

## SYNOPSIS

On September 27, 2016, Moises TINO-Lopez (TINO), a twenty-three-year-old citizen and national of Guatemala, died while in the custody of U.S. Immigration and Customs Enforcement (ICE) at the St. Francis Medical Center (SFMC), in Grand Island, Nebraska. The State of Nebraska Certificate of Death documents TINO's immediate cause of death as anoxic brain injury<sup>1</sup> due to, or as a consequence of cardiac arrest due to, or as a consequence of seizure.

TINO was detained from August 26, 2016, until his death, at the Hall County Department of Corrections (HCDC), in Grand Island, Nebraska, which is owned and operated by the Hall County Sheriff's Department (HCSD). ICE began housing detainees at HCDC in December of 2008, pursuant to a United States Marshals Service (USMS) Intergovernmental Service Agreement (IGSA) that requires the facility to comply with the ICE National Detention Standards (NDS) 2000. HCDC currently houses both male and female detainees of all classification levels for periods in excess of 72 hours. Medical care at HCDC is provided by Advanced Correctional Healthcare (ACH).

## DETAILS OF REVIEW

From November 29 through December 1, 2016, the ICE Office of Professional Responsibility, Office of Detention Oversight (ODO) staff visited HCDC to review the circumstances surrounding TINO's death. ODO was assisted in its review by contract subject matter experts (SME) in correctional healthcare and security who are employed by Creative Corrections, a national consulting firm. As part of its review, ODO reviewed immigration, medical, and detention records pertaining to TINO's custody, in addition to conducting in-person interviews of individuals employed by HCDC, as well as ICE Enforcement and Removal Operations (ERO) staff.

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

## IMMIGRATION HISTORY

On an unknown date, TINO entered the United States without admission or parole.

On August 26, 2016, TINO was encountered by ICE ERO at the ERO Saint Paul sub-office where he accompanied his wife to an appointment to update her address on file with ERO.<sup>2</sup> TINO was previously encountered in 2012 and was removed to Guatemala under section 212(a)(6)(A)(i) of the Immigration and Nationality Act.<sup>3</sup> At that time, ERO Saint Paul reinstated his prior order of removal and transported TINO to HCDC that same day.

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<sup>1</sup> Anoxic brain injury is injury to the brain due to lack of oxygen.

<sup>2</sup> See Form I-213, Record of Deportable/Inadmissible Alien, dated August 26, 2012.

<sup>3</sup> See Form I-213, Record of Deportable/Inadmissible Alien, dated June 23, 2012.



ACH Regional Nurse Manager who is a Registered Nurse (RN). An ACH Nurse Practitioner (NP) is onsite one to three hours per week, and is on call twenty-four hours per day, seven days a week. An ACH physician located in Peoria, Illinois, is HCDC's Director of Medical Operations. The physician does not provide any onsite services, but is available to consult with the NP twenty-four hours per day, seven days a week.

At 2:47 p.m., TINO was assigned to Unit B, upper bunk number three (B-03). Unit B is a 36-bed dormitory style unit for minimum custody detainees. ODO notes that per officer post orders, security rounds inside the unit are required every 30 minutes. The rounds are documented by way of an electronic system: officers carry a handheld device which they scan over a red tag located on every bed, selecting from a menu of 36 activities to record what the detainee is doing at the time of the round. As noted by Creative Corrections, reports from the time of TINO's detention at HCDC, September 6-19, 2016, reflect rounds were often made outside mandated timeframes.<sup>14</sup>

**On September 6, 2016**, at approximately 6:13 a.m., Officer [redacted] was standing in the sallyport between units B and C when he observed that TINO, who was lying on his bunk, appeared to be having a seizure. Officer [redacted] called for officer assistance over his radio and immediately entered Unit B.<sup>16</sup> Officers [redacted] responded to Officer [redacted] call. According to Officer [redacted] who speaks Spanish, when he entered Unit B, TINO had a blank face and was still shaking from seizures. He immediately called for medical assistance over his radio and asked TINO in Spanish whether he was ok, and if he knew where he was. The detainee did not respond.<sup>17</sup>

LPN [redacted] responded to Officer's [redacted] call for medical assistance. TINO was no longer seizing when she arrived in Unit B but had tremors in his hands and arms and had been incontinent of urine.<sup>18</sup> LPN [redacted] documented TINO did not respond to verbal stimuli or touch but did respond to an ammonia capsule, and noted TINO wanted to be left alone. LPN [redacted] also documented TINO's vital signs were normal, with the exceptions of an abnormally rapid pulse of 107 and elevated blood pressure of 154/68.<sup>19</sup> Officer [redacted] stated during his interview that he assisted LPN [redacted] attempts to communicate with TINO.

After LPN [redacted] assessed TINO, Officers [redacted] and Little picked up the mattress with TINO on it and moved him to lower bunk B-09. The officers also placed an extra mattress next to the bed in case TINO fell off his bunk. Officer [redacted] stated LPN [redacted] directed TINO be placed on 15 minute security checks per the facility's seizure protocol.<sup>20</sup> LPN [redacted] stated while TINO was placed on 15 minute checks and was to remain on the status until stable, she did not recall whether she directed initiation of seizure protocol for TINO.<sup>21</sup> Security records confirm TINO was reassigned to B-09 at 6:27 a.m. and placed on 15 minute checks; however,

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<sup>14</sup> ODO interview with Sergeant [redacted] November 30, 2016. See Exhibit 6, Appendix, page 32.

<sup>15</sup> Officer [redacted] was on vacation during the ODO site visit and could not be interviewed.

<sup>16</sup> See written statement by Officer [redacted] September 6, 2016.

<sup>17</sup> ODO interview with Officer [redacted] December 1, 2016.

<sup>18</sup> ODO interview with LPN [redacted] November 29, 2016.

<sup>19</sup> See Medical Progress Note by LPN [redacted] September 6, 2016. Creative Corrections notes elevated blood pressure is not unusual following seizure activity.

<sup>20</sup> ODO interview with Officer [redacted] December 1, 2016.

<sup>21</sup> ODO interview with LPN [redacted] November 29, 2016.

they also indicate that the 15 minute checks were not consistently conducted while TINO was on the status, from September 6-8, 2016.<sup>22</sup>

ODO notes HCDC's seizure protocol is not written or formalized, though it may be initiated for any and all detainees who experience a seizure, and may be initiated on an informal basis by security, or on a formal basis by medical. While not formalized, security<sup>23</sup> and medical staff<sup>24</sup> interviewed by ODO reported the following measures are taken when a detainee has a seizure:

*Security:*

- An email notification is sent to security.
- The detainee is placed on "15 minute checks," which requires an officer to check on the detainee at least every 15 minutes. The detainee must also be moved to a low bunk if he is currently assigned to a high bunk.
  - 15 minute checks may not be discontinued unless approved during the weekly multi-disciplinary meeting, which includes both medical and security staff.
- An "event" is entered into HCDC's classification review system to document whether the detainee needs to be moved to a safer location (i.e., lower bunk or lower tier).
- Each housing unit has a daily "Special Log" which is updated throughout the day to inform oncoming shifts of any notable events or issues, including a detainee being placed on 15 minute checks. Special Logs are created each day, as needed, but are not retained.

