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Office of Enforcement and Removal Operations ICE Health Service Corps

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



September 11, 2018

MEMORANDUM FOR:	(b)(6); (b)(7)(C) (b)(6); (b)(7)(C)
	Assistant Director
	ICE Health Service Corps
	(b)(6)· (b)(7)(C)
THROUGH:	(b)(6); (b)(7)(C)
	Deputy Assistant Director of Clinical Services/Medical Director
	ICE Health Service Corps
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Acting Deputy Assistant Director of Health Care Compliance ICE Health Service Corps

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Lead Compliance Risk Manager ICE Health Service Corps

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Risk Manager

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

ICE Health Service Corps

SUBJECT:

Mortality Review

Roger RAYSON, (b)(6); (b)(7)(C)

Executive Summary:

Mr. Roger RAYSON, a 47-year-old Jamaican male, was in U.S. Immigration and Customs Enforcement (ICE) custody from January 28, 2017, to March 13, 2017. During Mr. RAYSON's custody, he was treated for: human immunodeficiency virus (HIV) (a disease that alters the immune system, making people more vulnerable to infections and diseases); acquired immunodeficiency syndrome (AIDS) (the most advanced stage of HIV); Burkitt's non-Hodgkin lymphoma (an AIDS defining cancer; is rapidly fatal if untreated); subdural hematoma (a collection of blood outside the brain; the bleeding and increased pressure on the brain from a subdural hematoma can be life-threatening); dehydration; sepsis (a potentially life-threatening complication of an infection); pain; diabetes mellitus (DM); anemia; hypertension (HTN) (high blood pressure); esophageal reflux (GERD); metabolic disorder (a condition that results in metabolism problems); hypercalcemia (elevated calcium level in the blood); and gout (a type of inflammatory arthritis).

Prior to intake into ICE custody, Mr. RAYSON was in Federal Bureau of Prisons (BOP) custody and diagnosed with Burkitt's lymphoma in September 2016. He received only one dose of chemotherapy while in BOP custody (recommended treatment was eight cycles of chemotherapy every 21 days). In December 2016, a hematologist/oncologist stated that resuming Mr. RAYSON's chemotherapy at that time was contraindicated, because Mr. RAYSON would be at risk of serious and potentially fatal chemotherapy complications during his period of transition out of BOP custody on January 28, 2017, and pending deportation, where access to health care could not be guaranteed. Mr. RAYSON contacted a physician in Jamaica who was willing to resume his chemotherapy when he returned to the country.

Upon intake into ICE custody and housing in the LaSalle Detention Facility (LDF) in Jena, Louisiana (LA), health care staff noted that Mr. RAYSON was weak, ill-appearing, and had severe pain. From January 28 to February 2, 2017, he was admitted to LDF medical housing

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unit (MHU) for close observation and management of his serious medical conditions.

On January 29, 2017, Mr. RAYSON was treated and released from a local emergency room (ER) for vomiting and dehydration.

On February 2, 2017, Mr. RAYSON was discharged from the MHU into the general population (GP). Due to detainees expressing concerns about having an ill appearing detainee in the housing unit, Mr. RAYSON was housed in the special monitoring unit (SMU) for protective custody. While in SMU, Mr. RAYSON's condition continued to deteriorate (as evidenced by uncontrollable pain, vomiting, and progressing weakness). On February 11, 2017, he was emergently sent out via ambulance to a local ER.

On February 11, 2017, Mr. RAYSON was admitted to the hospital with diagnoses of dehydration, hypercalcemia, and possible sepsis. Mr. RAYSON was slowly improving until February 16, 2017, when he developed an altered mental status. On February 17, 2017, a computerized axial tomography (CT) scan of his brain showed he had a subdural hematoma.

On February 18, 2017, Mr. RAYSON was transported by air ambulance to a medical center where he received emergent neurosurgery to relieve the pressure on his brain from the subdural hematoma. Mr. RAYSON's condition stabilized and he was transferred back to a community hospital near LDF on February 21, 2017, where he continued to receive treatment for the subdural hematoma and sepsis.

On February 28, 2017, Mr. RAYSON's mental status changed. A CT scan revealed a reaccumulation of the subdural hematoma. The local hospital attempted to transfer Mr. RAYSON back to the neurosurgery services at the medical center, but the medical center did not accept him, and he remained in the local hospital where his condition continued to deteriorate.

On March 4, 2017, Mr. RAYSON was transferred to a different local hospital and admitted to the intensive care unit (ICU) for treatment of sepsis. During this hospitalization, his condition did not improve appreciably and on March 10, 2017, he was placed on "Do Not Resuscitate" status. He was not deemed a candidate for systemic therapy to treat his lymphoma and sepsis. He received palliative care consisting of IV antibiotics and morphine for pain. His condition continued to deteriorate.

On March 13, 2017, at 3:20 p.m., Mr. RAYSON went into cardiac arrest and died.

Mortality Review Findings: Based on the overall findings of this review, it cannot be determined whether the health care services provided at LDF contributed to Mr. RAYSON's death, because the medical examiner could not determine his manner of death (i.e., whether an accident, natural causes, or homicide caused the subdural hematoma).

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The following is a summary of health care delivery/program weaknesses found during this review:

1. Continuity of Care.

Mr. RAYSON did not receive access to appropriate and timely continuity of care in accordance with Performance-Based National Detention Standards (PBNDS) 2011 and IHSC policies.

- The LDF Health Services Administrator (HSA) and Clinical Director (CD) received
 notification of Mr. RAYSON's pending release and intake into ICE custody five weeks in
 advance. Although indicated, the HSA and/or CD did not request additional medical
 information from the BOP to determine if LDF could support Mr. RAYSON's medical
 needs. They informed Enforcement and Removal Operations (ERO) that Mr. RAYSON
 was medically cleared for admission into LDF.
- Obtaining additional medical information from BOP in advance would have shown the need to expedite Mr. RAYSON's deportation so he could resume treatment for his cancer.
- The HSA and/or CD did not inform LDF health care staff of Mr. RAYSON's pending transfer to LDF.
- Upon admission to the MHU, timely medical orders were not given to continue Mr. RAYSON's pain medications and diabetic diet.
- A January 30, 2017 order to obtain additional medical records from the BOP was not implemented.

2. Medication management.

LDF staff did not prescribe and administer medications to Mr. RAYSON in accordance with PBNDS 2011 standards, IHSC policies, and DEA regulations.

- Controlled substance pain medications were administered to Mr. RAYSON without appropriate orders from a medical provider.
- Nursing staff frequently administered as needed (PRN) medications without noting in the medical record the subjective and/or objective findings to support administration of the medication.
- Nursing staff frequently did not document timely monitoring of Mr. RAYSON's response to PRN medications.
- Medical providers gave verbal orders for medications in non-emergent circumstances, while they were present in the facility.
- An order for a PRN narcotic pain medication was incorrectly transcribed on the medication administration record (MAR) and administered as a regularly scheduled medication.

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3. Access to an appropriate level health care provider.

Mr. RAYSON did not receive timely and appropriate referral to an appropriate level health care provider in accordance with PBNDS 2011 standards.

- An advanced practice provider (APP) attempted to consult with the CD by telephone, but
 the CD was unavailable and the CD's voice mailbox was full. The APP did not attempt to
 notify the HSA of the CD's unavailability to receive instructions for an alternate CD to
 consult with.
- A registered nurse (RN) noted that Mr. RAYSON had abnormal vital signs (VS), but did not recheck them and/or consult a medical provider as indicated.
- Mr. RAYSON required skilled nursing care; discharge from the MHU to GP/SMU was inappropriate.
- APPs informed the CD that they did not feel comfortable caring for Mr. RAYSON due to the complexity of his medical care. LDF did not have a staff physician and the CD did not assume primary responsibility for Mr. RAYSON's medical management.
- When an LDF psychologist informed the HSA, CD, APP, and visiting IHSC Associate
 Medical Director (AMD) that Mr. RAYSON was "looking bad and should not be housed
 in SMU," a medical provider did not evaluate Mr. RAYSON and he remained in SMU.
- APPs repeatedly recommended transferring Mr. RAYSON to a hospital, but the CD
 persisted in recommending caring for Mr. RAYSON at LDF. Mr. RAYSON's condition
 warranted transfer to a higher level of care.
- Nursing staff regularly reported about Mr. RAYSON's deteriorating health status. In
 response to these reports, LDF clinic administration (HSA, AHSA, and CD) focused their
 efforts on communicating to ERO the need to deport Mr. RAYSON as soon as possible.
 However, LDF clinic administration did not ensure Mr. RAYSON received an
 appropriate level of care while detained.

4. Access to appropriate medical care.

Mr. RAYSON did not receive timely and appropriate access to medical care accordance with PBNDS 2011 standards.

- On one occasion, Mr. RAYSON remained in moderate to severe pain for over seven hours until a physician prescribed narcotic pain medication.
- Mr. RAYSON required skilled nursing care; discharge from the MHU to GP/SMU was inappropriate.
- CD review of Mr. RAYSON's abnormal urinalysis results was delayed four days. The
 CD did not develop an appropriate treatment plan in response to these results.
- The CD stated that he evaluated Mr. RAYSON numerous times while he was in the MHU, but he did not document these encounters in the medical record.

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- A physician did not examine or observe Mr. RAYSON after he was discharged from the MHU.
- The CD's care and treatment plan throughout Mr. RAYSON's LDF detention, as evidenced by the medical record, appears as if the CD deliberated Mr. RAYSON's care from afar without examining the patient when indicated and as requested by the APPs.
- An APP evaluated Mr. RAYSON in SMU but did not document this encounter.
- An LDF psychologist informed the CD and an APP that Mr. RAYSON "was looking bad" and should not be housed in SMU. A medical provider did not examine Mr. RAYSON.
- APPs repeatedly recommended transferring Mr. RAYSON to a hospital, but the CD
 persisted in managing Mr. RAYSON at LDF. Mr. RAYSON's condition warranted
 transfer to a higher level of care.

5. Access to appropriate nursing care.

Mr. RAYSON did not receive timely and appropriate access to nursing care accordance with PBNDS 2011 standards and IHSC policies.

- Nursing staff did not develop a nursing plan of care for Mr. RAYSON during his MHU admission.
- While Mr. RAYSON was admitted to MHU, nursing staff did not routinely document Mr. RAYSON's ability to engage in activities of daily living.
- Some nursing staff reported they were unable to provide skilled nursing care in the MHU because the beds could not be elevated to a level where nursing staff could perform care safely, and they could not elevate the head or foot of the bed to improve patient comfort.
- An RN noted that Mr. RAYSON had abnormal VS but did not recheck them and/or consult a medical provider as indicated.
- Nursing staff did not document taking VS every two hours as ordered by a medical provider.
- There were several instances of nursing staff failing to administer PRN medication for pain and/or nausea when indicated. For example, while housed in the MHU, on one occasion Mr. RAYSON did not receive medication to relieve his severe pain and nausea with vomiting for over nine hours; on another occasion he waited over eight hours.
- Nursing staff did not immediately notify a medical provider about Mr. RAYSON's abnormal urinalysis results.
- Generally, when nursing staff administered PRN pain medications or anti-nausea medications, they did not document Mr. RAYSON's symptoms that warranted administering these medications. In addition, they did not reevaluate Mr. RAYSON within an hour to determine if the medication relieved his symptoms.
- Nursing staff observed Mr. RAYSON's deteriorating status while in the SMU and reported it verbally during shift reports; however, they did not routinely document these observations in his medical record.

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6. Access to appropriate mental health care.

Mr. RAYSON did not receive timely and appropriate access to mental health care in accordance with PBNDS 2011 standards and IHSC policies.

 During Mr. RAYSON's health assessment and physical examination, an APP noted Mr. RAYSON was depressed. The APP did not refer Mr. RAYSON to mental health for evaluation.

7. Patient advocacy.

LDF health care staff did not advocate in a timely and appropriate manner for Mr. RAYSON to receive necessary and appropriate health care in accordance with PBNDS 2011 standards and their licensed health care professional duty of care.

- Nursing staff and/or the APP did not take steps to advocate for Mr. RAYSON, so an
 order for PRN narcotic pain medication was written in a timely manner. Mr. RAYSON
 remained in severe pain for over eight hours until the order was written.
- An RN medically cleared Mr. RAYSON for SMU even though he observed Mr. RAYSON "looked like he needed to be in a hospital." The RN did not take steps to advocate for a more appropriate placement.
- LDF health care administrators frequently advocated for Mr. RAYSON's rapid deportation; however, they did not take steps to ensure he received appropriate care while in detention.
- Although Mr. RAYSON was on the Significant Detainee Illness (SDI) list and staff reported his condition was deteriorating in SMU, the LDF HSAs did not visit Mr. RAYSON.
- LDF administrators did not take proactive steps to identify community resources to support the medical needs of patients at LDF.
- LDF administrators did not take proactive steps to transfer Mr. RAYSON to a detention facility with community resources that could meet Mr. RAYSON's needs.
- When the IHSC Medical Director/Acting Assistant Director (AD) requested a
 headquarters (HQ) level review of Mr. RAYSON's medical care, the review relied on
 summaries and reports created by LDF staff. The designated HQ reviewer did not
 conduct an independent review of Mr. RAYSON's medical records.

8. Special monitoring unit.

Mr. RAYSON did not receive appropriate access to SMU health care monitoring in accordance with PBNDS 2011 standards and IHSC policies.

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- An RN medically cleared Mr. RAYSON for placement into SMU without consulting a medical provider, even though the RN believed this placement was medically contraindicated.
- The documented observations of Mr. RAYSON's health status during most of the SMU nursing rounds were inconsistent with their verbal reports of his deteriorating status.

Recommendations

- Forward these findings to the IHSC Deputy Assistant Director (DAD) of Health Care Compliance (HCC).
- The IHSC DAD of HCC will share these findings through appropriate communication channels to ICE, the LDF administrator and health authority for review and to create a corrective action plan (CAP).
- The respective IHSC HCC Unit and ICE will ensure the CAP is implemented and sustained.

Mortality Review Detailed Report:

On March 13, 2017, IHSC received notification of the death of ICE detainee Roger RAYSON, A206 839 071. Mr. RAYSON, a 47-year-old Jamaican male, was in ICE custody from January 28, 2017, to March 13, 2017, and assigned to LDF, Jena, LA, on the date of his death. The Assistant Director for IHSC requested a mortality review to learn from Mr. RAYSON's death by reviewing the care provided and the circumstances leading up to his death. The goal of the mortality review is to determine the appropriateness of clinical care; ascertain whether changes to policies, procedures, or practices are warranted; and identify issues that require further study.

The following report is based on the findings and recommendations of the mortality peer review committee, which convened on April 6, 2017. The review was based on the following information: 1) Mr. RAYSON's LDF medical records, emergency medical services (EMS) and community hospital records; 2) notification reports; 3) ICE ENFORCE Alien Removal Module (EARM) and ICE ENFORCE Alien Detention Module (EADM) database records; 3) Mr. RAYSON's LDF detention file; 4) Mr. RAYSON's Alien file; 5) LDF post logs; 6) Mr. RAYSON's death certificate and autopsy report: 7) an on-site review and staff interviews conducted by fact-finder (b)(6); (b)(7)(C) at LDF on March 28 and 29, 2017; and 6) applicable LDF and ICE Detention Standards.

Observations and Recommendations:

Sequence of Events

November 24, 2014

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Mr. RAYSON entered the U.S. as a non-immigrant visitor and was found in possession of cocaine. He was released to the custody of the U.S. Marshal's Service (USM) and subsequently convicted and sentenced to federal prison with a projected release date of January 28, 2017.

December 21, 2016

ERO, Oakdale, LA, notified the LDF HSA of Mr. RAYSON's January 28, 2017 pending release date from the BOP Federal Medical Center (FMC), Lexington, Kentucky (KY), and requested a determination of whether he was medically cleared for housing at LDF. ERO provided the HSA with a copy of Mr. RAYSON's BOP medical summary.

The medical summary showed that Mr. RAYSON had the following health conditions: Burkitt's non-Hodgkin lymphoma; DM; anemia; HTN; GERD; metabolic disorder; gout; pain; and a history of arthritis. [Investigator's note: The medical summary did not include information about Mr. RAYSON's diagnoses of HIV and AIDS.]

Other information included in Mr. RAYSON's medical summary included the following treatment plans: weekly weights, daily VS, three times a day (TID) blood glucose monitoring, lower bunk, elevator pass, permanent sedentary work, regular- no pork, no milk diet, crutches, eye glasses, and no travel restrictions. [Investigator's note: The medical summary did not include information that Mr. RAYSON was pending an evaluation by a hematologist/oncologist (a doctor that specializes in the treatment of blood disorders and cancer).]

The medical summary showed that Mr. RAYSON was prescribed the following medications: abacavir (ABC) 600 mg, daily (for HIV), acetaminophen (APAP) 325 mg, every six hours, PRN (for pain), acyclovir 200 mg, twice daily (BID) (for HIV), allopurinol 300 mg, daily (for gout), enteric coated aspirin (ECASA) 81 mg, daily (for HTN/DM), dolutegravir sodium (DTG) 50 mg, daily (for HIV), ferrous gluconate 648 mg, daily (for anemia), fluconazole 200 mg, daily (for HIV), glipizide 10 mg, BID (for DM), hydrochlorothiazide (HCTZ) 12.5 mg, daily (for HTN), indomethacin 25 mg, BID, PRN (for gout), regular insulin per sliding scale, TID (for DM), lamivudine (3TC) 300 mg, daily (for HIV), levofloxacin 500 mg, daily (for infection), lisinopril 10 mg, daily (for HTN), and metformin 1000 mg, BID (for DM).

January 17, 2017

ERO Oakdale, LA, reminded the LDF HSA that they were still awaiting a response regarding whether Mr. RAYSON was medically cleared for admission into LDF. The HSA forwarded the medical summary to the LDF CD (hereafter identified as CD-1), who in turn stated that LDF could medically accommodate Mr. RAYSON if the LDF Assistant Field Office Director (AFOD) concurred. [Investigator's note: the LDF clinic did not contact FMC Lexington to request additional information or records.] The AFOD informed the HSA and CD-1 that Mr. RAYSON would be admitted to LDF if IHSC medically cleared him for admission.

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[Investigator's note: the LDF HSA and CD-1 did not notify LDF health care staff of Mr. RAYSON's pending admission.]

January 28, 2017 (Saturday)

At 2:30 a.m., Mr. RAYSON arrived at LDF. Mr. RAYSON's medical transfer summary and 56 pages of medical records from the BOP listed the following health problems: Burkitt's non-Hodgkin lymphoma, HIV, HTN, DM, gout, nausea, arthritis, anemia, GERD, metabolic disorder, and pain. His BOP medical transfer summary listed all the medications noted above plus oxycodone/acetaminophen (APAP) 5 mg/325 mg, two tablets, every six hours, PRN (a narcotic pain medication), and ondansetron 4 mg, every eight hours, PRN (for nausea). These medical records did not include information about the history, prior treatment, and current treatment plan for the Burkitt's lymphoma, or any other medical provider evaluations, observations, or treatment plans.

At 3:40 a.m., during the medical intake screening, Mr. RAYSON reported "feeling bad" secondary to 9/10 pain all over his body for the past one to two days. His VS were: temperature (T) 97.3, pulse (P) 94, respirations (R) 18, blood pressure (BP) 132/85, oxygen saturation (O2 sat) 100 percent (%), height 65.5 inches, weight 179 pounds (lbs.), and body mass index (BMI) 29.33. His finger stick glucose was 233. The nurse did not observe any physical abnormalities. The intake screening nurse consulted with an APP who ordered Mr. RAYSON housed in the MHU until evaluated by a medical provider later that morning. A nurse also administered pain medication (oxycodone/APAP).

Later that morning, an APP performed a health appraisal and physical exam. Mr. RAYSON reported he was diagnosed with HIV in December 2014 and Burkitt's non-Hodgkin lymphoma in August 2016, while incarcerated in a Florida (FL) prison. Mr. RAYSON received one chemotherapy (chemo) treatment in September 2016 while incarcerated in FL, and reported he was supposed to receive chemo every three weeks, but did not receive it. Mr. RAYSON transferred to FMC Lexington, KY, in November 2016.

During this encounter, Mr. RAYSON complained of constant 7/10 aching left upper forearm pain for the past four to five weeks. He also reported the following symptoms: nausea, vomiting, intermittent midline upper and lower abdominal pain and swelling, swollen glands in his head and neck, unintentional significant weight loss over a period of several months, ringing in his ears since a motor vehicle accident in 1992, cold intolerance, occasional weakness, and light headedness.

Mr. RAYSON's VS were: T 98.2, P 89, R 18, BP 124/76, O2 sat 98%, and weight 179 lbs. The following abnormalities were observed during the physical exam: General Appearance - ill appearing, thin, uncomfortable due to pain, visibly upset; Head - some edema with pain to the right lower scalp area extending up posteriorly to the right auricle, hair scarce and patchy; Neck - posterior cervical nodes enlarged, submandibular nodes enlarged; Lymph nodes - cervical nodes

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hard, cervical nodes enlarged, shoddy; Chest - port palpated in the left upper chest wall; Abdomen - small umbilical hernia; Musculoskeletal - slow shuffling gait; Extremities - hard fixed nodule palpated with tenderness left upper posterior forearm; Psych - depressed.

The APP diagnosed Mr. RAYSON with the following conditions: type 2 DM, anemia, HTN, GERD without esophagitis, gout, Burkitt's lymphoma, HIV, and osteoarthritis. The APP continued all the medications listed on Mr. RAYSON's transfer summary and ordered the following: a referral to the LDF physician for continuation of oxycodone; an oncology consultation; an infectious disease (ID) consultation; and a diet for health. [Investigator's note: The ID referral was sent out on January 31,2017. On February 9,2017 the ID denied the request "at this time." A referral to mental health or a request for additional medical records were not initiated.] The APP admitted Mr. RAYSON to the MHU because of his non-Hodgkin lymphoma and HIV, with nursing rounds and VS every eight hours. The APP attempted to consult with CD-1 by telephone; however, CD-1 was unavailable and the CD's voice mailbox was full. [Investigator's note: From January 27-February 11, 2017, another temporary duty CD was assigned to LDF; hereinafter identified as CD-2.]

January 29, 2017

An APP noted Mr. RAYSON had inflamed lymph nodes and was ashen, weak, and dehydrated. His health appraisal and examination were otherwise unchanged from the previous day. Mr. RAYSON was concerned about not receiving chemo. His VS were: T 98.3, P 88, R 18, and BP 122/85. The APP consulted with CD-2 and referred Mr. RAYSON to the Rapides Regional Medical Center (RRMC) ER for evaluation and treatment of his ill, dehydrated, and weak appearance, and frequent bouts of nausea and vomiting while taking ondansetron. He was transported to the ER via facility van because he could walk and did not have any respiratory or cardiac dysfunction.

Mr. RAYSON was evaluated in the RRMC ER for a chief complaint of acute onset of nausea and vomiting that day. Mr. RAYSON's examination and VS were within normal limits (WNL), except he had palpable lymph nodes on the right side of his neck. His laboratory studies included a complete blood count (CBC), comprehensive metabolic panel (CMP), and urinalysis (UA). The results were WNL except as follows: red blood count (RBC) 3.35; hemoglobin (Hgb) 10.3; hematocrit (Hct) 30.6; white blood count (WBC) 3.3; monocytes 18.0; metamyelocytes 1.0; sodium (Na) 134; glucose 119; osmolality 269; calcium (Ca) 5.44; lipase 8; and urobilinogen 2.0. The ER physician diagnosed Mr. RAYSON with vomiting, treated him with one liter of intravenous (IV) fluids, ondansetron 4 mg IV, and discharged him back to LDF.

At approximately 6 p.m., Mr. RAYSON returned to LDF and was readmitted to the MHU under the previous admission orders. His VS were: T 97.6, P 98, R18, BP 131/91, finger stick glucose 270, and pain level 7/10. Throughout the evening Mr. RAYSON continued to complain of 7/10 aching pain in his left shoulder and arm. At approximately 10 p.m., his VS were: T 97.7, P 125;

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BP 97/64, R 18. An RN acknowledged Mr. RAYSON's increased heart rate and noted that Mr. RAYSON was ill-appearing but did not have chest pain or shortness of breath. He was encouraged to relax and was given two tablets of oxycodone/APAP 5 mg/325 mg, for pain.

His VS were not rechecked, and a medical provider was not consulted.

January 30, 2017

The LDF HSA sent the following email to the LDF AFOD: "Medical Hx: Non-Hodgkin's Lymphoma Burkitt's, Diabetes, multiple other medical conditions. Received from Etowah, unannounced, over the weekend...He has serious medical conditions and we have already sent him to ER. We need to look at moving him out as soon as possible. Please advise."

An APP evaluated Mr. RAYSON. He complained of constant aching generalized 7/10 pain, with worse pain in his neck. He also complained of nausea, lower abdominal discomfort, and feeling cold. His physical examination was WNL except: General Appearance - ill appearance, uncomfortable due to pain, moaning, occasional crying; Neck - anterior and posterior cervical nodes enlarged; Lymph Nodes - cervical nodes firm, inguinal nodes enlarged and tender. His VS were: T 97.7, P 125, R 18, BP 97/64. [Investigator's note: These VS were taken at approximately 10 p.m. the previous evening. The APP presumed they were taken that morning.] The APP ordered the nurses to monitor Mr. RAYSON's VS every two hours and to report all abnormal findings and significant changes "by way of [telephone encounter]." The APP reordered all of Mr. RAYSON's previously ordered medications and added APAP 325 mg, one tablet, four times a day (QID), PRN. The APP also requested staff obtain Mr. RAYSON's laboratory studies (labs) and records from the previous facility. [Investigator's note: Every two-hour VS were not documented. An attempt to obtain the medical records in response to this request was not documented.]

An LDF staff physician (hereinafter identified as MD-1) evaluated Mr. RAYSON. MD-1 documented that Mr. RAYSON reported the following: in August 2016 a specialist performed a needle aspiration of an area of swelling in his right anterior neck; initially, the specialist informed Mr. RAYSON that he had a cyst, but three days later the swelling returned and a biopsy revealed he had Burkitt's lymphoma; Mr. RAYSON transferred to Lexington FMC and started chemo; he was supposed to receive eight cycles of chemo - every 21 days, but he received only one treatment; Mr. RAYSON received a positron emission tomography (PET) scan and a CT scan in January 2017, but he did not know the results; the BOP informed him that due to his impending release, his treatment should be completed at home. Mr. RAYSON complained of periodic 5/10 pain in his shoulders, left upper arm, knees, and ankles. He informed MD-1 that he did not want to continue taking oxycodone/APAP, because he did not want to develop a drug dependency, and indomethacin 50 mg adequately controlled his pain at Lexington FMC. He also complained of intermittent fatigue and swollen glands.

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Mr. RAYSON's physical examination was WNL except: General Appearance - frail; Lymph Nodes - healed surgical scar over the right anterior neck with some tenderness on palpation. His VS were: T 98, P 91, R 18, BP 121/81, weight 179 lbs., and finger stick glucose 210. MD-1 changed the indomethacin from 25 mg, BID, PRN, to 50 mg, BID, and did not continue the order for oxycodone/APAP. A UA was ordered for the next day. [Investigator's note: The UA was performed two days later, on February 1, 2017.] VS frequency changed to every shift and PRN, and Boost supplement BID was ordered.

[Investigator's note: MD-1 started an extended period of leave the next day. MD-1 handed-off care for Mr. RAYSON to CD-2 prior to his departure.]

At 5:46 p.m., an RN noted Mr. RAYSON was ill-appearing, tearful, intermittently upset, and complaining of 7/10 lower abdominal pain for which he received his evening dose of indomethacin.

January 31, 2017

At 5:44 a.m., nursing staff noted Mr. RAYSON had severe (9/10) generalized pain. Nursing staff notified an APP about Mr. RAYSON's pain and were informed that CD-2 needed to order additional pain medication; pain medication was not ordered at that time. At approximately 10:24 a.m., Mr. RAYSON had an episode of chest pain with exercise, with VS: T 97.7, P 112, BP 124/88. His electrocardiogram (EKG) was WNL and no further treatment was ordered. At approximately 11:22 a.m., during MHU APP rounds, Mr. RAYSON complained of generalized moderate (5/10) pain. His physical examination was WNL except: Neck - anterior and posterior cervical nodes enlarged. The APP noted his VS: T 97.7, P 112, R 18, BP 124/88. No additional pain medication was ordered. At 12:43 p.m., nursing staff noted Mr. RAYSON had moderate (7/10) pain. No additional pain medication was ordered. At 1:42 p.m., CD-2 ordered tramadol 100 mg (narcotic pain medication) orally, every six hours, PRN, for left leg pain, for one day only. At 7:26 p.m., Mr. RAYSON reported that his pain level was mild (3/10). [Investigator's note: Nursing staff did not document when the initial dose of tramadol was administered.] Mr. RAYSON received an additional dose of tramadol at 9:15 p.m.

February 1, 2017

At 2:20 a.m., Mr. RAYSON cried hysterically and reported excruciating severe (10/10) pain in his left knee, which was not relieved by tramadol. He also vomited once but denied nausea and refused anti-nausea medication. The on-call APP ordered a one-time dose of ketorolac 60 mg, intramuscularly (IM) (a nonsteroidal anti-inflammatory drug (NSAID)), and diphenhydramine 50 mg, IM (an antihistamine with sedating effect). At 4:07 a.m., Mr. RAYSON reported that his leg pain was moderate (4/10).

At approximately 6:15 a.m., an APP evaluated Mr. RAYSON. He complained of vomiting without nausea; "it just came up; my stomach was not hurting or anything." He also complained For Official Use Only. This document contains pre-decisional and/or deliberative process information exempt from mandatory disclosure under the Freedom of Information Act, 5:113.C. 352(b) (5). Do not release without prior approval of U.S. Immigration and Customs Enforcement, ICE Health Service Corps.

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of severe (8/10) generalized and left knee pain, and he was visibly limping. Mr. RAYSON refused his breakfast because he was not hungry and in pain. His physical examination revealed no swelling, heat, or erythema in his left knee; however, it was tender to palpation. The APP noted it was too soon to order additional pain medication because Mr. RAYSON received an injection at 2:30 a.m. The APP also noted the labs ordered the day before were still pending.

The APP was concerned about Mr. RAYSON's deteriorating condition from when she first evaluated him two days earlier, and at approximately 8 a.m., consulted with CD-2 about Mr. RAYSON's pain, adjustment of his pain medication, and the possibility of sending him back to the hospital. CD-2 elected to wait for the pending lab results to evaluate Mr. RAYSON's immunocompetency. CD-2 recommended that if Mr. RAYSON was not immunocompromised, he should be discharged from the MHU to GP, which may help with his mental health status and pain. CD-2 did not adjust Mr. RAYSON's current pain medications, which were indomethacin 50 mg, BID, and an order for tramadol 100 mg orally, every six hours, PRN, that was due to expire at 1:30 p.m. that day. The APP also submitted a request to the IHSC ID consultant to review Mr. RAYSON's records when the lab results were available.

On February 1, 2017, the following labs were drawn (non-fasting): RPR, CD4, HIV-RNA, Lipid panel, CMP, CBC with differential, and Hgb A1C. On February 2, 2017, the lab results were received and WNL except: Hct 29.8; Hgb 10.1; CD4 247; WBC 3.1; % CD8 pos. lymph. 67.7; neutrophils 1.3; CD4/CD8 ratio 0.28; RBC 3.38; % CD4 pos. lymph. 19.0; HIV-1 RNA by PCR < 20; log10 HIV-1 RNA TNP; genotype assay TNP; LDL 137; HDL 38; triglycerides 152; cholesterol 205; eGFR 53; Ca 11.4; potassium (K) 5.3; creatinine 1.53; glucose 113; Hgb A1c 7.9. In response to these results the following labs were ordered for the following week: Ca, CMP, and parathyroid hormone (PTH).

At approximately 12:45 p.m., an RN noted Mr. RAYSON complained of severe 7/10 generalized pain, with nausea and vomiting, and the RN observed that Mr. RAYSON appeared uncomfortable due to pain and he had limited range of motion in his left arm due to pain. The RN did not administer pain medication to Mr. RAYSON.

At approximately 3:50 p.m., a detention officer notified an RN that Mr. RAYSON was crying in his MHU room. The RN evaluated Mr. RAYSON. He complained of severe 10/10 pain in both legs and the right side of his neck. The RN observed Mr. RAYSON moaning in pain and was ill appearing. At approximately 4:30 p.m., an APP gave a one-time dose order for ketorolac 60 mg, IM, and diphenhydramine 50 mg, IM, and the RN administered the medication.

At approximately 6:30 p.m., an RN received an order from an APP to give Mr. RAYSON promethazine 25 mg, IM, now, and may repeat once in eight hours (anti-nausea medication), and an additional order that the RN "may give" only two more doses of ketorolac 60 mg, IM, and diphenhydramine 50 mg, IM, every six hours.

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February 2, 2017

At approximately 5:45 a.m., Mr. RAYSON complained of constant, knife-like, 10/10 severe pain in his right knee and back, that was unrelieved with medications. An RN observed Mr. RAYSON appeared severely ill, uncomfortable secondary to pain, disheveled, tearful, and lethargic. His VS were: T 97.5, P 98, R 18, BP 134/97, and finger stick glucose 137. Mr. RAYSON did not receive any PRN pain medication.

At approximately 8:30 a.m., the HSA emailed CD-2 to inform him that the APPs were concerned that Mr. RAYSON's condition was worsening and he may need to be admitted to a hospital. The HSA asked CD-2 to "look at him and advise how you feel we need to manage [him]." The HSA also informed CD-2 that he included Mr. RAYSON on the Serious Detainee Illness (SDI) list which was submitted to the IHSC Regional CD and Regional HSA. The HSA wrote the following information about Mr. RAYSON's condition on the SDI list: "dx HIV+, Burkitt's lymphoma, DM, HTN, Nausea, Severe Lymphadenopathy." No further information was provided.

At approximately 10 a.m., Mr. RAYSON received PRN APAP.

At approximately 10:30 a.m., CD-2 reviewed the following labs that were drawn (non-fasting) on February 1: RPR, CD4, HIV-RNA, Lipid panel, CMP, CBC with differential, and Hgb A1C. These lab results were WNL except: Hct - 29.8; Hgb - 10.1; CD4 - 247; WBC - 3.1; % CD8 pos. lymph. - 67.7; neutrophils - 1.3; CD4/CD8 ratio - 0.28; RBC - 3.38; % CD4 pos. lymph. - 19.0; HIV-1 RNA by PCR < 20; log10 HIV-1 RNA TNP; genotype assay TNP; LDL - 137; HDL -38; triglycerides - 152; cholesterol - 205; eGFR - 53; Ca - 11.4; potassium (K) - 5.3; creatinine - 1.53; glucose - 113; Hgb A1c - 7.9. In response to these results CD-2 diagnosed Mr. RAYSON as having hypercalcemia (elevated blood calcium level) and ordered the following labs in one week: Ca, CMP, and parathyroid hormone (PTH).

In addition, CD-2 discharged Mr. RAYSON from MHU to GP. CD-2 continued all of Mr. RAYSON's medications, which included the following pain medications: indomethacin 50 mg, BID, and one tablet of APAP 325 mg, PRN, QID. CD-2 also ordered a follow-up visit in one week, 1800 calorie ADA diet, full activities, no special needs, and cafeteria privileges.

