistant HSA (b)(6);(b) on April 27, 2017 at 6:36 p.m. informing them that JIMENEZ had jumped from the second tier and was placed in segregation. The email was sent outside normal business hours; therefore, LCDR (b)(6);(did not read it until the next time she reported for duty.

[104] *See* Daily Segregation Nursing Rounds dated April 28 through May 14, 2017.

[105] ERAU Interview with (b)(6);(b)(7)(C) dated June 20, 2017.

[106] RN (b)(6);(cleared JIMENEZ for segregation and conducted two segregation rounds.

[107] Of note, IHSC Directive 03-06, section 4-4, related to assessment of detainees in segregation states "Behavioral Health Professionals (BHP) or medical providers assess detainees placed in Special Management beds with active psychiatric symptoms (suicidal ideations, psychosis, etc.) on a daily basis. The BHP or medical provider uses his or her best efforts to transfer the detainee to a behavioral health bed if symptoms require stabilization, as soon as possible." As JIMENEZ exhibited and reported both active psychosis in the form of commanding auditory hallucinations throughout the two-month period of detention, daily segregation assessments by a BHP or medical provider were crucial.

After JIMENEZ was moved to the SMU, Unit Manager (b)(6);(b)(7) prepared an AS Order, and it was reviewed and approved by Chief of Security (b)(6);(b)(7 on April 28, 2017.[108] Chief (b)(6);(b)(7 completed a confinement record the same day, though there was no indication JIMENEZ was interviewed.[109] Also on April 28, 2017, Officer (b)(6);(b)(7)(C) [110] the officer assigned to investigate the jumping incident, interviewed JIMENEZ who calmly stated he jumped from the top tier because he wanted to commit suicide. Officer (b)(6);(b)(7)(C) referred the incident to the UDC/IDP, and security staff provided JIMENEZ a copy of his notice of rights, which he signed.[111]

On April 29, 2017, JIMENEZ completed a Detainee Request Worksheet addressed to ICE ERO Deportation Officer (DO) (b)(6);(b)(7)(C), in which he wrote he was physically assaulted by another detainee on April 13, 2017 and requested any photos[112] taken of his injuries.[113] In a response dated May 1, 2017, a staff member (identity unknown) wrote that the request was forwarded to security staff. During interview, Officer (b)(6);(stated that he never saw the request and did not respond to it.[114]

On May 1, 2017, LCDR (b)(6);(b) conducted a mental health assessment of JIMENEZ. During the encounter, the detainee stated he was not trying to be disruptive when he jumped on April 28, 2017, but that he had a lot of energy which he was trying to get out.[115] LCDR (b)(6);(b) noted JIMENEZ denied suicidal and homicidal ideations and that she counseled him on adaptive coping skills.[116] She also noted that she did not believe his mental health would deteriorate while in SMU. During the encounter, LCDR (b)(6);(b) also provided JIMENEZ with a copy of his medical records.

On May 2, 2017, at 2:00 p.m., Sergeant (b)(6);(b)(conducted JIMENEZ's IDP hearing.[117] During the hearing, JIMENEZ told her he was trying to hurt himself when he jumped on April 27, 2017, so Sergeant (b)(6);(b)(stopped the hearing and took him to the medical unit to be assessed by LCDR (b)(6);(b) [118] Sergeant (b)(6);(b)(noted LCDR (b)(6);(b)(evaluated JIMENEZ and cleared him to return to SMU. Sergeant (b)(6);(b)(resumed the IDP hearing. Based on his statements and the investigative report, Sergeant (b)(6);(b)(7 found JIMENEZ committed an act that could endanger a person or property and gave him a sanction of 20 days in disciplinary segregation with credit for time served. [119]

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[108] *See* Administrative Segregation Order, dated April 28, 2017.
[109] Exhibit 7: Confinement Record, dated April 28, 2017.
[110] First name unknown.
[111] *See* Investigation Report, dated April 28, 2017. The requirement to have the detainee sign the notice of rights is to ensure the detainee understands his rights during the UDC/IDP process.
[112] No photos of injuries sustained during the altercation on April 13, 2017 were found in the detainee's record.
[113] *See* Detainee Request Work Sheet, dated April 29, 2017.
[114] ERAU Interview with (b)(6);(b)(7)(, Deportation Officer, dated June 22, 2017.
[115] *See* Progress Note by LCDR (b)(6);(b)(7)(C) dated May 1, 2017.
[116] Adaptive coping skills are strategies for reducing stress.
[117] Exhibit 8: Institution Disciplinary Panel Report, dated May 3, 2017.
[118] ERAU interview with Sergeant (b)(6);(b)(7)(C) dated June 21, 2017.
[119] *See* Institution Disciplinary Panel Report, dated May 3, 2017.

LCDR (b)(6);(b) documented that she conducted mental health evaluation after JIMENEZ told security staff that he wanted to cut himself.[120] LCDR (b)(6);(b) noted JIMENEZ talked, laughed and smiled inappropriately throughout the encounter. She also noted his psychomotor activity was within normal range, he had no delusions, and was not suicidal or homicidal. Although JIMENEZ stated that he was tormented by voices and sounds all the time and that the voices encouraged him to do things he did not want to, LCDR (b)(6);(b) noted the auditory hallucinations encouraged JIMENEZ to do impulsive things but were not commanding in nature. LCDR (b)(6);(b)(stated during interview that this assessment was incorrect and that JIMENEZ's description of the voices indicated they were, in fact, commanding in nature.[121] They discussed the April 28, 2017 jumping incident, and JIMENEZ stated he jumped from the second tier of his housing unit because he wanted to hurt himself. JIMENEZ also discussed exposing himself earlier that day, and stated he was dancing naked while he waited for security staff to bring him a clean uniform when he suddenly had the impulse to get the nurses attention.[122] JIMENEZ reported he was compliant with his medications but believed his medication needed adjusting as it was not strong enough.[123] LCDR (b)(6);(b) noted JIMENEZ was scheduled for a follow up tele-psychiatry appointment with Dr. (b)(6);(b)(on May 15, 2017.