*Medical:*

- An email notification may be sent to security; however, the email is not mandatory, and no email notification was created in reference to TINO.
- 15 minute checks are not required for each instance in which a detainee experiences seizures, but are initiated as needed.
- A mid-level provider may order discontinuation of 15 minute checks upon examination of a detainee without prior approval.
- HCDC does not require that a medical alert, requiring provider clearance prior to the transfer/release of a detainee who has experienced a seizure, be included in the detainee's medical record.

At 6:42 a.m., LPN [redacted] administered the anti-seizure medication Depakote 250mg to TINO per order from NP [redacted] who directed the detainee receive Depakote twice daily. NI [redacted] also ordered TINO's Depakote level be read on September 8, 2016, to determine if a therapeutic level<sup>25</sup> was reached.<sup>26</sup> TINO's Medication Administration Record (MAR)<sup>27</sup> shows he received 15 of 18 doses of Depakote over the next nine days; however, three doses on September 7, 11,

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<sup>22</sup> See Exhibit 2: Creative Corrections Medical and Security Compliance Review, Appendix.

<sup>23</sup> ODO interviews with Sergeant [redacted] and Sergeant [redacted] November 30, 2016.

<sup>24</sup> ODO interviews with N [redacted] and Site Nurse Manager [redacted] (first name unknown), November 29, 2016.

<sup>25</sup> The therapeutic level of a drug in the bloodstream is the level at which the drug is effective without causing serious negative effects to the patient.

<sup>26</sup> See Narrative Progress Note by LPN H [redacted] September 6, 2016.

<sup>27</sup> See Exhibit 3: Medication Administration Records.

and 14, 2016 were not accounted for, and the medical record contains no refusal forms for those missed doses. Nevertheless, as noted by Creative Corrections, TINO's Depakote blood level was obtained on September 8, 2016 and was within therapeutic range.<sup>28</sup>

At 10:50 a.m., LPN [ ] saw TINO as a follow-up to the earlier seizure and because TINO complained of a headache, which she noted was "non-serious."<sup>29</sup> LPN [ ] stated she could not recall if any interpretation assistance was used for the encounter, but recalled TINO did not appear to be in a lot of pain.<sup>30</sup> TINO's vital signs were all within a normal range with the exception of a slightly elevated temperature of 99.4. Site Nurse Manager [ ] stated that the standardized pain scale<sup>31</sup> was not used at HCDC prior to TINO's death, but its use was implemented as a corrective action following his death.<sup>32</sup> NP [ ] ordered Tylenol 1000 mg twice daily for three days by telephone.<sup>33</sup>

**On September 7, 2016,** TINO was seen by NP [ ] for post-seizure follow-up and his initial health appraisal.<sup>34</sup> NP [ ] did not document whether there were any barriers to communication or whether an interpreter was used but stated TINO provided verbal consent to use a Spanish-speaking inmate to interpret. TINO's vital signs were all within normal limits. NP [ ] documented TINO had history of seizure disorder, a seizure occurred shortly after his arrival, and that he experienced persistent headaches since the seizure.<sup>35</sup> As noted by Creative Corrections, NP [ ] did not ask TINO about previous seizure activity including type, frequency, onset, and past treatment, and did not document a review of systems<sup>36</sup> with a hands-on evaluation. NP [ ] explained that because the health appraisal form, as structured, does not include a section for detailing the findings of a hands-on physical examination, she records only positive findings or issues of note.<sup>37</sup> NP [ ] documented three orders in the lower margin of the appraisal form: continue current orders,<sup>38</sup> extend Tylenol five more days, and contact ICE about the probable need for computerized tomography (CT) scan<sup>39</sup> of the head and a neurology consult.<sup>40</sup> NP [ ] stated that writing the orders in the lower margin was her only option because the form does not have a section for documenting the treatment plan, and that the form also does not have a space for the provider to sign. NP [ ] stated she believed documenting the orders in the margin without signing the form was sufficient.<sup>41</sup> The only

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<sup>28</sup> See Garcia Clinical Lab Report, September 10, 2016.

<sup>29</sup> See Medical Progress Note by LPN [ ] September 6, 2016.

<sup>30</sup> ODO interview with LPN [ ] November 29, 2016.

<sup>31</sup> The pain scale is a zero to ten method of determining the level of pain, with ten being the worst.

<sup>32</sup> ODO interview with Site Nurse Manager [ ] November 29, 2016.

<sup>33</sup> See Medical Progress Note by LPN [ ] September 6, 2016.

<sup>34</sup> See Exhibit 4: Medical Screen and Health History by LPN [ ] dated, August 26, 2016. ODO notes TINO's Medical Screen and Health History, is dated August 26, 2016. LPN [ ] stated she filled in the date when she initiated the form at the time of intake screening and then left the form for NP [ ] to complete during her next visit to the facility. The actual date the physical assessment was completed is known because NP [ ] documented September 7, 2016, next to her signature.

<sup>35</sup> See Medical Screen and Health History by LPN [ ] August 26, 2016.

<sup>36</sup> A review of systems is a list of questions, arranged by organ system, designed to uncover dysfunction and disease.

<sup>37</sup> ODO interview with NP [ ] November 29, 2016.

<sup>38</sup> Although not specified, this order is presumed to refer to the Depakote.

<sup>39</sup> A CT scan is a series of x-ray images taken from different angles and used to create sectional images of various parts of the body.

<sup>40</sup> See Medical Screen and Health History by LPN [ ] August 26, 2016.

<sup>41</sup> ODO interview with NP [ ] November 29, 2016.

signature on TINO's appraisal form is that of Site Nurse Manager [redacted] who transcribed the orders onto a MAR. Though she conducted the appraisal, NP [redacted] did not sign or initial the appraisal form.