At 10:45 a.m., an RN acknowledged CD-2's order to release Mr. RAYSON to GP. The RN also noted Mr. RAYSON complained of 7/10 pain with nausea and vomiting. He was ill appearing and uncomfortable due to pain, and ate 50 percent of his breakfast and drank a nutritional supplement. His VS were: T 98, P 100, BP 122/88, R 18. Mr. RAYSON was given a cool pack for his left knee pain.

At approximately 11:40 a.m., the IHSC ID consultant reviewed Mr. RAYSON's medical record and made the following assessments and recommendations:

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AIDS based on neoplastic process, in need of additional treatment given hypercalcemia and hyperkalemia (? Paraneoplastic vs bone mets), mild renal insufficiency. 1) Continue current [anti-retrovirals] ARVs; if [DTG] is not available in Jamaica can be substituted with raltegravir 2x/day. 2) May need hospital admission, needs oncology asap to determine, appt. pending per referrals tab; maintain good hydration, IVF if necessary. 3) Advise on how long he is likely to be in custody. 4) GC/chlamydia NAA. 5) Per [immunizations] records, he should receive, Hep A dose #2 now to complete initial series. Already has Hep B seroprotection. Prevnar followed by pneumovax in 8 weeks. Manactra dose #1 followed by dose #2 in 8 weeks. 6) Defer other chronic care management to [MD-1]; ID consult placed by [LDF APP] pending appt. given complexity of case, and collocated with oncology, may be best to manage with local ID. Please advise when remainder of labs are available or if any additional questions arise. The recommendations were provided to [LDF APPs and MD-1].

On February 2, 2017, the oncologist's office informed LDF they would need a pathology report confirming Mr. RAYSON's cancer diagnosis and his previous chemo treatment notes before they would schedule an appointment. The LDF medical records department requested these records from BOP.

At approximately 12:20 p.m., the following UA dip results were reported: Leukocytes - negative (Neg); Nitrate - Neg; Urobilinogen - 0.2; Protein - 2+; pH - 6.0; Blood - Neg; Specific Gravity - 1.030; Ketones - Moderate; Bilirubin - Moderate; Glucose - Neg; Color - Amber; Clarity - Dark. [Investigator's note: These test results were not WNL and were not reviewed by CD-2 until February 6, 2017.]

Mr. RAYSON was not immediately transferred to GP and remained in the MHU. At approximately 1:15 p.m., he complained of pain. CD-2 gave a verbal order to start tramadol 100 mg every six hours PRN for pain, for seven days. Mr. RAYSON received a dose of this medication at 1:30 p.m. At 2 p.m., Mr. RAYSON received morphine 30 mg orally, in response to a verbal order from CD-2. [Investigator's note: An order for the morphine was not written. CD-2 stated he intended to start Mr. RAYSON on PRN morphine.]

At approximately 2:30 p.m., Mr. RAYSON was crying and telling a nurse that he was in a lot of pain, afraid he was going to die, and needed to be sent out to a hospital.

At approximately 4:50 p.m., an RN noted Mr. RAYSON was pain free.

At approximately 6 p.m., an RN submitted a mental health referral for Mr. RAYSON indicating he may need medication for anxiety.

At approximately 7 p.m., Mr. RAYSON was transferred from the MHU to GP. An RN noted Mr. RAYSON was pain free at that time and he received a dose of PRN APAP.

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Detainees in the dormitories reportedly did not want Mr. RAYSON housed with them because of his medical issues. At approximately 8 p.m. Mr. RAYSON was transferred to SMU for "protective custody," after an RN medically cleared Mr. RAYSON for SMU housing. The RN noted that Mr. RAYSON "did not appear to have any acute or unresolved medical conditions that may worsen in segregation." During this evaluation he complained of 3/10 pain, and his VS were: T 98.6, P 112, BP 127/91, R 18.

At approximately 11:45 p.m., Mr. RAYSON received PRN tramadol.

February 3, 2017

At approximately 9 a.m., Mr. RAYSON received PRN APAP.

During SMU rounds at approximately 9:30 a.m., an RN noted Mr. RAYSON did not complain of pain. At approximately 2:10 p.m., Mr. RAYSON showered.

At approximately 3:53 p.m., a detention officer (DO) informed medical staff that Mr. RAYSON was crying and wanted to see a nurse. At approximately 4:15 p.m., an APP and RN evaluated Mr. RAYSON in SMU. He complained of weakness and severe aching 10/10 pain in the right side of his neck. He received a one-time dose of promethazine 25 mg, IM, diphenhydramine 50 mg, IM, and ketorolac 60 mg, IM.

At approximately 9:07 p.m., Mr. RAYSON was crying and requesting medical attention. The SMU DO contacted the medical clinic. The DO's log indicates that the pill line nurse gave Mr. RAYSON pain medication at approximately 9:27 p.m. and 11:44 p.m., however, the nurse did not document administering pain medication.

February 4, 2017

During SMU rounds at approximately 8:53 a.m., an RN noted Mr. RAYSON did not complain of pain.

At approximately 10:30 a.m., Mr. RAYSON received PRN tramadol. At approximately 2:30 p.m., Mr. RAYSON received PRN APAP. At approximately 4 p.m., Mr. RAYSON received PRN ondansetron.

At approximately 5:11 p.m., Mr. RAYSON refused dinner because he felt ill. He also refused to shower at approximately 8:51 p.m.

At approximately 11 p.m., Mr. RAYSON received PRN ondansetron.

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February 5, 2017

During SMU rounds at approximately 8:41 a.m., an RN noted Mr. RAYSON did not complain of pain.

At approximately 8:49 a.m., Mr. RAYSON returned to his cell after three minutes in the recreation yard because he felt ill. At approximately 9 a.m., he received PRN tramadol and ondansetron.

At approximately 2:30 p.m., Mr. RAYSON received PRN ondansetron, and at approximately 3 p.m., he received PRN tramadol.

At approximately 3:15 p.m., Mr. RAYSON was brought to the medical clinic and evaluated by an RN. Mr. RAYSON complained of nausea and electric, knife-like 10/10 severe generalized pain, and pain to his back, upper shoulders, right side of neck, and back of head. His physical examination was WNL except: General Appearance - unsteady gait with ambulation, in wheelchair, severely ill appearing, uncomfortable due to pain; Head - pain to right occipital area; Lymph Nodes - cervical nodes enlarged and extremely tender to palpation; Skin - pale; Musculoskeletal - can ambulate but unsteady gait at times; Psych - moaning and crying with pain complaints. His VS were: T 97.6, P 96, R 20, BP 133/96. The on-call APP ordered a one-time dose of promethazine 25 mg, IM, and ketorolac 60 mg, IM.

Approximately 90 minutes later, Mr. RAYSON was no longer moaning and crying and stated his pain decreased to 8/10. He had a poor appetite and ate a banana for dinner. He appeared extremely weak and his VS were: T 97.7, P 89, BP 125/86, R 16. At approximately 7:10 p.m., Mr. RAYSON was transported back to the SMU in a wheelchair.

At approximately 9 p.m., Mr. RAYSON received PRN APAP, ondansetron, and tramadol.

February 6, 2017

During a morning medical staff meeting, a psychologist informed the HSA, CD-2, APP, and a visiting IHSC Associate Medical Director (AMD) that Mr. RAYSON was looking bad and should not be in SMU. The APP recommended hospitalization, but CD-2 countered that recommendation and ordered additional pain medication; oxycodone/APAP 7.5 mg/325 mg two tablets, PRN, three times (TID) a day, for 10 days. The AMD commented that Mr. RAYSON needed to get released or get access to a higher level of care. A medical provider did not evaluate Mr. RAYSON and he remained in SMU.

At approximately 9 a.m., Mr. RAYSON complained to an RN during segregation rounds that he needed something for his pain. He complained of weakness and constant 10/10 neck and head pain that was worsening and not relieved with the current treatments. The RN observed that Mr.

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RAYSON was ill appearing, lying on the bed, and weak when he repositioned himself. Mr. RAYSON received PRN tramadol. The RN informed the HSA, Assistant HSA (AHSA), and CD-2 about Mr. RAYSON's deteriorating status. CD-2 ordered the additional pain medication noted above, and the clinic administrators informed the RN that they were collaborating with ICE to deport Mr. RAYSON by commercial air.

At approximately 11:45 a.m., a psychiatrist evaluated Mr. RAYSON. Mr. RAYSON stated that he did not need psychotropic medications, because he was doing well emotionally and had no problems with sleeping or appetite. He also reported that his pain was manageable with his current medications.

At approximately 12 p.m., Mr. RAYSON asked a DO to call medical because he had lower back pain. [Investigator's note: There is no documentation in the medical record or SMU log that demonstrates a response to this request.]

At approximately 3 p.m., Mr. RAYSON received oxycodone/APAP. [Investigator's note: CD-2 prescribed this medication for PRN administration; however, the medication was transcribed onto the medication administration record, and administered by nurses, for routine administration TID at 9 a.m., 3 p.m., and 9 p.m.]

The HSA emailed the following SDI list update to IHSC headquarters: "Complaining of increased pain; MD and [APP] are addressing problem."

At approximately 8 p.m., Mr. RAYSON showered. At approximately 9 p.m. he received PRN Tramadol and oxycodone/APAP.

February 7, 2017

At approximately 5 a.m., Mr. RAYSON received PRN tramadol. He also refused his breakfast because he did not get a no meat tray as requested.

The HSA emailed the following request to the AFOD: "Since he wants to go home and his condition seems to be worsening, any chance for a commercial flight?"

During segregation rounds at approximately 8:30 a.m., Mr. RAYSON complained of 9/10 lower back pain and light headedness that was aggravated with any physical activity. He reported the oxycodone/APAP helped relieve the pain. The RN observed that Mr. RAYSON walked across his cell to the door.

At approximately 9 a.m., and 3 p.m., Mr. RAYSON received oxycodone/APAP. At approximately 9:52 p.m., the pill-line nurse entered Mr. RAYSON's SMU cell to administer his 9 p.m. medications (including oxycodone/APAP) because Mr. RAYSON had difficulty

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standing up and was too weak to walk to the door. The nurse stated Mr. RAYSON's lips were not dry or cracked at this time, and he did not complain of vomiting.

February 8, 2017

At approximately 4:42 a.m., the SMU DO informed medical staff that Mr. RAYSON was in pain. At approximately 4:45 a.m., the pill-line nurse, detention supervisor and DO entered Mr. RAYSON's cell to administer PRN tramadol, because he was unable to walk to the cell door.

At approximately 6:50 a.m., Mr. RAYSON was transported to the medical clinic for laboratory tests. The following labs were drawn (fasting): CMP and Ca. A PTH was ordered but not submitted to the lab. The RN who drew Mr. RAYSON's labs stated his condition did not appear appreciably different from when she cared for him in the MHU.

At approximately 6:50 a.m., Mr. RAYSON was transported to the medical clinic via wheelchair for laboratory tests. The following labs were drawn (fasting): CMP and Ca. A PTH was ordered but not submitted to the lab. On February 9, 2017, the laboratory results were received and WNL except: Ca ionized 6.4; Ca 11.7; chloride 93; and glucose 112.

During morning shift change report, the night shift pill-line nurse reported that the last time she administered Mr. RAYSON's medication, it took three people to sit him up in his cell because of his weakness, pain and vomiting. Other nurses also commented that they observed similar issues with Mr. RAYSON over the past several days.

During SMU rounds at approximately 8:30 a.m., an RN noted Mr. RAYSON had no complaints.

At approximately 9 a.m., 3 p.m., and 9 p.m., Mr. RAYSON received oxycodone/APAP. He also received PRN ondansetron at approximately 9 p.m.

A request was sent from IHSC HQ to LDF to send a copy of Mr. RAYSON's medical records and his attending physician contact information to the IHSC DAD of HCC because the IHSC Medical Director/Acting Assistant Director requested a review of Mr. RAYSON's care. [Investigator's note: The DAD of HCC did not receive the requested medical records and did not review them in the IHSC electronic health record system. The DAD of HCC based a report/summary of Mr. RAYSON's care, dated March 6, 2017, on a summary of care and SDI reports written by LDF staff. Of note, there was no mention in this report of where Mr. RAYSON was housed while in LDF.]

February 9, 2017

During SMU rounds at approximately 5:45 a.m., an RN noted Mr. RAYSON had no complaints. At approximately 6 a.m., Mr. RAYSON received PRN tramadol and ondansetron.

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CD-2 reviewed Mr. RAYSON's BID finger stick glucose logs and lab results. CD-2 made the following medication changes: start glipizide 5 mg, at noon; stop tramadol 100 mg, every six hours, PRN; start tramadol 50 mg, every six hours, PRN; stop indomethacin; start alendronate sodium 5 mg, every morning (for hypercalcemia); stop HCTZ. Repeat labs were ordered for February 15, 2017, and follow up with the physician in two weeks.

At approximately 9 a.m., 3 p.m., and 9 p.m., Mr. RAYSON received oxycodone/APAP.

At approximately 10:08 a.m., Mr. RAYSON showered. At approximately 12 p.m., he refused lunch.

February 10, 2017

During SMU rounds at approximately 10:30 a.m., an RN noted Mr. RAYSON complained of chronic pain.

At approximately 9 a.m., 3 p.m., and 9 p.m., Mr. RAYSON received oxycodone/APAP.

At approximately 1:20 p.m., CD-2 ordered promethazine suppository 25 mg BID PRN, and Boost supplement BID. [Investigator's note: The indications for why this order was written are not documented in Mr. RAYSON's medical record.]

At approximately 5:43 p.m., Mr. RAYSON refused his dinner because of feeling ill. He also refused a shower at approximately 8:02 p.m.

February 11, 2017

At approximately 6 a.m., Mr. RAYSON received PRN ondansetron.

At approximately 7:32 a.m., the SMU CO notified medical that Mr. RAYSON was crying.

During SMU rounds at approximately 8:52 a.m., an RN noted Mr. RAYSON had no complaints.

At approximately 9 a.m. and 3 p.m., Mr. RAYSON received oxycodone/APAP.

At approximately 4:10 p.m., the evening pill-line nurse noted Mr. RAYSON's blood sugar fingerstick was 64 (low). The nurse did not administer Mr. RAYSON's 4 p.m. diabetes medication and gave him a Boost supplement to drink. Mr. RAYSON reported he was unable to hold anything down because of nausea and vomiting. He also complained of severe 10/10 pain "all over" and nothing relieved his pain. The nurse administered PRN ondansetron, tramadol, and APAP, and notified an RN.

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At approximately 4:30 p.m., an RN evaluated Mr. RAYSON in his SMU cell. He complained of severe 10/10 pain, vomiting, and weakness. His lips were dry and cracked, his appearance was poor and fragile. He appeared notably weaker from the last time the RN saw him a week before. Mr. RAYSON's cell smelled of urine, there was a half-filled bucket of vomitus, and vomitus on the floor. Mr. RAYSON was lifted into a wheelchair, because he was too weak to transfer himself, and transported to the medical clinic. His VS were: T 98.9, P 111, R 22, BP 112/78, and weight 167 lbs. (a 12-lb. weight loss since January 28, 2017). The RN notified an APP of Mr. RAYSON's condition and he was transferred to LaSalle General Hospital (LGH) via ambulance at approximately 5:45 p.m.

Mr. RAYSON was admitted to LGH with diagnoses of dehydration, hypercalcemia, and possible sepsis.

February 13, 2017

BOP responded to the February 2, 2017 LDF medical records request. They did not have a pathology report. The following was the oncologist's impression and recommendations:

Mr. RAYSON is a 47-year-old man with a diagnosis of [deleted by BOP] and [deleted by BOP associated Burkitt's lymphoma with high risk disease features at diagnosis [bulky adenopathy, multiple sites of disease, bone marrow involvement and high LDH]. He has so far received only I cycle of Hyper-CVAD with IT MTX and has been without treatment for the past 3 months. The optimal treatment of Burkitt's lymphoma using Rhyper-CVAD is for the delivery of 8 cycles of hyper-CVAD alternating with methotrexate and hi dose [illegible] with IT chemotherapy given every 21 days...He needs to be started on therapy very soon since he was at high risk of disease progression due to the delay in his treatment. His case is further complicated by his social situation and impending deportation. Starting cycle 2 with Methotrexate and high dose cytarabine in the next week or so will render cytopenic at the time of his deportation [illegible] put him at a risk of infectious complications, serious bleeding complications and potential fatal outcome if he has no access to health care at that time. Due to this I am very hesitant to initiate chemotherapy at this point if appropriate follow up and access to medical care cannot be guaranteed. I plan on corresponding with [BOP physician] of the FMC regarding these concerns.

February 12-15, 2017

Mr. RAYSON's condition slowly improved while hospitalized. He was weak, but able to ambulate to the bathroom. He had less vomiting and tolerated clear liquids.

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February 16, 2017

Mr. RAYSON developed an altered mental status and pulled his IV line out.

February 17, 2017

A CT scan of his brain showed that Mr. RAYSON had a 1-centimeter subdural hematoma in his right frontal parietal lobe which was compressing on the right lateral ventricle. (A subdural hematoma is a collection of blood outside the brain. Subdural hematomas are usually caused by severe head injuries. The bleeding and increased pressure on the brain from a subdural hematoma can be life-threatening.)

February 18, 2017

On February 18, 2017, Mr. RAYSON was transferred to Tulane Medical Center (TMC) via air transport and admitted for a chronic (non-traumatic) right subdural hematoma with midline shift. The same day he underwent a burr hole procedure to evacuate the hematoma. (Burr holes are small holes that a neurosurgeon makes in the skull. Burr holes are used to help relieve pressure on the brain when fluid, such as blood, builds up and starts to press on brain tissue.)

February 19-21, 2017

There were no complications during Mr. RAYSON's hospitalization at TMC and he was discharged back to LGH on February 21, 2017.

February 22-27, 2017

Mr. RAYSON's condition was stable and he continued to receive treatment for a non-traumatic subdural hematoma and sepsis (bacterial infection) secondary to unspecified staphylococcus.

February 28, 2017

Mr. RAYSON's mental status changed. A CT scan revealed a re-accumulation of the subdural hematoma. An LGH nurse reported that Mr. RAYSON fell a few days earlier. LGH hoped to transfer Mr. RAYSON back to TMC, but TMC did not accept him.

February 29-March 3, 2017

Mr. RAYSON remained at LGH and his condition continued to deteriorate.

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March 4-9, 2017

Mr. RAYSON was transferred to Lafayette General Hospital and admitted to the intensive care unit (ICU) for treatment of sepsis. During this hospitalization, his condition did not improve appreciably. He remained lethargic and was unable to swallow. Despite continued antibiotic treatment, he had a fever. A repeat CT scan showed the subdural hematoma was stable.

March 10-12, 2017

Mr. RAYSON was placed on "Do Not Resuscitate" status. He was not deemed a candidate for systemic therapy to treat his lymphoma and sepsis, and he received palliative care consisting of IV antibiotics and morphine for pain. His condition continued to deteriorate.

March 13, 2017

At 3:20 p.m., Mr. RAYSON went into cardiac arrest and died.

Cause of Death

Immediate cause: remote subdural hemorrhage due to unknown factors.

Underlying causes:

- Hypertensive atherosclerotic cardiovascular disease
- Diabetes mellitus
- Complications of HIV

Manner of Death

Could not be determined [Investigator's note: The medical examiner (ME) could not determine the manner of death, i.e., natural causes, accident, homicide, suicide, because the ME could not determine what event(s) caused the subdural hematoma.]

Strengths and Best Practices

The reviewers could not determine whether the care provided to Mr. RAYSON by LDF staff directly or indirectly contributed to his death, because the manner of his death was undetermined.

During this review, it was readily apparent that the LDF staff are earnest and dedicated professionals. Additional program strengths included: ERO providing advanced notification to LDF of Mr. RAYSON's pending release from BOP and his serious medical conditions; and LDF's MHU where a detainee can receive skilled nursing care 24/7.

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Weaknesses, Lessons Learned, and Process Improvement Recommendations

ICE detention standards used for this review: PBNDS 2011.

1. Continuity of care.

Mr. RAYSON did not receive access to appropriate and timely continuity of care in accordance with PBNDS 2011 standards and IHSC policies.

Five weeks prior to Mr. RAYSON's pending release from BOP, ERO notified the LDF HSA and CD. However, they did not take appropriate steps to ensure Mr. RAYSON had access to appropriate and timely continuity of care upon intake into ICE custody. Although indicated, the LDF HSA and CD did not request additional medical information from the BOP and CD-1 medically cleared Mr. RAYSON for admission into LDF, based solely on the information contained in the BOP medical summary. ERO provided LDF with a medical summary that did not list HIV and AIDs as medical problems, even though this summary listed numerous HIV related medications and a diagnosis of Burkitt's lymphoma (an AIDs defining condition). In addition, Burkitt's lymphoma is a cancer known for rapid progression and the medical summary was silent about the status of Mr. RAYSON's treatment for this condition. Based on the information contained/omitted from the medical summary, additional information was needed to determine whether LDF had sufficient health care resources in the facility and community to support Mr. RAYSON's medical needs.

Had additional information been obtained in advance of Mr. RAYSON's arrival, it would have shown that he did not receive appropriate care for his cancer while in BOP custody. In addition, according to the BOP hematologist/oncologist, Mr. RAYSON was at high risk for disease progression, he needed to restart chemotherapy as soon as possible, and because of the potential complications associated with chemo, the hematologist/oncologist recommended that Mr. RAYSON should not receive this treatment while in a short-term custody status. Had this information been known in advance, LDF medical staff could have shared it with ERO for consideration in expediting Mr. RAYSON's ICE processing and return to Jamaica. Mr. RAYSON stated he was already in communication with a physician in Jamaica who was willing to resume the recommended chemotherapy. Also, the HSA and/or CD-1 did not inform their staff about Mr. RAYSON's pending transfer and impeded LDF's ability to better prepare for his arrival.

On January 28, 2017, actions were not taken to ensure Mr. RAYSON received timely continuity of his pain medication and medical diet while housed in MHU awaiting an APP evaluation. At approximately 3:40 a.m., an APP was notified telephonically about Mr. RAYSON's arrival, medical conditions, medications, and current status (i.e., 9/10 pain). In response, the APP only ordered Mr. RAYSON housed in the MHU until evaluated by an APP (sometime after 7 a.m. that morning) and did not give orders for continuity of pain medication, or a diabetic diet in the interim. An RN did administer oxycodone/APAP to Mr.

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RAYSON; however, this was done without appropriate authorization (see discussion below about medication management).

On January 30, 2017, an APP wrote an order to obtain additional medical records from BOP. This order was not implemented.

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; sections II.5, II.6, II.8, II.13, II.20, and V.Z.
- IHSC Directive: 03-16 (Effective March 25, 2016), Medication Administration; section 4-2.c.

2. Medication management.

LDF staff did not prescribe and administer medications to Mr. RAYSON in accordance with PBNDS 2011 standards, IHSC policies, and DEA regulations.

On January 28, 2017, an RN administered oxycodone/APAP to Mr. RAYSON without an order from a medical provider. The RN believed he was authorized to administer this medication to Mr. RAYSON without an LDF medical provider order, because Mr. RAYSON arrived at LDF with a BOP medical transfer summary listing the medication and the medication arrived with Mr. RAYSON as well. IHSC does not authorize this practice and requires that all administered prescription medications must have an order from an authorized prescriber.

Frequently, nursing staff administered PRN medications without noting in the medical record the subjective and/or objective findings to support administration of the medication, e.g., complaints of nausea or pain. In addition, nursing staff frequently did not document appropriate timely monitoring of Mr. RAYSON's response to PRN medications administered, e.g., the patient's response within one hour of administration.

On February 2, 2017, CD-2, who was present in the clinic, gave a verbal order to an RN to administer a dose of Morphine 30 mg, orally, to Mr. RAYSON, and to obtain the medication from another patient's supply. An order for this medication was not written in Mr. RAYSON's medical record, nor did CD-2 complete a wet-ink hard copy of this controlled substance prescription. These actions were not in accordance with IHSC policy and DEA regulations.

On February 3, 2017, an APP gave a verbal order for medication, even though the APP was present in the clinic and it was not an emergency.

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On February 6, 2017, CD-2 wrote an order for oxycodone/APAP 7.5 mg/325 mg two tablets, PRN, TID, for 10 days. This order was incorrectly transcribed on to the MAR as TID, with regularly scheduled administration times at 9 a.m., 3 p.m., and 9 p.m.

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; sections II.20, V.A.2., V.G.
- IHSC Directive: 03-16 (Effective March 25, 2016), *Medication Administration*; section 4-2.c.
- IHSC Medication Administration Guide (Effective March 13, 2015); sections I.A., II., III.
- IHSC Directive: 09-02 (Effective March 25, 2016), Pharmaceutical Services and Medication Management; sections 4-1.f.(5), 4-5.c.

3. Access to an appropriate level health care provider.

Mr. RAYSON did not receive timely and appropriate referral to an appropriate level health care provider in accordance with PBNDS 2011 standards.

On January 28, 2017, an APP attempted to consult with CD-1 by telephone; however, CD-1 was unavailable and the CD's voice mailbox was full. The APP did not attempt to notify the HSA of CD-1's unavailability to receive instructions for an alternate CD to consult with.

On January 29, 2017, at approximately 10 p.m., Mr. RAYSON's VS were abnormal (P 125, BP 97/64). An RN acknowledged Mr. RAYSON's increased P and low BP and noted that he was ill-appearing, but did not have chest pain or shortness of breath. He was encouraged to relax and was given two tablets of oxycodone/APAP 5 mg/325 mg for pain. Although indicated, his VS were not rechecked, and a medical provider was not consulted.

On February 2, 2017, Mr. RAYSON was discharged from the MHU for placement in GP. It was inappropriate to discharge Mr. RAYSON from the MHU because he required skilled nursing care.

APPs informed CD-2 that they did not feel comfortable caring for Mr. RAYSON and wanted CD-2 to assume primary responsibility for Mr. RAYSON's medical management. CD-2 remained in a consultant/CD role.

On February 6, 2017, a psychologist informed the HSA, CD-2, APP, and IHSC AMD that Mr. RAYSON was looking bad and should not be housed in SMU. In response to this report, a medical provider did not evaluate Mr. RAYSON and he remained in the SMU.

Although APPs repeatedly recommended transferring Mr. RAYSON to a hospital, CD-2 persisted in managing Mr. RAYSON at LDF. Mr. RAYSON's condition warranted transfer to a higher level of care prior to February 11, 2017.

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Throughout Mr. RAYSON's detention at LDF, nursing staff regularly reported during shift change about Mr. RAYSON's deteriorating health status. In response to these reports, LDF clinic administration (HSA, AHSA, and CD-2) focused their efforts on communicating to EROthe need to deport Mr. RAYSON as soon as possible. LDF clinic administration did not ensure Mr. RAYSON received an appropriate level of care while he was detained, e.g., housing in MHU, appropriate monitoring and treatment planning, and timely referral to a hospital or another facility that had community resources to support Mr. RAYSON's medical needs.

Applicable standards of care for this finding:

PBNDS 2011: 4.3, Medical Care; sections II.8, V.A.2., V.A.7.

4. Access to appropriate medical care.

Mr. RAYSON did not receive timely and appropriate access to medical care accordance with PBNDS 2011 standards.

On January 31, 2017, from approximately 6 a.m. to 1 p.m., Mr. RAYSON complained of moderate (5/10) to severe (9/10) pain. In the morning, APPs referred ordering stronger/narcotic PRN pain medication to CD-2. CD-2 ordered tramadol at approximately 1:42 p.m.

On February 2, 2017, Mr. RAYSON was weak, ill-appearing, and had uncontrollable pain. The IHSC ID consultant noted that Mr. RAYSON was at risk for dehydration and may need IV fluid administration. Despite these indications for remaining in MHU for skilled nursing care/monitoring, CD-2 discharged Mr. RAYSON to GP.

CD-2 did not review Mr. RAYSON's abnormal urinalysis results that were reported on February 2, until February 6, 2017. CD-2 did not develop an appropriate treatment plan in response to these abnormal results which indicated Mr. RAYSON may have been dehydrated.

CD-2 stated that he evaluated Mr. RAYSON numerous times while he was in MHU, but he did not document these encounters in the medical record. CD-2 did not examine or observe Mr. RAYSON after he discharged him to GP on February 2, 2017. CD-2's care and treatment planning throughout Mr. RAYSON's LDF detention, as evidenced by the medical record, appears as if CD-2 deliberated Mr. RAYSON's care from afar without examining the patient when indicated and requested by the APPs.

On February 3, 2017, an APP evaluated Mr. RAYSON in SMU for complaints of uncontrolled pain and nausea. The APP did not document this evaluation in Mr. RAYSON's

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medical record. It is incumbent on all health care professionals to document the care they provide.

On February 6, 2017, a psychologist informed CD-2 and an APP that Mr. RAYSON "was looking bad" and should not be housed in SMU. A medical provider did not examine Mr. RAYSON.

Although APPs repeatedly recommended transferring Mr. RAYSON to a hospital, CD-2 persisted in managing Mr. RAYSON at LDF. Mr. RAYSON's condition warranted transfer to a higher level of care prior to February 11, 2017.

Applicable standards of care for this finding:

PBNDS 2011: 4.3, Medical Care; sections II.8, V.A.2.

5. Access to appropriate nursing care.

Mr. RAYSON did not receive timely and appropriate access to nursing care accordance with PBNDS 2011 standards and IHSC policies.

Nursing staff did not develop a nursing plan of care for Mr. RAYSON during his MHU admission. Based on Mr. RAYSON's condition, a nursing care plan should have included at a minimum appropriate monitoring and interventions to ensure adequate nutrition, pain management, hygiene, and safety.

While Mr. RAYSON was admitted to MHU, nursing staff did not routinely document Mr. RAYSON's ability to engage in activities of daily living, e.g., how much did he eat/drink, hygiene, toileting, or recreation. Some nursing staff reported they were unable to provide skilled nursing care in MHU to support assistance with bathing because the beds could not be elevated to a level where nursing staff could perform bed baths without injuring their backs. In addition, the nurses reported the MHU beds could not be adjusted (e.g., elevate head or foot of the bed) to improve patient comfort.

On January 29, 2017, Mr. RAYSON's VS were abnormal (P 125, BP 97/64). The RN caring for Mr. RAYSON did not monitor/repeat VS to determine if they returned to within normal limits, or consult with a medical provider.

On January 30, 2017, an APP wrote an order for every two hours VS. Nursing staff did not document taking VS every two hours.

On February 1, 2017, at approximately 6:41 a.m., Mr. RAYSON complained of 8/10 pain. At

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approximately 12:46 p.m., Mr. RAYSON complained of 7/10 pain with nausea and vomiting. Nursing staff did not administer PRN tramadol for pain or ondansetron for nausea. Mr. RAYSON did not receive medication for pain or nausea until approximately 4:30 p.m.

On February 1, 2017, nursing staff performed a dip urinalysis and the results were abnormal (showed Mr. RAYSON may have been dehydrated). Nursing staff did not immediately notify a medical provider about these abnormal results.

On February 2, 2017, at approximately 5:44 a.m., an RN noted Mr. RAYSON complained of 10/10 severe, knife-like pain, and nothing completely relieves his pain. The RN did not administer PRN ketorolac and diphenhydramine IM that was ordered for pain control. At approximately 10:45 a.m., Mr. RAYSON complained of severe 7/10 pain. An RN administered PRN APAP 325 mg for pain, but did not administer PRN ketorolac and diphenhydramine IM that was ordered for pain control or PRN ondansetron that was ordered for nausea. At approximately 1:30 p.m., Mr. RAYSON received tramadol 100 mg. At approximately 2 p.m., Mr. RAYSON received morphine 30 mg.

From February 3-4, 2017, while Mr. RAYSON was housed in the SMU, he had an order for PRN tramadol, every six hours. On February 3, 2017, nursing staff did not administer tramadol. However, at approximately 4:30 p.m., nursing staff contacted an APP about Mr. RAYSON's 10/10 pain and received an order for a one-time dose of ketorolac 60 mg and Phenergan 25 mg IM, which was administered. On February 4, 2017, Mr. RAYSON received one dose of PRN tramadol at 10:30 a.m.

On February 6, 2017, at approximately 12 p.m., Mr. RAYSON complained of pain and a SMU CO notified medical. There is no evidence in SMU logs or Mr. RAYSON's medical record to demonstrate a response to this notification. CD-2 wrote an order for PRN oxycodone/APAP 7.5 mg/325 mg two tablets, every six hours, at approximately 8:37 a.m. Mr. RAYSON did not receive this pain medication until approximately 3 p.m.

Generally, when nursing staff administered PRN pain medications or anti-nausea medications, they did not document Mr. RAYSON's symptoms that warranted administering these medications. In addition, they did not reevaluate Mr. RAYSON within an hour to determine if the medication relieved his symptoms.

Nursing staff observed Mr. RAYSON's deteriorating status while in SMU and reported it verbally during shift reports; however, they did not routinely document these observations in his medical record or during SMU rounds.

Applicable standards of care for this finding:

PBNDS 2011: 4.3, Medical Care; sections II.8, V.A.2.

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- IHSC Directive: 03-17 (Effective March 25, 2016), Medical Housing Units; section 5-3 c
- IHSC Medication Administration Guide (Effective March 13, 2015); section II.

6. Access to appropriate mental health care.

Mr. RAYSON did not receive timely and appropriate access to mental health care in accordance with PBNDS 2011 standards and IHSC policies.

During Mr. RAYSON's February 28, 2017 health assessment and physical examination, an APP noted Mr. RAYSON was depressed. The APP did not refer Mr. RAYSON to mental health.

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; sections II.1., V.A.2., V.O.1.b., V.O.3.
- IHSC Behavioral Health Services Guide (Effective March 25, 2016); sections VII., VIII.

7. Patient advocacy.

LDF professional health care staff did not advocate in a timely and appropriate manner for Mr. RAYSON to receive necessary and appropriate health care in accordance with PBNDS 2011 standards and their licensed health care professional duty of care.

On January 31, 2017, RNs and an APP reported that Mr. RAYSON was in moderate to severe pain (5-9/10) from approximately 5:44 a.m., until 12:43 p.m. During this period, Mr. RAYSON did not receive any PRN pain medication because the RNs and APP were awaiting an order for narcotic pain medication from CD-2. This order was not written until 1:42 p.m. Nursing staff and/or the APP did not take additional steps to advocate for Mr. RAYSON so an order for PRN pain medication was written in a timely manner.

On February 2, 2017, an RN medically cleared Mr. RAYSON for the SMU even though he observed Mr. RAYSON "looked like he needed to be in a hospital." The RN cleared Mr. RAYSON because CD-2 just released him from the MHU to GP, and if custody could not house Mr. RAYSON in GP, "then he had to go somewhere." The RN did not take additional steps to advocate for a more appropriate placement for Mr. RAYSON, e.g., notifying CD-2 that Mr. RAYSON was not housed in GP as ordered, and/or notify up the chain of command if CD-2 assented to this placement.