On May 5, 2017, Sergeant (b)(6);(b)(conducted JIMENEZ's IDP hearing regarding the indecent exposure charge.[124] During the hearing, which she held at his cell front, JIMEMEZ admitted to the incident and stated that he would not engage in such behavior again. Sergeant (b)(6);(b)(7) found JIMENEZ guilty and sanctioned him to three additional days of disciplinary segregation, which pushed his scheduled release from disciplinary segregation to May 19, 2017.

On May 7, 2017, JIMENEZ submitted a detainee grievance form stating he never received stamps he ordered through commissary on April 26, 2017. Sergeant (b)(6);(b)(7)(C) SDC's grievance officer, responded to the grievance on May 8, 2017, noting that JIMENEZ ordered and received four stamps.[125]

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[120] Exhibit 9: Progress Note by LCDR (b)(6);(b)(7)(C), dated May 2, 2017. JIMENEZ only told Sergeant (b)(6);(b) he wanted to "hurt" himself when he jumped from the second tier. ERAU was unable to determine why LCDR (b)(6);(specified he wanted to "cut" himself in her notation.

[121] ERAU Interview with LCDR (b)(6);(b)(7)(C) LCSW, dated June 20, 2017.

[122] At approximately 2:00 p.m., two nurses reported to an SMU officer that JIMENEZ exposed himself to them earlier that day while they conducted rounds. The officer wrote an incident report and charged JIMENEZ with indecent exposure. *See* Incident of Prohibited Acts and Notice of Charges, dated May 2, 2017. Later that day, the officer assigned to investigate the incident interviewed JIMENEZ, and the detainee stated that his undershorts fell down while he was "dancing on the door" and that he did not meant for them to fall. *See* Investigative Report, dated May 2, 2017. The investigating officer referred the incident to the IDP and provided JIMENEZ with a copy of the notice of his rights. *See* Detainee Rights at the Institution Disciplinary Panel Hearing, dated May 2, 2017. The IDP hearing took place on May 5, 2017.

[123] According to Dr (b)(6);(b)(7)(at no time did a nurse or LCDR (b)(6);(request a medication adjustment for JIMENEZ, which he would be authorized to order and/or adjust psychiatric medication, especially in consultation with Dr (b)(6);(b)(

[124] Exhibit 10: Institution Disciplinary Panel Report, dated May 5, 2017.

[125] *See* Detainee Grievance, dated May 7, 2017.

Also on this date, an officer reviewed JIMENEZ's classification level and recommended JIMENEZ remain at high custody, due to the two in-custody convictions.[126] . A supervisor approved the recommendation on May 8, 2017. (b)(6);(b)(7)(C) Case Manager, completed a 60-90 Day the Sexual Abuse Screening Tool assessment.[127]

On May 8, 2017, JIMENEZ submitted a detainee information request form to Sergeant (b)(6);(b) requesting a copy of pictures taken from when he was hit by another detainee on April 13, 2017. Neither Sergeant (b)(6); nor any other security staff answered this request.[128]

On May 9, 2017, while posted to Unit 7A during the afternoon shift, Officer (b)(6);(b)(heard JIMENEZ talking to himself in his cell. He recalled that he checked JIMENEZ, found the detainee yelling, and reported the behavior to RN (b)(6);(b)(7 who was conducting rounds in the unit at the time.[129] RN (b)(6);(b)(7 stated that when she went to JIMENEZ's cell, the detainee was standing on his toilet, yelling at the mirror, and kicking the air.[130] JIMENEZ told RN (b)(6);(b)(7) that he was hearing voices and that he spoke to LCDR (b)(6);(b) regarding an increase to his medication, but that she had yet increased it. RN (b)(6);(b)(7 told JIMENEZ she would discuss his symptoms with LCDR (b)(6);(b)(RN (b)(6);(b)(7 notified LCDR (b)(6);(b)(of JIMENEZ's symptoms via a telephone encounter sent at approximately 2:34 a.m. on May 10, 2017.[131] LCDR (b)(6);(b) responded to the telephone encounter at approximately 8:17 a.m. and stated that JIMENEZ had a tele-psych appointment with Dr. (b)(6);(b)(scheduled for May 15, 2017 during which he could discuss his medication dosage. LCDR (b)(6);(b) also noted, she would see JIMENEZ that week for both segregation rounds and a mental-health follow-up appointment. RN (b)(6);(b)(7 stated during interview that when she saw JIMENEZ over the weekend (May 13-14, 2017), he seemed calmer and did not display any erratic behavior.

On May 10, 2017, LCDR (b)(6);(b) encountered JIMENEZ during her weekly segregation round. She recalled during her interview that JIMENEZ was pounding on the walls and referring to himself as Julius Ceaser when she started the encounter, but by the end he was discussing his plans if he was deported and seemed very goal oriented. LCDR (b)(6);(b) documented that he was pleasant, cooperative, insightful, compliant with his medications, and denied suicidal or homicidal ideations.[132] At the conclusion of the encounter, JIMENEZ wished LCDR (b)(6);(b) a happy Mother's Day and said he would see her on Monday. LCDR (b)(6);(b) stated during interview that in hindsight earlier intervention in the form of placement on suicide watch may have been appropriate.[133]

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[126] *See* ICE Custody Classification Worksheet, dated May 7, 2017.
[127] *See* Sexual Abuse Screening Tool 60-90 day assessment, dated May 7, 2017.
[128] *See* Detainee Information Request, dated May 8, 2017.
[129] ERAU Interview with (b)(6);(b) dated June 22, 2017.
[130] ERAU Interview with (b)(6);(b)(7)(C) dated June 22, 2017.
[131] Exhibit 11: Telephone Encounter, dated May 10, 2017.
[132] *See* Progress Note by LCDR (b)(6);(b)(7)(C) dated May 12, 2017. LCDR (b)(6);(did not create a note for this encounter until May 12, 2017. This was the last encounter she has with JIMENEZ.
[133] ERAU Interview with (b)(6);(b)(7)(C) dated June 20, 2017.