Concerning the three orders themselves:

- *Order 1 (Depakote)*  
The MAR does not document whether three doses of the medication were given, missed, or refused on September 7, 11, and 14, 2016.
- *Order 2 (Tylenol)*  
The order for Tylenol was inaccurately transcribed on the MAR and was not given as ordered. First, although the NP prescribed 1000 mg twice daily, the MAR records reflect an order of 500 mg twice daily. Additionally, the MAR records Tylenol be given for five days (total), instead of an additional five days, totaling eight days of Tylenol.<sup>42</sup> As noted by Creative Corrections, because of the transcription error, the medication was provided at half the strength, for an abbreviated term.
- *Order 3 (CT Scan and Neurology Consult)*  
Although TINO's CT scan was completed on September 14, 2016 (see below), no action was taken to arrange for the neurology consult.<sup>43</sup> Site Nurse Manager [redacted] stated she took no action on the neurology consult because the order notated a "probable need" for a CT scan and neurology consult, and she assumed completing the CT scan was a necessary step prior to scheduling a neurology consult. Site Nurse Manager [redacted] stated she did not seek clarification from NP [redacted].

ODO notes the initial health appraisal form also did not document a dental screening. Specifically, questions about the general condition of the detainee's teeth, presence of inflammation, and date of last dental examination were left blank, and the form did not include an oral diagram to note baseline findings.

**On September 8, 2016**, at 6:00 a.m., TINO was removed from 15 minute checks.<sup>45</sup> ODO was unable to determine the impetus for the discontinuation. NP [redacted] stated she may have discontinued seizure protocol and 15 minute checks when she conducted the physical examination the evening prior, but did not specifically remember doing so. She stated that if she had discontinued 15 minute checks, she would have verbally notified the nurse on duty, who in turn would have notified a security supervisor.<sup>46</sup> TINO's medical record contains no documentation regarding the discontinuation, and both medical and security records lack any documentation regarding communication about the discontinuation.<sup>47</sup> ODO notes that on the date of TINO's hospitalization, Immigration Health Services Corps (IHSC) was erroneously

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<sup>42</sup> See Medical Administration Report, September, 2016.

<sup>43</sup> See Midwest Imaging Radiological Report by Dr. [redacted] September 15, 2016.

<sup>44</sup> ODO interview with Site Nurse Manager [redacted] November 29, 2016.

<sup>45</sup> Guardian System Electronic Logs, September 6-8, 2016.

<sup>46</sup> ODO interview with NP [redacted] November 29, 2016.

<sup>47</sup> *Id.*

informed by HCDC that the detainee's 15 minute checks were continued through September 19, 2016.<sup>48</sup>

**On September 12, 2016,** ERO St. Paul removed TINO from the manifest for a scheduled flight to Guatemala the following day at IHSC's request because the detainee showed signs of possible seizure activity.<sup>49</sup> Email communications by ERO staff indicate an HCDC nurse informed ERO that TINO recently had seizures and required evaluation by a neurologist before being cleared for transport.<sup>50</sup> IHSC Commander [redacted] was notified and directed TINO's removal be held and that the detainee would likely need to see the radiologist before being cleared for travel.<sup>51</sup> ODO notes neither TINO's detention file nor his medical record document his planned transfer.

**On September 14, 2016,** TINO underwent a CT scan of his head.<sup>52</sup> The resultant radiology report, signed by Dr. [redacted] of Midwest Imaging that same day, documents the CT scan showed "slight hyperdensity"<sup>53</sup> in the midline supratentorial region<sup>54</sup> above the corpus callosum,<sup>55</sup> and that an MRI could better evaluate the CT scan result, specifically to exclude the presence of any intraaxial lesions.<sup>56</sup> A handwritten notation at the bottom of the report states "9/16/2016 notified N.P."<sup>57</sup> Site Nurse Manager [redacted] identified the handwriting on the radiology report as her own and stated she provided NP [redacted] complete information from the radiology report by telephone, including the recommendation for an MRI.<sup>58</sup> As evidenced by the lack of documentation in the medical record and confirmed during her interview, NP [redacted] did not order an MRI as recommended by the radiologist, nor did she take any follow-up action on her prior, unfulfilled order for neurology consult.

**On September 15, 2016,** at 12:50 a.m., TINO was seen by LPN [redacted] in response to an electronic request he submitted complaining of a headache. LPN [redacted] documented TINO complained of a severe headache and vision problems and asked to stop taking Depakote as he believed it caused his headaches. LPN [redacted] noted she informed TINO he could refuse the medication, but his seizures might resume without it, and the detainee agreed to continue taking the medication. TINO's vital signs were all within normal limits. Following the encounter, LPN [redacted] notified NP [redacted] of TINO's complaints via telephone, and NP [redacted] provided an order for Tylenol 1000 mg orally one time, discontinuation of Depakote, and initiation of Keppra, an alternative anti-seizure medication, 500 mg twice daily. ODO notes NP [redacted] never

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<sup>48</sup> The summary was sent by fax to IHSC Commander (CDR) [redacted] IHSC Field Medical Coordinator on September 19, 2016.

<sup>49</sup> See ICE Significant Incident Report 2016SIR0018070 (September 20, 2016)0000.

<sup>50</sup> See Email from ICE ERO Assistant Helen Barton to ICE Deportation Officer (DO) [redacted] September 12, 2016.

<sup>51</sup> See Email from ICE DO [redacted] to IHSC CDR [redacted] September 12, 2016.

<sup>52</sup> See Exhibit 5: Midwest Imaging Referral Form by NP [redacted] September 14, 2016.

<sup>53</sup> Hyperdensity is one of several terms used to describe the relative density of an abnormality on a CT scan, and specifically means "more dense."

<sup>54</sup> The Midline supratentorial region is the part of the brain where the cerebrum is located. The cerebrum is responsible for the integration of complex sensory and neural function and the initiation and coordination of voluntary activity in the body.

<sup>55</sup> The corpus callosum is a broad band of nerve fibers joining the two hemispheres of the brain.

<sup>56</sup> Intraaxial lesions are lesions within the cellular tissue of the brain.

<sup>57</sup> See Midwest Imaging Radiological Report by Dr. [redacted] September 15, 2016.

<sup>58</sup> ODO interview with Site Nurse Manager [redacted] November 29, 2016.

signed the telephone order.<sup>59</sup> ODO also notes LPN [ ] did not document use of any interpretation service during this encounter; however, given TINO's limited English proficiency, the exchange of specific medical information suggests some type of interpretation assistance was provided.