LDF health care administrators frequently advocated for Mr. RAYSON's rapid deportation, which was indicated. However, they did not take steps to ensure he received appropriate care while in detention. The LDF HSAs did not visit with Mr. RAYSON, even though he was

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listed on the SDI list and on February 6, 2017, a psychologist raised concerns about Mr. RAYSON's deteriorating status in SMU.

LDF health care administrators stated they did not have a local community physician to consult with and arrange direct admissions to local hospitals. In addition, the administrators stated the local hospitals did not want to care for detainees and usually returned them after brief evaluation and treatment in the ER, rather than admit the detainees to the hospital. Considering these challenges, LDF administrators did not take proactive steps to identify community resources to overcome these challenges or make arrangements for Mr. RAYSON's transfer to a detention facility with community resources that could meet Mr. RAYSON's needs.

On February 8, 2017, the IHSC Medical Director/Acting AD requested the DAD of HCC to review the care Mr. RAYSON received at LDF. The DAD of HCC did not conduct an independent review of Mr. RAYSON's medical records and relied on summaries and reports created by LDF staff.

Applicable standards of care for this finding:

PBNDS 2011: 4.3, Medical Care; sections II.1., II.6.

8. Special monitoring unit.

Mr. RAYSON did not receive appropriate access to SMU health care monitoring in accordance with PBNDS 2011 standards and IHSC policies.

On February 2, 2017, an RN medically cleared Mr. RAYSON for placement into the SMU without consulting a medical provider, even though the RN believed this placement was medically contraindicated.

During SMU rounds on February 3, 4, 5, 8, 9, and 11, 2017, RNs documented that Mr. RAYSON had no medical complaints, was in no acute distress, he was well developed and well nourished. They also noted that he did not appear to have any acute or unresolved medical conditions that may worsen in segregation. The quality of these observations are suspect considering reports from nursing staff during shift change meetings and interviews to the contrary, and other records documenting Mr. RAYSON's deteriorating status.

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section II.27.
- PBNDS 2011: 2.12, Special Management Units; sections II.7., V.P.
- IHSC Directive: 03-06, Health Evaluation of Detainees in Special Management Units (SMU) (Effective March 24, 2016); sections 4-1.a.(1), 4-2.a.

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Recommendations

- Forward these findings to the IHSC DAD of HCC.
- The IHSC DAD of HCC will share these findings through appropriate communication channels to ICE, the LDF administrator and health authority for review and to create a corrective action plan (CAP).
- The respective IHSC HCC Unit and ICE will ensure the CAP is implemented and sustained.

Detainee Death Review: Roger RAYSON, (b)(6); (b)(7)(C) Medical and Security Compliance Analysis LaSalle Detention Facility, Jena, Louisiana

As requested by the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU), Creative Corrections participated in a review of the death of detainee Roger RAYSON while in the custody of the LaSalle Detention Facility, Jena, Louisiana. A site visit was conducted April 11 through 13, 2017 by (b)(6); (b)(7)(C) RAU Inspection and Compliance Specialist and team leader; (b)(6); (b)(7)(C) Inspection and Compliance Specialist; Creative Corrections contract personnel (b)(6); (b)(7)(C) Program Manager for the ICE/OPR contract; (b)(6); (b)(7)(C) Security Subject Matter Expert; and (b)(6); (b)(7)(C) Registered Nurse, Medical Subject Matter Expert. Contractor participation was requested to determine compliance with the ICE Performance Based National Detention Standards (PBNDS) 2011 governing medical care and security operations.

Included in this report is a case synopsis, description of the facility and its medical services, detention summary, a narrative review of events, and conclusions. RAYSON's vital signs documented during medical encounters are appended. The information and findings herein are based on analysis of detainee RAYSON's medical record and detention file, tour of the medical area and housing units, interviews of staff, and review of policies, video surveillance recordings, and available incident related documentation.

SYNOPSIS

Roger RAYSON was transferred to ICE from the Federal Bureau of Prisons and admitted to the LaSalle Detention Facility (LDF) on January 28, 2017. He was 47 years old. RAYSON arrived with a lengthy medical transfer summary and multiple medications for conditions that included cancer, HIV, diabetes, and hypertension. Medications for these conditions were continued, as were medications for ongoing pain.

RAYSON was placed in a cell in the medical housing unit prior to completion of the intake process. The day after his arrival, he was sent to a hospital emergency room due to his declining health. He returned to LDF within hours and was reassigned to the medical housing unit. Five days later, a physician directed his release to general population housing. Because RAYSON disclosed his medical diagnoses to other detainees, he was quickly removed from the housing unit and, upon clearance for segregation by a nurse, was placed on protective custody in the Special Management Unit. Over the course of the next nine days, his condition deteriorated and on February 11, 2017, he was sent to the local hospital. RAYSON was moved to different hospitals on two occasions and did not return to LDF prior to his death on March 13, 2017.



An autopsy was conducted on July 10, 2017. According to the pathologist's report, primary findings showed evidence of remote subdural hemorrhages, causing a traumatic brain injury. Contributing factors of obesity, hypertensive atherosclerotic cardiovascular disease, meningitis and complications of HIV were cited. The manner of death was undetermined pending further investigation.

There is no documentation detainee RAYSON sustained an injury caused by assault or other means while at LDF.

FACILITY DESCRIPTION

LDF is operated by the GEO Group, Inc. (GEO) of Boca Raton, Florida. On October 30, 2006, the LaSalle Economic Development District (LEDD) announced procurement for the operation and management of a detention facility. GEO was awarded the contract on July 25, 2007, and under an Intergovernmental Service Agreement, contracted with ICE for 1160 beds.

The first detainees were admitted on October 22, 2007. The facility was initially accredited by the American Correctional Association in 2009, and most recently reaccredited on February 9, 2015. LDF houses both male and female detainees and has a design capacity of 1335. On March 13, 2017, the date of RAYSON's death, the total detainee population was 1121.

A double fence with razor wire along the top encircles the LDF perimeter. Visitors must enter through a secure external sallyport, the gates to which are operated by officers in the central control center. Once inside the gates, visitors must display identification and pass through a metal detector before being permitted entry into the secure section of the facility. Personal items must be placed on a belt for screening through an X-ray machine. Video surveillance cameras are used throughout the facility to monitor and record events.

MEDICAL SERVICES

Healthcare is provided 24 hours a day, seven days a week by Immigration Health Services Corp (IHSC) and contractor InGenesis Medical Staffing headquartered in San Antonio, Texas. InGenesis subcontracts with STG International, Incorporated (STG) based in Alexandria, Virginia. IHSC personnel who are commissioned officers of the Public Health Service include the Health Services Administrator (HSA), Assistant HSA, Nurse Manager, three registered nurses (RN), a dentist, pharmacist, program manager, and a mental health professional. In addition, an IHSC physician employed under the General Schedule for Federal Pay serves as Clinical Director. The December 22, 2016 contractor staffing plan lists 49 positions, including a staff physician, five midlevel providers, 17 RNs, ten licensed practical nurses (LPN) and licensed vocational nurses (LVN), one psychiatrist, two mental health professionals, a pharmacist, two



pharmacy technicians, six medical records technicians, two radiology technicians, one dental assistant, and an administrative assistant. Additionally, two RNs and two LPN/LVNs provide services on an as needed, per diem basis. Review of the current employee list against the staffing plan found no vacancies.

According to (b)(6); (b)(7)(C)	HSA, the contractor staff physicia	n was hired
after detainee RAYSON's death. (b)(6); (b)(7)(C)		was present
at LDF on a limited basis during RAYSON's de	tention due to family medical leave.	He returned
a week prior to the site visit and was interviewed	ed for this review. IHSC physician	(b)(6); (b)(7)(C)
provided rotational coverage during (b)(6); (b)(7)(C)	absence.	

IHSC's electronic medical record system, e-Clinical Works (eCW), is used at LDF. It is noted that unless indicated, the times of medical encounters identified in this report are the times nurses and providers electronically entered their notes, per system-produced timestamps. The times encounters were actually conducted is not available unless documented in the notes.

DETENTION SUMMARY

Detainee RAYSON filed no grievances and had no disciplinary violations. Because he had no funds, he filed one request for a free phone call to his family, which was denied. When approved by a physician for release from medical housing, he was briefly assigned to a general population housing unit. He was moved to the Special Management Unit for protective custody when detainees in the general housing unit objected to his placement. Medical staff cleared RAYSON for segregation and at no time thereafter directed that he be returned to medical housing.

SUMMARY OF EVENTS

The LDF Admission/Release Form documents detainee RAYSON arrived at 2:15 a.m. on Saturday, January 28, 2017. (b)(6); (b)(7)(C) reported during interview that he arrived with one other detainee, and that their arrival was not expected. She commented that unanticipated arrivals are very unusual, especially in the middle of the night. (b)(6); (b)(7)(C) completed medical pre-screening in the intake area at 2:30 a.m., recalling during interview that RAYSON was in a wheelchair and looked very tired. He spoke English, and there were no barriers to communication. (b)(6); (b)(7)(C) acknowledged that officers handed her an envelope containing the medical transfer summary and medications, but she did not open it at the time. (b)(6); (b)(7)(C) stated it was clear RAYSON needed to go to the medical unit; however, she perceived no urgency and because there was a "full tank" of detainees in the medical at the time, she determined RAYSON could remain in intake temporarily. (b)(6); (b)(7)(C) reported that shortly thereafter, officers called to say the detainee was "hurting and crying." She had him brought to

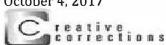
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the clinic pending full medical and mental health intake screening. According to the Medical Housing Unit (MHU) log, detainee RAYSON was placed in the unit at 3:48 a.m. on January 28, 2017. It is noted that the Housing History Grid documents the detainee's initial housing assignment was Eagle Block (unit) A and that he was transferred to the MHU 14 minutes later. Based on staff interviews, the MHU log, and the short period of time the Housing History Grid reflects he was assigned to Eagle Unit A, it is concluded the assignment to Eagle A was based on a preliminary classification of high (see below), prior to the detainee's direct placement in the MHU. There is no information supporting that he was ever physically moved to Eagle Unit A.

The MHU has one double occupancy and five single occupancy cells, all of which have standard metal bunks, mattresses, and security fixtures. There is no general infirmary area. During interview of [b)(6), (b)(7)(C) he stated LDF removed hospital beds from cells in the MHU due to destruction by detainees. Recreation is provided in the yard used by detainees in Falcon unit. Detainee RAYSON was assigned to MHU cell 6, one of the five single occupancy cells. There are two windows in the top half of the cell door, a cot in the middle and a toilet/sink combination fixture on the right side. After detainee RAYSON's placement, the count in the MHU was three detainees. Officers are required to check on each detainee every 30 minutes, electronically recording their rounds by inserting a pipe into a sensor positioned at each cell. Per IHSC Directive 03-17, Medical Housing Units, a provider is to make rounds at least daily; rounds by nursing staff are required at least once per shift. The directive does not detail requirements for nursing rounds with respect to conducting assessments, taking vital signs, or inquiring about a patient's pain level.

documented completion of intake screening at 5:23 a.m. He wrote that RAYSON spoke English and use of interpretation assistance was not needed. With the exception of a high blood glucose level of 233², baseline vital signs were within normal limits. His height was 65.5 inches, and he weighed 179 pounds. (b)(6); documented RAYSON's medical conditions were lymphoma³, diabetes, HIV infection³, hypertension⁵, anemia⁶, gout⁷, arthritis, and gastrointestinal reflux disease (GERD) ⁸, for which he was receiving the following medications:



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¹ The logbook is labeled "SSU" for Short Stay Unit, which at LDF, is used synonymously with Medical Housing Unit (MHU). The area is referred to as MHU in this report.

² Normal blood glucose (sugar) levels are 72-108 when fasting and up to 140 two hour after eating.

³ Lymphoma is cancer of the lymph nodes.

⁴ HIV is the virus that causes Acquired Immune Deficiency Syndrome (AIDS).

⁵ Hypertension is high blood pressure.

⁶ Anemia is a condition caused by low iron levels.

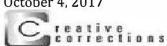
⁷ Gout is a form of arthritis characterized by severe pain, redness, and tenderness in joints.

Shortened to GERD, this condition causes reflux of acid from the stomach into the lower esophagus.

Medication	Purpose
Abacavir	Antiretroviral (ARV)
Acyclovir	ARV
Dolutegravir	ARV
Lamivudine	ARV
Levofloxacin	Antibiotic
Fluconazole	Antifungal
Glipizide	Anti-diabetic
Metformin	Anti-diabetic
Regular Insulin	Anti-diabetic
Allopurinal	Gout treatment
Hydrochlorothiazide	Anti-hypertensive
Lisinipril	Anti-hypertensive
Oxycodone with acetaminophen (Percocet) ¹⁰	Pain treatment as needed
Indomethacin	Anti-inflammation and pain treatment
Acetaminophen	Pain treatment
Enteric-coated aspirin	Pain treatment
Ondansetron	Anti-nausea
Ferrous gluconate	Iron supplement

All medications arrived with detainee RAYSON and were reconciled with the transfer summary provided by the Federal Bureau of Prisons (FBOP), Federal Medical Center (FMC), Lexington, Kentucky. wrote that detainee RAYSON complained of constant, "all over" pain at a level nine on a pain scale of zero to ten, with ten being worst. The medication administration record (MAR) documents that at 3:45 a.m., when he arrived in the clinic, RAYSON was given a dose of Percocet for pain. Administration of this and other medications was authorized per the transfer summary, which states, "All medications to be continued until evaluated by a physician unless otherwise indicated." Due to the abnormal screening results, he was referred to a provider. Medical conditions detailed on the transfer summary are discussed below.

Consistent with (b)(6); (b)(7)(C) comments to the review team, (b)(6); stated RAYSON's arrival was unanticipated. He also shared that he was concerned about the detainee's placement at LDF because the facility cannot provide the level of care necessary for a patient with multiple, serious diagnoses. Although (b)(6); was unaware the detainee was approved for admission, email messages provided to the review team by (b)(6); (b)(7)(C) document clearance for admission was granted. The HSA stated that when he is contacted regarding accepting detainees with serious medical conditions, he consults the Clinical Director who may attempt to defer acceptance, but

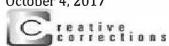


⁹ An antiretroviral is a drug that, in combination with other drugs, prevents the replication of the molecule viral ribonucleic acid (RNA) such as in HIV.

¹⁰ Oxycodone with acetaminophen is the generic form of Percocet. Percocet will used in this report in the interest of brevity.

may or may not succeed. The referenced email traffic is between (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C) who served as LDF's acting Clinical Director
prior to (b)(6); (b)(7)(C) beginning work. Per email dated January 17, 2017 from (b)(6);
(b)(6); (b)(7)(C) "We can accommodate these patient [sic] in our facility if AFOD
concurs." In a preceding email dated December 21, 2016, reference is made to LDF being
provided with FBOP medical summaries of RAYSON and other "subjects set to enter ICE
custody next month." The email requests clearance for housing at LDF which as noted, was
granted by $by^{(b)(6);(b)(7)(C)}$
Although he arrived at 2:15 a.m. on January 28, 2017, detainee RAYSON was not fully booked
into the facility until later that morning. (b)(6), (b)(7)(C) informed the review team that
when detainees are admitted during the night, the booking process is completed on the day shift.
Based on available documentation, reviewers cannot determine what processes were completed
prior to the detainee's transfer from intake to the MHU. The property inventory documents
RAYSON was received with one pair of pants, shirt, socks and underwear, as well as a Visa
card, address book and eyeglasses with case. He had no funds. Documentation reflects he was
issued facility clothing, linens, hygiene supplies, and detainee handbook; also, that he was
fingerprinted and shown the orientation video.
(b)(6): (b)(7)(C) classified detainee RAYSON using the ICE Custody Classification
Worksheet 11. He was rated high; however, review of the worksheet found medium high was the
correct rating. (b)(6): assigned six points in Item 1, Severity of Charge/Conviction Associated
with the ICE Encounter, and another six points in Item 2 for Single Most Serious Conviction.
Although instructions on the worksheet clearly state Item 1 is to be excluded in determining
points for Item 2, Importation of Cocaine was the charge/conviction used for both items. No
other criminal history was documented in the detention file. The rating was never approved by a
supervisor. The sections for recording the language spoken during the interview and Special
Vulnerabilities and Management Concerns were left blank. During interview of (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C) she stated case management staff typically use available information to classify
detainees before they arrive, then intake officers complete the process. It is concluded the
classification of high, determined prior to RAYSON's arrival, was likely applied without follow
up interview because the detainee was moved to the MHU on the midnight shift. It is also
concluded assignment to Eagle Unit A, discussed previously, was entered in the computer
system based on this rating. As noted above, detainee RAYSON was never physically placed in
Eagle Unit A.
(b)(6); (b)(7)(C) documented the initial MHU nursing round at 8:47 a.m. Detainee
(b)(6);(b)(7)(C) documented the initial MHU nursing round at 8:47 a.m. Detainee RAYSON's vital signs were within normal limits, and he reported a decrease in pain to level
two. The general examination found him in no acute distress, well developed, and well nourished, all of which are pre-populated fields in eCW which appear not to have been updated.
His skin, heart, lungs, chest, abdomen, extremities, and mental health status were all recorded as
This skin, near, range, chest, abdomen, extremities, and mental health status were all recorded as

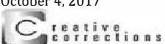
¹¹ The Custody Classification Worksheet is Appendix 2.2.A. of the ICE PBNDS 2011, Custody Classification System.



normal. The nursing plan called for hydration at one to two liters of water per day, encouragement to walk around and socialize with other detainees when outside, and instruction to notify a nurse or security of any needs. The plan also called for placement and locking of his bed at the lowest position to prevent falls. This cannot be explained given the MHU's standard security bunks. A special needs Diet for Health was implemented, and book and monitoring of vital signs every four hours. During interview, book every two hours and monitoring of vital signs every four hours. During interview, book presenting medical conditions and her observation he had a port. The reviewer notes there is no mention of a port in the medical record. In addition, it is noted book book policy.

(b)(6); (b)(7)(C) documented completion of detainee RAYSON's initial health assessment at 11:30 a.m. She entered his vital signs at 10:00 a.m., suggesting she started the health assessment before she documented the findings. The vital signs were normal and unchanged from those recorded by (b)(6); (b)(7)(C) earlier. (b)(6); (b)(7)(C) wrote RAYSON was a 47year old male presenting with multiple diagnoses; also, that she reviewed the lengthy transfer summary received from FMC Lexington. RAYSON told her he was incarcerated for smuggling cocaine and that his family "turned their backs on him." He learned he was HIV positive while in prison in December 2014. In August 2016, while incarcerated at FBOP's D. Ray James Federal Correctional Facility in Folkston, Georgia, a bump on his neck believed to be a cyst was surgically removed at a Florida hospital. RAYSON said the area swelled to "the size of a baseball", at which time he was returned to the hospital where diagnosed with non-Hodgkins lymphoma (Burkitts)¹³. He reported that although he was supposed to have chemotherapy every three weeks, his first and only chemotherapy treatment was sometime in September 2016. He was transferred to FMC Lexington in November 2016. Detainee RAYSON stated a physician in Montego Bay, Jamaica was prepared to treat him following deportation.

documented that during assessment, detainee RAYSON complained of level seven pain to the left upper arm. A review of the MAR found he received Percocet at 11:15 a.m., presumably in response to the reported pain. (b)(6):(b)(7)(C) documented he reported nausea and vomiting, swollen lymph nodes of the neck, and intermittent fatigue. He denied fever, night sweats, and anorexia¹⁴. He also denied past smoking or drug abuse but admitted to a significant history of alcohol abuse, drinking 24 beers per day prior to incarceration. His general appearance was described as alert, in no acute distress, ill-appearing, thin, uncomfortable due to



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 $^{^{12}}$ A port is a small medical appliance installed beneath the skin connected to a vein for venous medication therapy such as for chemotherapy.

¹³ Burkitt's lymphoma is a form of cancer occurring when too many abnormal white blood cells continue to grow and divide, crowding lymph nodes and causing them to swell. It is a very fast-growing cancer, especially for those with compromise immune systems, such as in HIV infection.

¹⁴ Anorexia is loss of appetite.

pain, cooperative, visibly upset, and tearful. Some edema 15 with pain was noted on the right lower scalp area extending up to the right ear. His hair was scarce and patchy, and his cervical nodes 16 were hard and enlarged. A nodule was palpated in an area of tenderness on the left upper forearm. The oral cavity examination found he had several missing molars. There were no abnormal findings for the eyes, nose, sinuses, throat, skin heart, lungs, chest, breasts, abdomen, or back. Mental health assessment found a depressed mood and sad affect. Asked whether she considered referring the detainee to mental health staff due to his depressed mood and sad affect, (15)(6)(17)(15) stated that in retrospect, she probably should have. Asked about his placement at LDF, she commented he required hospice 17 or palliative care 18, and that LDF was not an appropriate placement due to his terminal condition.

The treatment plan is summarized in the table below. Unless otherwise noted in this report, detainee RAYSON received ordered medications throughout the term of detention.

Condition	Treatment	
Diabetes	Enteric-coated aspirin, glipizide, regular insulin per sliding scale ¹⁹ , metformin, accuchecks twice daily, DFH, education on disease process, symptoms of hyperglycemia ²⁰ and hypoglycemia ²¹ , healthy lifestyle, medication and side effects.	
Anemia	Ferrous gluconate	
Hypertension	Hydrochlorothiazide, lisinopril, DFH, continue current plan of care.	
Gastrointestinal Reflux Disease	None at current time.	
Lymphoma	Ondansetron for nausea, hepatitis A vaccine given,	
	oncology referral, Percocet until evaluated by (b)(6); (b)(7)(C) or (b)(6); (b)(7)(C)	
Gout	Indomethacin and acetaminophen as needed.	
HIV	Abacavir, dolutegravir, acyclovir, fluconazole, lamivudine, levofloxacin, infectious disease referral consult.	

²¹ Hypoglycemia refers to lower than normal sugar level in the blood, requiring intake of sugar.



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¹⁵ Edema is an accumulation of excessive fluid in the tissues of the body, causing swelling.

¹⁶ Cervical nodes refer to the lymphatic nodes around the neck.

Hospice is the provision of comfort care for the terminally ill when treatment has stopped and death is inevitable.

¹⁸ Palliative care is the provision of comfort care and support during treatment of the terminally ill.

¹⁹ Sliding scale is Progressive increase in insulin based on pre-defined blood glucose levels.

²⁰ Hyperglycemia refers to excessive levels of sugar in the blood, requiring insulin or medication for normalization.

A Consultation Request and Hospital Transfer Form was completed for oncology²² consultation; however, none was found for the infectious disease consultation. The medical record includes documentation that the Cabrini Cancer Center, to which the oncology referral was directed, requested the pathology report and chemotherapy records before scheduling an appointment. Although the LDF record documents a medical records technician was to request past records, there is no evidence they were ever received or that an oncology consult appointment was scheduled.

Nursing rounds for the remainder of January 28, 2017 are summarized as follows:

Time	RN	Pain Level	Pain Medication	Vital Signs
10:59 a.m.	(b)(6);	Not noted	Yes	Not taken
12:22 p.m.	(0)(1)(0)	9	Yes	Not taken
1:30 p.m.		0	No	Within normal limits
9:04 p.m.		4	No	Within normal limits
9:34 p.m.		8	Yes	Not taken

completed the Prison Rape Elimination Act (PREA) Risk Assessment the day after intake, Sunday, **January 29, 2017**. She stated she recalled detainee RAYSON because he was in a wheelchair, commenting that he appeared to be in pain and was unable to stand up. It is concluded the PREA assessment was not completed until the day following intake because RAYSON was moved to the MHU before admission processing was complete.

(b)(6); (b)(7)(C) saw detainee RAYSON for provider assessment during the morning of January 29, 2017. She entered the encounter in the medical record at 11:22 a.m., although vital signs taken for the encounter were entered at 7:14 a.m. and events following her assessment, detailed below, suggest she saw the detainee earlier than 11:22 a.m. (b)(6); (b)(7)(C) documented, "47 year old male detainee is in MHU for seriously ill condition. He has Burkitt's non-Hodgkins Lymphoma. Requesting to see the judge and be deported. Also wants to be able to talk to his lawyer and family and wants to take a shower and get some fresh clothes. He is most concerned with getting chemotherapy for his disease." Vital signs were within normal limits. The general examination found him ill appearing, thin, visibly upset and tearful, and uncomfortable due to pain. Review of the MAR finds RAYSON was given Percocet at 8:45 a.m. for pain management. Concerning his reported desire to receive fresh clothes, intake documentation reflects he was issued and signed a receipt for jail clothing upon admission. There is no documentation he showered before being moved from intake, or was offered a shower when placed in the MHU.

Following a 10:40 a.m. nursing round documented by (b)(6); (b)(7)(C) she contacted (b)(6): to report detainee RAYSON complained he had not had a bowel movement in three days. (b)(6)

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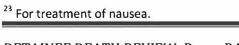
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²² Oncology is a specialty in cancer treatment.

ordered his transport to Rapides Regional Medical Center (RRMC) due to, "ill
appearance, color ashen, declining health."
According to the MHU logbook, detainee RAYSON was moved to intake at 11:15 a.m. for transport to the hospital. An incident report written by (b)(6); (b)(7)(C) documents he was transported by facility van at 11:56 a.m. "for further treatment and evaluation for inflammation of the lymph nodes." RRMC is located approximately 39 miles from LDF. (b)(6); (b)(7)(C) report does not document the time of arrival at the hospital; however, according to the RRMC emergency room record, detainee RAYSON was evaluated at 1:26 p.m. The record documents he was seen for complaints of vomiting, with reported onset that day, and that he was given ondansetron via intravenous (IV) line. Following laboratory and radiology studies, he was discharged at 3:20 p.m. with no new orders. Per the Housing History Grid, he returned at 7:26 p.m. During interview, (b)(6); (b)(7)(C) expressed surprise the detainee came right back, stating she thought he would be admitted. She further commented that RRMC was chosen over LaSalle General Hospital (LGH), the hospital closest to LDF, because LGH often returns patients quickly. According to (b)(6): had a provider been present at the facility, an attempt to intervene may have been made.
return from the emergency room, per order of $(b)(6)$; $(b)(7)(C)$ Her note documents vital signs were within normal limits with the exception of a slightly elevated blood pressure of 131/91. Percocet
was administered at 7:10 p.m. following his complaint of shoulder pain at a level seven. It is
noted the MHU log documents the time of his return to the unit was 7:44 p.m.
RAYSON complained of recurring left shoulder pain at a level six. Vital signs were within normal limits with the exception of an abnormally rapid pulse of 125. (b)(6); (b)(7)(C) documented there was no accompanying chest pain or shortness of breath associated with the rapid heart rate. She encouraged him to "relax" and "maintain a healthy life style." Percocet and indomethacin were administered for pain management.
On Monday. January 30, 2017, detainee RAYSON submitted a request for a free phone call to ask his family to send money for commissary and phone calls because he had no funds. The request noted that detainee RAYSON "can't read nor spell" and that he asked an officer to write the request. The response from (b)(6); (b)(7)(C) dated January 31, 2017 states, "We only conduct attorney calls." On interview, (b)(6); (b)(7)(C) stated detainees are provided with a free three minute phone call during the intake process and thereafter, only legal calls are provided free of charge. Detainee RAYSON's detention file does not document that he was offered or completed a free phone call during intake or at any point during his detention.



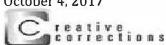


documented completion of a provider round at 9:06 a.m. She said (b)(6); (b)(7)(C) during interview that, "The very first time I put my eyes on this man," it was obvious he should not be at LDF. She indicated she sent an email to (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) so stating. In her medical record entry, she noted laboratory tests completed at the hospital showed abnormal levels of hemoglobin²⁴, hematocrit²⁵, white blood cells, sodium, and lipase²⁶, as well as an elevated calcium level, indicative of a cancerous process. Detainee RAYSON denied vomiting but stated he refused his breakfast tray because food aromas triggered nausea. He was given a different meal upon request of (b)(6), (b)(7)(C) He complained of general pain, mostly in his neck, rating it level seven. Percocet was administered for pain management. His vital signs were identical to those taken the previous night, all within normal limits with the exception of an elevated pulse of 125. (b)(6); (b)(7)(C) noted referral for an oncology consultation was pending approval. New treatment orders included vital signs checks every two hours and reporting of all abnormal readings or significant changes to a provider. The order for provider notification of abnormal vital signs was not forwarded to nursing staff as an electronic action item; therefore,

the instruction was not fulfilled. As discussed below, later in the day, (b)(6); (b)(7)(C)

ordered vital signs checks were to be taken only once per shift.

(b)(6); (b)(7)(C) documented provider rounds at 1:30 p.m. this date, January 30, 2017. His summary of detainee RAYSON's medical history states Burkitt's lymphoma was first diagnosed in August 2016 after seeing a specialist for a swelling over the right anterior neck. RAYSON was told it was a cyst following a needle aspiration. Three days later, the anterior neck became swollen again, and a biopsy revealed Burkitt's lymphoma. He was sent to FMC Lexington and was started on chemotherapy at that time, with plans to receive a total of eight cycles every 21 days. (b)(6); (b)(7)(C) wrote RAYSON received only one treatment; also, that he reported he was told that because his time was short, his treatment could be completed at home. It is noted that the meaning of the reference to the detainee's time being short is unclear, although during interview, (b)(6); (b)(7)(C) speculated that RAYSON was given only one treatment of chemotherapy because his counts were too low. Per (b)(6); (b)(7)(C) note, RAYSON reported he had a CT Pet Scan²⁷ in January 2017 but the results were unknown. His history of HIV infection was first diagnosed in November 2014, and he was give antiretroviral medications thereafter. He believed he became infected through unprotected sex, denying a history of IV drug use. (6)(6); wrote RAYSON was also being treated for diabetes first diagnosed in 2014, arthritis, and gout. RAYSON stated he did not want to continue taking Percocet for fear of becoming dependent, indicating a 50 mg dose of indomethacin given for pain at the FMC was "holding him," presumably meaning it sufficiently addressed his pain without the need for a narcotic. He



verbally

²⁴ Hemoglobin is a red protein responsible for transporting oxygen in the blood,

²⁵ Hematocrit is the ratio of the volume of red blood cells to the total volume of blood.

²⁶ Lipase is an enzyme produced by the pancreas which catalyzes the breakdown of fats and glycerol.

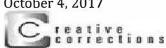
²⁷ A CT Pet Scan is an advanced nuclear imaging technique which reveals information about the structure and function of cells and tissues in the body during a single imaging session.

complained of level five pain in his shoulders, upper right arm, knees, and ankles, with an associated symptom of nausea. Vital signs were all within normal limits, although his glucose was abnormally elevated at 210. When advised to follow up with his primary care provider upon return to Jamaica, RAYSON replied that the appointments were already scheduled. assessment findings and diagnoses remained unchanged. Treatment included an increase in indomethacin from 25 mg to 50 mg, and he was to be followed daily by a provider while in the MHU.

During interview, (b)(6); (b)(7)(C) commented that detainee RAYSON was not appropriately placed at LDF because he required tertiary care²⁸ not available in such a remote location. He also shared his broader concern about the increasing number of detainees with serious medical conditions, noting LDF's limited staffing and medical housing, and paucity of community (b)(6); (b)(7)(C) shared (b)(6); (b)(7)(C) bpinion concerning community resources. resources. stating that there are few specialty clinics nearby, and many local doctors do not want to treat detainees.

Given the opinion of the providers and other medical staff that the detainee needed a higher level of care than available at LDF, reviewers inquired as to efforts to expedite his removal, release, or transfer. (b)(6); (b)(7)(C) stated that shortly after RAYSON arrived, he received an email or phone call from medical staff asking that the detainee be removed as quickly as possible. He said he recommended administrative removal but learned detainee RAYSON did not qualify. He then completed a sworn process seeking expedited removal and within a day or two, received a removal order. The first available charter flight to the detainee's home country of Jamaica was February 23, 2017; however, as detailed below, RAYSON was not medically cleared to travel on that date. (b)(6):(b)(7)(C) stated compassionate release was also considered, but RAYSON reported he was estranged from his family. He said the focus of their efforts was compassionate release or expedited removal rather than seeking transfer to another detention facility.

(b)(6); (b)(7)(C) documented completion of the afternoon nursing round for January 30, 2017 at 2:17 p.m. Detainee RAYSON's vital signs were within normal limits, although he complained of level seven pain in his left arm. (b)(6), (b)(7)(C) general examination findings were that he was cooperative but ill appearing and uncomfortable due to pain. She stated she did not administer pain medication because the detainee was given Percocet five hours earlier. Review of the MAR confirmed RAYSON was given Percocet at 9:00 a.m.; however, review also found he received no more pain medication until his 9:00 p.m. dose of indomethacin. Percocet provides relief for only four to six hours; therefore, detainee RAYSON's level seven pain likely remained unabated until he received indomethacin at 9:00 p.m.



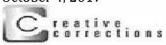
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²⁸ Tertiary care is specialized consultative care by specialists working in a location that has personnel and facilities for special investigation and treatment of complex clinical conditions.

The MHU logbook documents detainee RAYSON refused his dinner meal this date. During evening nursing rounds at 6:57 p.m., (b)(6): (b)(7)(C) found detainee RAYSON upset and complaining of lower abdominal pain at a level seven. His vital signs were within normal limits. The general examination described him as ill appearing and tearful. Boost, a nutritional supplement, was provided and his regular dose of indomethacin was administered for pain. (b)(6): (b)(7)(C) noted ICE personnel were interviewing him at his bedside, after which he displayed an improved mood.
January 31, 2017. Per her note, detainee RAYSON complained of severe generalized pain at a level nine. Vital signs were all within normal range, although his glucose was abnormally low 73. He was not given insulin, which the reviewer notes is consistent with American Diabetes Association guidelines setting 80 as the blood sugar level below which insulin should not be administered. The MAR documents RAYSON was given his scheduled dose of indomethacin for pain.
The MHU logbook documents detainee RAYSON went to recreation from 9:31 a.m. to 10:47 a.m.
At 11:30 a.m., (b)(6); (b)(7)(C) documented detainee RAYSON denied pain, and his vital signs were all within normal limits with the exception of an abnormally elevated pulse of 112. He denied chest pain or shortness of breath associated with the rapid heart rate, although he reported experiencing chest pain earlier when exercising. The general examination noted no heart murmurs and regular rate and rhythm. He documented an EKG performed per (b)(6); (b)(7)(C) revealed a normal sinus rhythm with tachycardia ²⁹ , and that no treatment was ordered. Although not expressly stated in the note, it is concluded (b)(6); (b)(7)(C) contacted (b)(6); (b)(7)(C) acknowledged receipt of (b)(6); (b)(7)(C) notification that the EKG and vital signs were within limits. The reviewer notes common causes of a rapid heart rate are dehydration, anxiety, pain, and fear. Appropriately, nurses routinely documented patient education, to include the importance of drinking one to two liters of water.
(b)(6); (b)(7)(C) documented a provider round at 12:31 p.m. She described detainee RAYSON as "brighter today and slightly more talkative" and wrote that he reported general body pain at a level five. Vital signs were all within normal limits with the exception of an abnormally elevated pulse rate of 112. The general examination again found enlargement of the anterior and posterior cervical nodes. He was educated on ways to handle and minimize stress and to follow up with his own physician if deported or released. There were no changes to the treatment plan.