At an unknown time on May 10, 2017, (b)(6);(b)(7)(C) Physician Assistant (PA), entered an encounter note for JIMENEZ which documented the reason for the appointment as "hearing voice." The encounter note was otherwise blank. [134]

On May 13, 2017, between 10:31 a.m. and 11:50 a.m., JIMENEZ visited with his mother in SDC's visitation area.[135] Officer (b)(6);(b)(7)(C) who escorted JIMENEZ from SMU to visitation, stated JIMENEZ's state of mind seemed normal during their conversation during the escort.

On May 14, 2017, at an unknown time, JIMENEZ submitted a request form addressed to DO (b)(6);(stating that he did not receive forms that his lawyer sent. DO (b)(6);(did not respond prior to JIMENEZ's death the following day.[136]

Officer (b)(6);(b)(7 who was assigned to Unit 7A during the day shift[137] stated that JIMENEZ seemed fine during his shift on this date, though he recalled JIMENEZ removed the sheets from his bed and used them to jump rope. JIMENEZ told Officer (b)(6) he was jumping rope with the sheets to stay in shape.[138]

At 8:59 p.m., RN (b)(6);(b)(7 encountered JIMENEZ during pill pass. According the medication administration record, JIMENEZ took his risperidone at this time.[139]

At 10:00 p.m., Officer (b)(6);(b)(7)(C) assumed the Unit 7A post for the night shift (10:00 a.m. to 6:00 p.m.).[140] Officer (b)(6);(stated during interview that during his first few rounds that night, JIMENEZ did not talk to him which, in retrospect, was unusual.[141]

As seen in surveillance footage of Unit 7A, Officer (b)(6);(left his post without being relieved on six occasions during the night of May 14, 2017,[142] in contravention of the SMU post orders which state the unit officer may not leave the post unless properly relieved by another officer.[143] Officer (b)(6);(stated during interview that he stepped outside the unit on several occasions to call the unit control officer as the intercom system inside the unit did not work. Additionally, during his shift, Officer (b)(6);(documented seven rounds, with five of them being verified on surveillance video. Of the five verified rounds, one occurred outside the 30 minute timeframe

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[134] *See* Progress Note by (b)(6);(b)(7)(C) PA, dated May 10, 2017. Because PA (b)(6);(b) was no longer employed at SDC at the time of the review, ERAU was unable to determine who referred JIMENEZ to PA (b)(6);(b) and what transpired during the encounter.
[135] *See* Confinement Activity Record, dated May 13, 2017.
[136] *See* Detainee Request Worksheet, dated May 14, 2017.
[137] *See* Post Log book, dated May 14, 2017.
[138] ERAU Interview with (b)(6);(b) dated June 22, 2017.
[139] Medication Administration Record, dated May 14, 2017.
[140] *See* Post Log book, dated May 14, 2017.
[141] ERAU Interview with (b)(6);(b)(7)(dated June 21, 2017.
ERAU notes that there was a second officer in Unit 7A standing one-on-one vigil with a detainee on suicide watch the night of May 14, 2017. All staff interviewed stated that, as the vigil officer, that second officer was not expected or at liberty to perform any other duties on the unit, as to do so could put the detainee he was watching at risk.
[143] Exhibit 12: Stewart Detention Center Facility Policy 140 Segregation dated May 20, 2016.

required by the ICE PBNDS 2011.[144] Specifically, more than 77 minutes lapsed between the last round during which Officer (b)(6); observed JIMENEZ alive, at approximately 11:26 p.m., and the next, at approximately 12:43 a.m., when he found JIMENEZ hanging unconscious from the sprinkler head.

In accordance with SDC policy, which requires shift supervisors to make rounds in the SMU at least once per shift, at approximately 11:58 p.m., Lieutenant (b)(6);(b)(7)(C) conducted a round in Unit 7A and stopped outside JIMENEZ's cell where he read the paperwork[145] hanging to the left of his cell door for approximately 28 seconds.[146] ERAU was unable to ascertain from the video footage whether Lieutenant (b)(6);(b)(7)(looked inside JIMENEZ's cell,[147] but in his incident report, Lieutenant (b)(6);(b)(7)(documented that he observed JIMENEZ on his bunk during the round.

Date of Death[148]

On May 15, 2017, at 12:27 a.m. Officer (b)(6);(removed a detainee from an upper tier cell and escorted him out to the medical unit per the direction of medical staff.[149] He returned approximately eight minutes later. Officer (b)(6);(stated during interview that he escorted the detainee[150] Officer (b)(6);(acknowledged that instead of leaving Unit 7A unattended while he escorted the detainee, he should have called for another officer to conduct the escort.[151]

After returning to the unit at approximately 12:37 a.m., Officer (b)(6);(initiated a security round at approximately 12:43 a.m., which he started at JIMENEZ's cell.[152] Officer (b)(6);(logged that this round occurred at 12:28 a.m. Officer (b)(6);(stated that when he looked inside JIMENEZ's cell, he noticed the detainee was not in his bunk. He then looked more carefully into the cell and observed the detainee hanging by a sheet from the sprinkler head. Officer (b)(6);(immediately placed a medical emergency call over his radio and hurried out of the unit to get the cut down tool[153] from Unit 7 control. Officer (b)(6);(b)(7)(C) immediately responded to Unit 7A after he heard Officer (b)(6);(medical emergency call, and when he reached the unit's sallyport, Officer (b)(6); was exiting