TINO's MAR shows the following with regard to the administration of his Keppra from September 15 to 19, 2016: the first dose was administered on September 15, 2016, the day it was ordered; the MAR does not document administration of the morning dose on September 16, 2016; the evening dose on September 16, 2016, was administered; TINO refused all subsequent doses.<sup>60</sup> Although refusal forms were filed on September 16, 17, 18 and 19, 2016, no one documented the reason for the refusal, and none of the forms were signed by the detainee.<sup>61</sup> Certified Medical Assistant (CMA) [ ] stated because detainees are not allowed to have pens in segregation, she and a witnessing officer sign refusal forms in lieu of the detainees.<sup>62</sup> LPN [ ] and CMA [ ] both stated they were unsure whether TINO was informed his anti-seizure medication was changed from Depakote to Keppra.<sup>63</sup>

At approximately 8:40 p.m., TINO reported to Officer [ ] that another detainee pushed him as he was entering the shower, threw his personal items on the floor, and told him to leave the area. TINO stated he put his clothes back on and left. Officer [ ] notified Sergeant [ ] who immediately reported to the unit.<sup>64</sup> Sergeant [ ] interviewed TINO and his alleged aggressor and determined both should be placed in segregation pending disciplinary hearings. Sergeant [ ] stated when a physical altercation between detainees or inmates is alleged, HCDC's standing practice is to place all involved parties in segregation.<sup>65</sup>

At 9:46 p.m., both detainees were escorted to segregation Unit E. TINO was assigned to cell 205 which is on the upper tier. Sergeant [ ] stated he would have either assigned TINO to a cell on the lower tier, or placed a second mattress next to the detainee's bunk, had he known TINO was on seizure protocol seven days prior.<sup>66</sup> Sergeant [ ] completed an Administrative Segregation Placement Form, but instead of documenting a specific reason for placing TINO in segregation, he noted "Pending Disciplinary Hearing."<sup>67</sup>

**On September 16, 2016,** Sergeant [ ] completed a disciplinary hearing notice for TINO documenting the detainee was charged with the facility violations of second, third and fourth degree assault, as well as obstruction of corrections operations in the first degree. Sergeant [ ] documented the charges were based on officer reports.<sup>68</sup> ODO notes TINO's record contains no documentation he assaulted another detainee, and no officers interviewed by ODO reported TINO assaulted another detainee. Sergeant [ ] stated that because additional charges cannot be added to a disciplinary report once it is served to a detainee, he typically includes any

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<sup>59</sup> See Medical Progress Note by LPN [ ] September 15, 2016.

<sup>60</sup> See Exhibit 3.

<sup>61</sup> See Refusal of Medical Treatment Release Form, September 16-19, 2016.

<sup>62</sup> ODO interview with CMA [ ] November 30, 2016.

<sup>63</sup> ODO interviews with LPN [ ] and CMA [ ] November 29 and 30, 2016.

<sup>64</sup> See HCDC Incident Report by Officer [ ] September 15, 2016.

<sup>65</sup> ODO interview with Sergeant [ ] November 30, 2016.

<sup>66</sup> *Id.*

<sup>67</sup> See Exhibit 6: HCDC Administrative Segregation Placement Form by Sergeant [ ] September 15, 2016.

<sup>68</sup> See HCDC Disciplinary Hearing Notice by Sergeant [ ] September 16, 2016.



potential charges and lets the disciplinary hearing officer determine which charges are relevant. Sergeant [ ] also stated the obstruction of corrections operations charge is added any time a detainee takes an officer away from his normal duties. TINO was served the notice of his disciplinary hearing the same day. ODO notes the notice was completed in English.<sup>69</sup> Officer [ ] translated the disciplinary hearing notice for TINO the following day when the detainee asked why he was in segregation. Officer [ ] stated TINO expressed concern the disciplinary action would affect his immigration case.<sup>70</sup> ODO notes TINO died the day before his disciplinary hearing which was scheduled for September 20, 2016.

LPN [ ] stated nurses are required to visually check on every detainee in Unit E once per shift.<sup>71</sup> Nursing shifts at HCDC vary from between seven and twelve hours. ODO notes required rounds were consistently documented while TINO was in segregation.

At 9:30 a.m., Site Nurse Manager [ ] met with TINO to discuss medication compliance. She took his vital signs during the encounter and documented all were normal. Site Nurse Manager [ ] documented discussing the potential for recurring seizures and even death when seizure medication is delayed or refused, and noted TINO understood and indicated he would continue taking his medication. Site Nurse Manager [ ] documented she used google translate to communicate with TINO during the encounter.<sup>72</sup>

**On September 19, 2016,** Officer [ ] was passing out lunch trays in Unit E, when an inmate, who was assisting, called him over to TINO's cell. When Officer [ ] arrived at the cell approximately 46 seconds later, he observed TINO lying on his bunk, rigid, and shaking slightly with his eyes rolled back. Officer [ ] immediately called for medical and officer assistance via radio.<sup>73</sup>

At 12:24 p.m., approximately 34 seconds after Officer [ ] radioed for assistance,<sup>74</sup> Officer [ ] responded to Unit E.<sup>75</sup> Officer [ ] stated as soon as he saw Officer [ ] come through the unit door, he radioed Master Control to open TINO's cell door, and the cell door was opened a few seconds later.<sup>76</sup> Officer [ ] stated he did not enter the cell immediately because standard operating procedure requires a minimum of [ ] officers be present before a segregation cell is opened to ensure officer safety. When Officer [ ] and Officer [ ] entered TINO's cell, the detainee was still rigid and was initially unresponsive to their efforts to gain his attention. LPN [ ] arrived at TINO's cell with Sergeant [ ] a few seconds after Officers [ ] and administered an ammonia inhalant<sup>77</sup> to the detainee.<sup>78</sup> LPN [ ] documented TINO was on his side when she arrived at his cell, was

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<sup>69</sup> ODO interview with Sergeant [ ] November 30, 2016.

<sup>70</sup> ODO interview with Officer [ ] December 1, 2016.

<sup>71</sup> ODO interview with LPN [ ] November 29, 2016.

<sup>72</sup> See Medical Progress Note by Site Nurse Manager [ ] September 16, 2016.

<sup>73</sup> ODO interview with Officer [ ] December 1, 2016; video surveillance footage of Unit E dated, September 19, 2016.

<sup>74</sup> See Incident Report by Officer [ ] September 19, 2016; video surveillance footage of Unit E dated, September 19, 2016. ODO notes the video surveillance footage was not time-stamped; all times noted are gleaned from incident reports or medical notes.

<sup>75</sup> See Incident Report by Officer [ ], September 19, 2016.

<sup>76</sup> ODO interview with Officer [ ] December 1, 2016.

<sup>77</sup> Ammonia-based inhalants are used to arouse consciousness.