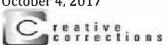




In a telephone encounter timed 1:42 p.m., (b)(6); (b)(7)(C) klocumented (b)(6); ordered tramadol, a narcotic pain medication, every six hours as needed for one day for left leg pain. An unsigned entry in the medical record states the order was received, but includes no further information documenting the assessment that precipitated the order. According to the MAR, tramadol was not given until 9:15 p.m., seven to eight hours later. However, the reviewer concludes RAYSON was likely given a dose when initially ordered by (b)(6). Review of the Controlled Substance Administration Log found the tramadol was signed out at 1:00 p.m., suggesting (b)(6); (b)(7)(C) received the order and administered the medication prior to her entry of the telephone encounter at 1:42 p.m. Supporting this conclusion is (b)(6); (b)(7)(C) 8:29 p.m. nursing round entry documenting RAYSON reported much improvement since receiving tramadol, stating his pain decreased to level three. She also wrote detainee RAYSON was ill appearing yet alert, well hydrated, and in no distress. His mood was appropriate, and he was calm and cooperative. He had no complaint besides minimal pain. Vital signs were all within normal limits, and there were no abnormal findings. As noted, the detainee was given a dose of tramadol at 9:15 p.m.; however, no pain assessment justifying its administration at this time was documented. According to (b)(6); (b)(7)(C) note, RAYSON reported pain at level three less than an hour earlier, and no pain level was noted thereafter.

In an entry timed 5:40 a.m. on Wednesday, February 1, 2017, presumably summarizing events during her shift, (b)(6); (b)(7)(C) documented detainee RAYSON cried "hysterically" during the night, holding his leg. He complained of left leg pain at level ten, and stated he received tramadol but it did not relieve the pain. He vomited once but denied nausea and refused the offer of anti-nausea medication, ondansetron. ((b)(6);(b)(7)(C)) was notified, and a verbal order was received for injections of Toradol and Benadryl to be given immediately on a one-time basis. According to the MAR, injections were administered at 2:30 a.m. Shortly after receiving the medication, RAYSON stated he was feeling a little better, and he was described as resting quietly in bed, in no distress. Vital signs were within normal limits. His finger stick glucose registered 163, so he was provided two units of regular insulin. He reported a pain level of four following administration of medication.

(b)(6); (b)(7)(c) conducted a provider assessment at 7:48 a.m., documenting detainee RAYSON slept very little through the night. He refused his breakfast because he was in pain and was not hungry. The NP's examination of the left knee found it was not swollen, hot, or erythemic³⁰, but RAYSON reported tenderness when it was firmly pressed. He reported general pain over his whole body at a level eight. (b)(6), (b)(7)(C) wrote that he refused her offer of a cane to assist in ambulation. It is noted she did not document whether she explained that use of a cane would help prevent falls, nor is there documentation RAYSON was asked to sign a refusal form. (b)(6) noted it was too early to give him anything else for pain as he had last received Toradol at 2:30 a.m. As his condition seemed to be deteriorating, her plan was to contact (b)(6): to request an adjustment in pain medication and to recommend sending him back to the hospital.



³⁰ Ervthemic means red.

An addendum to this note documents (b)(6); (b)(7)(C) spoke with (b)(6); regarding her concern for detainee RAYSON's decompensating condition. Per her note, (b)(6); elected to wait for results of lab tests ordered at the hospital to evaluate his immune competency. If the results showed he was not immune-compromised, RAYSON was to be sent to general population to help with his pain and psyche. (b)(6); stated during interview that he wished to see the lab results to determine if RAYSON's white blood cell count was high enough to protect him from opportunistic infectious diseases if placed to general population.

By way of telephone encounter, (b)(6); (b)(7)(C) initiated contact with (b)(6); (b)(7)(C) IHSC Infectious Disease Specialist, to review RAYSON's medical record. The (b)(6) informed the review team that (b)(6); (b)(7)(C) is routinely contacted to discuss all patients with a diagnosed or possible communicable disease. (b)(6); (b)(7)(C) made the following recommendations by way of return telephone encounter:

- Continue current antiretroviral therapy;
- Oncology consult as soon as possible to determine need for hospital admission, maintain good hydration, intravenous fluids if necessary;
- Advise how long he is likely to be in custody;
- Gonococcal and chlamydia nucleic acid amplification (NAA) tests³¹;
- Give second dose of hepatitis A vaccine, Prevnar³², followed by pneumovax³³ in eight weeks, Menactra³⁴ dose one followed by dose two in eight weeks;
- Defer other chronic care management to (b)(6); (b)(7)(C)



³¹ NAA tests are the Center for Disease Control's preferred method to detect sexually transmitted diseases. This method detects the genetic material of the bacteria causing the infection by amplifying or making numerous copies of the genetic material so that the bacteria can be identified.

³² Prevnar is a type of pneumococcal vaccine to prevent pneumonia.

³³ Pneumovax is a type of Pneumococcal vaccine to prevent pneumonia

³⁴ Menactra is a meningococcal vaccine to protect against meningitis and other meningococcal diseases.

conducted nursing rounds at 1:47 p.m., documenting detainee RAYSON's complaint of generalized pain at level seven accompanied by nausea and vomiting. His vital signs were all within normal limits. There were no active orders for as-needed pain medication at this time, the supply of Percocet sent with RAYSON by the FBOP having been depleted on January 30, 2017. Although his last dose of regularly scheduled pain medication, indomethacin 50 mg, was given at 9:00 a.m. and not scheduled again until 9:00 p.m., (b)(6); did not contact a provider to obtain an order for pain medication. Asked during interview if she considered seeking an order, her reply was that RAYSON was difficult, demanding, and cantankerous. Other staff interviewed by the review team did not voice that opinion.

The MHU logbook documents that at 3:50 p.m., detainee RAYSON was crying and the nurse was informed. At 4:08 p.m. a nurse whose name was not noted entered detainee RAYSON's cell to check his vitals. There is no corresponding documentation in the medical record.

RAYSON complained of severe level ten pain in his right neck and in both lower extremities. Vital signs were all within normal limits with the exception of a mildly elevated blood pressure of 134/82. His finger stick glucose was elevated at 206 for which he was given regular insulin and was educated on diet and the importance of good blood glucose control. The nursing note documents he was given another injection of Toradol and Benadryl for pain management per one time dosing order of (b)(6); (b)(7)(C); however, no corresponding entry was made on the MAR. Per order of (b)(6); (b)(7)(C) via telephone encounter, (b)(6); (b)(7)(C) documented she administered an injection of Phenergan at 6:30 p.m.; however, the medical record does not indicate why this medication, which is commonly used for acute nausea and vomiting, was offered at this time. However, as noted, RAYSON previously experienced nausea and vomiting, symptoms not uncommon given his condition.

At 6:54 a.m. on Thursday, **February 2, 2017**, (b)(6); (b)(7)(C) documented that detainee RAYSON reported severe pain at level ten in his right knee and back, stating that nothing completely relieved it. Vital signs were within normal limits with the exception of a mildly elevated blood pressure of 134/97. (b)(6); (b)(7)(C) noted there were no symptoms related to the elevated blood pressure, although RAYSON was educated on the need to report any headache, dizziness, or visual changes should they develop. His general appearance was "elderly", severely ill appearing, uncomfortable due to pain, disheveled, tearful, and lethargic. His complexion was "gray looking", he had poor eye contact, and his affect was irritable. He was assisted back to a reclined position for comfort. Pain medication was not offered at this time, possibly because he was scheduled to receive his regular dose of pain medication at 9:00 a.m.

The next medical record entry, also dated February 2, 2017, was by (D)(6); As Reason for Appointment, he entered, "MHU [Discharge] Note", specifying in the narrative that the time of approved discharge was 10:30 a.m. the same day. He also wrote that RAYSON's physical condition was stable. There is no documentation (D)(6); physically assessed RAYSON prior to



making the discharge determination. Hands-on physical examination, to include routine examination of the heart, lungs, stomach and bowels was not documented, nor was subjective assessment of the detainee's current pain level, effectiveness of pain medication, and other complaints of discomfort. The reviewer notes that less than three hours earlier, (b)(6); described RAYSON as severely ill appearing, lethargic, uncomfortable due to pain at level ten, and needing assistance to recline to a more comfortable position.

Medical record documentation also does not provide evidence (D)(6); physically assessed the detainee at any point prior to or following this date. Other than telephone encounters, the February 2, 2017 MHU Discharge Note was his only entry. During interview by telephone, (D)(6) was asked if he ever evaluated RAYSON in person. He said he recalled going to meet the detainee when he returned to LDF from RRMC, noting he was conversant and not in acute pain at the time. Stated that in the following days, he was given the impression RAYSON felt isolated in the MHU and believed that the isolation was detrimental to his mental health. For that reason, and after reviewing lab studies, he decided to discharge the detainee from the infirmary. Reviewers were unable to establish whether (D)(6); evaluated RAYSON, but did not document in-person assessment, or whether the decision was made based on his review of the lab results and conclusion that transfer from the MHU would support RAYSON's mental health.

In his MHU Discharge Note, (b)(6): documented lab studies showing a continued elevation in RAYSON's calcium level, which as noted previously, is indicative of a cancerous process. He did not address what the results indicated with respect to compromised immunity secondary to HIV infection. Review found the lab studies showed detainee RAYSON's white blood count was low at 3.1 compared to the laboratory's reference range of 3.4 to 10.8; in addition, his CD4 count was low at 247 compared to the reference range of 359 to 1519. CD4 cells are a type of white blood cell which normally attack infection, but are destroyed by HIV infection, compromising immunity. Counts lower than 200 meet the diagnosis of AIDS. Orders included an 1800 calorie diabetic diet and cafeteria privileges, with no activity restrictions or special needs allowance for a device to assist with ambulation. Follow up in one week was scheduled.

The reviewer's final observation pertaining to the MHU Discharge Note is that two versions were provided. The first was electronically signed by (b)(6); at 6:31 p.m. on March 6, 2017, more than a month following the discharge order of February 2, 2017. Under Treatment, an order to start indomethacin twice a day for 30 days was noted, as was approval for cancellation of the prescription on February 9, 2017. Although electronically signed, the "Sign off status" showed as pending. The second version of the note was electronically signed on March 27, 2017, almost two weeks following detainee RAYSON's death. Under Treatment, receipt of approval to cancel the prescription for indomethacin appears, although the order to start the medication was removed. The March 27, 2017 version also shows the sign off status as pending. The reviewer cannot positively explain why there are two, slightly different versions of the note. However, it is presumed that the first was updated after the medical record was provided to



ERAU shortly following the death. The reviewer also cannot explain the delay in signing the notes, or modification following the death.

The MHU logbook documents detainee RAYSON refused recreation on the day (b)(6); approved his discharge from the MHU. An entry timed 1:15 p.m. states that after he asked for a nurse "due to his pain," an EKG was performed and the detainee was given pain medication. He was then noted to be "calming down." A 2:26 p.m. entry documents RAYSON "is continuously crying and telling the nurse he needs to go to hospital. He's afraid he's going to die and that he's in a lot of pain." According to the logbook, the detainee's blood pressure was taken at 3:45 p.m.

Medical record entries loosely correspond with the MHU log. (b)(6); documented at 1:11 p.m., detainee RAYSON complained of level seven pain throughout his body, accompanied by nausea and vomiting. Vital signs were within normal limits with the exception of a slightly elevated heart rate of 100. His weight remained 179 pounds. Tramadol 100 mg, to be repeated every six hours as needed for seven days, was ordered by (b)(6); via telephone encounter timed 1:23 p.m. There is no corresponding reference to the order for tramadol in (b)(6); (b)(7)(C) nursing note. The MAR documents the medication was administered at 1:30 p.m. by (b)(6); (b)(7)(C) at 1:30 p.m. At 2:00 p.m., (b)(6); (b)(7)(C) also administered morphine tablets. 2:00 p.m. was also the time (b)(6); (b)(7)(C) | signed out the morphine, a narcotic pain medication, on the Controlled Substance Administration Log. The order, handwritten on the MAR as, "Morphine tabs 30 mg (per (b)(6);)", is not referenced in any progress note, telephone encounter, or order. During interview of (b)(6); (b)(7)(C) she could not recall which RN instructed her to administer the morphine. Administration of a controlled substance, absent a prescription written by a DEA-registered provider, is illegal; therefore, based on available information, the reviewer notes this is a grievous medication error. There is no documentation the apparent error was investigated and addressed. The reviewer also notes that only 30 minutes elapsed between administration of tramadol at 1:30 p.m. and 30 mg of morphine at 2:00 p.m., an insufficient amount of time to determine the effectiveness of tramadol in relieving RAYSON's pain. Tramadol levels in the blood peak up to two hours after dosing. Oral doses of morphine and tramadol together increase sedation and drowsiness, requiring close clinical monitoring for potentially serious interactions. It is noted that (b)(6); (b)(7)(C) was adamant that she administered both the tramadol and the morphine after detainee RAYSON was moved to the segregation unit, which as discussed below, was not until the evening. Her claim is contradicted by her own MAR entries (1:30 p.m. for tramadol and 2:00 p.m. for morphine), as well as (b)(6); (b)(7)(C) documentation of completion of a nursing round in the MHU at 6:04 p.m. (b)(6); (b)(7)(C) describes detainee RAYSON was alert and oriented, and his respirations were even and unlabored. He was provided acetaminophen (Tylenol) per his request to help prevent the return of pain. Vital signs were all within normal limits.

A 7:04 p.m. entry in the medical record by (b)(6); (b)(7)(C) documents that per GEO, RAYSON was transferred to Eagle Charlie unit (Eagle C). The MHU logbook documents 6:55 p.m. was the time of the transfer. A notable outlier to these times is recorded on the Housing History Grid, which documents RAYSON's transfer to Eagle C at 11:34 a.m. It is surmised Eagle C was



designated as the housing unit to which the detainee would be assigned when security was first notified he was cleared for general population, well before actual transfer from the MHU. It is noted that although Eagle C appears in all written documentation, the review team learned through interviews that he never entered that unit. Instead, he was transferred from the MHU to Eagle A unit. Both Eagle A and Eagle C units are 48-bed, general population dormitories for detainees classified high and medium high. Nowhere is it documented that RAYSON was placed in Eagle A rather than Eagle C.

informed the review team that following the detainee's transfer to Eagle
A, an officer called him to report several detainees were objecting to RAYSON's placement.
(b)(6); (b)(7)(C) stated that although both Eagle A and Eagle C units are maximum security
dormitories, detainees housed in Eagle A are less tolerant than detainees assigned to Eagle C
unit. When he reported to Eagle A, (b)(6); (b)(7)(C) was informed by a group of detainees that
RAYSON told them of his medical condition, including that he was HIV positive. (b)(6);
escorted RAYSON into the hallway to speak with him privately. He said the detained
acknowledged that he shared his medical condition with other detainees when asked, stating he is
honest with everyone and does not lie about his HIV status. (b)(6); (b)(7)(C) said RAYSON
declined an offer to assign him to another high custody housing unit, saying "he wanted to be
with his people, but since that didn't work out, it probably wouldn't work out elsewhere." Asked
to explain, (b)(6); (b)(7)(C) stated Eagle A was chosen for detainee RAYSON because it houses
non-Hispanic high custody detainees, including detainees from RAYSON's home country of
Jamaica. (b)(6), (b)(7)(C) confirmed this information, indicating that when
possible, Hispanic and non-Hispanic detainees classified high are housed separately to avoid
conflicts related to ethnicity and culture. (b)(6); (b)(7)(C) said he then offered to return
RAYSON to the MHU, the only alternative being segregation. The detainee reportedly chose
segregation because the Special Management Unit (SMU) has a television and he wanted to
watch the Super Bowl. The detainee did not verbally report to the sergeant, nor was there any
documented or stated evidence, that he was assaulted by other detainees while in Eagle A unit.
(b)(6); (b)(7)(C) stated he took detainee RAYSON to the clinic for segregation clearance. He
(b)(6); (b)(7)(C) stated he took detainee RAYSON to the clinic for segregation clearance. He said that when they arrived, (b)(6); immediately said, "Oh no—he can't come back here",
remarking that RAYSON was cleared for general population. (b)(6); (b)(7)(C) also shared that
(b)(6); (b)(7)(C) reaction was consistent with complaints received by medical staff that afternoon
concerning the delay in transferring RAYSON from the MHU, a delay he attributed to the need
to wait for a bed to become available in Eagle A unit.
to wait for a bed to become available in Eagle A unit.
documented completion of medical clearance for segregation at 8:15 p.m. He wrote
detainee RAYSON was spontaneous in speech and answered all questions appropriately. He
appeared to be within normal limits of behavior, affect, and cognitive functioning, and "he did
not appear to have any acute or unresolved medical condition that might worsen in segregation."
He reported general pain at level three. Recorded vital signs were within normal limits, with the
exception of an abnormally increased heart rate of 112. During interview, (b)(6); (b)(7)(C) stated he



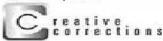
was informed other detainees did not want RAYSON in the dorm so security put him in segregation, commenting the detainee "seemed fine" with the move. He said as far as he was concerned, discharged RAYSON from the MHU and he saw no medical reason he should not be placed in segregation. He also saw no reason to notify a provider.

shift supervisor, recalled that a sergeant reported to him that other detainees did not want RAYSON in the dorm. He commented that based on his experience, this placed the detainee at risk for harassment. (b)(6), (b)(7)(C) reported he received permission from the Warden, Associate Warden or Major to move detainee RAYSON to the SMU "for his own protection." (b)(6); (b)(7)(C) completed an administrative segregation order documenting "Other detainees do not want the detainee in the dorm (Medical Issues.)", marking the checkbox, "Detainee has requested admission for Protective Custody". The sections for the detainee's signature and whether he requested a hearing on his placement were both left blank. Per the order and a document titled, "Notice of Detainee Placement in the Restricted Housing Unit", detainee RAYSON was assigned to segregation at 8:05 p.m. on February 2, 2017, approximately one hour after he was transferred from the MHU. It is noted the Housing History Grid form incorrectly lists the date of transfer to SMU as February 4, 2017. Detainee RAYSON was provided and signed an administrative segregation orientation form. RAYSON was assigned to cell 5 in Eagle B, a 12-cell segregation unit. The cells are doubleoccupancy, although (b)(6); (b)(7)(C) stated detainees are typically housed alone while in segregation. The cells in Eagle B are numbered 1 to 12 from right to left. The officer's desk and podium are at the front of the unit, and there is a fenced area in the dayroom for conducting legal research. There is one television, also positioned in the dayroom. There are two showers, one of which is Americans with Disabilities Act compliant, both observed to be in excellent sanitary condition. The door to detainee RAYSON's cell, number 5, opens from right to left and has two viewing windows on the top half and a food/handcuff trap in the center. There is a bunk bed on the right and a stainless steel toilet/sink combination fixture on the left. The cell has an intercom button; however, when asked where it connects for communication with an officer. (b)(6); (b)(7)(C) stated the intercom does not work. On the back wall is a large window with a view to the outside. Upon inspection, reviewers observed a significant amount of graffiti inside the cell. There are two officers assigned to Eagle B. According to (b)(6); (b)(7)(C) rounds are required every 30 minutes, electronically documented using the pipe system. It is

rounds are required every 30 minutes, electronically documented using the pipe system. It is noted one section of the SMU post orders require checks four times an hour on an irregular basis; another section requires rounds at least every 30 minutes. (b)(6), (b)(7)(C) stated pipe system reports are regularly reviewed by the Warden to verify completion of rounds within required timeframes. In addition to documenting security rounds, officers record services and privileges on a Confinement Record form specific to each detainee.

LDF Policy 10.4.1, Restricted Housing Unit: Administrative Restriction, states that detainees have the opportunity to shave and shower "at least three times per week." It also states, "Detainees in restricted housing units receive daily exercise outside of their cells, unless security

DETAINEE DEATH REVIEW: Roger RAYSON Medical and Security Compliance Analysis October 4, 2017



or safety considerations dictate otherwise. Detainees in the RHU for administrative purposes will be offered at least two hours of exercise per day, seven days a week, unless documented security, safety or medical considerations dictate otherwise." Detainee RAYSON's Confinement Records document he was offered recreation and a shower daily, but as discussed below, sometimes declined.

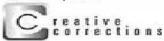
Nurses are required to make rounds in the SMU once per day. There is no requirement for provider rounds or for nurses to conduct assessments or take vital signs absent a provider order. Nurses who made rounds in the SMU after RAYSON was placed in segregation (see below) informed the review team rounds are conducted by knocking on the door and asking if detainees are alright. They stated vital signs are not taken and assessments are not completed because officers do not open cell doors during rounds. Consistent with nurses' statements, the post orders state, "... the officer will never enter the cell of any detainee without first applying mechanical restraints (handcuffs) and without the assistance of another officer."

As detailed below, detainee RAYSON remained on administrative segregation for protective custody from the day assigned, February 2, 2017, until taken to the hospital on February 11, 2017. Given his poor state of health, the review team interviewed staff concerning RAYSON's discharge from the MHU and housing in in the SMU. (b)(6); (b)(7)(C) said they were surprised when they learned of his discharge from the MHU; (b)(6); (b)(7)(C) respected previously, (b)(6); stated he likely would not have made the same decision. As noted previously, (b)(6); stated he discharged RAYSON from the MHU after reviewing lab results indicating he was stable, and for his mental health.

Concerning RAYSON's placement in segregation, (b)(6); (b)(7)(C) stated he was not notified and that he was "fuming" when he saw the detainee there. When he went to medical to inquire, (b)(6) informed him RAYSON was on "comfort therapy" and that he wanted him to be up and moving around. It is noted that while movement is possible in general population housing, detainees housed in the SMU are locked in their cells up to 22 hours a day, per policy. Asked if he inquired about the possibility of returning RAYSON to the MHU, (b)(6); (b)(7)(C) said medical would not agree because, "They don't like general population detainees in medical housing." During interview of (b)(6); (b)(7)(C) he stated he had not reviewed circumstances surrounding RAYSON's discharge from the MHU and assignment to segregation because the IHSC headquarters reviewer asked that he not do so pending her completion of interviews. He did, however, comment that he believes providers were aware the detainee was moved to segregation and evidently, were "alright with it."

expressed concern regarding RAYSON's housing in the SMU. [b)(6); (b)(7)(C) remarked that his move to segregation made it harder for medical staff to monitor him and "complicated things." [b)(6); stated that when he learned detainee RAYSON was in the SMU, he "did a little digging" and was told RAYSON requested segregation. He indicated that while he did not believe housing in the SMU was appropriate given RAYSON's condition, he did not intervene because

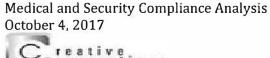
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the detainee "wanted to be there." When asked, [b)(6); said he did not consider returning him to the MHU. As noted, (b)(6); (b)(7)(C) stated he would not have discharged RAYSON from the MHU in the first place, but general population having not worked out, he believed he should have been returned to the MHU rather than placed in segregation. When asked about the concerns of medical staff regarding the detainee's placement in the SMU, (b)(6); (b)(7)(C) pointed out they directed RAYSON's transfer from the MHU and cleared him for placement in segregation. He added that during his rounds in the SMU, made almost daily, he was not informed and did not observe any conditions leading him to question the appropriateness of the detainee's placement. The day of his admission to the SMU, February 2, 2017, the Confinement Log documents RAYSON refused recreation and a shower. During interview of (b)(6); (b)(7)(C) indicated she was assigned to the post when he arrived. She said, "I asked him if he was ok because he looked pretty bad." (b)(6); (b)(7)(C) also reported he "moaned and cried all night." Review of the MAR verified RAYSON was given his regularly scheduled dose of indomethacin at 9:00 p.m. and as-needed pain medication tramadol at 11:45 p.m. (b)(6), (b)(7)(C) conducted a medical segregation round at 9:43 a.m. on Friday, February 3, 2017, documenting RAYSON denied pain. It is noted reviewers were informed by nursing staff that if the detainee appeared to be resting quietly, they did not attempt to wake him to inquire about pain. Therefore, according to nursing staff, recorded denial of pain or pain at level zero should not be construed to mean the detainee stated he was experiencing no pain. At 5:53 p.m., (b)(6); (b)(7)(C) documented detainee RAYSON complained of level ten pain in his neck. By way of telephone encounter, (b)(6), (b)(7)(C) was notified and verbal orders were received for injections of Phenergan, Benadryl, and Toradol. Although the nursing note documents the injections were administered, there is no corresponding documentation on the MAR. Additionally, there was no documented follow-up to determine if the pain resolved. A segregation status review was completed this date by (b)(6); (b)(7 (C) (b)(6); and signed by (b)(6); (b)(7)(C) The form does not document whether or not detainee RAYSON was interviewed during the status review. No change in status was recommended. The Confinement Record documents the detainee accepted all three meals and showered on this date, although he again refused recreation. The record also documents his cell was searched. On Saturday, **February 4, 2017**, (b)(6); (b)(7)(C) documented a segregation round at 9:12 a.m. She recorded detainee RAYSON had a pain level of zero. She did not note whether she woke him during this round. The Confinement Record for this date documents the detainee refused recreation and a shower but again accepted all meals.

The Confinement Record for Sunday, February 5, 2017 documents detainee RAYSON showered and went to recreation, and accepted breakfast and lunch. The record also documents



DETAINEE DEATH REVIEW: Roger RAYSON



his cell was searched. A status review was completed and approved the same date; however, the form does not document interview of the detainee and the signatures of the staff persons were not legible. Removal from protective custody was not recommended.

The first medical record entry for February 5, 2017 was a note by (b)(6); (b)(7)(C) documenting completion of a segregation round at 9:13 a.m. RAYSON's recorded pain level was zero, although again, it is unknown whether he was awake when the round was conducted and reported he had no pain. At 6:09 p.m., (b)(6); (b)(7)(C) documented a sick call encounter to address RAYSON's complaint of level ten pain in his back, shoulders, right side of his neck, back of head, and other generalized discomfort. She stated during interview that she was called to the SMU by an officer who said, "You have to get down here. He is wailing." With (b)(6); (b)(7)(C) assistance, RAYSON was taken to the clinic in a wheelchair. (b)(6); (b)(7)(C) note states detained RAYSON described the pain as electric, frequent, knife like, persistent, and progressive. He also stated he was nauseated and had no appetite. Vital signs were within normal limits with the exception of a mildly elevated blood pressure of 133/96. He was not weighed due to his reported severe pain. He was described as alert, unsteady with ambulation, severely ill appearing, uncomfortable due to pain, and cooperative. By way of telephone encounter, (b)(6), (b)(7)(C) ordered Phenergan and Toradol by injection, and as written on the telephone encounter by (b)(6), (b)(7)(C) "Release back to segregation when pain level decreases." (b)(6); (b)(7)(C) later documented on the telephone encounter, "Verbal order correct as written."

At 6:46 p.m., [b)(6); (b)(7)(C) documented she followed up to determine the effectiveness of the medication treatment. Vital signs remained within normal limits. The general examination found RAYSON's gait remained unsteady, he was awake and no longer moaning or crying, and his pain was decreased to level eight. [b)(6); (b)(7)(C) was notified and per her verbal order, RAYSON was released from the MHU. It is noted that despite detainee RAYSON's observed weakness and unsteadiness in gait, a Special Needs form authorizing a cane, walker, or wheelchair to prevent falls was not prepared. It is also noted that during interview, [b)(6); (b)(7)(C) said that when called, she was told the detainee was feeling better and wanted to return to the "dorm." She said she did not know at the time that he was assigned to the SMU. She said that had she known, she "wouldn't have been comfortable with it," but may not have directed that he remain in the MHU because she did not know the reason he was segregation.

During interview with (b)(6); (b)(7)(C) concerning the events of the evening, she said she discussed RAYSON with (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) the next day, telling them that he was very sick and needed to be housed in the MHU. She further reported telling (b)(6); that RAYSON needed to go to the hospital because "he was dying and in a lot of pain." When asked if she was comfortable sending detainee RAYSON back to segregation as ordered by (b)(6); (b)(7)(C) (b)(6); (b)(6); (c)(7)(C) (c)(6); (c)(7)(C) (c)(6); (c)(7)(C) (c)(6); (c)(7)(C) (c)(6); (c)(7)(C) (c)(6); (c)(7)(C) (c)(7)(C)

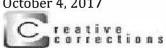




Per the Confinement Record, on February 6, 2017, detainee RAYSON refused recreation but accepted a shower and all three meals. The medical record documents (b)(6); (b)(7)(C) conducted a segregation round at 10:29 a.m., at which time detainee RAYSON complained of neck and head pain at a level ten. He was described as ill appearing, lying on the bed, and demonstrating weakness on repositioning. The plan was to provide pain medication following consultation with weakness on repositioning. A telephone encounter timed 8:03 a.m. documents (b)(6); ordered Percocet three times daily as needed, for ten days. The MAR shows it was administered at 3:00 p.m. and 9:00 p.m. There is no documentation of follow-up assessment to determine the effectiveness of the medication 35.

documented a segregation mental health assessment at 11:30 a.m., writing that per the nursing notes, RAYSON's condition deteriorated while in segregation. It is noted that although nursing staff commented on the detainee's deterioration during interviews with the review team, there is no corresponding documentation in nursing notes as \(\begin{align*} \begin{alig

conducted a mental health assessment later the same day pursuant to a telephone consultation request from [b)(6); (b)(7)(C)] The request by [b)(6); (b)(7)(C)] is not documented in the medical record. The general examination found detainee RAYSON was calm, cooperative and easily agreeable to the assessment. This information stands in contrast with information reported by [b)(6); (b)(7)(C) who, as noted, stated the detainee was uncooperative. (b)(6); (b)(7)(C) who, as noted, stated the detainee was uncooperative. (b)(6); (b)(7)(C) who as noted, stated the detainee was uncooperative. (b)(6); (b)(7)(C) who as noted, stated the detainee was uncooperative. (b)(6); (b)(7)(C) who as noted, stated the detainee was uncooperative. (b)(6); (b)(7)(C) who as noted, stated the detainee was uncooperative. (b)(6); (b)(7)(C) who as noted, stated the detainee was uncooperative. (b)(6); (b)(7)(C) who as noted, stated the detainee was uncooperative. (b)(6); (b)(7)(C) who as noted, stated the detainee was uncooperative. (b)(6); (b)(7)(C) who as noted, stated the detainee was uncooperative. (b)(6); (b)(7)(C) who as noted, stated the detainee was uncooperative. (b)(6); (b)(7)(C) who as noted, stated the detainee was uncooperative. (b)(6); (b)(7)(C) who as noted, stated the detainee was uncooperative. (b)(6); (b)(7)(C) who as noted, stated the detainee was uncooperative. (b)(6); (b)(7)(C) who as noted, stated the detainee was uncooperative. (b)(6); (b)(7)(C) who as noted, stated the detainee was uncooperative. (b)(6); (b)(7)(C) who as noted, stated the detainee was uncooperative. (b)(6); (b)(7)(C) who as noted, stated the detainee was uncooperative. (b)(6); (b)(7)(C) who as noted, stated the detainee was uncooperative. (b)(6); (b)(7)(C) who as noted, stated the detainee was uncooperative.



³⁵ Standard nursing practice in pharmacology involves medication assessment to focus on whether the patient is experiencing expected therapeutic benefits from the medications (e.g. pain relief) and identify any adverse side effects.

³⁶ Psychomotor agitation refers to a series of unintentional and purposeless motions stemming from tension and anxiety.

³⁷ A delusional thought process in which a neutral event is believed to have a special and personal meaning.

aggression, fair anger control, and was abstract with proverbs. He had fair impulse and sexual control. (b)(6):(b)(7)(C) documented she did not order psychotropic medications due to the detainee's unwillingness to take them; follow up in two weeks. RAYSON signed a refusal form for the offered medications, and was told to request sick call if services are needed before the follow up appointment and if he continues in segregation. In addition, RAYSON was educated on the need to engage in activities such as exercise as much as he can tolerate, and to engage in other activities like reading, writing, watching television and interacting with other detainees.

The Confinement Record for **February 7, 2017** documents detainee RAYSON refused recreation, a shower, and breakfast. He accepted the lunch and dinner meals. The Out of Cell Activity Log documents he met with \[\frac{(b)(6); (b)(7)(C)}{\infty} \] \frac{\text{from 9:16 a.m. to }}{\infty} \] 10:03 a.m.; however, as discussed above, the medical record documents \[\frac{(b)(6); (b)(7)(C)}{\infty} \] encounter with detainee RAYSON was on February 6, 2017. There is no entry on the Out of Cell Activity Log for February 6, 2017 documenting RAYSON saw \[\frac{(b)(6); (b)(7)(C)}{\infty} \] this date, and medical record documents no mental health encounter on February 7, 2017. The discrepancy cannot be resolved. The Out of Cell Activity Log for February 7, 2017 also documents that from 3:55 p.m. to 4:41 p.m., detainee RAYSON spoke with "ICE".

Per ICE Significant Incident Report dated March 14, 2017, the Consulate of Jamaica issued a travel document this date, February 7, 2017, valid until February 23, 2017. According to (b)(6):

[b)(6):

February 23, 2017 was the first scheduled flight to Jamaica.

There were two medical record entries for February 7, 2017, the first by b(b)(6); (b)(7)(C) documenting she completed a segregation round at 9:20 a.m. She wrote that RAYSON answered no when asked, "Do you have any medical complaints or concerns at this time?" and "Are you currently in pain?" In a subsequent note, timed ten minutes later at 9:30 a.m., b(b)(6); (b)(7)(C) documented detainee RAYSON complained of constant level nine pain in his low back which began two to three days ago. He was noted to ambulate weakly from the bed to the door for discussion. He reported the pain medication started the day before helped with his discomfort, but none was given that morning. According to the MAR, he received Percocet at 9:00 a.m., 3:00 p.m., and 9:00 p.m.

The Confinement Record documents that on **February 8, 2017**, detainee RAYSON refused recreation and a shower but accepted all three meals. (b)(6); (b)(7)(C) documented a segregation round at 11:28 a.m., noting detainee RAYSON's pain level was zero. She did not document if the detainee was awake during the round.

A seven-day review of the detainee's placement in segregation was conducted on **February 9**, **2017**. (b)(6); (b)(7)(C) conducted the review but failed to document interview of the detainee and check either "Recommend removal" or "Do not recommend removal". Despite the fact no

³⁸ A paranoid thought process in which a person believes he is being threatened, mistreated, or discriminated by other persons or external forces.



DETAINEE DEATH REVIEW: Roger RAYSON Medical and Security Compliance Analysis

recommendation was made, a staff member whose signature is illegible documented that he or she concurred with the recommendation. The Confinement Record for this date documents detainee RAYSON refused recreation but accepted a shower and his cell was searched. He accepted the breakfast meal but refused both lunch and dinner.

A medical record entry timed 5:47 a.m. documents the detainee's pain level was zero during a segregation round conducted by (b)(6):(b)(7)(C) was not interviewed; therefore, it is unknown whether she is an employee of InGenesis or STG. It is also unknown whether she woke the detainee to obtain the documented pain level.