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[144] *See* Surveillance Video of Unit 7A on May 14 and 15, 2017.
[145] Paperwork hanging next to the cell includes logs showing JIMENEZ's meals, recreation, visits, medication delivery times, and the time of each security round.
[146] *See* Surveillance Video of Unit 7A on May 14, 2017.
[147] The SMU Post Orders state that observation of detainees involves "looking in each cell to ensure that no unusual or unauthorized activities are occurring." Although Lieutenant (b)(6);(b)(7 does not appear to look into JIMENEZ's cell in the video footage, ERAU cannot affirmatively determine whether he did. Lieutenant (b)(6);(b)(7 resigned prior to ERAU's review and was not interviewed.
[148] The description of events is based on review of video from 10:00 p.m. to 2:00 p.m., staff written and verbal reports, Confinement Watch and Activity logs, and a medical record entry describing the emergency response.
[149] *See* Surveillance Video of Unit 7A, dated May 14-15, 2017.
[150] ERAU interview with Officer (b)(6);(b)(7)(June 21, 2017.
[151] ERAU notes SDC's SMU Post Orders also require a two-officer escort of detainees moving from the SMU.
[152] Officer (b)(6) falsely logged a security round at 12:28 a.m. According to the surveillance video, Officer (b)(6);(was not on the unit at the time of security round entry. The time between Officer (b)(6);(last confirmed round to when JIMENEZ is found is 81 minutes.
[153] A cut down tool is a designed to safely and effectively cut through fabric in rescue and emergency situations.

the unit into the sallyport to retrieve the cut down tool.[154] Officer (b)(6);(told Officer (b)(6);(b)(the emergency was in cell 102.[155]

After entering the unit, Officer (b)(6);(b)(proceeded directly to cell 102 where he saw JIMENEZ hanging. Officer (b)(6);(returned to the pod approximately 15 seconds later, proceeded immediately to JIMENEZ's cell, and opened the cell door. Officer (b)(6);(b)(stated that when he and Officer (b)(6); entered the cell, he observed JIMENEZ hanging from the sheet with his feet touching the ground. He immediately lifted JIMENEZ and Officer (b)(6);(cut the sheet. After cutting the sheet, the officers laid JIMENEZ on the ground. Officer (b)(6);(b)(stated he shook and spoke to JIMENEZ, but the detainee did not respond. He observed the detainee was not breathing, so he instructed Officer (b)(6);(to get a CPR breathing mask and started chest compressions.[156]

Officer (b)(6);(left the cell to get a mask, and at approximately 12:46 a.m. Lieutenant (b)(6);(b)(7)(and Officer (b)(6);(b)(7)(C) who brought a handheld video camera with her, entered the unit. Officer (b)(6);(b)(started recording as soon as she entered the unit, and stated on the recording that the time was 12:30 a.m., although the time was actually 12:46 a.m. as evidenced by the Unit 7A surveillance video footage and unit control logs.[157]

Lieutenant (b)(6);(b)(7)(and Officer (b)(6);(b)(7 observed JIMENEZ was on his back with his feet toward the sink and his head toward the back wall, and that the sheet was still around his neck. The officers removed the sheet, and Officer (b)(6);(b)(7 continued to perform chest compressions. Officer (b)(6);(reentered at 12:46 a.m. with the breathing mask.

At approximately 12:47 a.m., RN (b)(6);(b)(7)(C) and RN (b)(6);(b)(7 arrived at JIMENEZ's cell with a medical bag and a gurney. RN (b)(6);(b) stated during interview that the detainee was gray when they arrived, that his lips and fingertips appeared cyanotic,[158] and that he had marks around his neck.[159] RN (b)(6);(b)(7 documented that she and RN (b)(6);(b) performed a quick assessment of detainee's circulation, airway and breathing, and discovered he had no pulse or breath sounds.[160] RN (b)(6);(b) took over chest compressions, and Officer (b)(6);(gave RN (b)(6);(b)(7 the CPR breathing mask to initiate rescue breaths.

At approximately 12:48 a.m., RN (b)(6);(b)(7 asked if anyone called 911, and Lieutenant (b)(6);(b)(7)(C) replied he was calling 911 at that moment. The Stewart County Fire and Emergency Medical

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[154] The surveillance video shows Officer (b)(6) exiting, and Officer (b)(6);(b) entering Unit 7A at approximately 12:44 a.m.
[155] ERAU interview with Officer (b)(6);(b) June 21, 2017.
[156] Surveillance video shows a limited view of Officer (b)(6);(b) performing chest compressions on JIMENEZ.
[157] Officer (b)(6);(b)(7)(C) who was the designated Emergency Response Team (ERT) camera operator, took over operation of the handheld camera during the emergency response when she arrived on the scene. The events surrounding the response to JIMENEZ are largely based on the audio and video footage from the handheld camera, and supplemented by interviews with staff, where noted.
[158] Cyanotic refers to bluish discoloration of the skin and mucous membranes due to not having enough oxygen in the blood stream.
[159] ERAU Interview with RN (b)(6);(b)(7)(dated June 22, 2017.
[160] *See* Progress Note by (b)(6);(b)(7)(C) RN, dated May 15, 2017.

Services (EMS) report shows they received the 911 call from SDC at 12:48 a.m., a unit was dispatched at 12:49 a.m., and was en route to the facility at 12:51 a.m.[161] The report states the distance to SDC was two miles.

At approximately 12:51 a.m., RN (b)(6);(b) asked security staff if an ambulance was on the way and expressed that JIMENEZ needed one urgently. An officer responded that an ambulance was on the way. While waiting for Emergency Medical Services (EMS) to arrive, RN (b)(6);(b) and RN (b)(6);(b)(7) rotated performing chest compressions and applied an automated external defibrillator (AED) to JIMENEZ. The AED repeatedly found JIMENEZ had no cardiac activity and advised that CPR be continued.

At approximately 12:55 a.m., the ambulance arrived at SDC,[162] and two EMS responders arrived at JIMENEZ's cell at 12:59 a.m.[163] One of the responders left the cell approximately 30 seconds later to retrieve equipment from the ambulance, while the other checked JIMENEZ's pulse and moved him away from the cell wall. SDC's AED, which was still attached, instructed the user to cease CPR while it evaluated JIMENEZ's condition; however, the EMS responder instructed RN (b)(6);(b)(7) to continue performing chest compressions and said he would apply the EMS' AED pads and start intravenous (IV) line[164] when his partner returned.[165]

At approximately 1:00 a.m., the EMS responder took over chest compressions and asked SDC staff when JIMENEZ was last seen alive. As heard on the handheld video, an individual off camera (identity unknown) stated JIMENEZ was last seen alive at 12:30 a.m., though Officer (b)(6);(was not in the unit at 12:30 a.m.