<sup>78</sup> ODO interview with Officer [ ] December 1, 2016.

drooling, and his eyes were closed, but he was no longer seizing.<sup>79</sup> She noted the ammonia inhalant failed to arouse TINO, but he exhibited some response to a sternal rub. Once TINO demonstrated a response, LPN [ ] moved him to the floor with the assistance of Officer [ ]. She noted the detainee showed no evidence of head injury or incontinence of bowel or bladder, and he nodded “yes” when she asked in both English and Spanish if he was ok. She noted his pupils were reactive to light, and he was able to recite his name. She also noted that when TINO sat up, he became sick and vomited a small amount of bile. After TINO indicated he was ok a second time, LPN [ ] returned to the medical unit to call the provider while Sergeant [ ] remained with the detainee. ODO notes both Sergeant [ ] and Officer [ ] documented TINO was placed on 15 minute checks, and Officer [ ] entered the status change at 1:00 p.m.<sup>80</sup> TINO remained on 15 minute check status from 1:00 p.m. to 4:15 p.m., when the medical emergency was called. During this time, all required security checks were done, although seven of the checks exceeded 15 minutes by one to two minutes.<sup>81</sup>

LPN [ ] notified NP [ ] by telephone that TINO had a seizure but was stable, and NP [ ] ordered Ativan 2 mg<sup>82</sup> as needed for seizures.<sup>83</sup> TINO’s medical record reflects NP [ ] never signed the order for Ativan, and the detainee never received the Ativan. According to Site Nurse Manager [ ] Ativan is not on HCDC’s stock medication list.<sup>84</sup> LPN [ ] stated the local Walgreen’s pharmacy also did not have Ativan in stock, so Site Nurse Manger [ ] obtained it through a secondary pharmacy, U-Save;<sup>85</sup> however, Site Nurse Manger [ ] was unable to procure the Ativan that same day, or before TINO had another seizure.<sup>86</sup> LPN [ ] also documented that, per NP [ ] TINO may require a neurology consultation and an MRI. ODO notes NP [ ] previously ordered a neurology consultation for TINO, and that an MRI was recommended by the radiologist who interpreted TINO’s CT scan five days earlier; however, no action was taken on either.

LPN [ ] returned to the housing unit after speaking with NP [ ]. According to Sergeant [ ] although TINO seemed a bit more awake by the time LPN [ ] returned, he vomited a second time and was shaky. LPN [ ] documented when she returned to the TINO’s cell, the detainee was able to sit up, follow commands, and stand with the assistance of Sergeant [ ] and Officer [ ]. Once he was standing, LPN [ ] Sergeant [ ] and Officer [ ] assisted TINO in walking toward a new cell on the lower tier of the unit. TINO vomited while descending the stairs and was carried the rest of the way by the LPN and officers.<sup>87</sup> TINO was placed on a mattress on the floor of cell E-103, a single occupancy cell on the lower tier.<sup>88</sup> LPN [ ] documented the detainee vomited again once he was situated in the new cell. She took his blood pressure which was within normal limits and then returned to the medical unit to update NP [ ]. LPN [ ] documented she spoke to NP [ ] by

<sup>79</sup> See Narrative Progress Note by LPN [ ] September 19, 2016.

<sup>80</sup> See Incident Reports by Sergeant [ ] and Officer [ ] September 19, 2016.

<sup>81</sup> See Exhibit 2, Appendix.

<sup>82</sup> Ativan is a medication used to treat anxiety disorders, sleep disorders, and active seizures.

<sup>83</sup> See Narrative Progress Note by LPN [ ] September 19, 2016.

<sup>84</sup> See Medical Progress Note by Site Nurse Manager [ ] September 16, 2016.

<sup>85</sup> ODO interview with LPN [ ] November 29, 2016.

<sup>86</sup> ODO interview with Site Nurse Manager [ ] November 29, 2016.

<sup>87</sup> ODO interview with Sergeant [ ] November 30, 2016.

<sup>88</sup> See video surveillance footage of Unit E, September 19, 2016.

telephone, and NP [ ] ordered monitoring of TINO's vital signs<sup>89</sup> and directed the detainee be sent to the emergency room (ER) if his condition did not improve over the next thirty minutes.<sup>90</sup> NP [ ] confirmed she expected the nurse to take a full set of vital signs.<sup>91</sup>

Shortly after LPN [ ] returned to medical to contact the provider, she called the unit to ask Sergeant [ ] to prepare TINO for transport to the emergency room. Sergeant [ ] stated as he initiated the process of identifying officers for the transport, LPN [ ] called and asked him to wait because she learned TINO was refusing medications and wanted to call the provider again. In a progress note timed 1:10 p.m., LPN [ ] documented she reviewed TINO's record, learned the detainee was refusing his Keppra, and called NP [ ] back to inform her. She documented NP [ ] directed the detainee be monitored and educated on taking his medication. After receiving LPN [ ] second call, Sergeant [ ] went to medical, and LPN [ ] informed him NP [ ] directed TINO be observed for 30 minutes. Sergeant [ ] then returned to the housing unit and learned from Officer [ ] that TINO vomited a small amount while Sergeant [ ] was gone. Sergeant [ ] observed TINO in his cell and noted the detainee appeared alert and seemed to be improving. He returned to TINO's cell with LPN [ ] shortly thereafter, and Officer [ ] accompanied them to provide interpretation assistance. Sergeant [ ] noted that although Officer [ ] spoke to TINO in Spanish, TINO did not seem to understand. Sergeant [ ] then asked a Guatemalan detainee to assist with interpretation, and the detainee reported TINO complained of a headache. Through the Guatemalan detainee, LPN [ ] informed TINO he needed take his medications, and TINO agreed to take his evening dose. LPN [ ] documented she advised TINO to drink water and she would look into getting him a pain medication for the headache.<sup>92</sup> She noted TINO's blood pressure was within normal limits but did not record any other vital signs. She also noted he was on 15 minute security checks. After evaluating TINO, both LPN [ ] and Sergeant [ ] left his cell. Sergeant [ ] stated TINO appeared much improved by the time they left.<sup>93</sup> ODO notes TINO was not checked again by medical staff prior to the medical emergency call, more than two and a half hours later.

At 4:15 p.m., Officer [ ] who temporarily relieved Officer [ ] observed TINO lying on his stomach on his mattress on the floor during a security check. Officer [ ] finished his security checks of two additional detainees and then returned to TINO's cell. Officer [ ] stated TINO was still on his stomach with his face directly in the mattress, and when he knocked on the cell door window, he received no response. He then called Master Control by radio to have the door opened. Officer [ ] stated that although a second officer was not present, he believed the situation to be an emergency justifying immediate entry, especially since TINO had a seizure earlier. Upon entering the cell, Officer [ ] shook TINO's shoulder, received no response, and then rolled TINO onto his side. As he turned TINO's head, Officer [ ] noted an area of foamy clear vomit on the mattress and that TINO's lips were blue. Officer [ ] immediately called for assistance by radio.<sup>94</sup> As seen

<sup>89</sup> ODO found no documentation indicating that vital signs were taken over the next 30 minutes.

<sup>90</sup> See Narrative Progress Note by LPN [ ] September 19, 2016.