As noted above, when [0](6): discharged detainee RAYSON from the MHU on February 2, 2017, he directed follow up in one week, February 9, 2017. The medical record documents his review this date of morning blood glucose readings of 151,143, 106, 135, 79 and the evening readings of 270, 255, 101, 206, 197, 285, 209, 168, 208, 188. Based on the elevated readings, he added a pre-lunch dose of glipizide. He also decreased pain medication tramadol to half the previously prescribed dose and discontinued the blood pressure medication hydrochlorothiazide and anti-inflammatory/pain medication indomethacin. He started alendronate (Fosamax) every morning for thirty days. Laboratory studies were reordered. During interview, (b)(6); explained Fosamax was ordered to help manage the elevated calcium level. There is no documentation of in person follow up.

On **February 10, 2017**, the Confinement Record documents the detainee refused recreation and a shower, and accepted breakfast and lunch but refused the dinner meal. Per the medical record, the daily segregation round was conducted at 10:19 a.m. by (b)(6): (b)(7)(C) , who recorded a pain level of zero. She did not note whether or not the detainee was awake. A telephone encounter timed 1:20 p.m. documents a medication order was received for promethazine hydrochloride 25 mg suppository as needed twice daily for two days to treat GERD. There is no documentation in the medical record or MAR supporting this order was processed. There is also no documentation explaining what prompted the telephone encounter.

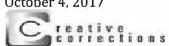
As noted, RAYSON refused his dinner meal this date, and periodically refused others following placement on segregation. Review of the Confinement Records finds a total of five meals were refused, although never more than two in a row, and the dinner meal on February 5, 2017, was not documented as given or refused. During interview, bi(6); (b)(7)(C) stated a detainee should be seen by medical after three or more meals are missed or refused, but acknowledged that the expectation is not codified in policy. There is no documentation medical was notified RAYSON was missing meals.

February 11, 2017 was the day detainee RAYSON was moved from LDF for hospitalization. It is noted that despite all evidence pointing to RAYSON's transfer to the hospital this date, officers documented that on February 12, 2017, detainee RAYSON refused a shower and recreation and accepted breakfast, calling into question the overall accuracy of the logs. The



following account of events of February 11, 2017 is based on security, medical, and video documentation.

The Confinement Record documents detainee RAYSON accepted the breakfast and lunch meals but refused recreation and a shower. The officer assigned to the SMU for the day shift was According to an entry in the Echo Bravo logbook, at 7:35 a.m. (b)(6); notified medical because detainee RAYSON was crying in his cell. She stated during interview that it "got to my heart the way he sounded," and that when she called medical, she said, "You've got to get here right away." Asked for her observations of detainee RAYSON prior to this date, she said she does not recall that he ever showered on her shift, made only one phone call, and did not go to recreation because he was too weak. She also stated RAYSON "laid there and whined all the time." documented a segregation round at 7:55 a.m., possibly in response to (b)(6); call. She did not record a pain level, but gave detainee RAYSON a dose of Percocet. She did not note or report during interview any observations concerning sanitary conditions in his cell. (b)(6); (b)(7)(C) documented that at 4:00 p.m., RAYSON was "sick, vomiting, low blood sugar." Per video surveillance footage, her actual time of entry to the SMU was 4:51 p.m. (b)(6), (b)(7)(C) note documents the detainee complained of pain throughout his whole body at a level ten, associated with "nausea and vomiting, radiating pain, and tearing." He stated nothing was relieving his pain. (b)(6); (b)(7)(C) wrote she was unable to obtain vital signs due RAYSON's being in segregation, but his finger stick blood glucose level was very low at 64. Diabetes medications Metformin and glipizide were held, and he received no regular insulin. He was given Boost nutritional supplement but was unable to keep it down. His lips were dry and cracked, and his appearance was described as poor. During interview, (b)(6); (b)(7)(C) provided additional information, stating she went to the unit to perform blood sugar checks and before she entered the second door, heard detainee RAYSON crying. She went to his cell and observed him sitting on his bed. She noted vomit and feces on his clothes, and observed the cell was "filthy", with urine and vomit on the floor and vomit in the emesis pan. (b)(6); (b)(7)(C) commented he "couldn't have cleaned it if he wanted to" because he was weak and appeared to be dehydrated. It is noted there is no reference in the medical record to issuance of an emesis pan or like receptacle, although (b)(6); (b)(7)(C) stated during interview that while assigned to the SMU at some point, RAYSON asked for a bucket because he had to vomit. She said she called medical and a nurse later brought a "tray thing." This information is not documented on the Confinement Record or elsewhere; therefore, the date cannot be determined. (b)(6); (b)(7)(C) informed the review team that she called (b)(6); (b)(7)(C) and requested that a wheelchair be brought to the unit to transport RAYSON to the clinic. She stated it was clear he needed to be sent to the hospital. Per video surveillance footage, (b)(6), (b)(7)(C) entered the unit with wheelchair at 5:03 p.m. Consistent with (b)(6); (b)(7)(C) account, (b)(6); (b)(7)(C) reported to the review team that she observed a "bucket full" of vomit, and that RAYSON had urinated and DETAINEE DEATH REVIEW: Roger RAYSON Page 27



defecated on himself. She also commented that the stench was so bad she almost vomited herself. It is noted security staff did not document observation of poor sanitary conditions in the cell while making rounds this date or previously, and during interview of (b)(6); (b)(7)(C) she stated she did not recall seeing urine or vomit.

(b)(6); (b)(7)(C) assisted with putting RAYSON in the wheelchair, noting that his lips were dry and cracked and that he could barely hold his head up. (b)(6); (b)(7)(C) reported that officers wanted to place the detainee in restraints, which is required per policy when moving detainees in segregation, but upon request of (b)(6); (b)(7)(C) they did not do so. The Eagle B logbook documents detainee RAYSON left for medical at 5:19 p.m.; video shows he left via wheelchair at 5:09 p.m. The camera at the main entrance to the clinic shows (b)(6); (b)(7)(C) entering with detainee RAYSON at 5:11 p.m.

medical record entry, detainee RAYSON's vital signs were within normal limits with the exception of an abnormally rapid heart rate of 111, an elevated respiratory rate of 22, and elevated temperature of 98.9. His weight was recorded at 167, a 13 pound loss since he was last weighed taken nine days earlier, February 2, 2017. (b)(6); (b)(7)(C) contacted (b)(6); (b)(7)(C) by telephone and received an order to transfer detainee RAYSON to LaSalle General Hospital (LGH) by ambulance. During interview, (b)(6); (b)(7)(C) stated it was clear RAYSON had to go to the hospital, remarking that she observed his condition significantly declined over the period he was in segregation. (b)(6); (b)(7)(C) also reported that RAYSON's declining condition was discussed at daily meetings with nurses and (b)(6); information confirmed by (b)(6); (b)(7)(C)

The Central Control Log documents that a LaSalle ambulance entered the vehicle sallyport at 5:44 p.m. Per video surveillance footage, emergency medical services (EMS) responders entered the clinic with a gurney at 5:45 p.m., detainee RAYSON was assisted onto the gurney at 5:47 p.m., and he was wheeled out of clinic at 5:48 p.m. The Central Control log documents the ambulance exited the facility at 6:03 p.m. and arrived at the LGH emergency room at 6:11 p.m. Per (b)(6); (b)(7)(C) medical record entry, his pain remained at level ten at the time of ambulance transfer to the hospital.

b)(6); (b)(7)(C) accompanied the detainee to the hospital in the ambulance; (b)(6); (b)(7)(C) followed in the chase vehicle. The log maintained by the officers documents RAYSON was initially placed in emergency room number four after arrival at LGH at 6:09 p.m. Blood work and X-rays were taken and at 9:07 p.m., the detainee was admitted. (b)(6); (b)(7)(C) documented in the medical record that RAYSON was admitted to room 215 for dehydration and elevation of blood calcium.

As detailed below, detained RAYSON remained at LGH until transferred to the Tulane Medical Center six days later, February 17, 2017. He returned to LGH on February 22, 2017, then was transferred to Lafayette General Hospital on March 4, 2017. He remained there until his death



on March 13, 2017. The following timeline summarizes updates on RAYSON's status received from hospital staff and documented in the medical record by RNs, provider notes in the medical record, entries to the hospital log maintained by officers, and information provided by staff during interviews.

February 12, 2017

Hospital update: Patient admitted with possible sepsis and receiving two antibiotics. He had a fever of 102-103 degrees.

Per the officer's logbook, at 2:37 a.m. RAYSON had a fever of 103.6 degrees and six minutes later, vomited on his bed and clothing. At 4:09 a.m. his temperature was 102.8. At 5:13 a.m. he got up from the bed to use the restroom but urinated on himself before he could get there. Subsequent entries for this date document RAYSON was able to use the restroom on his own twice in the morning and that he had a CT scan³⁹.

February 13, 2017

Hospital update: The patient's temperature was down; no vomiting; still weak and receiving intravenous (IV) antibiotics.

The logbook documents detainee RAYSON watched television, slept and used the restroom. He refused breakfast and initially refused lunch because it included pork, but hospital staff replaced his tray with a non-pork meal. At 12:16 p.m. he was given a blood transfusion. Due to incontinence, hospital staff placed the detainee in a diaper.

February 14, 2017

Hospital update: Patient weak and complaining of stomach pain. He requested pain medications every four hours.

Per logbook entries, the detainee vomited several times and was given anti-nausea medication. and (b)(6); (b)(7)(C) came to LGH to check on the detainee. At 2:00 p.m., (b)(6); (b)(7)(C) The reviewers note there is no corresponding entry in the medical record documenting this visit.

February 15, 2017

Hospital update: IV antibiotics continued; patient eating and drinking better.

Officers logged the following:

Time	Entry
3:50 a.m.	Detainee sitting up in bed and "crying in pain." When notified, nurse
	replied he would have to wait until 5:00 a.m. for additional pain

 $^{^{39}}$ A CT scan uses a computer-processed combinations of many x-ray measurements taken from different angles to produce cross-sectional images of specific areas of the body.



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	medication.	
4:30 a.m.	Nurse administered pain medication after RAYSON continued to cry out	
	in pain.	
6:39 a.m.	Detainee was again crying and complaining about the pain.	
6:53 a.m.	Detainee was again crying and complaining about the pain.	
7:40 a.m.	Detainee complained about pain in his right knee.	
8:00 a.m.	Detainee was still crying about pain.	
8:26 a.m.	A nurse administered IV pain medication.	
9:54 a.m.	Detainee was taken for a CT scan of his right knee.	
10:27 a.m.	Detainee was started on IV antibiotics.	
11:30 a.m.	Detainee was crying and complaining of pain.	
11:41 a.m.	Detainee threatened to pull out his IV. He stated he is in pain and the	
	staff are not helping him. Per the entry, he said "they are killing him."	
	The nurses advised him the medication is on a time schedule and that he	
	cannot get pain medication every time he asks for it.	
12:17 p.m.	The doctor advised the detainee his CT scan was "fine" and it is just	
	arthritis.	
12:20 p.m.	Detainee refused lunch.	
6:00 p.m.	Detainee continued to complain about pain and to demand more medication.	

Officers on the following shift, 6:00 p.m. to 6:00 a.m. the next day, logged that the detained continued to cry in pain and request more pain medication.

February 16, 2017

Hospital update: Patient's condition stable; IV antibiotics continued.

Per the log, detainee RAYSON pulled out his IV at 7:50 a.m. An hour later, the doctor entered the room and asked the reason. The IV was then replaced. At 10:45 a.m., restraints were applied as the detainee was refusing to stay in bed. At 5:28 p.m., the detainee again pulled out his IV. At 6:15 p.m., pain medications were delivered via an injection. RAYSON rested quietly in bed or slept from 7:30 p.m. to 6:00 a.m. the next morning.

February 17, 2017

Hospital update: A CT of head was completed due to the detainee's confusion. A large subdural hematoma 40 was found.

Per the logbook, the detainee was taken for a chest X-ray and brain scan at 8:45 a.m. At 4:40 p.m., he cried about pain in his belly, knee and head. At 7:30 p.m., hospital staff made the decision to transfer detainee RAYSON to Tulane Medical Center in New Orleans, approximately



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⁴⁰ A subdural hematoma is a collection of blood below the outer membrane covering the brain.

233 miles away. At 7:56 p.m., the detainee was placed in an ambulance with (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) following in the chase vehicle. The ambulance arrived at Tulane at 00:05. (b)(6); (b)(7)(C) recalled on interview that the ambulance was "really rolling" during the trip to New Orleans.

February 18, 2017

Hospital update: CT scan of head showed a subdural hematoma. The CT scan was ordered because the patient's mental status declined during his hospital stay. Once results were received, efforts to have the patient transferred were made "for hours" before getting acceptance at Tulane. Patient was transferred to Tulane Medical Center-Downtown during night. He was admitted to ICU bed 3372. According to a Tulane Hospital RN, a hematoma evacuation was performed after RAYSON arrived at Tulane. Patient in stable condition.

Per the log, the detainee underwent a burr hole procedure⁴² at 9:54 a.m., completed at 10:47 a.m. At 3:49 p.m., the detainee attempted to remove his catheter and medical restraints were applied to his arms. Throughout the rest of this day, detainee RAYSON slept and when awake, complained of pain and attempted to get out of his bed.

February 19, 2017

Hospital update: Patient stable and resting. Results of a CT scan were awaited.

Log entries at 8:11 a.m. and 12:16 p.m. document officers informed nursing staff that the detainee's head wound was bleeding. Throughout the day, the detainee slept or watched television without incident, although he continued to request pain medication.

February 20, 2017

Hospital update: Patient stable, alert and oriented; head incision closed.

The log documents detainee RAYSON's right knee was X-rayed at 3:08 p.m. and the drain was removed from his head at 4:22 p.m. The detainee continued to moan and cry in pain throughout the day.

February 21, 2017

Hospital update: No change in the patient's status. He was treated for pain; IV antibiotics continued.



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⁴¹ Hematoma evacuation means removal of the blood collection, in this case using a burr to drill a hole into the cranium

⁴² Burr hole is a procedure to enter the skull in order to begin hematoma evacuation.

Per the log, at 5:55 p.m. Tulane Medical Center discharged detainee RAYSON by ambulance for return to LGH. The ambulance arrived at LGH At 10:30 p.m. and the detainee was admitted to room 210.

February 22, 2017

Hospital update: Patient stable and doing well.

documented receipt of the Tulane Medical Center discharge note summarizing the procedures completed during his five-day hospitalization. He had one positive blood culture for methicillin resistant staphylococcus aureaus (MRSA). The procedures were considered successful, and he was returned to LGH for continued antibiotic (Vancomycin) treatment for 14 days. At the time of discharge he was described as neurologically stable.

The log documents RAYSON ate lunch and asked to sit up in a chair. He declined dinner. (b)(6); (b)(7)(C) who worked the 6:30 p.m. to 6:30 a.m. shift, stated it seemed the detainee "had rebounded." He recalled that they spoke and the detainee asked for water. Throughout the shift, RAYSON mainly slept.

February 23, 2017

Hospital update: Patient stable and resting after medication was administered for pain.

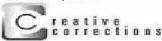
Log entries document the detainee sat in a ch	nair and watched television.	At 12:25 p.m. (b)(6);
(b)(6); (b)(7)(C)	arrived.	

documented in the medical record that RAYSON was alert, oriented, with good neurological cognitive and physical status. He continued to receive IV antibiotics. Per (b)() note, detainee RAYSON stated, "I am ready to get back to my country." RAYSON signed an authorization to release information to his consulate once removed to Jamaica. He was told that he needed to complete the course of antibiotics and a possible repeat CT scan before being cleared to fly. He acknowledged the information and expressed his appreciation for everything done.

As noted previously, (b)(6); (b)(7)(C) stated that the first available ICE flight to Jamaica after issuance of the travel document was scheduled for this date, February 23, 2017. He informed the review team that a new travel date was set for on or after March 12, 2017, and the next scheduled charter flight was March 23, 2017. According to the AFOD, ERO explored an air ambulance and other options for removing RAYSON ahead of that date. Approval for a commercial flight was granted pending medical clearance.

A log entry timed 4:50 p.m. notes the detainee began to cry and complain about pain. At 7:40 p.m., detainee RAYSON threatened to disconnect the IV and flip over medical items if he did not receive assistance. He then slept for most of the night until he began crying again at 5:00 a.m.





February 24, 2017

Hospital update: Patient treated for pain; IV antibiotics continued; vital signs stable; no fever.

Per the log, RAYSON hollered out in pain and complained about pain in his chest and knee. Throughout the night he slept or cried in pain when awake.

February 25, 2017

Hospital update: Vital signs stable. Patient has poor appetite and was vomiting some. Narcotic treatment given for pain.

The log documents that the detainee was rude and "doesn't cooperate" with medical staff. He declined lunch and complained of belly pain. At 12:25 p.m. he removed his IV from the port. At 2:05 p.m., he vomited and was provided with medication. The detainee declined his supper tray and stated food makes him sick. After he declined all three meals, a nurse's aide brought him chicken broth and Jell-O. He refused both.

February 26, 2017.

Hospital update: Patient's appetite poor and eating little. No nausea or vomiting. Vital signs stable.

Per the log, detainee RAYSON slept throughout the night until he began screaming in pain at 5:30 a.m. At 8:35 a.m. the detainee was not cooperative with medical staff. The detainee refused his breakfast and lunch trays and complained of a bad headache. At 3:25 p.m. he removed all of his clothes including his diaper. At 4:50 p.m., he was crying and the officer asked him what was wrong. He replied that he didn't know. At 6:10 p.m., the detainee refused to cooperate with an aide's attempt to take his blood pressure.

who worked the 6:30 p.m. to 6:30 a.m. shift, reported to the review team that he called the nurse to lift the detainee up to go the bathroom. He stated the detainee was "kind of rebellious" if he didn't get out of bed right away. The log documents that at 8:25 p.m., "[Detainee] roll out of bed; nurse was insistent [detainee] Had no medical issues."

February 27, 2017

Hospital update: Vital signs stable; IV antibiotics continued; medicated for pain three times.

Log entries document that at 6:30 a.m., the detainee "is more or appears more drowsy than usual." At 8:22 a.m., RAYSON was very confused and did not cooperate with the nurse. He declined the lunch tray and complained of belly and chest pain. At 1:15 p.m., he drank half a cup of chicken broth. At 1:45 p.m., (b)(6); (b)(7)(C) entered the detainee's room. It is noted there was no corresponding entry in the medical record. At 5:20 p.m., detainee RAYSON sat up in a chair but he refused his dinner tray ten minutes later.



February 28, 2017

Hospital update: CT scan pending due to change in mental status.

The log documents detainee slept throughout the night until he was taken for an X-ray at 4:32 a.m. He refused breakfast. Per request of hospital staff, handcuffs were removed at 10:52 a.m. after approval was given by (b)(6); (b)(7)(C) who personally reported to LGH to review the situation. At 11:34 a.m. detainee RAYSON was again taken for an X-ray and refused his lunch tray when he returned to his room. He made several attempts to get out of his bed during the afternoon.

Per entry to the LDF medical record, (b)(6); (b)(7)(C) made a round at the hospital with attending physician (b)(6); (b)(7)(C) He wrote that according to (b)(6); (b)(7)(C) RAYSON's mental status changed. A CT scan revealed a re-accumulation of blood related to the subdural hematoma. (b)(6) was in the process of arranging transfer of the patient back to the neurosurgery service at Tulane. (b)(6); (b)(7)(C) wrote that while the doctors were making rounds, the nurse informed them that the patient sustained a fall a few days earlier. As noted above, the hospital log documents that after RAYSON rolled out of bed to the floor on February 26, 2017, nurses stated he had no related medical issues. The LGH record includes no reference to the fall or assessment thereafter. No further information was available.

March 1, 2017

Hospital update: Patient responding only to painful stimuli. Dextrose (sugar) IV fluids given.

The log documents the detainee slept throughout the night without any incidents but refused his breakfast and lunch trays. At 12:38 p.m., (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) visited the detainee. At 4:52 p.m., the dinner tray was delivered but the detainee was "too weak to eat." No unusual incidents were logged throughout the night.

RAYSON responded verbally, continued to receive IV antibiotics, and maintained stable vital signs. However, his nutritional intake was inadequate. The information was sent to the neurosurgeon at Tulane, and (b)(6); (b)(7)(C) was waiting on a response to determine if RAYSON would be transferred.

March 2, 2017

Hospital update: Patient remains lethargic and mentally compromised. IV antibiotics continued.

Per the log, the detainee refused his breakfast and lunch trays and was no longer taking any food, liquids or medications by mouth. At 12:35 p.m., he was given a platelet infusion and at 1:20 p.m. (b)(6); (b)(7)(C) arrived to evaluate the detainee. The detainee did not respond to staff and continued sleeping. The detainee then slept through the night.

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In an entry to the medical record, (b)(6); (b)(7)(C) documented (b)(6); (b)(7)(C) informed him "refusal of acceptance to Tulane did not happen. He states that he is awaiting a response from the neurosurgeon at Tulane." As the officers logged, the detainee had received a transfusion of platelets. His vitals remained stable, and he responded to verbal stimuli with eye opening.

March 3, 2017

Hospital update: Patient's only response is moaning when turned.

Per the log, a nurse fed RAYSON at 7:25 a.m. He watched television. At 11:42 a.m., the nurse again fed the detainee and at 12:13 p.m., (b)(6); (b)(7)(C) visited the detainee. At 5:30 p.m., the nurse tried to feed the detainee dinner but he refused. Detainee RAYSON slept throughout the night.

wital signs remained stable. (b)(6); (b)(7)(C) was waiting to hear from the neurosurgeon, and informed (b)(6); (b)(7)(C) that he planned to contact an infectious disease specialist in New Orleans.

Per RAYSON's account summary, a deposit of \$50 was made to his account by (b)(6); (b)(7)(C)

March 4, 2017

Hospital update: Condition worsening; persistent fever. Patient developed sepsis⁴³ and was pending transfer to Lafayette General Hospital. The Consultation Request and Hospital Transfer Form prepared by (b)(6); (b)(7)(C) authorized transfer due to "severe decline in condition."

The log documents a nurse's aide told officers detainee RAYSON was not eating but was holding food in his mouth. At 12:22 p.m., the detainee was taken for a CT scan. At 4:28 p.m., detainee RAYSON was moved to emergency room two for intubation. An ambulance was en route to take detainee RAYSON to Lafayette General Hospital. At 6:10 p.m., detainee RAYSON was placed in the ambulance for transfer to Lafayette General Hospital in Lafayette, LA, 127 miles away. The ambulance arrived at the Lafayette hospital at 8:21 p.m. and RAYSON was admitted to the Intensive Care Unit (ICU). According to the log entry, the hospital staff had to re-intubate the detainee because, "the tube was in his stomach and not in his lungs."

March 5, 2017

There was no hospital update documented in the medical record.



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⁴³ A life-threatening complication of an infection

Per the log, at 1:47 p.m. the nurse told the officers they were going to take RAYSON off the ventilator. The detainee had "mittens"⁴⁴ on his hands to prevent him from removing medical tubes. At various points throughout the day he attempted to remove the mitts from his hands.

March 6, 2017

Hospital update: Patient remains on a ventilator; in much better state than when admitted. Cooling blanket in place, with no fever. IV antibiotics continued.

The log documents that at 7:13 a.m. the nurse informed the detainee they would attempt to remove the breathing tube. When asked, the detainee could not lift or move his arms or legs but he was able to wiggle his toes. At 7:45 a.m., the detainee's daughter called the hospital inquiring about visiting hours and was directed to call LDF. At 9:00 a.m., the breathing tube was removed and the detainee was stable but still listed as critical. At 10:35 a.m., the detainee's fiancée called the hospital to say she was flying in to see RAYSON. Per the officer's log entry, an LDF Captain whose name he did not document stated the fiancée was not authorized to visit.

March 7, 2017

Hospital update: Little change; patient remains on IV nutrition and hydration.

Per the log, RAYSON's fiancée was reportedly in the waiting area at 00:15 a.m. The hospital security officer and an LDF officer went to the waiting area and informed her that only the detainee's daughter was approved to visit. She was instructed to contact b)(6); (b)(7)(C) or ERO staff for permission to visit.

The last entry to the LDF hospital log is timed 6:40 a.m. when officers documented they were relieved by staff from the Pine Prairie Detention Center. This facility, located in Pine Prairie, LA, is also operated by GEO and is closer to Lafayette General Hospital. It is noted that the first entry to the Pine Prairie log documents officers took over vigil duties at 6:38 p.m. The discrepancy cannot be explained. If other Pine Prairie officers were on the previous shift, they made no entries to the log.

March 8, 2017

Hospital update: No change; patient has fever and remains lethargic.

Per the hospital log, detainee RAYSON had a CT scan at 1:20 p.m. The log also documents hospital staff drew blood, gave IV <u>fluids and pain medications</u>, and <u>bathed</u> him. At 6:16 p.m., the detainee had a visit by his <u>daughter</u>, (b)(6); (b)(7)(C) At 7:20 p.m., nursing staff notified the officers that the detainee's girlfriend tried to visit him earlier in the day by posing as his daughter and was escorted off the premises. At 9:20 p.m., the detainee's daughter



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⁴⁴ The referenced mittens are presumed to be hand restraint mitts commonly used in hospitals for the stated purpose.

left RAYSON's room for the night. At 10:50 p.m., the detainee vomited and was provided with anti-nausea medicine. At 11:24 p.m., the detainee was put on oxygen.

March 9, 2017

Hospital update: No change; patient has fever and remains lethargic.

The log documents detainee RAYSON's daughter returned at 9:08 a.m. She visited until 9:58 a.m. and returned to visit from 1:02 p.m. to 1:58 p.m. No unusual occurrences were logged throughout the night.

March 10, 2017

Hospital update: Lethargy and fever persists. A Do Not Resuscitate (DNR) order was filed.

Per the log, RAYSON was taken for a CT scan at 4:13 a.m. His daughter visited at 1:14 p.m.

March 11, 2017

Hospital update: Patient continues to decline; IV morphine and antibiotics continue.

The log documents RAYSON's daughter visited from 8:58 a.m. to 10:05 a.m. and from 1:01 p.m. to 2:00 p.m.

March 12, 2017

Hospital update: Patient being treated for fever; pain medications were increased.

The logbook documents no events of note during the day.

March 13, 2017

Hospital update: Continued lethargy and no verbal response.

His entry states the death was due to cardiopulmonary arrest.

Per incident report of assigned officer (b)(6); (b)(7)(C)	, RAYSON's condition
began "deteriorating quickly" this date. He wrote that at 3:10 p.m., RA	YSON's "vital signs and
breathing decreased" and at 3:12 p.m. his "breathing came to a stop." 1	He was pronounced dead
by $(6)(6)$; at 3:20 p.m. and at 5:30 p.m., the detainee's body was rele	ased to the custody of
Lafayette forensics. Entries in the logbook are consistent with (b)(6); (b)(7)(C) report.
(b)(6); (b)(7)(C) documented RAYSON's death at 3:20 n m	in the medical record

Documented actions in the aftermath of RAYSON's death are as follows:

• (b)(6); (b)(7)(C) documented on March 13, 2017 that notifications were made to IHSC headquarters, the AFOD and local ICE personnel upon RAYSON's death.



- According to ERO memorandum dated March 13, 2017, the Consulate of Jamaica in Miami, FL was notified by ERO New Orleans of RAYSON's death, and Jamaican Consular officials notified his next of kin.
- Notification to the OPR Joint Intake Center by email from (b)(6); (b)(7)(C) 45 dated March 13, 2017 listed the preliminary cause of death as lymphoma.
- A death report completed by (b)(6); (b)(7)(C) on March 14, 2017 lists the apparent manner of death as cardiopulmonary arrest, consistent with (b)(6); (b)(7)(C) medical record entry.
- On March 14, 2017, the \$50 deposited in detainee RAYSON's account on March 3, 2017 was refunded to the depositor via a check.
- An autopsy was conducted approximately four months following RAYSON's death, July 10, 2017. According to report of forensic pathologist (b)(6); (b)(7)(C) primary findings showed evidence of remote subdural hemorrhages causing a traumatic brain injury. He noted, "Likely the subdural hemorrhage led to a traumatic brain injury which ultimately caused the death. The complications of contributing factors such as obesity, hypertensive atherosclerotic cardiovascular disease 7, meningitis 8, and complications of HIV, including treatment, cannot be ignored as well. Subdural hemorrhages are of different ages on the left and right, but both are at least weeks old. The subarachnoid hemorrhages on the bilateral temporal lobe poles may be countercoup injuries indicating a fall but are not typical of this. The platelet count of 51,000 is not low enough for a spontaneous hemorrhage as a cause of the subdural hemorrhages. Since it is not known what caused the subdural hemorrhage, the manner of death is best considered undetermined until further investigation has ruled out a possible homicide."
- The State of Louisiana, Department of Health, Office of Public Health issued Certification of Death on August 4, 2017. In the section, "Cause of Death", instructions on the form call for noting "IMMEDIATE CAUSE (Final disease or condition resulting in death)", and sequentially listing conditions leading to the immediate cause. The underlying cause, defined as "disease or injury that initiated the events resulting in



⁽b)(6)(b)(7)(C) is not identified by title or function on the email.

⁴⁶ Blood pooling between the brain and its outermost covering

⁴⁷ Build-up of fats, cholesterol and other substances in and on the artery walls

⁴⁸ Inflammation of the brain and spinal cord membranes typically caused by an infection

⁴⁹ Bleeding in the space between the brain and the tissue covering the brain

⁵⁰ One of four major lobes of the brain

⁵¹ An injury that occurs on the side opposite of the area that was hit

⁵² Cells that are involved in clotting of blood.

death", is to be entered last. The immediate cause of death was, "Remote subdural hemorrhage due to unknown factors." Sequentially, hypertensive artherosclerotic cardiovascular disease, diabetes mellitus, and complications of HIV were listed. Obesity was documented as a significant condition contributing to death but not resulting in the underlying cause. The manner of death "could not be determined."

CONCLUSIONS

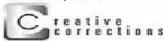
Medical

Detainee RAYSON was seriously ill when he arrived at LDF during the early morning hours of January 28, 2017. He was seen by a provider within hours of admission, and medications accompanying him from FBOP were continued. Regularly scheduled medications were given as ordered during the detention period, although there were occasional gaps in administration of asneeded medications for pain and documentation thereof. In addition, there was one very grievous medication error when RAYSON was given morphine without documentation of provider order. An oncology consultation ordered by the provider during the initial physical examination was in process but not completed during the detention period, and an infectious disease consultation also ordered during physical examination was not processed. The recommendations of IHSC's infectious disease consultant were not reviewed by LDF providers.

The seriousness of RAYSON's medical condition was recognized and of considerable concern to medical staff. They communicated their concerns to the AFOD, whose efforts to expedite RAYSON's removal were complicated and ultimately thwarted by the detainee's condition, which precluded medical clearance to fly. Medical staff also attempted to have the detainee hospitalized. He was sent to the emergency room the day after his arrival at LDF, but to the surprise of providers, was returned to the facility after evaluation in the emergency room. No subsequent attempt at hospitalization was made during the ten days that followed, until February 11, 2017 when RAYSON was taken to the emergency room in apparent medical crisis. However, according to (b)(6); (b)(7)(C) she recommended to (b)(6); (b)(7)(C) she recommended his return to the hospital in discussion with (b)(6); on February 6, 2017.

Detainee RAYSON was housed in the MHU for the first four days following admission. Nurses and NPs made required rounds, and RAYSON was evaluated once by hysician started family leave that would extend into the detainee's second and final transfer to a hospital. Serving in before the physician started family leave that would extend into the detainee's second and final transfer to a hospital. Serving in before the physician started family leave that would extend into the detainee's second and final transfer to a hospital. Serving in before the population on February 2, 2017, documenting he was stable, in spite of severe pain, lethargy, and tearfulness only three hours prior. In the preceding days, RAYSON's pain level was most often reported at seven and on two occasions, as high as ten. Two reports of level ten pain as well as





vomiting were documented the day before (b)(6); discharged RAYSON from the MHU. Reports of pain below level seven followed administration of pain medication.

The medical record does not document [b](6); assessed RAYSON in person prior to directing his discharge from the infirmary, nor does it reference information reported by [b)(6); during interview; specifically, that he made the decision after reviewing lab test results showing RAYSON was not immune-compromised. He also stated he believed that discharge from the MHU would support the detainee's mental health because he would not be isolated.

After directing RAYSON's discharge from the MHU, and following notification the detainee was experiencing level seven pain before he was moved, both ordered narcotic medication tramadol every six hours as needed. In clearing RAYSON for housing in general population, both did not order nursing checks; therefore, it is unclear how the detainee's pain would be monitored for administration of pain medication as needed. In addition to the order for tramadol, the MAR indicates both ordered narcotic medication morphine, given a half hour after RAYSON received tramadol. Other than the note on the MAR, there is no documentation supporting the order for morphine was given.

RAYSON spent less than an hour in the general population dormitory before being removed at the insistence of other detainees. The RN who cleared him for segregation stated returning the detainee to medical housing was not an option because a provider discharged him and his status was unchanged. Despite RAYSON's serious medical condition, no provider was notified he was being placed in segregation. In the SMU, medical monitoring consists of once daily rounds by RNs which do not entail conducting assessments or taking vital signs. In addition, detainees in the SMU are restricted to their cells for time equaling or exceeding that in the MHU, defeating intended purpose of allowing RAYSON more freedom of movement and less isolation.

On February 5, 2017, three days after placement in the SMU, RAYSON was brought to the clinic reporting severe generalized pain and nausea. Medications were ordered and given, and after he reported his pain decreased from level ten to level eight, (b)(6); (b)(7)(C) directed that he return to his housing area. According to (b)(6); (b)(7)(C) who disagreed with the decision, she advocated RAYSON's return to the MHU and/or hospitalization to (b)(6); (b)(7)(C) said that although he was not comfortable with RAYSON's housing in segregation, he did not intervene because it was his understanding RAYSON wanted to be there.

RAYSON's condition continued to deteriorate. On February 11, 2017, he was moved to the clinic after a nurse went to the SMU and found him crying and complaining of level ten pain throughout his entire body. He had vomited, defecated and urinated on himself, and vomit filled a receptacle, likely an emesis pan. His blood glucose was low, and his temperature and heart rate were elevated. Nursing staff called a provider and received an order to transport RAYSON to



the hospital by ambulance. There were no delays in arranging for his transport and facilitating access by emergency responders.

Detainee RAYSON was first hospitalized at LGH, then was transferred to Tulane Medical Center. He returned to LGH before being transferred to Lafayette General Hospital where he died on March 13, 2017. With only one exception, nurses obtained daily updates from hospital staff. (b)(6); (b)(7)(C) visited RAYSON while at LGH and (b)(6); (b)(7)(C) maintained communications with the LGH attending physician.

Compliance Findings

Creative Corrections cites the following deficiencies in the ICE PBNDS 2011 governing medical care:

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

- On January 30, 2017, detainee RAYSON was given no pain medication for over seven hours after reporting pain at level seven.
- On February 1, 2017, the RN did not contact a provider for a pain medication order after RAYSON reported level seven pain. He received no medication for seven hours when given a regularly scheduled dose.

Medical Care, section (V)(D), which states, "Consent forms and refusals shall be documented and placed in the detainee's medical file."

• On February 1, 2017, when RAYSON reportedly refused a cane to assist in ambulation, he was not asked to sign a refusal form. The medical record does not document the provider discussed with the detainee that a cane was necessary for fall prevention, and risks associated with falls.