At approximately 1:02 a.m., the second EMS responder returned to the cell with the EMS AED and drug box.[166] The EMS responders gave JIMENEZ an injection of epinephrine[167] and intubated him. Approximately two minutes later, the EMS responders started JIMENEZ on an IV line and applied their AED pads to his chest while RNs (b)(6);(b)(7)(C) continued to rotate performance of chest compressions.

At approximately 1:08 a.m., one of the EMS responders placed an ambu bag[168] on JIMENEZ's mouth. Fifteen seconds later, one of the EMS responders stated that he heard breath sounds in both of JIMENEZ's lungs. The EMS responders gave JIMENEZ a second injection of epinephrine at approximately 1:09 a.m., and at approximately 1:11 a.m., Officer (b)(6);(b)(7 brought the EMS backboard into the cell, and the EMS responders moved JIMENEZ on to it. Approximately three

[161] *See* EMS Report, dated May 15, 2017.
[162] *See* EMS Report, dated May 15, 2017.
[163] *See* Surveillance video of Unit 7A on May 15, 2017.
[164] IV lines are started for quick delivery of medication, fluid replacement, and correction of electrolyte imbalance.
[165] *See* Handheld video for May 15, 2017.
[166] An EMS drug box is a hard or soft case container with all of the medications an EMS responder needs during a medical emergency.
[167] Epinephrine is used to reverse cardiac arrest by increasing blood pressure and circulation during CPR. The EMS report documents the injection was epinephrine.
[168] An ambu bag is a hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately.

minutes later, an EMS responder and RN (b)(6);(b) moved JIMENEZ from the cell on the backboard and placed him on a gurney. An EMS responder and RN (b)(6);(b) wheeled the gurney out of Unit 7A at approximately 1:16 a.m. while the EMS responder continued performing chest compressions.

At approximately 1:17 a.m., the EMS responders loaded JIMENEZ into their ambulance, and Officer (b)(6);(b)(7)(stopped recording with the handheld camera. RN (b)(6);(b)(stated during interview that he used the ambu bag to give JIMENEZ rescue breaths all the way to the ambulance, then performed chest compressions as the EMS responders placed JIMENEZ in the ambulance. He stated one of the EMS responders asked him to accompany them to the hospital, but he said no.[169] Officer (b)(6);(b)(7)(C) who was assigned to accompany the detainee in the ambulance stated the ambulance remained at SDC for approximately ten minutes after JIMENEZ was loaded into it because the EMS responders had to await the arrival of a third EMS responder to drive the ambulance so that they both could continue providing care.[170]

The Central Control log shows that SDC called for a second EMS unit at approximately 1:15 a.m. Once it arrived, the ambulance carrying JIMENEZ departed SDC at approximately 1:30 a.m. Officer (b)(6);(b) rode to the hospital in the front of the ambulance. During the drive to the Phoebe Sumter Medical Center (PSMC) in Americus, GA, which is approximately 37 miles from SDC, the EMS responders gave JIMENEZ 1 mg of epinephrine intravenously on 10 occasions, as well as sodium bicarbonate[171].[172]

The ambulance arrived at PSMC at approximately 2:03 a.m., and the EMS responders brought JIMENEZ into the emergency room (ER). ER personnel continued performing chest compressions on JIMENEZ and noted that he had fixed and dilated pupils upon arrival, as well as a swollen neck, with frothy bloody sputum pouring from his endotracheal tube.[173] ER personnel were unable to successfully resuscitate JIMENEZ, and at 2:15 a.m., the ER doctor, Dr. (b)(6);(b)((first name unknown), terminated resuscitation efforts and pronounced JIMENEZ dead. Dr. (b)(6);(b) recorded JIMENEZ's preliminary cause of death as self-inflicted strangulation.[174]

Officer (b)(6);(stated that after Dr. (b)(6);(b) pronounced JIMENEZ dead, hospital personnel turned him over to the coroner. Officer (b)(6);(b) and Officer (b)(6);(b)(7 who drove a chase vehicle to the hospital and arrived after JIMENEZ was pronounced dead, departed the hospital at approximately 5:50 a.m. and returned to SDC to write incident reports.

According to JIMENEZ's medical record, at approximately 1:56 a.m., HSA (b)(6);(b)(7)(C notified LCDR (b)(6);(b) that JIMENEZ attempted to hang himself in his cell and was transported via

[169] In general, once medical care has been turned over to EMS, facility medical personnel do not continue to participate. The role of the officer while in the ambulance, or at the hospital, is for custody supervision only.
[170] ERAU interview with Officer (b)(6);(b)(7)(dated June 22, 2017.
[171] Sodium bicarbonate is used during medically supervised CPR to treat acidosis, sometimes a result of cardiac arrest.
[172] *See* EMS report.
[173] An endotracheal tube is placed into the trachea through the mouth or nose to establish and maintain an airway.
[174] *See* Emergency Room Report, dated May 15, 2017.

EMS to the PSMC ER. At approximately 7:21 a.m., RN (b)(6);(b)(7) prepared a progress note documenting the medical response to JIMENEZ earlier that morning. These were the only entries in the medical record concerning JIMENEZ's death.