<sup>91</sup> ODO interview with NP [ ] November 29, 2016.

<sup>92</sup> See Narrative Progress Note by LPN [ ] September 19, 2016.

<sup>93</sup> ODO interview with Sergeant [ ] November 30, 2016.

<sup>94</sup> ODO interview with Officer [ ] December 1, 2016.

in the video surveillance footage, security personnel responded to TINO's cell approximately 41 seconds after Officer [redacted] entered it.<sup>95</sup>

The responding officers included Officer [redacted] Sergeant [redacted] and Corporal [redacted] [redacted].<sup>96</sup> Sergeant [redacted] described TINO's appearance as bluish in color when he arrived at the cell.<sup>97</sup> The officers initiated cardio pulmonary resuscitation (CPR) immediately after checking for a pulse, ensuring TINO's airway was clear and determining the detainee was not breathing. Chest compressions were performed by Officer [redacted] Officer [redacted] performed rescue breathing, and Sergeant [redacted] called for the automated external defibrillator (AED) and for an ambulance via radio.<sup>98</sup> At 4:24 p.m., Master Control Officer [redacted] called Grand Island Fire Department (GIFD) Emergency Medical Services (EMS) after receiving Sergeant [redacted] call for an ambulance.<sup>99</sup>

LPN [redacted] arrived at the cell approximately 48 seconds after the responding security personnel with an emergency bag containing an AED.<sup>100</sup> LPN [redacted] stated CPR was being performed by officers when she arrived, and that Sergeant [redacted] used safety scissors in the emergency bag to cut off TINO's uniform shirt before placing the AED pads on his chest. She noted no shock was advised by the AED, and CPR was continued by Officers [redacted] and [redacted] while she directed an officer to retrieve an oxygen tank from the medical unit.<sup>101</sup>

Once retrieved, an ambu bag was attached to the oxygen tank to give breaths to TINO while CPR was continued. LPN [redacted] noted the AED was applied one additional time, and again no shock was advised. Officers continued to perform chest compressions until the paramedics arrived.<sup>102</sup>

At 4:32 p.m., the ambulance arrived at HCDC, and EMS personnel assumed care of TINO at 4:34 p.m.<sup>103</sup> Sergeant [redacted] stated that, per request of the EMS responders, TINO was moved into the dayroom to give them more space to provide emergency care.<sup>104</sup> EMS indicated the detainee suffered a cardiac arrest, and TINO was hooked up to the cardiac monitor via defibrillation pads. Ventilation to the detainee was initiated via bag valve mask, and an intravenous line was started. The cardiac monitor confirmed TINO was asystole,<sup>105</sup> and a dose of epinephrine<sup>106</sup> was administered. TINO was placed on the EMS cot and intubated. Upon

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<sup>95</sup> See video surveillance footage of Unit E, September 19, 2016.

<sup>96</sup> ODO notes that in addition to video from inside Unit E, video surveillance footage from [redacted] different cameras outside the unit were viewed to help establish a timeline of emergency response events. Because none of the video is date or time stamped, the footage was of limited value for timeline purposes; however, the video does show facility staff responded immediately and with urgency from locations throughout the facility, and promptly retrieved the AED and oxygen tank to aid in the emergency response.

<sup>97</sup> ODO interview with Sergeant [redacted] November 30, 2016.

<sup>98</sup> ODO interview with Sergeant [redacted] November 30, 2016.

<sup>99</sup> See GIFD Prehospital Care Report, September 22, 2017. ODO notes Officer [redacted] documented the time of the call as 4:20 p.m. in his written incident report.

<sup>100</sup> See video surveillance footage of Unit E dated, September 19, 2016.

<sup>101</sup> ODO interview with LPN [redacted] November 29, 2016.

<sup>102</sup> See Narrative Progress Note by LPN [redacted] September 19, 2016.

<sup>103</sup> See GIFD Prehospital Care Report, September 22, 2017.

<sup>104</sup> ODO interview with Sergeant [redacted] November 30, 2016.

<sup>105</sup> Asystole is a cardiac arrest rhythm with no discernible electrical activity.

<sup>106</sup> Epinephrine is commonly known as adrenaline and works by quickly improving breathing, stimulating the heart, and raising blood pressure.

reassessment of his cardiac rhythm, an organized sinus tachycardia rhythm<sup>107</sup> was detected and a strong carotid<sup>108</sup> pulse was confirmed. TINO was placed in the ambulance at 4:44 p.m. for transport to the Saint Frances Medical Center (SFMC) in Grand Island, NE.<sup>109</sup> LPN [redacted] documented she gave the paramedics an update on TINO before they departed and that TINO had a pulse at that time. LPN [redacted] also documented she notified NP [redacted] and IHSC CDR [redacted] and provided SFMC with TINO's medical history.<sup>110</sup>

At 4:44 p.m., the ambulance departed HCDC with Sergeant [redacted] riding along. Sergeant [redacted] documented the ambulance arrived at SFMC at 4:49.<sup>111</sup> ODO notes the EMS report documents the arrival time was 4:51 p.m.<sup>112</sup> Sergeant [redacted] stated during his interview that the medical equipment in the ambulance showed TINO had a pulse.<sup>113</sup> The EMS report documents ventilations were continued during the transport, and once TINO arrived at SFMC, patient care was turned over to emergency department staff.<sup>114</sup> Sergeant [redacted] and Officer [redacted] who drove the chase vehicle, remained with TINO.<sup>115</sup>

At 5:20 p.m., Sergeant [redacted] documented TINO was placed on a ventilator in the ER, and at 7:23 p.m. TINO was moved to the intensive care unit (ICU). Per HCDC policy, two officers were assigned to vigil duty at the hospital, including one certified to carry a firearm. ODO notes HCDC does not maintain a logbook for hospital details. Instead, the officers enter brief written reports in the facility's computer system summarizing events during their shift. Reports by TINO's vigil officers from September 20 to 23, 2016, documented no unusual incidents.<sup>116</sup>

At 10:22 p.m., TINO was admitted to SFMC under the care of attending physician Dr. [redacted]. [redacted] TINO was intubated and mechanically ventilated. His diagnosis was severe hypoxic ischemic brain injury,<sup>117</sup> and the treatment plan was to rule out brain death. Palliative care<sup>118</sup> was implemented and family supportive care was provided by an advanced practice RN. Because TINO's wife was noted to speak K'iche, special arrangements were made for language interpretation, and she and her child were allowed to remain at the hospital throughout TINO's stay.<sup>119</sup>

**On September 22, 2016**, per the family's direction, a Do Not Resuscitate (DNR) order was placed.

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<sup>107</sup> Organized sinus tachycardia rhythm is a sinus rhythm with an elevated rate of impulses, defined as a rate greater than 100 beats/min (bpm) in an average adult.