Medical Care, section (V)(J)(2), which states, "If, at any time during the screening process, there is an indication of need of, or a request for mental health services, the HSA must be notified within 24 hours. The CMA, HSA or other qualified licensed health care provider shall ensure a full mental health evaluation, if indicated."

• During the initial health assessment the day of arrival, the NP did not refer detainee RAYSON for mental health assessment, though she described him as having a depressed mood and sad affect.



Medical Care, section (V)(S), which states, "Distribution of medication (including over the counter) shall be performed in accordance with specific instructions and procedures established by the HSA in consultation with the [Clinical Medical Authority]. Written records of all prescribed medication given to or refused by detainees shall be maintained."

- On January 31, 2017, an ordered dose of tramadol was signed out on the Controlled Substance Administration Log at 1:00 p.m. and per medical record entry, was provided at 1:42 p.m. Administration is not documented on the MAR.
- On February 2, 2017, a dose of morphine was signed out on Controlled Substance Administration Log and documented as given on the MAR. The MAR entry documents the morphine was given per order of (b)(6); however, no order was found in the medical record. As discussed in the narrative, administration of a controlled substance, absent an order from DEA-registered provider, is illegal. Determination of circumstances surrounding the apparent medication error is beyond the scope of this analysis given its gravity. There was no documentation of internal review.
- The medical record documents injections of Benadryl and Toradol were given on February 3, 2017. There is no corresponding documentation on the MAR.
- On February 10, 2017, a provider order for promethazine hydrochloride suppositories twice daily was not noted or transcribed onto the MAR, nor is there documentation the suppositories were given.

Medical Care, section (V)(U), which states, "Consistent with the IHSC Detainee Covered Services Package, detainees will be provided medical prosthetic devices or other impairment aids, such as eyeglasses, hearing aids, or wheelchairs, except when such provisions would impact the security or safety of the facility.

- Although detainee RAYSON was described as frail with an unstable gait, he was not provided with a cane, walker or wheelchair when he was discharged from the MHU on February 2, 2017.
- After RAYSON returned to the SMU after being treated in the clinic on February 5, 2017, he was not provided with a cane, walker or wheelchair despite being described as unsteady when walking.

Areas of Note

It is recognized LDF's medical professionals were limited in the care they were able to provide detainee RAYSON given his complex and advanced medical conditions. Multiple providers were involved in his care, and exercised judgment within their purview as clinicians. The



following areas of note are based on documented and reported information and do not constitute evaluation of clinical judgment.

Referral for Specialty Consultations and Hospitalization

- (b)(6); (b)(7)(C) order for an infectious disease consultation was not processed, nor is there documentation the recommendations of IHSC's infectious disease specialist were reviewed by any LDF providers.
- Detainee RAYSON was sent, but not admitted to RRMC when taken by ambulance the day following his arrival. No further attempts at hospitalization were made, although (b)(6): documented and (b)(6): (b)(7)(C) reported that they recommended to (b)(6): that RAYSON be returned to a hospital.

Discharge from the MHU

On the morning of February 2, 2017, (b)(6); ordered RAYSON's discharge from the MHU upon determination that he was stable and would benefit from housing in a less restrictive environment. His determination followed review of lab studies and a nursing assessment which described the detainee as being in severe level ten pain, lethargy, and tearfulness; however, there is no documentation (b)(6); assessed RAYSON in person. Just one day before, February 1, 2017, (b)(6); recommended to (b)(6); that the detainee be returned to the hospital or that the pain medication regimen be adjusted. Neither recommendation was acted upon pending (b)((b)(6); review of the lab studies which ultimately led to his conclusion that RAYSON was stable. After (b)(6); (b)(7)(C) recommendation and just prior to (b)(6); order to discharge RAYSON from the MHU, the detainee was given injections of Toradol and Benadryl for level seven pain. Following the discharge order but before he was transferred from the MHU, RAYSON reported level ten, then level seven pain for which (b)(6); ordered narcotic medication tramadol as needed for six days. Morphine was also given for pain. The order for discharge from the MHU in favor of general population housing remained in place. Reviewers are unclear as to (b)(6); vision for how RAYSON's pain which, since his arrival at LDF, was best managed with asneeded medications, would be monitored and effectively addressed in general population. From a security perspective, placement of a seriously ill detainee with ambulatory challenges, experiencing periodic nausea and vomiting, and receiving narcotics for widespread, frequent pain, was well beyond what officers are trained and should be expected to handle.

Segregation

goal of supporting RAYSON's mental health by decreasing his isolation and moving him to general population is understood given the restrictive nature of medical housing at LDF. However, when the attempt to house RAYSON in general population quickly failed due to other detainees' objections, he was cleared for housing in segregation by an RN. In clearing RAYSON for segregation, (b)(6), accurately stated a provider had discharged him from the MHU; however, the RN did not appear to take into account the totality of RAYSON's condition and events since (b)(6), ordered the discharge, including the order for as needed narcotic medication. The RN's documentation that the detainee "did not appear to have any acute or

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unresolved medical condition that might worsen in segregation" is contradicted by the medical record. At the very least, notification and deferral of the clearance decision to a provider was warranted given RAYSON's advanced illness. Although cells in the MHU are configured and equipped in the same manner as cells in the SMU, and detainees housed therein are subject to much the same restrictions as detainees on segregation, medical monitoring in the MHU far exceeds that in the SMU.

and (b)(6); (b)(7)(C) both stated they were not comfortable with RAYSON's placement in the SMU given his medical condition, but neither took steps to return him to the MHU. (b)(6); (c)(7)(C) stated he did not want to interfere because it was his understanding that RAYSON requested segregation; (b)(6); (b)(7)(C) stated she was uncertain of the reason he was on segregation. Both statements imply sensitivity to the fact segregation is a status assigned for security reasons, without apparent consideration of what led to RAYSON's placement on protective custody. Specifically, he was assigned to the segregation because medical staff did not return him to the MHU, not because the SMU was the first choice of security staff when housing in general population did not work out. If, as both (b)(6); (b)(7)(C) indicated, they were not comfortable with RAYSON's housing in the SMU, it was within their authority to readmit him to the MHU.

Medical Record Integrity

(b)(6); did not sign his note directing RAYSON's discharge from the infirmary for more than a month following the decision, then following the detainee's death, slightly modified it. Signing notes in close proximity to their entry supports the integrity of the medical record.

Medication Administration

In addition to the above-cited deficiencies related to administration of medications, the reviewer notes the following:

- On February 3 and 6, 2017, nurses did not follow up to assess the effectiveness of pain medication. This is standard nursing practice.
- Pain assessments prior to administration of narcotics were not consistently documented.
 Detainee RAYSON was given tramadol on January 31, 2017 without documentation of
 pain assessment, and on February 2, 2017, he was given morphine without pain
 assessment and just 30 minutes following administration of tramadol. Assessing and
 documenting a patient's pain level before administering as needed medication is standard
 nursing practice.

Safety and Security

Detainee RAYSON was moved from intake to the MHU prior to completion of admission processing. According to (b)(6),(b)(7)(C) this was precipitated by a call from an officer stating the



detainee was "hurting and crying." Admission processes not completed in intake included PREA risk assessment and classification interview. The assigned classification was incorrect and not reviewed by a supervisor.

RAYSON remained in the MHU for four days when cleared for general population by ChATMCN.

Once transferred to a dormitory, other detainees objected to his placement because when asked, RAYSON disclosed his medical conditions. According to a sergeant, the detainee declined assignment to another general population dormitory, opting for segregation rather than return to the MHU so he could watch the Super Bowl. When RAYSON arrived in the clinic for clearance to be housed in the SMU, the RN reportedly first stated he could not return to the MHU before clearing him for segregation. The detainee was assigned to protective custody and placed in the SMU.

During RAYSON's nine-day stay in segregation, status reviews were conducted in required timeframes; however, there is no documentation the review included interview of the detainee, and the forms did not consistently document a recommendation and signatures. The Confinement Record documents RAYSON was offered and periodically refused showers, recreation, and meals. The accuracy of Confinement Records is called into question by the fact entries were made the day after RAYSON left LDF for the hospital, February 12, 2017.

Officers interviewed stated it was clear detainee RAYSON was very sick, reporting he sometimes wailed and cried out in pain. There is no security documentation to this effect, and by the SMU was inappropriate due to RAYSON's medical condition. The morning the detainee was hospitalized, a nurse responded to the SMU and administered pain medication after the officer reported the detainee was crying in his cell. Approximately eight hours later, a different nurse heard RAYSON crying as she entered the post to perform blood pressure checks. She went to his cell and observed he had urinated, vomited, and defecated on himself, and vomit and feces were on the floor. Another nurse called to the post described the same conditions and commented the stench was so strong she almost became ill herself. Inexplicably, the officer stated she did not notice the conditions before or after the nurses arrived. RAYSON was moved by wheelchair to the clinic, then was taken to the hospital by ambulance. As noted in medical conclusions, there were no delays facilitating his departure from the facility.

From February 11, 2017 to March 13, 2017, RAYSON was admitted and treated at three different Louisiana hospitals. Officers kept a detailed log of events during these hospital stays. All security staff on duty at the time of detainee RAYSON's death filed timely incident reports.

Compliance Findings

Creative Corrections cites the following deficiencies in relevant components of the 2011 ICE PBNDS governing security, and violations of facility policies and post orders.



Custody Classification System, section (V)(A)(4), which states, "Each detainee's classification shall be reviewed and approved by a first-line supervisor or classification supervisor."

• No supervisor approved the classification completed on detainee RAYSON on January 28, 2017.

The lack of supervisory approval also violates LDF policy and procedure 12.1.4, section (III)(A)(3), which states, "The first-line supervisor will review and approve each detainee's classification."

Telephone Access, section (V)(E)(3), which states, "Even if telephone service is generally limited to collect calls, each facility shall permit detainees to make direct or free calls to the offices and individuals listed below: immediate family or others for detainees in personal or family emergencies or who otherwise demonstrate a compelling need (to be interpreted liberally).

"The indigent detainee may request a call to immediate family or others in personal or family emergencies or on an as-needed basis."

• Detainee RAYSON had no funds in his account and was indigent at the time of the request. A free call to his family should have been permitted.

Environmental Health and Safety, section (V)(A)(3), which states, "The facility administrator shall ensure that staff and detainees maintain a high standard of facility sanitation and general cleanliness."

• There was significant graffiti present in the SMU cell used to house detainee RAYSON when inspected by the review team. In addition, numerous staff expressed concern with the condition of the cell prior to detainee RAYSON's removal to the hospital on February 11, 2017. Multiple staff stated there was vomit, urine and feces in the cell and that the smell was intolerable.

Special Management Units, section (V)(A)(1)(c), which states, "Use of administrative segregation to protect vulnerable populations shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing options exist, and as a last resort. Detainees who have been placed in administrative segregation for protective custody shall have access to programs, services, visitation, counsel and other services available to the general population to the maximum extent possible."



RAYSON's medical condition well qualified him as a vulnerable detainee, particularly in
a high custody housing unit. Although he reportedly requested protective custody rather
than assignment to an alternative general population unit or to the MHU, nowhere is his
request for protective custody documented (see following deficiency). Furthermore,
return to the MHU was the most viable housing option given his condition. It is
understood that only medical providers have the authority to place detainees in the MHU;
however, even as his condition deteriorated, no effort was made by security to explore his
return to the MHU.

Special Management Units, section (V)(A)(2)(e), which states, "If the segregation is ordered for protective custody purposes, the order shall state whether the detainee requested the segregation, and whether the detainee requests a hearing concerning the segregation."

• The segregation order did not document whether the detainee requested protective custody and whether he requested a hearing regarding the assignment.

This deficiency also constitutes a violation of LDF policy and procedure 10.4.1 Restricted Housing Units, section (II)(B)(7), which states, "If the restriction housing is ordered for [protective custody] purposes, the order will state whether the detainee requested the restriction housing; also, whether the detainee requests a hearing concerning the restriction housing."

Special Management Units, section (V)(A)(3)(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."

 There is no documentation detainee RAYSON was interviewed during the 72 hour review. Because he was not interviewed, there was no documented consideration of whether housing in segregation was suitable given his medical condition, and whether return to the MHU should be pursued.

Special Management Units, section (V)(A)(3)(b) and (c), which states, "A supervisor shall conduct an identical review after the detainee has spent seven days in administrative segregation, and every week thereafter, for the first 30 days and every 10 days thereafter, at a minimum.

"The review shall include an interview with the detainee, and a written record shall be made of the decision and its justification."

• There is no documentation detainee RAYSON was interviewed during the seven day review of his status. The same concern noted in the above deficiency applies to this



deficiency. Without an interview, the detainee did not have the opportunity to request a change in his status, and the staff person who conducted the review may or may not have observed or been aware he was as ill as he was.

Sexual Abuse and Assault Prevention and Intervention, section (III)(G)(1), which states, "Detainees shall be screened upon arrival at the facility for potential vulnerabilities to sexually aggressive behavior or tendencies to act out with sexually aggressive behavior."

• The PREA Risk Assessment was not completed until January 29, 2017, the day after detainee RAYSON arrived at LDF.

Areas of Note

- The intercom in the SMU cell #5 was inoperable.
- Forms and logs documenting movement within LDF listed conflicting times. In addition, the date of RAYSON's arrival and date of transfer to the SMU documented on the Housing History Grid were incorrect.
- The SMU Confinement Record documented that detainee RAYSON participated in and refused activities on February 12, 2017, after he departed for the hospital.
- Post Orders for Restricted Housing Unit Officers provide inconsistent requirements with respect to security rounds. Section (12) states, "The officer shall be responsible for checking detainees in RHU four times per hour on an irregular basis"; section (13)(e) states, "Rounds must be made to ensure the health, safety and welfare of all subjects at least every 30 minutes on an irregular schedule."
- On March 7, 2017, events at the hospital were not logged for a period of 12 hours. The log maintained by LDF officers ends at 6:40 a.m. and the Pine Prairie Detention Center log does not begin until 6:38 p.m.



APPENDIX

Vital Signs

DATE	TEMPERATURE	PULSE	RESPIRATIONS	BLOOD PRESSURE	PULSE OXYGEN	BLOOD SUGAR	WEIGHT
1/28/2017	97.3	94	18	132/85	100	233	179
1/28/2017	98.2	89	18	124/76	98		179
1/28/2017	97.6	80	16	116/78			
1/29/2017	98.3	88	18	122/85			
1/29/2017	98.3	79	20	129/85	97		
1/29/2017	97.6	98		131/91	99		
1/29/2017	97.7	125	18	97/64			
1/30/2017	98.0	91	18	121/81	99	210	179

DETAINEE DEATH REVIEW: Roger RAYSON Medical and Security Compliance Analysis October 4, 2017



1/30/2017	98.2	76	16	122/80	97		
1/31/2017	96.0	89	18	128/85		73	
1/31/2017	98.0	89	18	128/85			179
1/31/2017	97.7	112	18	124/88	98		
1/31/2017	98.1	98	18	110/81	96	101	
2/1/2017	98.6	85	16	137/83		163	
2/1/2017	98.0	82	18	135/86			
2/1/2017	98.7	99	18	134/82	100	206	
2/1/2017	97.5	98	18	134/97	U	137	
2/2/2017	98.0	100	18	122/88			179
2/2/2017	97.8	86	20	132/87	100		
2/2/2017	98.6	112	18	127/91			179
2/5/2017	97.6	96	20	133/96	99		
2/5/2017	97.7	80	16	125/86			
2/5/2017	98.9	111	22	112/78			167







RAYSON, ROGER

A/hh/A): SubID: M206839701
Facility Code: JENADLA
47 Y old Male, DOB: 05/03/1969 Account Number: 1000537503 830 Pine Hill Rd, JENA, LA-71342

Appointment Facility: Jena/Lasalle Detention Facility

01/28/2017 Appointment Provider: (b)(6); (b)(7)(C)

1. Pre Screen @ 0230 per [h)/61:
Patient Identification: Patient Identification Patient properly identified by 2 sources including: Picture, Verbally Chaperone Present? Yes Interpretation Provided? Detainee speaks English fluently Pre-Screening: Pre-Screen Was the detainee transferred from another facility? Yes Did a medical transfer summary accompany the detainee? Yes Was the medical summary reviewed? Yes Do you have a current illness or health problems? Yes Are you taking any medications? Yes Are you currently in pain? No Are you afraid someone will hurt you? No Do you want to hurt yourself? No Were there any communication barriers? No
Examination Intake Screening: Intake Pre-Screening Appearance: Normal Behavior: Normal State of Consciousness: Alert Ease of Movement: No noticeable restrictions or difficulties Breathing: Normal Skin: No abnormalities noted
Appointment Provider: (b)(6); (b)(7)(C)
Electronically signed by (b)(6): (b)(7)(C) on 01/28/2017 04:52:30 (Central Standard Time) Sign off status: Completed
Jena/Lasalle Detention Facility 830 PINEHILL ROAD JENA, LA 71342 Tel: 318-992-7613 Fax:



RAYSON, ROGER

A(b)(6): SubID: M206839701
Facility Code: JBNADLA
47 Y old Male, DOB: 05/03/1969
Account Number: 1000537503

830 Pine Hill Rd, JENA, LA-71342

Appointment Facility: Jena/Lasalle Detention Facility

Appointment Provider: (b)(6): (b)(7)(C)

01/28/2017

Allergies

N.K.D.A

Reason for Appointment

1. Intake Screening @ 0340

History of Present Illness

Intake:

Initial Assessment

Was the Pre-Screening Progress Note reviewed? Yes Patient was identified by 2 sources: Picture, Verbally

If detainee was transferred from another facility, did a medical transfer summary accompany the detainee? Yes

What language do you speak? English

Interpretion provided? Not applicable, patient speaks English

Chaperone Present? Yes

Do you have an e-mail address? No

Medical Screening

How do you feel today? Bad

Are you currently in pain? Yes

The severity of pain is rated at 9/10

The pain began 1-2 days ago

The pain is located all over

The character of pain is constant

Are there any aggravating or alleviating facors? Yes

Explain: arthritis, lyphoma

Do you have any current or past medical problems? Yes

If yes, explain. , Non-Hodgkin lymphorna, DM, HTN, Anemia, GERD, Metabolic disorder, Gout, Nausea, Pain, Arthritis, HIV

Are you currently or have you ever taken any medication on a regular basis, including over the counter and herbal? Yes

Do you have your medications with you? Yes

List medications: Abacavir 300 mg 2 caps po daily, Acetaminophen 325 mg po every 6 hours pm, Acyclovir 200 mg po bid, Allopurinol 300 mg po daily, ASA EC 81 mg po daily, Dolutegravir 50 mg po daily, Ferrous Gluconate 324 mg 2 tabs po daily, Fluconazole 200 mg po daily, Gipizide 10 mg po bid, HCTZ 12.5 mg po daily, Indomethacin 25 mg po bid pm gout. Regular Insulin SQ pm per sliding scale, Lamivudine 150 mg 2 tabs po daily, Levofloxacin 500mg po daily, Lisinopril 10 mg po daily, Metformin 1000 mg po bid, Oxycodone/acetaminophen 5/325 mg 2 tabs po every 6 hours pm, Ondansetron 4 mg po every 8 hours pm nausea

Do you have any allergies to include allergies to medication or food? No

Are you nowor have you ever been treated by a doctor for a medical condition to include hospitalizations, surgeries, infectious or communicable diseases? Yes

If yes, explain. For Dx above

Have you ever had a persistent cough for more than three weeks, coughed up blood, had a persistent fever, night sweats, or unexplained weight loss? No

Do you have previous hx of TB? No

Have you had any recent acute changes with your vision or hearing? No Wears glasses

Do you have any specific dietary needs? No

Are you a Transgender? No

Have you ever had or have you ever been vaccinated against Chicken Pox? Admits prior infection Oral Screening

Are you having any significant dental problems? No

Mental Health Screening

Have you ever tried to kill or harm yourself? No

Are you currently thinking about killing or harming yourself? No

Do you have a history of assaulting or attacking others? No

Do you have a physical or emotional trauma due to abuse or victimization? No

Do you know of someone in this facility whom you wish to attack or harm? No

Do you now or have you ever heard voices that other people do not hear, seen things or people that others do not see, or felt others were trying to harm you for no logical or apparent reason? No

Have you ever received counseling, medication or hospitalization for mental health problems?

Have you been a victim of physical or sexual abuse or engaged in behaviors that would put you at risk? No

Do you feel that you are currently in danger of being physically or sexually assaulted? No

Have you ever sexually assaulted anyone? No

Trauma Screening

Have you ever witnessed, experienced, or been confronted with an event or events that involved actual or threatened death or serious injury? No

Learning/Cultural/Religious Assessment

Is there anything important to know about your religious or cultural beliefs that are of concern to you while in detention? No

Have you ever had difficulties learning or understanding written information? Yes

Explain Limited reading and writing ability

Substance Use/Abuse Screening

Have you ever been treated for drug or alcohol problems or suffered withdrawal symptoms from drug use? No

Do you now or have you ever used tobacco products? No Do you now or have you ever drank alcohol? No Do you now or have you ever used drugs? No

Vital Signs

	Pain scale	
9 outof 10	01/28/2017 04:19:20 AM	(b)(6); (b)(7)(C)
	Temp	
97.3 F	01/28/2017 04:19:20 AM	
	HR	
94/min	01/28/2017 04:19:20 AM	
	BP	
132/85 mm Hg	01/28/2017 04:19:20 AM	
	RR	
18 /min	01/28/2017 04:19:20 AM	
	Wt	
179 lbs	01/28/2017 04:19:20 AM	
	Ht	
65.5 in	01/28/2017 04:19:20 AM	
	BMI	
29.33 Index	01/28/2017 04:19:20 AM	
	Fingerstick Glucose	
233	01/28/2017 04:19:20 AM	
	Oxygen sat %	
100 %	01/28/2017 04:19:20 AM	
	RA / #Liters O2 via:	
RA	01/28/2017 04:19:20 AM	Ì

Examination

Intake Screening:

Intake Exam

Patient appears to have normal physical/emotional characteristics and no barriers to communication? Yes

Is the patient oriented to person, place and time? Yes

Bizarre or crazy behavior observed: No

Skin Broken out in bumps/rash observed: No

Excessive sweating observed: No

Abnormal breathing (persistent cough, hyperventilation, etc) observed: No

Physical disabilities observed: No

Agitation observed: No

Malnourished appearance observed: No

Cuts, bruises, jaundice, lesions, scars or tattoos observed: No

Nits or Active lice observed: No

Developmental disabilities observed: No Inability to focus or concentrate observed: No

Shaking/tremors observed: No Needle Tracks observed: No

Does the patient wear glasses or contacts? No

Assessments

1. Abnormal intake screening, referred to medical provider - 00.4 (Primary)

Treatment

1. Abnormal intake screening, referred to medical provider

Notes: Tuberculosis and CXR explained to patient and process completed with appropriate shielding. Physical exam scheduled for patient. Access to medical/dental/mental health care, grievance process explained to patient. Patient given the Medical Orientation and Health Information Brochure and Dealing with Stress Brochure based on the language spoken by the patient. Patient verbalized understanding of any teaching or instruction. Patient was asked if he or she had any additional questions, and any questions were addressed. (h)(6): FNP contacted. Detainee placed in MHU until seen by a provider this AM. Pain meds given as ordered on transfer.

Procedure Codes

82962 GLUCOSE BLOOD TEST

Disposition: Medically Cleared for Custody, with TB clearance Notes: In MHU #6 until seen by a provider

Appointment Provider: (b)(6), (b)(7)(C)				

Electronically signed by (b)(6); (b)(7)(C) on 01/28/2017 05:23:08 (Central Standard Time) Sign off status: Completed
Jena/Lasalle Detention Facility 830 PINEHILL ROAD JENA, LA 71342 Tel: 318-992-7613 Fax:

Patient: RAYSON, ROGER DOB: 05/03/1969 Progress Note: (b)(6): (b)(7)(C) 01/28/2017

Note generated by eClinical Works EMR/PM Software (www.eClinical Works.com)



RAYSON, ROGER

SubiD: M206839701 Facility Code: JENAOLA 47 Y old Male, DOB: 05/03/1969 Account Number: 1000537503 830 Pine Hill Rd, JENA, LA-71342

Appointment Facility: Jena/Lasalle Detention Facility

Appointment Provider: (b)(6); (b)(7)(C)

Surgical History

surgery to remove cyst, also separate surgery for port 2016

Family History

Mother: alive

01/28/2017

Father: alive

Daughter(s): alive

Son(s): alive

Sister(s): alive

Brother(s): alive

3 brother(s), 6 sister(s). 2 son(s), 2 daughter(s)-

Has no communication with his family except for one

sister (b)(6): Patient stays in touch with his children.

Social History

Tobacco Use:

Tobacco Use

Do you now or have you ever used tobacco

products? No

Drugs/Alcohol:

Drugs

Have you used drugs other than those for medical

reasons in the past 12 months? No

Alcohol Screen

Do you drink alcohol? Yes

What type of alcohol do you drink? Beer

How often do you drink? daily

How much do you drink when you drink? 24

When was your last drink? More than 24 months

Do you notice over a period of time that you need to drink more for the same effect? No

Have you ever been in treatment of alcohol use? No

Have you ever gone through alcohol withdrawal in the past? No

Have you ever been convicted for driving under the influence of alcohol? No

Abuse History.

Physical Abuse

Have you ever suffered from physical abuse? No Sexual Abuse

Have you ever been a victim of sexual abuse? No

Allergies

NKDA

Hospitalization/Major Diagnostic Procedure

non-hodgkin's lymphoma fall 2016 MVA injuries to bilateral jaw line, other lacerations

Review of Systems

Anorexia denies. Malaise denies. Oral Lesions (herpes/thrush) denies. Nausea/Vomiting admits. Constipation denies. Diarrhea denies. Abdominal pain/swelling admits intermittently. Weight loss/gain admits after chemo. Peripheral

Neuropathy denies. TB Infection denies. History of Pneumonia denies. AIDS Diagnosis denies. Stool

Changes denies. Jaundice denies. Joint Pain denies. Pruritis denies. Anorectal

pain/lesions denies. General/Constitutional:

Change in appetite denies. Chills denies. Fatigue denies. Fever denies. Headache denies. Lightheadedness denies. Night sweats denies. Sleep disturbance denies. Weight gain denies.

Reason for Appointment

1. Diabetes/anemia/htn/non hodgkin lymphoma burkitts/hiv

History of Present Illness

Physical Exam:

Initial Assessment

Intake Screening was reviewed? Yes

Dental Screening

Do you have any significant dental problems? no

Do you have any dental prosthesis? none

Medical History

Do you have Asthma? Denies

Do you have Cancer? Admits

Do you have Cardiovascular disease? Denies

Do you have Hypertension? Admits

Do you have Hyperlipidemia? Denies

Do you have Diabetes? Admits

Have you had a stroke? Denies

Do you have seizure disorder? Denies

Do you have hepatitis? Denies

Do you have HIV? Admits

Do you now or have you ever had TB? Denies

Do you or have you had any STDs? Denies

Have you ever had or have you ever been vaccinated against Chicken Pox? Admits prior infection

Mental Health History

Manicepisodes? Denies

Depression? Denies

Severe Anxiety? Denies

Psychosis? Denies

History of Psychotropic medications? Denies

Suicide Attempts/Gestures? Denies

Violence towards others? Denies

Mental Health hospitalizations? Denies

Learning difficulties? Denies

Preventative/Screening Medicine History

Have you had a colonoscopy? Admits

Was it normal? Normal

When was your last colonoscopy? 08/2016

Have you had a DRE? Admits

When was your last one? 01/2015

Patient Identification:

Patient Identification

Patient properly identified by 2 sources including: Picture, Verbally

Chaperone Present? No

Interpretation Provided? Provider fluent in detainee's native language

Patient properly identified by 2 sources including: Picture, Verbally

Interpretation Provided? Detainee speaks English fluently

Chaperone Present? No

Patient Identification

Patient properly identified by 2 sources including: Picture, Verbally

Chaperone Present? No

Interpretation Provided? Provider fluent in detainee's native language Patient properly identified by 2 sources including: Picture, Verbally

Interpretation Provided? Detainee speaks English fluently

Chaperone Present? No

Pain Assessment:

Pain

Are you currently in pain? No

Are you currently in pain? Yes

The pain is located left upper forearm

The severity of pain is rated at 7/10

The severity of the pain is moderate

The pain began 4-5 weeks ago The character of the pain is aching, is constant

The associated symptoms are abdominal pain, light headedness

The pain is aggravated by none

The pain is relieved by other

Describe: a shot given (name unknown)

Pain

Are you currently in pain? No

Are you currently in pain? Yes

The pain is located left upper forearm

The severity of pain is rated at 7/10

The severity of the pain is moderate

Weight loss admits, is unintentional, is significant over a period of several months.

Ophthalmologic:

Blurred vision denies. Diminished visual acuity denies. Discharge denies. Itching and redness denies. Pain denies.

redness denies. Pain denies.

<u>ENT:</u>
Blocked ear denies. Decreased hearing denies.

Decreased sense of smell denies. Difficulty swallowing denies. Dry mouth denies. Ear pain denies. Nosebleed denies. Ringing in the ears admits, affecting both ears since MVA. Sinus pain denies. Sore throat denies. Endocrine:

Cold intolerance admits, that is moderate.
Difficulty sleeping denies. Dizziness denies.
Excessive sweating denies. Excessive thirst denies.
Frequent urination denies. Heat intolerance denies.
Weakness admits sometimes. Weight
loss admits after chemo.

Respiratory.

Breathing pattern denies. Chest pain denies.
Cough denies. Hemoptysis denies. Pain with inspiration denies. Shortness of breath at rest denies. Shortness of breath with exertion denies. Sputum production denies.
Wheezing denies.

Cardiovascular:

Chest pain at rest denies. Chest pain with exertion denies. Claudication denies. Cyanosis denies. Difficulty laying flat denies. Dizziness denies. Dyspnea on exertion denies. Fluid accumulation in the legs denies. Irregular heartbeat denies. Orthopnea denies. Palpitations denies. Shortness of breath denies. Weakness admits at times. Gastrointestinal:

Abdominal pain admits intermittently midline of the abdomen upper and lower sections. Blood in stool denies. Change in bowel habits denies. Constipation denies. Decreased appetite denies. Diarrhea denies. Difficulty swallowing denies. Exposure to hepatitis denies. Heartburn denies. Hematemesis denies. Nausea admits, frequent. Rectal bleeding denies. Vomiting admits. Weight loss admits after chemo.

Hematology.

Men Only:

Breastiump denies. Dizziness denies. Easy bruising denies. Fever denies. Groin mass denies. Prolonged bleeding denies. Recent transfusion denies. Swollen glands admits in neck/head. Weakness sometimes. Weight loss admits after chemo.

Difficulty initiating stream denies. Dribbling after urination denies. Hard testide denies. Hernia denies. Hypospadias denies. Lump in groin denies. Penile discharge denies. Rash or blisters on penis denies. Scrotal pain denies. Scrotal swelling denies. Undescended testicle denies.

Genitourinary.

Abdominal pain/swelling admits intermittently midline upper and lower. Blood in urine denies. Difficulty urinating denies. Frequent urination denies. Painful urination denies. Peripheral Vascular:

Absent pulses in hands denies. Absent pulses in feet denies. Blanching of skin denies. Cold extremities denies. Decreased sensation in extremities denies, Pain/cramping in legs after exertion denies, Painful extremities denies. Ulceration of feet denies. Podiatric:

Achilles pain denies. Ankle pain denies. Ankle swelling denies. Ball of foot pain denies. Big toe pain denies. Difficulty walking denies. Fever denies. Foot numbness denies. Joint dislocation denies. Sole pain denies. Wound oozing denies.

Skin:

The pain began 4-5 weeks ago

The character of the pain is aching, is constant

The associated symptoms are abdominal pain, light headedness

The pain is aggravated by none

The pain is relieved by other

Describe: a shot given (name unknown)

Narrative:

47 year old male detainee presents for PE-C with multiple diagnosis. He reports he was detained for smuggling in cocaine. He states his family has turned their back on him. While he incarcerated Dec 2014, he found out he had HIV. In August 2016 he had a bump on his neck, was told it was a cyst and was surgically removed, Jacksonville FI hospital. The area swelled up like a baseball and he was returned to the hospital where they diagnosed him with Non-Hodgkin Lymphoma. He had his first Chemo at a hospital in Florida "sometime in September". States he was suppossed to have chemo every three weeks and hasn't had chemo since the first time in Sept. Was at D. Ray James Correctional facility when diagnosed, move to FMC Lexington in November 2016. I have found the name of Larkin community Hospital in South Mami hospital but he does not believe this is the hospital that diagnosed him or where he received chemo. Pain to the left upper arm. At other times, pain is more generalized. He reports nausea/vomiting, swollen lymph nodes of neck, intermittent fatigue. Denies fever, night sweats, anorexia. Most meats make him nauseous such as bolognia, turkey ham, all pork, beef. He states he has been in touch with a physician in Montego Bay that is ready to treat him.

Medical Housing Unit:

Nursing Rounds

Diagnosis/Reason for admission to M-IU: Use Notes Section . Observation Non-Hodgkin's Lymphoma/I-HIV

Date/time for admission Use Notes section 1/28/2017 11:09

Level of Care required: Medical Level 1

Care needed: oral medication, routine observation.

Frequency of nursing checks: Every 8 hrs.
Frequency of vital signs: every 8 hrs.
Medication orders: Yes, see medication orders
Diagnostic Tests/Treatment orders: Yes, see orders

Diet Orders: Yes, see Special Needs Activities or Restriction orders: As tolerated

Follow-up plan (frequency of provider rounds): Use Notes Section .F/U by physician

Patient education:

Discharge plan: . Unknown at this time

Vital Signs

	Pain scale	
7 outof 10	01/28/2017 09:59:02 AM	(b)(6);
	Temp	(b)(7)(C)
98.2 F	01/28/2017 09:59:02 AM	
	HR	
89 <i>I</i> min	01/28/2017 09:59:02 AM	
	BP	
124/76 mm Hg	01/28/2017 09:59:02 AM	
	RR	
18 /min	01/28/2017 09:59:02 AM	j)
	Wt	
179 lbs	01/28/2017 09:59:02 AM	
	Ht.	
65.5 in	01/28/2017 09:59:02 AM	
	ВМІ	
29.33 Index	01/28/2017 09:59:02 AM	
	Oxygen sat %	
98 %	01/28/2017 09:59:02 AM	

Examination

General Examination:

GENERAL APPEARANCE: alert, in no acute distress, male, ill-appearing, thin, uncomfortable due to pain, cooperative, visibly upset, tearful.

HEAD: Some edema with pain to the right lower scalp area extending up to posterior to the right auricle. Hair scarce and patchy.

ENT: EYES:, normal, PERRLA, conjunctiva clear, EARS:, normal, auditory canal clear, light reflex present, NOSE:, nares patent, SINUSES:, sinuses non-tender to palpation, ORAL CAVITY:, mucosa moist, missing several molars, THROAT:, normal, no erythema, no exudate, pharynx normal, tonsils normal.

EYES: pupils equal, round, reactive to light and accommodation.

EARS: normal, auditory canal clear.

NOSE: nares patent.