Post-Death Events

Following JIMENEZ's death, Officer (b)(6); completed three separate incident reports, all dated May 15, 2017.[175] The first report documented his actions after he found JIMENEZ hanging, and his chronology aligns with the events in the surveillance footage. In the second report, Officer (b)(6);(documented that he made rounds at 12:00 a.m. and 12:28 a.m., neither of which were corroborated by the surveillance video. In the third report, Officer (b)(6);(documented that he initiated CPR after cutting JIMENEZ down, which also was not corroborated by the surveillance video. Officer (b)(6);(stated during interview he wrote the two-page incident report first, the second incident report while on the unit, and the third incident report while in the administrative area of SDC. Officer (b)(6);(admitted to not making the rounds he documented in the log book due having to escort another detainee off the pod.[176]

On May 26, 2017, facility investigator (b)(6);(b)(7)(C) who was assigned to investigate JIMENEZ's death, submitted her written investigation report to Assistant Warden (b)(6);(b)(7)[177] Based on her review of the first two of Officer (b)(6);(reports (the third report was not made available to her until ERAU's review), video surveillance footage, and interviews with various staff members, (b)(6);(b)(7)(C) concluded that Officer (b)(6);(did not conduct security rounds as requested and falsified documentation. Core Civic subsequently terminated Officer (b)(6);(

On July 7, 2017, the Georgia Bureau of Investigations, Division of Forensic Sciences issued an autopsy report and documented JIMENEZ's manner of death was suicide by hanging.[178]

MEDICAL CARE AND SECURITY REVIEW

ERAU reviewed the medical care JIMENEZ received by SDC, as well as the facility's efforts to ensure that he was safe and secure while detained at the facility. ERAU found deficiencies in SDC's compliance with certain requirements of the ICE PBNDS 2011:

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

    - JIMENEZ requested an increase or change in his medication on five occasions, as he experienced increasingly commanding auditory hallucinations and exhibited

[175] *See* Incident Statements from Officer (b)(6);(b)(7)(dated May 15, 2017.
[176] ERAU Interview with (b)(6);(b)(7)(dated June 21, 2017.
[177] Exhibit 13: Facility Investigation dated May 26, 2017.
[178] Exhibit 14: Georgia Bureau of Investigations, Division of Forensic Sciences Autopsy Report dated July 25, 2018.

behaviors pointing to increasing symptoms of psychosis. Due to limited psychiatric coverage, his requests were not evaluated by the psychiatrist pending a scheduled tele-psychiatry appointment, which was postponed to accommodate patients determined more acute than JIMENEZ.

2. ICE PBNDS 2011, *Significant Self-harm and Suicide Prevention and Intervention*, Section (V)(C), which states, "Detainees who are identified as being 'at risk' for significant self-harm or suicide shall immediately be referred to the mental health provider. The evaluation shall take place within 24 hours. Until this evaluation takes place, security staff shall place the detainee in a secure environment on a constant one to one visual observation."

    - A nurse did not refer JIMENEZ for urgent mental health assessment after he jumped from the second tier of the housing unit on April 27, 2017.

    - On May 10, 2017, JIMENEZ was observed talking to himself, yelling, and beating on the wall. He told a nurse who spoke with him that he wanted to kill himself; however, the nurse and charge nurse opted to initiate a telephone encounter to the mental health professional rather than place JIMENEZ on constant one-to-one observation or contact the on-call provider for orders to do so.

3. ICE PBNDS 2011, *Significant Self-harm and Suicide Prevention and Intervention*, Section (K), which states, "A critical incident debriefing shall be offered to all affected staff and detainees within 24 to 72 hours after the critical incident."

    - SDC did not offer a debriefing to all detention staff involved in the medical emergency.

4. ICE PBNDS 2011, *Custody Classification System*, Section (V)(H)(3), which states, "Staff shall complete a special reclassification within 24 hours before a detainee leaves the Special Management Unit (RHU)".

    - SDC did not complete a special reclassification when JIMENEZ was released from RHU on April 18, 2017.

5. ICE PBNDS 2011, *Disciplinary System*, Section (V)(H)(2)(c), which states, "The detainee in IDP proceedings shall have the right to: "…having an IDP hearing within 24 hours after the conclusion of the investigation."

    - SDC's investigator for the Thursday, April 27, 2017 disciplinary incident involving JIMENEZ's jump from the second tier concluded the investigation on April 28, 2017 and referred the incident to the UDC or IDP. SDC did not hold the IDP hearing until Tuesday, May 2, 2017 and did not initiate a UDC review.[179]

[179] This delay also violates SDC Policy 15-100, *Detainee Discipline,* which mirrors the standard.

6. ICE PBNDS 2011, *Disciplinary System*, Section (V)(H)(3), which states, "The detainee in IDP proceedings shall have the right to: present statements and evidence, including witness testimony, on his/her behalf."

    - Although JIMENEZ requested a witness at his hearing for fighting, the hearing documentation does not reflect that a witness was called, or that JIMENEZ rescinded the request.[180]

7. ICE PBNDS 2011, *Disciplinary System*, Section (V)(H)(4), which states, "The IDP shall: conduct the hearing on the first business day after receiving the UDC referral, unless the detainee waives the 24 hour notification provision and requests an immediate hearing. In cases where a hearing is delayed, the reason(s) must be documented (e.g., a continuing investigation of facts, unavailability of one or more witnesses, etc.) and approved by the facility administrator."

    - The UDC referred the April 13, 2017 disciplinary incident to the IDP on Friday, April 14, 2017, but the IDP hearing was not held until Tuesday, April 18, 2017.

8. ICE PBNDS 2011, *Special Management Units*, Section (V)(A)(1), which states, "A supervisor shall conduct a review within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted. The review shall include an interview with the detainee."

    - The 72-hour reviews conducted by Chief of Security (b)(6);(b)(on April 16, 2017, and April 28, 2017, do not document that JIMENEZ was interviewed.

9. ICE PBNDS 2011, *Special Management Units*, Section (V)(B)(2)(b), which states, "The completed disciplinary segregation order shall be immediately provided to the detainee in a language or manner the detainee can understand, unless delivery would jeopardize the safe, secure, or orderly operation of the facility."

    - There is no documentation that the IDP reports from May 3, 2017, and May 5, 2017, imposing disciplinary segregation sanctions, were issued to JIMENEZ. The signature and date sections are blank on both forms.

10. ICE PBNDS 2011, *Special Management Units*, Section (V)(L), which states, "Detainees in RHU shall be personally observed and logged at least every 30 minutes on an irregular schedule."