<sup>108</sup> The carotid pulse is an arterial pulse felt on either side of the wind pipe in the neck.

<sup>109</sup> See GFID Prehospital Care Report, September 22, 2017.

<sup>110</sup> See Narrative Progress Note by LPN [redacted] September 19, 2016.

<sup>111</sup> See HCDC Incident Report by Sergeant [redacted] September 20, 2016.

<sup>112</sup> See GFID Prehospital Care Report, September 22, 2017.

<sup>113</sup> ODO interview with Sergeant [redacted] November 30, 2016.

<sup>114</sup> See GFID Prehospital Care Report, September 22, 2017.

<sup>115</sup> ODO interview with Sergeant [redacted] November 30, 2016.

<sup>116</sup> See HCDC Incident Report by Sergeant [redacted] September 20, 2016.

<sup>117</sup> A severe consequence of global cerebral ischemia due to cardiac arrest or other causes.

<sup>118</sup> Palliative care improves the quality of life of patients and their families who are facing problems associated with life-threatening illness, through the prevention and relief of suffering.

<sup>119</sup> See SFMC Orders and Progress Record, September 19, 2016.

**On September 23, 2016**, an electroencephalogram<sup>120</sup> (EEG) was conducted and confirmed brain death. After the test was completed, hospital staff met with TINO's family, and with assistance from both a Spanish and K'iche interpreter, advised them TINO would never wake up.<sup>121</sup> At approximately noon, the security vigil at the hospital was discontinued per direction of Deputy Field Office Director (DFOD) [REDACTED].<sup>122</sup>

**On September 27, 2016**, TINO's family agreed to discontinue his life support, and TINO was pronounced dead at 4:05 p.m.<sup>123</sup> Sergeant [REDACTED] received a call from an SFMC nurse at 4:46 p.m. notifying him that TINO passed away. He notified Director [REDACTED] ERO staff, and the Nebraska State Patrol.<sup>124</sup> The State Patrol sent an officer to collect TINO's body for autopsy.<sup>125</sup>

**On September 28, 2016**, a check in the amount of \$866.02 for the funds in TINO's account was made out to his wife. The check and TINO's personal property were given to [REDACTED] at the ERO office in Grand Island. SDDO [REDACTED] informed ODO [REDACTED] signed a receipt for both funds and property.<sup>126</sup>

### Autopsy

An autopsy was performed on September 28, 2016.<sup>127</sup> The findings, signed October 17, 2016, cite the cause of death as complications of seizure disorder, not otherwise specified, and the manner of death as natural. TINO's death certificate, filed December 27, 2016 and issued February 14, 2017, cites his immediate cause of death as anoxic brain injury due to, or as a consequence of, cardiac arrest and seizure.<sup>128</sup>

### MEDICAL CARE AND SECURITY REVIEW

ODO reviewed the medical care TINO was provided by HCDC, as well as his safety and security while detained at the facility. ODO found deficiencies in HCDC's compliance with certain requirements in the Medical Care standard in the ICE NDS 2000.

### CONCLUSIONS

1. **ICE NDS 2000, Medical Care, section (III)(A), General**, states, "All facilities will employ, at a minimum, a medical staff large enough to perform basic exams and treatments for all detainees."
  - Midlevel provider coverage at HCDC is limited to one to three hours per week. The facility's physician, who is located in Peoria, Illinois, provides no on-site services or supervision of the NP beyond remotely reviewing her orders every three months. In

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<sup>120</sup> An electroencephalogram is a test to detect abnormalities related to electrical activity of the brain.

<sup>121</sup> See SFMC Orders and Progress Record, September 22-23, 2016.

<sup>122</sup> ODO interview SDDO [REDACTED] November 30, 2016.

<sup>123</sup> See SFMC Orders and Progress Record, September 27, 2016.

<sup>124</sup> See HCDC Incident Report by Sergeant [REDACTED] September 27, 2016.

<sup>125</sup> ODO interview with Sergeant [REDACTED] November 30, 2016.

<sup>126</sup> ODO interview ICE SDDO [REDACTED] November 30, 2016.

<sup>127</sup> See Exhibit 7: Autopsy report, October 17, 2016.

<sup>128</sup> See Exhibit 8: State of Nebraska Death Certificate by Chief Deputy Attorney [REDACTED] February 17, 2017.

addition, HCDC has no onsite RNs to provide administrative oversight of health care operations or clinical supervision of LPNs. Although the medical record and reported information fully supports that the NP responds to phone calls from LPNs when she is not present at the facility, it is a challenge to conduct patient encounters and review telephone orders and diagnostic reports during her one to three hours per week at the facility.

2. **ICE NDS 2000, Medical Care, section (III)(D), *Medical Screening (New Arrivals)***, states, “If language difficulties prevent the health care provider/officer from sufficiently communicating with the detainee for purposes of completing the medical screening, the officer shall obtain translation assistance. Such assistance may be provided by another officer or by a professional service, such as a telephone translation service. In some cases, other detainees may be used for translation assistance if they are proficient and reliable and the detainee being medically screened consents.”
  - Neither TINO’s medical record nor his detention file document TINO was ever asked his primary language. All staff interviewed indicated the detainee spoke no English, but spoke at least limited Spanish. Use of interpretation assistance was documented during three of TINO’s medical encounters. On two of the three occasions, a detainee or inmate was used for interpretation assistance, but TINO’s medical record contains no documentation his consent was obtained on either occasion. On the third occasion, Site Nurse Manager [REDACTED] used Google Translate to discuss medication compliance with TINO in Spanish.
  - LPN [REDACTED] stated she did not use interpretation assistance during TINO’s intake screening. Instead, she had the detainee answer yes or no as she pointed to questions on the Spanish version of the screening form. She acknowledged the language barrier prevented her from asking follow-up questions when TINO reported an eye problem during the screening.
3. **ICE NDS 2000, Medical Care, section (III)(D), *Medical Screening (New Arrivals)***, states, “The health care provider of each facility will conduct a health appraisal and physical examination on each detainee within 14 days of arrival at the facility. Health appraisals will be performed according to NCCHC and JCAHO standards.” According to NCCHC standard J-E-04, Initial Health Assessment, “A *physical examination* is an objective, hands-on evaluation of an individual. It involves the inspection, palpation, auscultation, and percussion of a patient’s body to determine the presence or absence of physical signs of disease.”
  - NP [REDACTED] did not document completion of a hands-on physical examination during TINO’s initial health appraisal. During her interview, she stated although she completes hands-on examinations in practice, she only documents positive findings or findings of note.
4. **ICE NDS 2000, Medical Care, section (III)(E), *Dental Treatment***, states, “An initial dental screening exam should be performed within 14 days of the detainee’s arrival.”