ORAL CAMITY: normal, mucosa moist, no lesions, palate normal, tongue in midline, missing teeth.

THROAT: no erythema, no exudate, pharynx normal, tonsils normal, uvula midline. NECK/THYROID: carotid pulse normal, no thyroid nodules, no thyromegaly, thyroid nontender, trachea midline, posterior cervical nodes enlarged, submandibular nodes enlarged.

LYMPH NODES: cervical nodes hard, cervical nodes enlarged, shoddy.

SKIN: normal, no rashes, no suspicious lesions.

HEART: no murmurs, regular rate and rhythm, S1, S2 normal.

LUNGS: normal, clear to auscultation bilaterally, no wheezes, rales, rhonchi.

Hives denies. Rash denies. Scalylesions of skin/scalp denies. Skin lesion(s) denies. Neurologic:

Balance difficulty denies. Coordination admits. Difficulty speaking denies. Dizziness denies. Fainting denies. Gait abnormality denies. Headache denies. Irritability denies. Loss of strength admits sometimes. Loss of use of extremity denies. Low back pain denies. Memory loss denies. Pain admits to left arm. Seizures denies. Tics denies. Transient loss of vision denies. Tremor denies. Psychiatric:

Anxiety denies. Auditory/visual hallucinations denies. Delusions denies. Depressed mood admits. Difficulty sleeping denies. Eating disorder denies. Homicidal Thoughts denies. Inability to concentrate denies. Loss of appetite denies. Wental or Physical abuse denies. Stressors admits due to current situation. Substance abuse denies. Suicidal thoughts denies.
Pain to the left upper forearm.

CHEST: normal, no gross rib deformity, normal shape and expansion, port palpated to the left upper chest wall.

BREASTS: normal.

ABDOMEN: bowel sounds present, liver edge one finger breadth below costal margin, no guarding or rigidity, no hepatosplenomegaly, no organomegaly, no rebound tenderness, soft, nontender, nondistended; small umbilical hernia.

RECTAL: not examined.

BACK: normal, full range of motion.

MALE GENITOURINARY: not done.

MJSCULOSKELETAL: slow shuffling gait, no deformities, full range of motion,.

PERIPHERAL PULSES: 2+ dorsalis pedis, 2+ radial, 2+ ulnar, 2+ brachial, 2+ carotid.

EXTREMTIES: nodule palpated in area of tenderness to the left upper forearm posteriorly, hard nodule palpated that is fixed.

NEUROLOGIC: alert and oriented, cooperative with exam.

PSYCH: alert, oriented, cognitive function intact, good eye contact, no auditory or visual hallucinations, speech clear, thought content without suicidal ideation, delusions, mood depressed, affect sad.

Assessments

- 1. Type 2 diabetes mellitus without complications E11.9 (Primary)
- 2. Anemia in other chronic diseases classified elsewhere D63.8
- 3. Essential (primary) hypertension I10
- 4. Gastro-esophageal reflux disease without esophagitis K21.9
- 5. Burkitt lymphoma, unspecified site C83.70
- 6. Gout, unspecified M10.9
- 7. Unspecified osteoarthritis, unspecified site M19.90
- 8. Human immunodeficiency virus [HIV] disease B20

Treatment

1. Type 2 diabetes mellitus without complications

Start Aspirin EC Tablet Delayed Release, 81 MG, 1 tablet, Orally, Daily AM, 90 days, 90, Refills 0, KOP: No, Drug Source: In House Pharmacy, Notes: Required for travel

Start GlipiZIDE Tablet, 10 MG, 1 tablet, Orally, BID, 90 days, 180 Tablet, Refills 0, KOP: No, Drug Source: In House Pharmacy, Notes: Required for travel

Start Insulin Regular Solution, 100 unite/ml, Sliding Scale, Subcutaneous, BID, 30 days, 1, Refills 2, KOP: No, Drug Source: In House Pharmacy, Notes: Not required for travel

Start Metformin HCl Tablet, 1000 MG, 1 tablet with meals, Orally, BID, 90 days, 180 Tablet, Refills 0, KOP: No, Drug Source: In House Pharmacy, Notes: Required for travel

Notes: Last labwork-last Monday at FMC Kentucky. DFH diet Patient education on

diet/exercise/lifestyle for self care Education on disease process and complications from uncontrolled blood glucose Educated on s/s of hyperglycemia/hypoglycemia Education on medication and side effects

accuchecks bid to s/s.

2. Anemia in other chronic diseases classified elsewhere

Start Ferrous Gluconate Tablet, 324 (38 Fe) MG, 2 tablets, Orally, Daily AM, 90 days, 180, Refills 0, KOP: No, Drug Source: In House Pharmacy, Notes: Required for travel

3. Essential (primary) hypertension

Start Hydrochlorothiaade Capsule, 12.5 MG, 1 capsule, Orally, Daily AM, 90 days, 90, Refills 0, KOP: No, Drug Source: In House Pharmacy, Notes: Required for travel

Start Lisinopril Tablet, 10 MG, 1 tablet, Orally, Daily AM, 90 days, 90, Refills 0, KOP: No, Drug Source: In

House Pharmacy, Notes: Required for travel Notes: B/P stable, continue current POC

DFH diet.

4. Gastro-esophageal reflux disease without esophagitis

Notes: Denies this problem at current time.

5. Burkitt lymphoma, unspecified site

Start Ondansetron HCl Tablet, 4 MG, 1 tablet as needed for nausea, Orally, TID, 90 days, 270 Tablet, Refills 0, KOP: No, Drug Source: In House Pharmacy, Notes: Required for travel

Notes: Last ppd 1/5/16- 0 mm negative

Hepatitis Avaccine given

Last labwork - last Monday at FMC Kentucky

Diagnosed 8/2016, one chemo treatment given in Sept 2016

Oncologyreferral made

Also taking Oxycodone 5/325- will refer to Dr. Qor Dr. Holloway, for now nursing can continue to give medication as directed.

Referral To:Oncology (Pending Approval)

Reason:Oncology- Non-Hodgkins

6. Gout, unspecified

Start Indomethacin Capsule, 25 MG, 1 capsule with food or milk as needed, Orally, BID, 90 days, 180 Capsule, Refills 0, KOP: No, Drug Source: In House Pharmacy, Notes: Required for travel Start Acetaminophen Tablet, 325 MG, 1 tablets as needed, Orally, QID, 90 days, 360 Tablet, Refills 0, KOP: No, Drug Source: In House Pharmacy, Notes: Not required for travel

Start Allopurinol Tablet, 300 MG, 1 tablet, Orally, Daily AM, 90 days, 90, Refills 0, KOP: No, Drug Source: In House Pharmacy, Notes: Required for travel

Notes: No current episode.

7. Human immunodeficiency virus [HIV] disease

Start Abacavir Sulfate Tablet, 300 MG, 2 lablet, Orally, Daily AM, 90 days, 180, Refills 0, KOP: No, Drug Source: In House Pharmacy, Notes: Required for travel

Start DOLUTEGRAMR SODIUM Tablet, 50mg, 1 tablet, Orally, Daily AM, 90 days, 90, Refills 0, KOP: No, Drug Source: In House Pharmacy, Notes: Required for travel

Start Acyclovir Capsule, 200 MG, 1 capsule, Orally, BID, 90 days, 180 Capsule, Refills 0, KOP: No, Drug Source: In House Pharmacy, Notes: Required for travel Start Fluconazole Tablet, 200 MG, 1 tablet, Orally, Daily AM, 90 days, 90, Refills 0, KOP: No, Drug Source: In House Pharmacy, Notes: Required for travel Start Lamivudine Tablet, 300 MG, 1 tablet, Orally, Daily AM, 90 days, 90, Refills 0, KOP: No, Drug Source: In House Pharmacy, Notes: Required for travel Start Levoflo xacin Tablet, 500 MG, 1 tablet, Orally, Daily AM, 90 days, 90, Refills 0, KOP: No, Drug Source: In House Pharmacy, Notes: Required for travel Notes: PPD 06/04/15 negative 0mm Hep A given 2/19/15 Infectious Disease Referral Consult. Referral To:Infectious Disease (Pending Approval) Reason:Infectious Disease-HIV
8. Others Action Started- Facility Tasks - View Orders
Preventive Medicine Educated on access to care via sick-call processor for any medical/dental. or mental health issues. Educated on handwashing before meals and when hands dirty, Educated on maintaining hydration of at least 10-12 cups of water daily to prevent dehydration and promote good health, Pt verbalized understanding. F/U with own physician if deported and/or released. Follow Up daily (Reason: MHU)
Appointment Provider: (b)(6); (b)(7)(C)
Confirmatory sign off: (b)(6); (b)(7)(C) 01/31/2017 03:14:04 PM
Electronically signed by (b)(6); (b)(7)(C) on 01/28/2017 11:30:21 (Central Standard Time) Electronically co-signed by (b)(6); (b)(7)(C) on 01/31/2017 at 03:14 PM MDT Sign off status: Completed
Addendum: 01/28/2017 12:23 PM (b)(6); (b)(7)(C) Tried to notify (b)(6); (b)(7)(C) Cell voice boxwas full.
Jena/Lasalle Detention Facility 830 PINEHILL ROAD JENA, LA 71342 Tel: 318-992-7613 Fax:

Appendix 2.2.A: ICE Custody Classification Worksheet

ICE Custody Classification Worksheet

Part 1. Basic Information Initial	1	Reclassification	Spec	ial Classific	cation
Field/Sub Office:	LDF		-Date: /	28.17	7
Officer Name: (b)(6); (b)(7)(C) Language (s	s) Used di	uring the Interview:			-
			· · · · · · · · · · · · · · · · · · ·		
Alien Number: (b)(6), (b)(7)(C)	DOB:	5.3.69	Gender:	□F	D M
Last Name: Rayson		First Name:	L B09	er	
Part 2. Special Vulnerabilities and Manage					
Does a Special Vulnerability exist? Inquire based on your assessment the vulnerability Also indicate whether there are other mandecision.	y exists, s	elect the appropriate	e boxes below	dy DY	
serious physical illness serious mental illness disability elderly pregnancy nursing sole caretaking responsibility risk based on sexual orientation/geoder victim of persecution/torture victim of sexual abuse or violent crime victim of human trafficking	identity				
Provide further explanation as necessary:					
If any boxes are checked, consult with the lo other management considerations, and recon		_		lacement a	nd

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Withheld pursuant to exemption

(b)(7)(E)

of the Freedom of Information and Privacy Act

Page 094

Withheld pursuant to exemption

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

of the Freedom of Information and Privacy Act

Case Number: b)(7)(E)

REPORT OF THE FORENSIC PATHOLOGIST LOUISIANA FORENSIC CENTER, LLC

P. O. Box 398

Youngsville, LA 70592
Phone (b)(6); (b)(7)(C)
Fax 337-504-2808

Name of Decedent: Rayson, Roger Date/Time of Death: 03/13/17, 1520 hours Address: LaSalle Detention Facility Date/Time of Autopsy: 03/14/17, 0945 hours Social Security Number: Not available Body Identified By: Homeland Security Date of Birth: 05/03/69, age 47 Place of Death: Lafavette General Medical Center Investigator: None Witnesses: None (b)(6); (b)(7)(C) 7/10 2017 Prosector: Completed: (b)(6); (b)(7)(C) Forensic Pathologist Assisted By: (b)(6); Louisiana Forensic Center

CAUSE OF DEATH

MANNER OF DEATH

Undetermined

Remote subdural hemorrhage due to unknown factors with contribution of hypertensive atherosclerotic cardiovascular disease, diabetes mellitus,

obesity (BMI=33) and complications of HIV

ANATOMIC SUMMARY

- I. Blunt force injuries to head:
 - A. Subdural hemorrhages, remote, bilateral, adherent:
 - 1. Right sided, 12 x 10 x 2.0 cm, light brown, concave underlying brain
 - 2. Left, 8.0 x 5.0 x 0.2 cm, brownish red
 - Mass effect:
 - a. Right to left 1.0 cm shift
 - 4. Status post burr holes x2, right
 - B. Subarachnoid hemorrhage, bilateral temporal lobes
 - C. Loss of gray-white interface at vertex (consistent with ischemic stroke)
 - D. No skull fracture
 - E. No scalp hemorrhages
 - F. No brain contusions
 - G. Brain fixed in formalin and saved in formalin following sectioning
- II. Miscellaneous injuries:
 - A. Contusion, left abdomen, left chest and left axilla
 - B. Ecchymosis, right antecubital space (likely venipuncture)
 - C. No internal body organ injuries
 - D. No injuries to the hands
- III. Hypertensive atherosclerotic cardiovascular disease:
 - A. Cardiomegaly, 550 grams
 - B. Atherosclerosis, aorta and coronary arteries, minimal to moderate

Case Number: (b)(7)(E)

- C. Nephrosclerosis, bilateral, minimal to moderate
- IV. Obesity, BMI=33:
 - A. Hepatosplenomegaly, renomegaly and cardiomegaly
- V. Meningitis
- VI. Evidence of medical intervention/fluid overload:
 - A. Edematous extremities and scrotum
 - B. Bilateral pleural effusions (1000 cc apiece) and ascites fluid (100 cc), serosanguinous)
 - C. Port-A-Cath, left chest
- VII. Toxicology positive:
 - A. Morphine
- VIII. Clinical history of HIV+ status:
 - A. No evidence of AIDS

Rayson, Roger Page 3 of 8

Case Number:	(b)(7)(E)

EXTERNAL EXAMINATION

The decedent has edematous extremities and scrotum.

The body is that of a normally-developed, obese black Hispanic man accompanied with no personal items. The body is identified by the Homeland Security. An identification tag is present on the left toe and wrist. The body weighs 200 pounds, is 65 inches in height and appears compatible with the reported age of 47 years. The body is cold. Rigor is present to an equal degree in all extremities. Fixed lividity is distributed on the posterior surfaces of the body, except in areas exposed to pressure. The scalp hair is brown and 2.0 cm in length. Facial hair consists of a beard. The irides are brown, the corneas are clear, the sclerae white, and the conjunctivae are tan and free of petechiae. The pupils measure 3.0 mm bilaterally. The external auditory canals are free of foreign material and abnormal secretions. The nasal skeleton is palpably intact. The nares and oral cavity have blood within them but are otherwise free of foreign material. The lips are without evidence of injury. The teeth are natural without restorations. Examination of the neck reveals no evidence of injury. The chest is unremarkable. The abdomen is unremarkable. The extremities show no gross bony deformities. The fingernails are intact. There are no tattoos. Needle tracks are not observed. The external genitalia are those of a normal adult, appearing circumcised man. The posterior torso is essentially without note. The anus is atraumatic. The skin is free of abrasions, lacerations and burns. Scars from prior trauma are noted.

EVIDENCE OF THERAPY

There is no evidence of recent medical intervention

Evidence of prior medical intervention consists of a Port-a-Cath in the left upper chest and a healing incision over a burr hole on the right head.

There is no evidence of organ procurement.

EVIDENCE OF EXTERNAL INTERNAL INJURY

Blunt force injuries to head:

There are subdural hemorrhages that are adherent over bilateral hemispheres. On the right the subdural hemorrhage is light brown measuring 12 x 10 x 2.0 cm with an underlying concavity. On the left the subdural hemorrhage measures 8.0 x 5.0 x 2.0 cm and is brownish red. There is a mass effect with a right to left 1.0 cm shift. The decedent is status post neurosurgery with two burr holes on the right. There are subarachnoid hemorrhages on bilateral temporal lobe poles. There is a loss of gray-white interface along the vertex. There are no skull fractures and no scalp hemorrhages. There are no brain contusions. The brain is fixed in formalin prior to sectioning and saved in formalin following sectioning.

Case Number:	(b) (7)(E)
CASE THE BOTT	

Miscellaneous Injuries:

There is a contusion over the left abdomen and an ecchymosis over the right antecubital space, both possibly due to medical intervention. There are no internal body organ injuries. There are no injuries to the hands. There are also contusions on the left mid chest and near the axilla.

INTERNAL EXAMINATION

Body Cavities:

The body is opened by the usual thoracoabdominal incision and the chest plate is removed. No adhesions are present in any of the body cavities. There is 1000 cc of serosanguinous fluid within each thoracic cavity and 100 cc of serosanguinous ascites fluid. All body organs are present in the normal anatomical positions. The subcutaneous fat layer of the chest wall is 2.0 cm thick. The subcutaneous fat layer of the abdominal wall is 4.0 cm thick.

Musculoskeletal System:

Muscle development is normal. No bone or joint abnormalities are noted.

Neck:

Examination of the soft tissues of the neck, including strap muscles, thyroid gland and large vessels, reveal no abnormalities. The hyoid bone and larynx are intact.

Cardiovascular System:

The heart weighs 550g and has a normal configuration. The pericardial surfaces are smooth, glistening and unremarkable; the pericardial sac is free of significant fluid or adhesions. The coronary arteries arise normally, follow the usual distribution and are widely patent with evidence of minimal to moderate atherosclerosis but no thrombosis. The chambers and valves exhibit the usual size-position relationship and are unremarkable. The left ventricle measures 0.8 cm thick, the septum measures 0.8 cm thick and the right ventricle measures 0.3 cm thick. The myocardium is red-brown, firm with no focal lesions; the atrial and ventricular septa are intact. The foramen ovale is closed. The aorta shows minimal to moderate atherosclerotic involvement. The pulmonary trunk does not show significant atherosclerotic involvement. The aorta and the pulmonary trunk and their major branches arise normally and follow the usual course. The ductus arteriosus is closed. The vena cavae and their major tributaries return to the heart in the usual distribution and are free of thrombi.

Respiratory System:

The lungs are congested with pleural effusions as described above. The upper airway is clear of debris and foreign material; the mucosal surfaces are smooth, yellow-tan and unremarkable. The right lung weighs 500g; the left lung weighs 550g. The pleural surfaces

Rayson, Roger Page 5 of 8 Case Number: (b)(7)(E)

are smooth and glistening with no focal lesions. The pulmonary parenchyma is pink and soft except in areas of dependent congestion which are dark red and firmer. No mass lesions are noted. The bronchial tree and pulmonary arteries are normally developed. There is no evidence of thromboembolic disease.

Alimentary System:

The tongue exhibits no evidence of recent injury. The esophagus is lined by gray-white, smooth mucosa. The gastric mucosa is unremarkable and the lumen contains 10 cc of brown fluid. The small and large bowels are unremarkable. The pancreas has an autolyzed, red/tan, lobulated appearance and the ducts are clear and of normal caliber. The appendix is present.

Liver and Biliary System:

The liver weighs 2700g. The hepatic capsule is smooth, glistening and intact covering moderately firm, red/brown parenchyma. The usual lobular architecture is identified on section. No mass lesions are noted. The gallbladder contains 30 ml green-brown bile; the mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent, without evidence of calculi.

Genitourinary System:

The right kidney weighs 300g; the left kidney weighs 300g. The renal capsules are smooth and thin, semitransparent and strip with the usual difficulty. The underlying cortical surfaces are coarsely granular and red-brown. On section the cortices are sharply delineated from the medullary pyramids, which are red-purple and unremarkable. The calyces, pelves and ureters are without note. The urinary bladder contains no urine; the mucosa is gray-tan and smooth. The prostate gland, seminal vesicles and testicles are without note.

Reticuloendothelial System:

The spleen weighs 750g. It has a smooth, intact capsule covering red-purple, moderately firm parenchyma; the lymphoid follicles are unremarkable. The regional lymph nodes appear normal. The bone marrow is red and firm. The thymus is absent.

Endocrine System:

The pituitary, thyroid and adrenal glands are unremarkable.

Head/Central Nervous System:

Evidence of Injury to the brain is described above. The brain has been fixed in formalin prior to sectioning and saved in formalin following sectioning. There are burn holes but otherwise the scalp is reflected and is intact. There are burn holes otherwise the calvarium of the skull is intact and removed. The dura mater is disrupted secondary to burn holes. The dural sinuses are patent. The brain is removed and weighs 1300g. The basilar portion of the cranial vault is

Case Number: (b)(7)(E)

intact. The leptomeninges are thin and delicate. The cerebral hemispheres are symmetrical. The structures at the base of the brain, including the cranial nerves and blood vessels, are intact. Coronal sections through the cerebral hemispheres reveal no focal lesions. The ventricular system is of normal caliber. Transverse sections through the brainstem and cerebellum reveal no abnormalities. The spinal cord is not dissected.

Histologic Sections:

Representative samples from various organs are preserved in a storage container in 10% formalin. Representative tissue samples are submitted for histology in 10 cassettes (neuropathological examination).

Neuropathological examination and block key:

- 1. Left subdural hemorrhage: The section shows lysed red blood cells and a layer of fibroblasts measuring 6 cell layers thick as well as multiple layers of lymphocytes and capillary formation.
- 2. Right subdural hemorrhage: The section shows lysed erythrocytes with calcifications, fibroblasts in a 20 cell layer thick as well as layers of lymphocytes with capillary formation.
- 3. Pons: The section shows edema and necrosis along with lymphocytes in the leptomeninges.
- 4. Medulla: The section shows edema and necrosis along with lymphocytes in the leptomeninges.
- 5. Cerebellum: The section shows edema and necrosis.
- 6. Hippocampus: The section shows lymphocytes in the leptomeninges.
- 7. Cerebral cortex, watershed, left: The section shows lymphocytes in the leptomeninges as well as decreased cellularity in the cerebral cortex.
- 8. Globus pallidus, right: The section shows edema and necrosis.
- 9. Internal capsule, left: The section shows edema and necrosis.
- 10. Corpus callosum and cingulate gyrus, right: The section shows edema and necrosis.

Toxicology:

Femoral vein blood and vitreous humor are collected and submitted to the laboratory. A toxicology screen is requested.

Rays	on,	Ro	ger
Page	7 o	f 8	

Case Number: (b)(7)(E)

Photography:

Photographs are taken during the course of the autopsy.

Radiology:

X-Rays are not obtained.

Diagrams Used:

Male diagram.

Comment:

CIRCUMSTANCES:

The decedent was a 47-year-old black Hispanic man who was reportedly an inmate under ICE detention at the GEO facility in Jena, LA. He apparently died on 03/13/17. No investigation is provided but there are medical records. According to admission records on 02/11/17 at LaSalle General Hospital he was brought from the jail for vomiting for four days with associated weakness, weight loss and anorexia. He reportedly was HIV seropositive since 2014 and diagnosed with Burkitt's lymphoma with an excisional biopsy in 2016. It is also noted that he had hypertension, non-insulin dependent diabetes, gout and chronic pain syndrome. At that time medications were listed as Tramadol, oxycodone, indomethacin, Allopurinol, acetaminophen, ondansetron, levofloxacin, zidovudine/lamivudine, fluconazole, acyclovir, abacavir-dolutegravir-lamivudine, abacavir, lisinopril, Metformin, glipizide, aspirin and insulin as well as ferrous sulfite. Bleeding times were normal. An assessment on 02/17/17 refers to a transfer from LaSalle to Tulane for treatment for a subdural hematoma. He was reportedly transported to Tulane where he apparently had neurosurgery. A CT of the head from 02/28/17 describes a recurrent subdural hematoma evacuated on 02/18/17 without focal findings. The subdural is reportedly right-sided with a mild mass effect. A note from 03/03/17 reports a platelet count of 51,000 and a white blood count of 2, 290. The hematocrit is 28.4%. According to this note (6)(6); of Tulane Neurosurgery said the mass on imaging was a hygroma requiring no treatment at present. A note of assessment on 03/04/17 reports the previous cerebrovascular accident and also notes hepatitis as well HIV. This note reports that he was transferred to Lafayette General Hospital without incident but no medical records are available. A CT from 03/04/17 describes a stable mixed density right extra-axial collection most consistent with a subdural hematoma with a mass effect on the right frontal lobe and a leftward shift. This exam is not changed from 02/28/17. A discharge summary from 03/13/17 describes methicillin-resistance staphylococcus aureus as well as subdural hematoma and pancytopenia. Reportedly he was transfused with two units of packed red blood cells on February 13, 2017. During his hospital course he reportedly had a temperature up to 102.8°F. He was observed to be leukopenic, hypoglycemic and hypercalcemic. The CD4 count was 226. Reportedly he was transferred to Tulane Medical Center Neurosurgery but no records are available. The autopsy was on 03/14/17 in the morning and he was presumed to die on 03/13/17 or early on 03/14/17.

Rayson, Roger Page 8 of 8 Case Number: (b)(7)(E)

FINDINGS:

The primary finding at autopsy is evidence of remote subdural hemorrhages causing a traumatic brain injury. In addition there is hypertensive atherosclerotic cardiovascular disease and obesity. There are subdural hemorrhages over each hemisphere with the larger being on the right with an apparently older age of being light brown while the left is remote but younger and smaller. There is a mass effect with a right to left midline shift of 1.0 cm. There are subarachnoid hemorrhages on the bilateral temporal lobe poles. There are burr holes secondary to neurosurgery intervention. There is an ischemic stroke with loss of gray-white matter interface. There are no skull fracture, no scalp hemorrhages, and no brain contusions. There are also contusions on the left mid chest and near the left axilla.

There is evidence of hypertensive atherosclerotic cardiovascular disease with enlarged heart at 550 grams, minimal to moderate atherosclerosis of the aorta and coronary arteries, and nephrosclerosis of the kidneys. The decedent is obese with a BMI of 33 and has organomegaly likely as a result of this. The heart, kidneys, liver, and spleen are all enlarged. There is evidence of meningitis with inflammation of the leptomeninges.

There is evidence of medical intervention and fluid overload. The extremities and scrotum are edematous. There are bilateral pleural effusions and ascites fluid. There is a Port-a-Cath on the left chest. Toxicology is positive for Morphine. There is no evidence of AIDS opportunistic infections identified at autopsy.

OPINION:

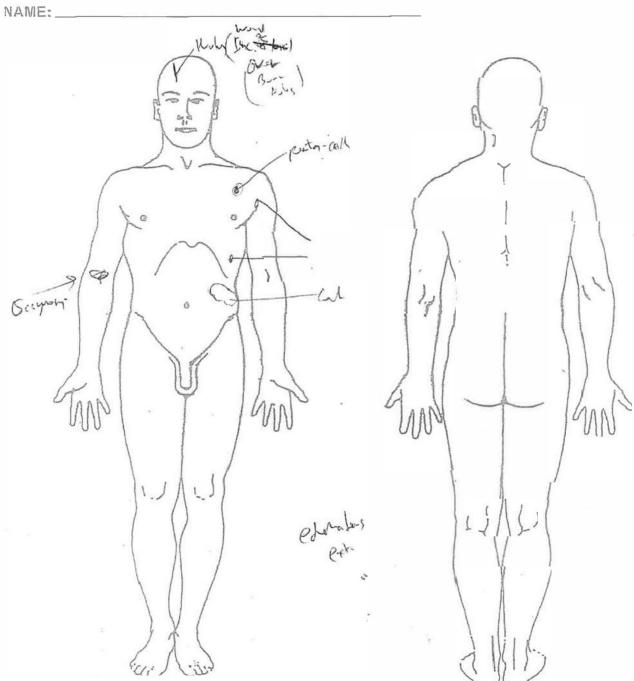
Likely the subdural hemorrhage led to a traumatic brain injury which ultimately caused the death. The complications of contributing factors such as obesity, hypertensive atherosclerotic cardiovascular disease, meningitis and complications of HIV including treatment cannot be ignored as well. Subdural hemorrhages are of different ages on the left and right but both are at least weeks old. The subarachnoid hemorrhages on the bilateral temporal lobe poles may be countercoup injuries indicating a fall but are not typical of this. The platelet count of 51,000 is not low enough for a spontaneous hemorrhage as a cause of the subdural hemorrhages. Since it is not known what caused the subdural hemorrhage, the manner of death is best considered undetermined until further investigation has ruled out a possible homicide.

LOUISIANA FORENSIC

— Center —

Rayson, Roger

CASE	No.:	



LCG FORM #2449-5 (9/10)



NMS Labs

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3701 Welsh Road, PO Box 433A, Willow Grove, PA 19080-0437 Phone: (b)(6); (b)(7)(C) Fax: (215) 657-2972

(h)(6): (h)(7)(C)

(b)(6); (b)(7)(C) PhD, F-ABFT, DABCC-TC, Laboratory Director

Toxicology Report

Report Issued 03/23/2017 10:03

To: 10592

Louisiana Forensic Center, LLC

Attn (b)(6); (b)(7)(C)
PO Box 1320

Broussard, LA 70518

Patient Name

RAYSON, ROGER

Patient ID

068-17 HOME

Chain

17084815

Age 47 Y Gender Workorder DOB 05/03/1969

Male

17084815

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Positive Findings:

Compound	Result	<u>Units</u>	Matrix Source	
Morphine - Free	76	ng/mL	001 - Blood	

See Detailed Findings section for additional information

Testing Requested:

Analysis Code	Description	
8041B	Postmortem, Basic w/Vitreous Alcohol Confirmation, Blood (Forensic)	72.

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Miscellaneous Information
001	Gray Top Tube	8.5 mL	Not Given	Blood	3 48.0
002	Gray Top Tube	4.3 mL	Not Given	Blood	
003	Red Top Tube	5.4 mL	Not Given	Vitreous Fluid	

All sample volumes/weights are approximations.

Specimens received on 03/17/2017.



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Workorder Chain Patient ID 17084815 17084815 068-17 HOME

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Detailed Findings:

Analysis and Comments	Result	Units	Kpt. Limit	Specimen Source	Analysis By	
Morphine - Free	76	ng/mL	5.0	001 - Blood	LC-MS/MS	_

Other than the above findings, examination of the specimen(s) submitted did not reveal any positive findings of toxicological significance by procedures outlined in the accompanying Analysis Summary.

Reference Comments:

Morphine - Free (Codeine Metabolite) - Blood:

Morphine is a DEA Schedule II narcotic analgesic. In analgesic therapy, it is usually encountered as the parent compound, however, it is also commonly found as the metabolite of codeine and heroin. In illicit preparations from which morphine may arise, codeine may be present as a contaminant. A large portion of the morphine is bound to the blood proteins or is conjugated; that which is not bound or conjugated is termed 'free morphine'. Hydromorphone is a reported metabolite of morphine.

In general, free morphine is the active biologic agent. Morphine has diverse effects that may include analgesia, drowsiness, nausea and respiratory depression. 6-monoacetylmorphine (6-MAM) is the 6-monoacetylated form of morphine, which is pharmacologically active. It is commonly found as the result of heroin use.

Peak serum concentrations occur within 10 to 20 minutes of a 10 mg/70 kg inframuscular dose, with an average concentration of 60 ng/mL 30 minutes following administration. M administration of the same dose resulted in an average concentration of 80 ng/mL after 30 minutes. Chronic pain patients receiving an average of 90 mg (range 20 - 1460) daily oral morphine had average serum concentrations of 73 ng/mL (range 13 - 710) morphine. In 15 cases where cause of death was attributed to opiate toxicity (heroin, morphine or both), free morphine concentrations were 0 - 3700 ng/mL (mean = 420 +/- 940). In comparison, in cases where COD was unrelated to opiates (n=20) free morphine was 0 - 850 ng/mL (mean = 90 +/- 200). The ratio of whole blood concentration to serum or plasma concentration is approximately one.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded one (1) year from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Workorder 17084815 was electing signed on 03/23/2017 09:06 b	
(b)(6); (b)(7)(C)	
Certifying Scientist	

Analysis Summary and Reporting Limits:

All of the following tests were performed for this case. For each test, the compounds listed were included in the scope. The Reporting Limit listed for each compound represents the lowest concentration of the compound that will be reported as being positive. If the compound is listed as None Detected, it is not present above the Reporting Limit. Please refer to the Positive Findings section of the report for those compounds that were identified as being present.

Acode 50016B - Opiates - Free (Unconjugated) Confirmation, Blood (Forensic)

-Analysis by High Performance Liquid Chromatography/ TandemMass Spectrometry (LC-MS/MS) for:

Compound	Rpt. Limit	Compound	Rpt. Limit
6-Monoacetylmorphine - Free	1.0 ng/mL	Hydrocodone - Free	5.0 ng/mL
Codeine - Free	5.0 ng/mL	Hydromorphone - Free	1.0 ng/mL
Dihydrocodelne / Hydrocodol - Free	5.0 ng/mL	Morphine - Free	5.0 ng/mL



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 Workorder
 17084815

 Chain
 17084815

 Patient ID
 068-17 HOME

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Analysis Summary and Reporting Limits:

Compound	Rpt. Limit	Compound	Rpt. Limit
Oxycodone - Free	5.0 ng/mL	Oxymorphone - Free	1.0 ng/mL
Acode 8041B - Postmortem, Bas	ic w/Vitreous Alcohol Confir	mation, Blood (Forensic)	

-Analysis by Enzyme-Linked Immunosorbent Assay (ELISA) for:

Compound	Rpt. Limit	Compound	Rpt. Limit
Amphetamines	20 ng/mL	Fentanyl / Acetyl Fentanyl	0.50 ng/mL
Barbiturates	0.040 mcg/mL	Methadone / Metabolite	25 ng/mL
Benzodiazepines	100 ng/mL	Methamphetamine / MDMA	20 ng/mL
Buprenorphine / Metabolite	0.50 ng/mL	Opiates	20 ng/mL
Cannabinoids	10 ng/mL	Oxycodone / Oxymorphone	10 ng/mL
Cocaine / Metabolites	20 ng/mL	Phencyclidine	10 ng/mL

-Analysis by Headspace Gas Chromatography (GC) for:

Compaund	Rot. Limit	Compound.	Rot. Limit
Acetone	5.0 mg/dL	Isopropanol	5.0 mg/dL
Ethanol	10 mg/dL	Methanol	5.0 mg/dL

CERTIFICATION OF DEATH

BIRTH NUMBER:

STATE FILE NUMBER: 2017-024-00687

DECEDENT	DECEDENT'S NAME - (LAST, FIRST, MIDDLE, SUFFIX)	DATE OF BIRTH	DATE OF DEATH		TIME OF DEATH		
	RAYSON, ROGER ANTHONY	05/03/1989	03/17/2017		03: 20PM		
	PLACE OF BIRTH - (CIY, STATE, COUNTRY)	SEX	SOCIAL SECURITY	NUMBER	AGE		
	NEGRIL, WESTMORELAND JAMAICA	MALE	NONE		47 YEARS		
	DECEDENT'S ALIAS NAME(S) - (LAST, FIRST, MIDDLE, SUFFIX):						
	RESIDENCE OF DECEDENT - (STREET ADDRESS, CITY, STATE, ZIP	CODE, COUNTRY)		MITHIN CITY LIMITS?	PARISH COUNTY		
	830 PINEHILL RD., JENA, LA 71342 UNITED STATES			NO	LASALLE		
PERSONAL	EVER IN U.S. ARMED FORCES?	OCCUPATION		INDUSTRY OF OCCUP	ATION		
	NO	CLUB PROMOTER		ENTERTAINMENT			
	MARITAL STATUS	[3][5] India	NAME OF SURVIVIN	G SPOUSE (LAST, FIR	ST, MIDDLE, SUFFIX)		
	NEVER MARRIED	15111115					
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	RACE: BLACK OR AFRICAN AMERICAN	VIII II K	11111				
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	INPATIENT CITIZENT		UNAVETTE GENER	AL MEDICAL CENTER	7		
	FACILITY ADDIRESS - (STREET ADDIRESS, CITY, STATE, ZIP CODE.	COUNTRY)			PARISHICOUNTY		
	1214 COO LIGHT ST . LAFATE TE L. DSOLUT	1-			AFAYETTE		
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	CREMATION		CHARLA HUNER	SERVICES & CHEMA			
	PLACE OF DESTION (CITY, STATE, COUNTY)	11(U)/			DATE OF DISPOSITION		
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	LOUISIANA FUNERAL SERVICES AND CREMATORY	108 HARDWARE RD.	BROUSPARD, LA 70				
	NAME OF FUNERAL DIRECTOR (LAST, FIRST, MIDDLE, SUFFIX)	LICENSE NUMBER	A 100	CORONER NOTIFIED?			
	(b)(6): (b)(7)(C)	(b)(6).		Y			
	SIGNATURE OF FUNERAL DIRECTOR *e-sign*		The later of	0ATE 8/2/2017			
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DETAINEE DEATH REVIEW – Roger RAYSON JICMS #201705095

SYNOPSIS

On March 13, 2017, Roger RAYSON (RAYSON), who was a forty-seven-year-old citizen and national of Jamaica, died while in the custody of U.S. Immigration and Customs Enforcement (ICE) at Lafayette General Hospital, Lafayette, Louisiana (LA). The State of Louisiana Department of Health's Certification of Death documented the cause of RAYSON's death as remote subdural hemorrhage due to unknown factors with hypertensive atherosclerotic cardiovascular disease, diabetes mellitus, and complications of HIV.