    - Officer (b)(6);(logged security rounds at 11:22 p.m. on May 14, 2017, and at 12:00 a.m. and 12:28 a.m. on May 15, 2017. Video surveillance footage shows he made

[180] This also violates SDC Policy 15-100, *Detainee Discipline*, section 15-100.4 (F)(5) which mirrors the standard.

a round at 11:26 p.m. on May 14, 2017, as logged but does not show that he conducted rounds at 12:00 a.m. and 12:28 a.m. on May 15, 2017.[181]

AREAS OF CONCERN

Although not reflective of any violation of the requirements of the detention standards, ERAU notes the following violations of SDC policy related to safety and security:

- SDC Policy CoreCivic-GEI-01, *General Emergency Information*, Section (III)(A)(3), which states, "Any employee who discovers an inmate/resident engaging in self-harm shall immediately: If the suicide attempt involves hanging by the neck, alert other staff to retrieve the cut down tool and make every effort to relieve the pressure off the victim's neck. Upon arrival of the cut down tool, cut down the victim."

    - Instead of calling for responding staff to bring the cut down tool on May 15, 2017, Officer (b)(6);(b left the unit it to retrieve one himself causing a delay of approximately one minute in opening the cell door and relieving the pressure off JIMENEZ's neck.

ERAU notes the following violation of SDC post orders.

- SDC Housing Unit Post Orders, FAC-PO-16, Section (III)(A)(1,2), which state, "Maintain inmate/resident accountability by making frequent, irregular tours throughout the housing unit. Be observant and visible to the inmate/resident population; Monitor activities within the housing unit throughout your tour of duty;" and,

  SDC Housing Unit Post Orders, FAC-PO-16, Section (II)(C), which states, "If assigned to the Emergency Response Team (ERT), ensure you are aware of your responsibilities and have access to any necessary equipment required for a response."

    - Officer (b)(6);(b)(7)(the designated ERT camera operator, did not respond with the handheld camera on May 15, 2017.

- SDC Housing Unit Post Orders, FAC-PO-16, Section (III)(A)(1, 2), which state, "Maintain inmate/resident accountability by making frequent, irregular tours throughout the housing unit. Be observant and visible to the inmate/resident population; Monitor activities within the housing unit throughout your tour of duty"; and,

  SDC Housing Unit Post Orders, FAC-PO-150, Section (IV)(A), which states, "Never leave your post for any reason unless properly relieved by an assigned officer or the Shift Supervisor/Unit Manager."

[181] This also violates SDC Policy FAC-PO-140*Restricted Housing Unit Post Orders*, section (III)(B)(1), which states, "Detainees in RHU shall be personally observed and logged at least every thirty (30) minutes on an irregular schedule."

- No officers were in JIMENEZ's housing unit on April 13, 2017, when he was assaulted by another detainee.

- No officers were in JIMENEZ's housing unit on April 27, 2017, when he jumped from the upper tier.

- Officer (b)(6);(left his post on seven occasions between the hours of 10:00 p.m. on May 15, 2017, and 2:00 a.m. on May 16, 2017.

- SDC Restricted Housing Unit Post Orders, CoreCivic-PO-16, Section (III)(B)(1)(ii), which states, "Observation will be documented on the 10-1F Confinement Watch Log or equivalent contractually required form."

  - Officer (b)(6);(documented rounds at 12:00 a.m. and 12:28 a.m. on May 15, 2017. Video evidence shows he did not make these rounds.

- SDC Restricted Housing Unit Post Orders, CoreCivic-PO-16, Section (III)(G)(2)(b), which states, "The inmate/resident will be escorted by a minimum of two (2) employees who must maintain physical control of the inmate/resident at all times."

  - On May 15, 2017, Officer (b)(6);(escorted a detainee from Unit 7A to Unit 5 by himself.

- SDC Restricted Housing Unit Post Orders, CoreCivic-PO-16, Section (III)(B)(1)(i) which requires the observation of detainees during rounds to include, "…looking in each cell to ensure that no unusual or unauthorized activities are occurring."

  - Video surveillance footage does not show that Lieutenant (b)(6);(b)(7)(looked in JIMENEZ's cell during his round at 11:58 a.m. on May 14, 2017, or when he returned to the cell 12 minutes later.

ERAU identified the following concerns regarding the vacancies for mental health care practitioners at SDC.

- Coinciding with the time of JIMENEZ's detention, SDC experienced a year-long vacancy in the full-time psychiatrist position, and a vacancy in one of three mental health professional positions. Further, during the last weeks of JIMENEZ's detention, LCDR (b)(6);(b) became the sole mental health provider onsite at SDC, due to the other LCSW's departure for family leave. In the absence of a full-time psychiatrist, IHSC allotted SDC six hours per week for detainees to meet with a psychiatrist via teleconference. SDC medical staff stated that they created system to triage and prioritize the most seriously ill detainees for the tele-psychiatry services, which created a two to three month backlog of appointments. This backlog resulted in SDC postponing JIMENEZ's one-month follow up appointment for two months, until LCDR (b)(6);(b)(7 intervened and shortened the

postponement to one month. The follow-up appointment was never completed because JIMENEZ's suicide occurred the day it was scheduled.

ERAU identified multiple concerns related to the response to JIMENEZ's jump from the second tier of his housing unit on April 27, 2017.

- Security personnel who escorted JIMENEZ to medical after he jumped from the second tier of his housing unit on April 27, 2017, did not inform RN (b)(6);(b who medically cleared him for segregation, that he jumped. According to the HSA, security staff does not typically inform nurses of the reason detainees require medical clearance for purposes of being medically-cleared for segregation; however, Creative Corrections advises that the extraordinary nature of the act of jumping form the upper tier to the lower, and fact that serious self-injury may have resulted, warranted that RN (b)(6);(be notified.

- In the medical clearance for segregation, RN (b)(6);(b documented that JIMENEZ's vital signs were normal but did not document completion of a mental health assessment, or examination for injuries, pain, suicidal ideation, or other information fundamental to granting segregation clearance.

- According to the disciplinary investigation report completed the next day, JIMENEZ told the investigator that he jumped because he wanted to commit suicide. Despite this declaration and the fact that JIMENEZ was in segregation -- not on suicide watch -- the investigating officer did not refer him for urgent mental health assessment.