- TINO’s medical record contains no documentation a dental exam was ever completed.
5. **ICE NDS 2000, Medical Care, sections (III)(I), *Delivery of Medication***, states, “Distribution of medication will be according to the specific instructions and procedures established by the health care provider. Officers will keep written records of all medication given to detainees.”
- TINO’s MAR does not document whether three doses of anti-seizure medication Depakote were given, missed, or refused between the dates of September 6-15, 2016.
  - Tylenol 1000 mg twice daily for eight days (three days, extended by five days) was incorrectly transcribed on September 7, 2016, to read Tylenol 500 mg twice daily. Consequently, TINO was given the medication for a total of five days at half the ordered strength.
  - TINO’s MAR does not document an immediate dose of Tylenol 1000 mg ordered on September 15, 2016, was given.
  - TINO’s MAR does not document whether the morning dose of anti-seizure medication Keppra was given or refused on September 16, 2016.
  - Ativan was ordered on September 19, 2016, after TINO’s first of two seizures that date, but was never administered due to unavailability. As noted, Ativan given as an emergency treatment may prevent recurrent seizures.

#### AREAS OF NOTE

- HCDC does not have a written policy governing seizure protocol and 15 minute check status. While TINO’s placement on 15 minute checks following his first seizure on September 6, 2016 was appropriate, neither medical nor security records document who initiated or discontinued the status, and the medical record makes no reference to his placement on or removal from 15 minute status checks at all. Consequently:
  - Medical and security staff reported inconsistent understanding of procedures for placement and removal from the status and for monitoring requirements while the status is active;
  - There is no clear and coherent mechanism to ensure officers are informed of a detainee’s placement on or discontinuation from the status;
  - Potential for communication lapses, missed rounds, and extended or premature removal from the status exists. In TINO’s case, the Housing Control Log documents he was placed on 15 minute checks on September 6, 2016, at approximately 6:30 a.m. The next related entry documents he was on 15 minute check status until 6:00 a.m. on September 7, 2016. In fact, per electronic security reports, 15 minute rounds were conducted until 6:00 a.m. on September 8, 2016.



- Concerns related to HCDC’s medical staff deviating from standard practices.
  - Following TINO’s first seizure on September 6, 2016, an anti-seizure medication was given, and a lab test was ordered to verify its effectiveness. The next day, the provider also ordered a CT scan and neurology consult. Despite the nature and significance of these actions, a medical hold or alert requiring provider clearance prior to release or transfer was not documented in the medical record. Site Nurse Manager [redacted] stated there is no system in place to do so. Although there was no alert, ERO documentation indicates TINO’s planned deportation on September 13, 2016, was stopped when a nurse provided IHSC notification a neurology consult was necessary before TINO could be cleared. There is no entry in the medical record documenting this communication. In addition, although proper, there is no documentation of provider authority to deny clearance pending the neurology consult.
  - The form used to document TINO’s initial health appraisal, “Medical Screen and Health History,” is inadequate to support documentation of a hands-on physical examination, including findings and treatment plan. As noted above, NI [redacted] stated she completed but did not document, her hands-on physical examination of TINO due to the limitations of the form. She also attributed her missing signature on orders resulting from the physical examination to the form’s inadequacies. While the provider is responsible for assuring documentation is complete, the form used at HCDC does not effectively support fulfillment of the responsibility.
  - The standardized pain scale was not used during any of TINO’s medical encounters.
- Concerns related to provider orders, and inadequate implementation of provider orders and medication refusal protocols.
  - NP [redacted] did not sign her September 15, 2016 telephone order for Tylenol 1000 mg stat and replacement of Depakote with the alternative anti-seizure medication Keppra.
  - A full set of vital signs was not obtained as ordered by the provider on September 19, 2016.
  - NP [redacted] September 7, 2016 referral for CT scan and neurology consult was not fully processed. Because the wording of the referral led the Site Nurse Manager to assume NP Bader would decide whether or not to initiate the neurology consultation upon receipt and review of the CT scan results, she submitted a MedPAR and scheduled the CT scan, but took no action on the neurology consult.
  - After learning TINO’s referral for neurology consult was not in IHSC’s approval queue, NP [redacted] took no follow-up action on the referral.

- HCDC failed to address TINO’s refusal of anti-seizure medication Keppra, which was ordered on September 15, 2016, to replace Depakote. TINO accepted the first dose but refused the second. Although he was counseled by Site Nurse Manager [redacted] at that time, between September 15 and 19, 2016, he refused five consecutive doses. Without documentation of whether or not language assistance was provided and the reason for the refusal, it remains unclear if TINO understood the potential consequences of non-compliance, which is standard nursing practice. Also, at no time was NI [redacted] notified TINO was refusing the medication.
- Concerns related to TINO’s placement in administrative segregation, and the consistency of security rounds conducted in administrative segregation.
  - No justification was documented for charging TINO with disciplinary violations and placing him in administrative segregation on September 15, 2016.
    - TINO reported to a Spanish speaking officer that another detainee pushed him and demanded he leave the shower area. Both detainees were subsequently interviewed by Sergeant [redacted] and neither reported TINO laid hands on the alleged aggressor, yet TINO was charged with three assault charges and obstruction of corrections operations. Sergeant [redacted] reported HCDC’s standing practice is to charge all parties involved in an alleged physical altercation with all potential disciplinary infractions and place them in segregation.
    - Further, responding to detainee allegations is a fundamental part of an officer’s job and does not constitute obstruction of corrections operations. ODO notes concern that a practice of automatically invoking the disciplinary process and segregating a detainee for reporting aggressive behavior by another detainee may deter reporting of assaultive incidents of all types, including sexual.
  - HCDC has no established procedures for ensuring disciplinary reports and segregation orders are provided in a language the detainee understands. The document issued to TINO specifying the disciplinary charges and his rights was in English, and was not translated for him upon issuance. According to Office [redacted] the documents were not translated until the next day, when TINO asked why he was placed in segregation.
  - Hall County Jail Policy 3C-01, Inmate Well-Being Checks, states, “General Population inmates shall be observed, at a minimum, once every thirty minutes. Inmates in Administrative and Disciplinary Segregation shall be observed at a minimum, once every thirty minutes.”
    - Electronic reports from the Guardian system showed rounds were not consistently conducted within 30 minutes.



**EXHIBITS:**

1. Medical Intake Screening
2. Creative Corrections Medical and Security Compliance Analysis
3. Medication Administration Records
4. Medical Screen and Health History
5. Midwest Imaging Radiological Report
6. HCDC Administrative Segregation Placement Form
7. Autopsy Report
8. State of Nebraska Death Certificate