- Although Core Civic notified medical personnel, including the HSA and the Assistant HSA, of JIMENEZ's jump in an email sent after business hours that same day (a Thursday), medical staff did not ensure he received a mental health assessment until the following Monday.

ERAU identified the following area of concern regarding segregation nursing rounds.

- While all segregation nursing entries appeared to comply with the IHSC policy requiring face-to-face visits, RN (b)(6);(b reported that her practice is to knock on the cell door to ensure the detainee knows she's present and then move on to the next cell.

ERAU identified the following area of concern regarding the use of telephone encounters.

- Six days prior to JIMENEZ's suicide, RN (b)(6);(b)(7 saw him in his cell late during the evening shift, standing on the toilet, hitting the wall, kicking, and yelling at the mirror. She consulted the charge nurse and at 2:34 a.m., sent a telephone encounter to LCDR (b)(6);(b)(documenting her observations and conversation with JIMENEZ, including that he was hearing voices telling him to kill himself. Because telephone encounters are not a means of immediate communication, LCDR (b)(6);(b) did not see RN (b)(6);(b)(7)(information until more than five hours later. RN (b)(6);(b)(7 could have alternatively notified the on-call provider.

ERAU identified the following area of concern regarding CPR administration.

- RNs (b)(6);(b) and Anderson rotated performance of chest compressions for 12 minutes while awaiting the arrival of EMS. They did not request officer assistance, and no officers offered to relieve them. SDC's Safety Officer stated that officers are trained and expected to assist medical staff during an emergency, to include CPR.

ERAU identified the following areas of concern regarding the activation of 911.

- Security staff did not call EMS until nursing staff arrived on scene, five minutes after JIMENEZ was discovered hanging.

ERAU identified the following area of concern regarding JIMENEZ's low heart rate.

- Nine of JIMENEZ's fifteen heart rate checks were below the lower-normal threshold of 60. At no time did nurses conduct a further assessment to determine possible causes, or establish a baseline to determine the detainee's normal heart rate. According to Assistant HSA (b)(6);(b)(7 establishment of a baseline with provider notification of below baseline findings is expected, although not required by nursing protocols. Even without a baseline, HSA (b)(6);(b)(7)(C acknowledged a provider should have been notified when JIMENEZ's heart rate was 45. Creative Corrections recommends that SDC clarify nursing expectations when patients have below normal heart rates.

ERAU identified the following area of concern regarding special needs forms.

- Security staff did not follow medical direction for JIMENEZ's assignment to a lower bunk on a low tier, which was issued by way of special needs forms.

ERAU identified the following areas of concern regarding security rounds.

- During two of three disciplinary incidents involving JIMENEZ, no officers were present on the housing unit. Additionally, during the hours preceding JIMENEZ's suicide, the RHU officer, (b)(6);(b)(7)(C) left the post seven times, including for eight minutes after the detainee was last seen alive. Although SDC policy clearly states that officers are not to leave their posts until properly relieved, the randomness of these incidents and the fact that different officers were involved, suggests that these incidents were not unique. Creative Corrections advises that continual staff supervision is both fundamental and critical to assuring the safety of detainees and facility security.

- In addition to leaving the unit unsupervised on seven occasions the night of JIMENEZ's suicide, Officer (b)(6);(falsely logged that he completed security rounds at 12:00 a.m. and 12:28 a.m., neither of which were corroborated by video surveillance footage. These entries indicate Officer (b)(6); observed JIMENEZ alive at these times when he did not.

- Video evidence shows Officer (b)(6);(made a round at JIMENEZ's cell at 11:25:59 p.m. and his next round at 12:43:25 a.m., when he found the detainee hanging. The elapsed time between rounds was in violation of facility policy, which requires officer rounds are to be made every 30 minutes. Because SDC does not have a system to record rounds electronically, Creative Corrections recommends the supervisors verify officer compliance through random review of video footage rather than strict reliance on logs entries.

- Supervisors are required to make one round in the RHU per shift. Video surveillance footage shows Lieutenant (b)(6);(b)(7)(reviewed documents outside JIMENEZ's cell at 11:58 p.m. and 12:11 a.m., but did not look directly into the cell on either occasion.

ERAU also identified the following areas of concern regarding disciplinary hearing and review of charges.

- Video showing JIMENEZ's involvement in an altercation with another detainee on April 13, 2017 was reviewed by the Unit Manager immediately following the incident. Despite the fact the video provided clear evidence that JIMENEZ was assaulted and did not fight back, he was charged with fighting and placed in segregation pending disciplinary hearing. During the five days JIMENEZ was segregated, the charge was reviewed by the investigating officer and UDC, and his placement on segregation was reviewed by the Security Chief. No action was taken to dismiss the charge and return JIMENEZ to general population, suggesting the process for reviewing the merit and validity of disciplinary charges was a perfunctory exercise, only.

EXHIBITS

1. Creative Corrections Medical and Security Compliance Analysis.
2. Progress Note by LCDR (b)(6);(b)(7)(C) dated March 14, 2017.
3. Progress Note by LCDR (b)(6);(b)(7)(C) dated April 11, 2017.
4. Confinement Review, dated April 16, 2017.
5. Institution Disciplinary Panel Report, dated April 18, 2017.
6. Progress Note by NP (b)(6);(b)(7)(C) dated April 25, 2017.
7. Confinement Record, dated April 28, 2017.
8. Institution Disciplinary Panel Report, dated May 3, 2017.
9. Progress Note by LCDR (b)(6);(b)(7)(C) dated May 2, 2017.
10. Institution Disciplinary Panel Report, dated May 5, 2017.
11. Telephone Encounter, dated May 10, 2017.
12. Stewart Detention Center Facility Policy 140 Segregation, dated May 20, 2016.
13. Facility Investigation, dated May 26, 2017.
14. Georgia Bureau of Investigations, Division of Forensic Sciences Autopsy Report, dated July 25, 2018.