RAYSON was detained at the LaSalle Detention Facility (LDF), Jena, LA, from January 28, 2017 to March 13, 2017. LDF is owned and operated by the GEO Group, Inc. (GEO), under an Inter-Governmental Service Agreement (IGSA), which requires the facility to comply with the ICE Performance Based National Detention Standards (PBNDS) 2011. At the time of RAYSON's death, LDF housed approximately 943 male and 178 female detainees of all classification levels for periods in excess of 72 hours. Medical care at LDF is provided by ICE Health Service Corps (IHSC), supported by both a contractor and subcontractor, InGenesis Medical Staffing (InGenesis), and STG International, Incorporated (STG), respectively.

DETAILS OF REVIEW

From April 11 to 13, 2017, ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited LDF to review the circumstances surrounding RAYSON's death. ERAU was assisted 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. As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to RAYSON, in addition to conducting in-person interviews of individuals employed by GEO, InGenesis, STG, and the local field office of ICE's Office of Enforcement and Removal Operations (ERO).

During the review, the ERAU 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. ERAU determined the following timeline of events, from the time of RAYSON's transfer to ICE custody, through his detention at LDF, and eventual death at Lafayette General Hospital.

¹ Remote subdural hemorrhage refers to a previously occurring pooling of blood between the brain and its outermost covering.

² Hypertensive atherosclerotic cardiovascular disease refers generally to heart disease.

³ Diabetes refers to a disease resulting in too much sugar in the blood.

⁴ HIV stands for human immunodeficiency virus. It weakens a person's immune system by destroying important cells that fight disease and infection and is the virus that causes Acquired Immune Deficiency Syndrome (AIDS).

⁵ See Exhibit 1: Creative Corrections Medical and Security Compliance Analysis.

IMMIGRATION AND CRIMINAL HISTORY

On November 24, 2014, RAYSON attempted to enter the United States at the Fort Lauderdale/Hollywood International Airport in Fort Lauderdale, Florida (FL), as a nonimmigrant visitor with a B-2 visa. U.S. Customs and Border Protection (CBP) referred RAYSON to secondary inspection where CBP officers discovered cocaine in his luggage and arrested him.⁷ CBP released RAYSON to the custody of U.S. Marshals Service (USMS) later that day and lodged a Form I-247, Immigration Detainer – Notice of Action, against RAYSON with USMS.⁸ USMS placed RAYSON at the Broward County Jail in Fort Lauderdale, FL, pending trial for importation of a controlled substance.

On February 5, 2015, RAYSON was transferred to the custody of the Federal Bureau of Prisons (FBOP) at the Miami Federal Detention Center (FDC) in Miami, FL. 9 On April 24, 2015, he was tried and convicted of importation of cocaine by the U.S. District Court for the Southern District of Florida and sentenced to 30 months incarceration. 10 RAYSON remained at the Miami FDC until July 30, 2015, when the FBOP transferred him to the D. Ray James Correctional Institution in Folkston, Georgia. 11 On November 3, 2016, BOP transferred RAYSON to the Lexington Federal Medical Center in Lexington, Kentucky (FMC Lexington). 12

On January 28, 2017, BOP released RAYSON to the custody of ERO New Orleans, ¹³ and ERO booked him into LDF that same day. 14 On January 31, 2017, ICE issued RAYSON a Notice and Order of Expedited Removal, charging him with inadmissibility pursuant to Section 212(a)(7)(A)(i)(I) of the Immigration and Nationality Act (INA or the Act), as an immigrant not in possession of a valid unexpired entry document required by the Act. 15

NARRATIVE

ERAU determined the following timeline of events, from the time RAYSON was admitted to LDF until his death at Lafayette General Hospital on March 13, 2017.

On January 28, 2017, at 2:15 a.m., RAYSON arrived at LDF. 16

⁶ See Form 1-213, Record of Deportable/Inadmissible Alien, dated January 31, 2017.

⁷ See Sworn Affidavit from (b)(6); (b)(7)(C) dated No. ⁸ See Form 1-247, Immigration detainer, dated November 24, 2014. dated November 25, 2014.

⁹ See BOP Inmate History, dated November 28, 2017.

¹⁰ See Form I-213, Record of Deportable/Inadmissible Alien, dated January 31, 2017.

¹¹ See Bureau of Prisons Sentence monitoring, computation data screen, dated December 15, 2016; See BOP Inmate History, dated November 28, 2017.

¹² See BOP Inmate History, dated November 28, 2017.

¹³ See Bureau of Prisons Notice of Release and Arrival, dated January 28, 2017.

¹⁴ See LDF Admission/Release Form, dated January 28, 2017.

¹⁵ See Form I-860, Notice and Order of Expedited Removal, dated January 31, 2017.

¹⁶ See LDF Admission/Release Form, dated January 28, 2017.

At 2:30 a.m., (b)(6); (b)(7)(C)	performed RAYSON's medical pre-
screening and noted RAYSON spoke English fluently,	behaved normally, and reported having
current health problems. 17 (b)(6); (b)(7)(C) stated she receive	ved RAYSON's medical transfer summary
and medications but did not review the transfer summa	
completing the pre-screening, (b)(6); (b)(7)(C) left RAYSON	N in the intake area to await his intake
medical screening; however, when intake officers calle	ed shortly after her departure to notify her
RAYSON was crying and complaining of pain, she dir	ected the officers to escort him to the
clinic.	

At 3:40 a.m., shortly after RAYSON's arrival to the clinic, (b)(6); (b)(7)(C) completed RAYSON's medical intake screening and documented the following: 19

- RAYSON spoke English and did not require language interpretation assistance.
- RAYSON's vital signs²⁰ were within normal limits, with the exception of an elevated blood glucose level of 233.²¹
- RAYSON reported experiencing constant pain throughout his body and rated it -- on a pain scale of zero to ten, with ten being worst -- a level nine.
- RAYSON reported several existing medical conditions, including lymphoma,²² diabetes, ²³ HIV infection, hypertension, ²⁴ anemia, ²⁵ gout, ²⁶ arthritis, ²⁷ and gastroesophageal reflux disease (GERD).²⁸
- RAYSON arrived at LDF with the medications listed in Table 1, below.

Table 1: Medications in RAYSON's possession upon arrival at LDF

Medication	Purpose
Abacavir	Antiretroviral ²⁹ (ARV)
Acyclovir	ARV
Dolutegravir	ARV
Lamivudine	ARV
Levofloxacin	Antibiotic

¹⁷ See Exhibit 2: LDF eClinicalWorks Appointment (Intake Prescreening), dated January 28, 2017.

¹⁸ ERAU interview with (b)(6); (b)(7)(C) April 12, 2017.

¹⁹ See Exhibit 3: LDF eClinicalWorks Appointment (Intake Screening), dated January 28, 2017.

²⁶ 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

Normal blood glucose (sugar) levels are 72-108 when fasting and up to 140 within two hours after eating.

²² Lymphoma is cancer of the lymph nodes.

²³ Diabetes is a disease in which blood glucose, or blood sugar, levels are too high.

²⁴ Hypertension refers to high blood pressure.

²⁵ Anemia is a condition caused by low iron levels.

²⁶ Gout is a form of arthritis characterized by severe pain, redness, and tenderness in joints.

²⁷ Arthritis symptoms include pain, joint inflammation, and swelling.

²⁸ This condition causes reflux of acid from the stomach into the lower esophagus.

²⁹ An antiretroviral is a drug that, in combination with other drugs, prevents the replication of the molecule viral ribonucleic acid (RNA) such as in HIV.

Fluconazole	Antifungal
Glipizide	Anti-diabetic
Metformin	Anti-diabetic
Regular Insulin	Anti-diabetic
Allopurinal	Gout treatment
Hydrochlorothiazide	Anti-hypertensive
Lisinipril	Anti-hypertensive
Oxycodone with acetaminophen (Percocet) ³⁰	Pain treatment as needed
Indomethacin	Anti-inflammation and pain treatment
Acetaminophen	Pain treatment
Enteric-coated aspirin	Pain treatment
Ondansetron	Anti-nausea
Ferrous gluconate	Iron supplement

During the intake screening, (b)(6); reconciled all medications in RAYSON's possession with the transfer summary provided by FMC Lexington and gave RAYSON one dose of Percocet for pain. The administration of the Percocet and other medications was authorized by the transfer summary, which stated RAYSON's medication should be continued until evaluated by a physician or unless otherwise indicated. At the conclusion of the intake screening (b)(6); (b)(7)(C) referred RAYSON for a provider evaluation based on the detainee's abnormal screening results.

At 3:48 a.m., RAYSON was placed in the Medical Housing Unit (MHU).³⁴

At approximately 7:38 a.m., (b)(6), (b)(7)(C) encountered RAYSON during an MHU nursing round and documented RAYSON's vital signs were within normal limits, that he reported level two pain in his left arm and that he was instructed to maintain adequate hydration and to recreate outside and socialize.

At approximately 10:00 a.m., (b)(6); (b)(7)(C) completed RAYSON's initial health assessment and documented the following:

• RAYSON's vital signs were within normal limits.

³⁰ Oxycodone with acetaminophen is the generic form of Percocet. This report refers to this medication as Percocet.

³¹ See Bureau of Prisons, Health Services, Inmate GCT Release, dated January 27, 2017.

³² See LDF Medication Administration Record, from January 1, 2017 through January 31, 2017.

³³ See Bureau of Prisons, Health Services, Inmate GCT Release, dated January 27, 2017.

³⁴ LDF's Medical Housing Unit (MHU) is also referred to as the Short Stay Unit for logging purposes. This report refers to the area is as MHU; *See* Medical Housing Unit (MHU) log, dated January 28, 2017. Per IHSC Directive 03-17, Medical Housing Units, a provider is required to make rounds at least once daily, and nurses are required to make rounds at least once per shift. Additionally, LDF policy requires officers posted in the MHU to check on each detainee at least once every 30 minutes.

- RAYSON was alert, in no acute distress, ill-appearing, thin, uncomfortable due to pain, cooperative, visibly upset, and tearful.
- RAYSON complained of level seven pain to his left upper arm.
- RAYSON denied past smoking or drug abuse but admitted to a history of alcohol abuse.
- RAYSON stated a physician in Montego Bay, Jamaica was prepared to treat him following deportation.
- RAYSON presented with a painful edema³⁵ on the right side of his head.
- RAYSON reported that while in BOP custody, he learned he was HIV positive and was also diagnosed with non-Hodgkins lymphoma (Burkitts). 36
- RAYSON stated he started chemotherapy at D. Ray James Correctional Facility in September 2016 but only received one chemotherapy treatment prior to his transfer to FMC Lexington in November 2016.
- RAYSON reported nausea and vomiting, swollen lymph nodes of the neck, and intermittent fatigue. He denied fever, night sweats, and anorexia.³⁷
- RAYSON reported a depressed mood.³⁸

LDF's medical treatment plan for RAYSON is summarized in <u>Table 2</u>. ³⁹ Unless otherwise noted, RAYSON received his ordered medications throughout the duration of his detention at LDF.

Table 2: Medical Treatment Plan for RAYSON

Condition	Treatment
Diabetes	Administration of enteric-coated aspirin, glipizide, regular insulin per sliding scale, 40 metformin. Accucheks 41 twice daily. Education on disease process, symptoms of hyperglycemia 42 and hypoglycemia, 43 a healthy lifestyle, and medications and their side effects.
Anemia	Administration of ferrous gluconate
Hypertension	Administration of hydrochlorothiazide, lisinopril, and to continue current plan of care.
Gastroesophageal Reflux	None at current time.

³⁵ An edema is an accumulation of excessive fluid in the tissues of the body, causing swelling.

³⁶ Burkitt's lymphoma is a form of cancer occurring when too many abnormal white blood cells continue to grow and divide, crowding lymph nodes and causing them to swell. It is a very fast-growing cancer, especially for those with compromise immune systems, such as in HIV infection.

Anorexia is an eating disorder causing people to obsess about weight and what they eat.

Despite his report of a depressed mood and (b)(6); bbservation of RAYSON's sad emotional state, (b)((b)(6); did not refer RAYSON to mental health staff.

³⁹ See Exhibit 4: LDF eClinicalWorks Appointment (initial health assessment), dated January 29, 2017. During her interview, (b)(6): opined that RAYSON's extensive health problems and terminal condition warranted hospice or palliative care, which LDF is not equipped to provide.

⁴⁰ Sliding scale refers to the progressive increase in insulin doses based on pre-defined blood glucose levels.

⁴¹ Accucheks are a test used to monitor blood glucose levels to assist in managing diabetes.

⁴² Hyperglycemia refers to excessive levels of sugar in the blood, requiring insulin or medication for normalization.

⁴³ Hypoglycemia refers to lower than normal sugar level in the blood, requiring intake of sugar.

Disease	
Lymphoma	Administration of ondansetron for nausea, a Hepatitis A vaccine, and Percocet until evaluated by (b)(6); (b)(7)(C) Referral for an oncology consultation.
Gout	Administration of indomethacin and acetaminophen as needed.
HIV	Administratoin of abacavir, dolutegravir, acyclovir, fluconazole, lamivudine, levofloxacin. Referral for an infectious disease consultation. 44

completed an urgent referral request for RAYSON to receive an oncology⁴⁵ consultation, ⁴⁶ per her treatment plan, but did not complete a referral request for the infectious disease consultation. The Cabrini Cancer Center in Alexandria, LA, acknowledged receipt of RAYSON's oncology referral on February 2, 2017 and requested RAYSON's pathology and chemotherapy records prior to scheduling an appointment. 47 A notation by (b)(6); date shows she directed medical records staff to obtain RAYSON's previous medical records and forward them to the Cabrini Cancer Center. However, the record contains no evidence medical records staff forwarded the records or that the Cabrini Cancer Center ever scheduled his oncology consultation.

At an undocumented time on January 28, 2016, (b)(6); (b)(7)(C) completed RAYSON's initial custody classification assessment using the ICE Custody Classification Worksheet. 48 ERAU notes the following concerns regarding RAYSON's classification:

- Idid not complete sections pertaining to language and special (b)(6); (b)(7)(C) vulnerabilities and management concerns.
- (b)(6); (b)(7)(C) erroneously classified RAYSON as high custody instead of mediumhigh.
- A supervisor did not review and approve RAYSON's classification rating.

On January 29, 2017, at approximately 7:14 a.m., (b)(6); conducted a provider round and documented that although RAYSON's vital signs were within normal limits, he appeared ill, thin, upset and tearful, and uncomfortable due to pain. (b)(6); gave RAYSON a dose of Percocet for pain management.⁴⁹

⁴⁴ Creative Corrections advises it is standard nursing practice to seek consultation with an infectious disease specialist for patients with HIV.

Oncology is the medical specialty for cancer treatment.

⁴⁶ See ICE Consultation Request and Hospital Transfer Form, dated January 28, 2017.

⁴⁷ See LDF eClinicalWorks Telephone Encounter, dated February 2, 2017.

⁴⁸ See Exhibit 5: ICE Custody Classification Worksheet, dated January 28, 2017.

⁴⁹ See LDF eClinicalWorks Appointment, dated January 29, 2017.

At 10:40 a.m., (b)(6); (b)(7)(C) encountered RAYSON during an MHU nursing round, and RAYSON complained of not having a bowel movement for three days. 50 (b)(6); (b)(7)(C) notified(b)(6); the complaint, and (b)(6); ordered RAYSON be sent to the Rapides Regional Medical Center (RRMC) for evaluation. 51 At 11:15 a.m., officers escorted RAYSON to the intake area in preparation for transport to the hospital,⁵² and at 11:56 a.m., officers transported RAYSON to RRMC in a facility van.⁵³ The time of RAYSON's arrival at RRMC was not documented. According to the RRMC emergency room record, emergency room staff evaluated RAYSON at 1:26 p.m. for complaints of vomiting⁵⁴ and treated him with ondansetron⁵⁵ via intravenous (IV) line. 56 RRMC completed laboratory and radiology studies which found abnormal levels of hemoglobin, ⁵⁷ hematocrit, ⁵⁸ white blood cells, sodium, and lipase, ⁵⁹ and an elevated calcium level, indicative of a cancerous process. RRMC discharged RAYSON at 3:19 p.m. with no new orders. 60 At approximately 5:49 p.m., RAYSON returned to LDF and was re-admitted to the MHU.⁶¹ (b)(6) [b](6): Istated she was surprised RAYSON returned to LDF that evening as she expected RRMC to admit him. (b)(6); (b)(7)(C) who saw RAYSON upon his readmission, documented RAYSON's vital signs were within normal limits, with the exception of a slightly elevated blood pressure of 131/91, and that she gave the detainee Percocet for shoulder pain. 62 (b)(6); (b)(7)(C) completed a nursing round at approximately 10:13 p.m., during which RAYSON complained of shoulder pain at a level seven. (5) (6)(6); (b)(7)(C) gave RAYSON both Percocet and indomethacin for pain. RAYSON's vital signs were within normal limits with the exception of an abnormally high pulse of 125.⁶⁴ On January 30, 2017, at 7:42 a.m., (b)(6); (b)(7)(C) encountered RAYSON during her MHU provider rounds and documented RAYSON's vital signs were within normal limits with 50 See LDF eClinical Works Appointment (b)(6); dated January 29, 2017. 51 See LDF eClinicalWorks Appointment, dated January 29, 2017. ⁵² See MHU Logbook, dated January 29, 2017. 53 See Incident Report by (b)(6); (b)(7)(C) dated January
54 See RRMC Emergency Provider Report, dated January 29, 2017. Idated January 29, 2017. 55 Ondansetron is used for treatment of nausea. ⁵⁶ See RRMC Emergency Provider Report, dated January 29, 2017. ⁵⁷ Hemoglobin is a red protein responsible for transporting oxygen in the blood, 58 Hematocrit is the ratio of the volume of red blood cells to the total volume of blood. ⁵⁹ Lipase is an enzyme produced by the pancreas which catalyzes the breakdown of fats and glycerol. ⁶⁰ See RRMC Emergency Provider Report, dated January 29, 2017. ⁶¹ See LDF eClinicalWorks Appointment, dated January 29, 2017. ⁶² Normal blood pressure is 120/80, with 90/60 to 139/89 considered within normal range; See LDF eClinicalWorks Appointment (RN Hudnall), dated January 29, 2017. See LDF Medication Administration Record, from January 1, 2017 through January 31, 2017. 63 See LDF eClinicalWorks Appointment (h)(6): (h)(7)(C) , dated January 29, 2017. 64 (b)(6); (b)(7)(C) noted RAYSON had no accompanying chest pain or shortness of breath.

blood cell counts were already low due to the HIV, continuing the therapy would have increased RAYSON's susceptibility to other potentially deadly infectious diseases.

71 A CT Pet Scan is an advanced nuclear imaging technique which reveals information about the structure and function of cells and tissues in the body during a single imaging session.

72 A blood sugar level of 210 indicates the need for diabetes management through diet or pharmaceuticals.

- RAYSON stated he did not wish to continue taking Percocet for fear of developing a dependency and that indomethacin sufficiently alleviated his pain. (b)(6); (b)(7)(C) increased his dose of indomethacin for pain from 25 mg to 50 mg.
- (b)(6); (b)(7)(C) ordered daily provider checks for RAYSON while he remained in the MHU.

exercising, but that the pain abated by the time of the encounter. His vital signs were within normal limits with the exception of an abnormally elevated pulse of 112.83 Following her encounter with RAYSON, (b)(6); (b)(7)(C) notified NP Peloquin that the detainee complained of chest pain when exercising, and (b)(6); (b)(7)(C) ordered an electrocardiogram (EKG).⁸⁴ At 11:00 a.m. (b)(6); (b)(7)(C) completed an EKG on RAYSON which showed a rapid heart rate but not at a level requiring treatment or action.85 At 12:31 p.m., (b)(6): (b)(7)(C)] encountered RAYSON and documented his vital signs were normal with the exception of an abnormally elevated pulse. (b)(6); (b)(7)(C) made no changes to the detainee's treatment plan. At 1:42 p.m., (b)(6); ordered RAYSON receive Tramadol, a narcotic pain medication, every six hours as needed for one day for left leg pain. 86 (b)(6); (b)(7)(C) administered RAYSON the first dose of Tramadol at the time of initial order by (b)(6); At 7:27 p.m., [b)(6); (b)(7)(C) noted RAYSON reported significant pain improvement as a result of the Tramadol. 88 She also noted RAYSON's vital signs were within normal limits and though the detainee appeared ill, he was well hydrated, in no distress, and in minimal pain. At 9:15 p.m., (b)(6); (b)(7)(C) administered a second dose of Tramadol to RAYSON. 89 Creative Corrections notes less than two hours earlier RAYSON reported his pain was significantly improved and that (b)(6)(b)(7)(C) did not conduct a pain assessment to justify the administration of a second dose of Tramadol. 90 Also on this date, ERO issued an Expedited Removal Order for RAYSON. 91 (b)(6); (b)(7)(C) stated ERO sought several options for RAYSON including administrative removal, compassionate release, and expedited removal. 92 Because RAYSON did not qualify for an 82 See LDF eClinicalWorks Appointment, dated January 31, 2017. 83 ERAU notes that (b)(6), (b)(7)(C) notation contains discrepant information in that she documented the detainee's pulse was elevated, but that his heart rate and rhythm were regular. Since pulse is a product of heart rate, an elevated pulse would indicate an elevated heart rate. 84 See LDF eClinicalWorks Appointment, dated January 31, 2017. An EKG is a test that checks for problems with the electrical activity of the heart. 85 See EKG test results, dated January 31, 2017. See LDF eClinicalWorks Telephone Encounter, dated January 31, 2017. ⁸⁶ See LDF eClinicalWorks Telephone Encounter, dated January 31, 2017. ERAU notes (b)(6); transcribed by (b)(6), (b)(7)(C) and that the notation includes no information regarding the event or assessment that precipitated the Tramadol order.

87 See LDF Medication Administration Record, from January 1, 2017 through January 31, 2017. See LDF eClinicalWorks Appointment, dated January 31, 2017. ERAU notes (5)(6)(7)(C) did not document the first dose of Tramadol on RAYSON's MAR. 88 See LDF eClinicalWorks Telephone Encounter (b)(6); (b)(7)(C) dated January 31, 2017. ⁸⁹ See LDF Medication Administration Record, from January 1, 2017 through January 31, 2017.

90 See LDF eClinicalWorks Appointment, dated January 31, 2017.

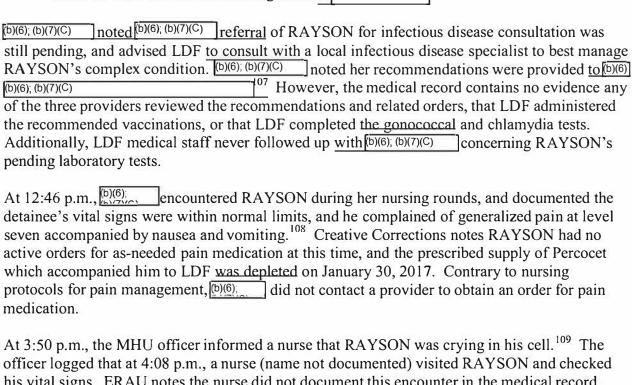
92 ERAU Interview with (b)(6). (b)(7)(C) Interview, April 11, 2017.

91 See Form I-860, Notice and Order of Expedited Removal, dated January 31, 2017.

administrative removal, and because he did not have family to receive him for compassionate release, expedited removal was the only viable option.

On February 1, 2017, (b)(6); (b)(7)(C) documented that during her night rounds
she encountered RAYSON crying hysterically and complaining of level ten pain in his left leg,
and noted the detainee vomited once. She notified (b)(6); (b)(7)(C) who ordered immediate
administration of Toradol and Benadryl via injection. 93 (b)(6); (b)(7)(C) administered the medications
at approximately 2:30 a.m. 94
at approximately 2.30 a.m.
At 4:07 a.m., (b)(6); (b)(7)(C) conducted a nursing round during which RAYSON stated he
felt better shortly after receiving the injections and reported his pain at a level four. 95 (b)(6); (b)(7)(C)
noted RAYSON's vital signs were normal, though his blood glucose level was high and required
administration of insulin, which (b)(6); (b)(7)(C) administered.
At 6:41 a.m., (b)(6); (b)(7)(C) encountered RAYSON during her MHU provider rounds and documented RAYSON slept very little the night before and had level eight pain throughout his body. (b)(6); (b)(7)(C) examined RAYSON's left knee and found no swelling, heat, or redness, though RAYSON stated the knee was tender when pressed. (b)(6); (b)(7)(C) noted that it was too soon to administer more pain medication and that she offered RAYSON a cane to assist with walking which he refused. ERAU notes (b)(6); did not ask RAYSON to sign a refusal form for the cane.
Following the encounter, (b)(6); (b)(7)(C) informed (b)(6); she was concerned about RAYSON's deteriorating physical and mental condition. (b)(6); indicated he would review RAYSON's January 29, 2017 laboratory tests from RRMC, and if the tests demonstrated his white blood cell count was high enough to protect him from opportunistic infections, he be discharged to general population housing to help with his mental health. 97
At 9:20 a.m., [b)(6); (b)(7)(C)] contacted [b)(6); (b)(7)(C)] IHSC Infectious Disease Specialist to review RAYSON's medical record. [b)(6); (b)(7)(C)] stated [b)(6); (b)(7)(C)] is routinely contacted to discuss all patients with a diagnosed or possible communicable disease. 99 After reviewing RAYSON's record, [b)(6); (b)(7)(C)] made the following recommendations in an email sent the following day:
Continue RAYSON's current antiretroviral therapy.
Toradol is a nonsteroidal anti-inflammatory drug used to treat pain. Yee LDF eClinicalWorks Appointment, dated February1, 2017; See LDF Medication Administration Record, from February 1, 2017 through February 28, 2017. See LDF eClinicalWorks Appointment, dated February1, 2017. Ibid. Yee LDF eClinicalWorks Appointment, dated February1, 2017.
98 See LDF eClinical Works Telephone Encounter, dated February 1, 2017. Telephone encounters are an electronic
means of communication between nurses and providers.
99 ERAU interview with (b)(6): (b)(7)(C) April 11, 2017.
¹⁰⁰ See LDF eClinicalWorks Telephone Encounter, dated February 1, 2017.

- Provide RAYSON an oncology consultation as soon as possible in order to determine the need for hospital admission.
- Maintain good hydration and provide intravenous fluids if necessary.
- Provide gonococcal¹⁰¹ and chlamydia¹⁰² nucleic acid amplification (NAA) tests.¹⁰³
- Administer a second dose of the hepatitis A vaccine, Prevnar, ¹⁰⁴ followed by pneumovax ¹⁰⁵ over eight weeks, and two doses of Menactra ¹⁰⁶ also over eight weeks.
- Defer all other chronic care management to (b)(6); (b)(7)(C)



his vital signs. ERAU notes the nurse did not document this encounter in the medical record.

At 5:59 p.m. (b)(6); (b)(7)(C) encountered RAYSON during an MHU nursing round and documented the detainee's vital signs were within normal limits with the exception of a mildly elevated blood pressure, and that he complained of severe pain in his right neck and both legs at a level ten. 110 (b)(6), (b)(7)(C) gave RAYSON an injection of Toradol and Benadryl for pain.

¹⁰¹ Gonococcus is the bacteria responsible for the sexually transmitted infection gonorrhea.

¹⁰² Chlamydia is a common sexually transmitted infection that may not cause symptoms.

¹⁰³ NAA tests are the Center for Disease Control's preferred method to detect sexually transmitted diseases. This method detects the genetic material of the bacteria causing the infection by amplifying or making numerous copies of the genetic material so that the bacteria can be identified.

104 Prevnar is a type of pneumococcal vaccine to prevent pneumonia.

¹⁰⁵ Pneumovax is a type of pneumococcal vaccine to prevent pneumonia

¹⁰⁶ Menactra is a meningococcal vaccine to protect against meningitis and other meningococcal diseases.

¹⁰⁷ See LDF eClinicalWorks Telephone Encounter, dated February 1, 2017.

¹⁰⁸ See LDF eClinicalWorks Appointment, dated February 1, 2017.

¹⁰⁹ See MHU Logbook, dated February 1, 2017.

¹¹⁰ See LDF eClinicalWorks Appointment, dated February 1, 2017.

ERAU notes she did not document administration of these medications on RAYSON's MAR. (b)(6); (b)(7)(C) Ilso noted RAYSON's finger stick glucose was elevated, and she gave him
regular insulin.
At 6:30 p.m. (b)(6); (b)(7)(C) gave RAYSON an injection of Phenergan, commonly used to treat acute nausea and vomiting. (b)(6); (b)(7)(C) did not document the reason for giving the injection.
On February 2, 2017, at 5:44 a.m., b)(6); encountered RAYSON during her nursing round and documented the detainee's vital signs were within normal limits with the exception of mildly elevated blood pressure. b)(6); documented RAYSON had no symptoms related to the elevated blood pressure. She also noted RAYSON reported level ten pain in his right knee and back, and appeared severely ill, uncomfortable due to pain, disheveled, tearful, and lethargic. 112
At 10:30 a.m., after reviewing RAYSON's January 29, 2017 laboratory tests, (b)(6); ordered the detainee's discharge from the MHU that same day. In the order, (b)(6); noted RAYSON's physical condition was stable. In otation does not state whether he completed an inperson assessment of RAYSON prior to making the discharge determination, and he declined during his interview to affirmatively state whether he conducted an inperson assessment of the detainee at any time while he was detained. As noted by Creative Corrections, (b)(6); discharge order did not articulate a plan for managing RAYSON's as needed medications once he moved to a general population housing unit.
At 10:43 a.m., (b)(6); assessed RAYSON to clear him for release to general population. She documented the detainee's vital signs were within normal limits, with the exception of a slightly elevated heart rate of 100. 115 (b)(6); noted RAYSON complained of level seven pain throughout his body, as well as nausea and vomiting. Per (b)(6); (b)(7)(C) documentation, she cleared RAYSON for release to general population. As noted below, RAYSON was not moved to general population until approximately 6:55 p.m.
At 1:15 p.m., RAYSON asked the MHU officer to see a nurse for his pain. Although a nurse did not assess RAYSON pursuant to his request, at 1:23 p.m, bi(6); ordered RAYSON receive 100 mg of Tramadol every six hours as needed for seven days after reviewing bi(6); 10:43 a.m. note. At 1:30 p.m., bi(6); (b)(7)(C) administered RAYSON the ordered dose of Tramadol. As noted by Creative Corrections, bi(6); did not order nursing checks for RAYSON upon his move to general population, though the administration of as needed pain medication, like Tramadol, typically requires regular checks by nurses to assess pain levels.
See LDF eClinicalWorks Telephone Encounter, dated February 1, 2017. See LDF eClinicalWorks Appointment, dated February 2, 2017. ERAU interview with(b)(6): (b)(7)(C)]April 12, 2017. See LDF eClinicalWorks Appointment, dated February 2, 2017. See LDF eClinicalWorks Appointment, dated February 2, 2017. See MHU Logbook, dated February 2, 2017. See LDF eClinicalWorks Telephone Encounter, dated February 2, 2017. See LDF eClinicalWorks Telephone Encounter, dated February 2, 2017. See LDF Medication Administration Record, from February 1, 2017 through February 28, 2017.

As documented in RAYSON's Medication Administration Record (MAR), at approximately
2:00 p.m., $(b)(6)$; $(b)(7)(C)$ administered the detainee morphine in tablet form. (b)(6); $(b)(7)(C)$
included a notation on the MAR that (b)(6); ordered morphine for the detainee; however, the
order is not otherwise referenced in any progress note, telephone encounter, or provider order.
(b)(6); (b)(7)(C) stated during her interview that a nurse instructed her to administer the morphine,
but she did not remember which nurse. 120 Creative Corrections advises that lawful
administration of a narcotic pain medication, such as morphine, requires a written prescription by
a DEA-registered provider. Creative Corrections also notes that only 30 minutes elapsed
between administration of Tramadol and morphine, even though maximum pain relief from
Tramadol occurs when the levels of the medication in the blood peak, up to two hours after
administration. Creative Corrections notes that oral doses of Tramadol and morphine together
increase sedation and drowsiness, and require close clinical monitoring for potentially serious
interactions. 121
At 4:53 p.m., (b)(6); (b)(7)(C) encountered RAYSON during her MHU nursing round and
documented the detainee's vital signs were within normal limits, that he was alert and oriented,
and that his respirations were even and unlabored. 122 She also noted she gave RAYSON a dose
of Tylenol. 123
of Tylohol.
At 6:55 p.m., security staff transferred RAYSON from the MHU to general population housing
unit Eagle A. 124 Shortly after his arrival, RAYSON informed the other detainees in the unit of
his HIV positive status, and detainees complained to their housing unit officer that they felt
unsafe with RAYSON in the unit. 125 The officer informed his supervisor, (b)(6); (b)(7)(C)
who met with RAYSON privately and asked whether he preferred to transfer to another
high custody housing unit, return to the MHU, or move to administrative segregation in the
Special Management Unit (SMU). Because the SMU has a television, which the MHU does not,
and RAYSON wanted to watch the Super Bowl that coming Sunday, he requested a transfer to
SMU. 126 (b)(6); (b)(7)(C) discussed moving RAYSON with his shift supervisor, (b)(6);
(b)(6); (b)(7)(C) who agreed that leaving RAYSON in Eagle A placed the detainee at risk for
harassment from the other detainees. (b)(6);(b)(7)(C) stated he received permission to move
RAYSON to the SMU for RAYSON's own protection from either the Warden, Associate
Warden, or Major, though he did not remember from whom specifically.
119 <i>Ibid.</i> As noted by Creative Corrections, (b)(6); also signed the morphine out on the clinic's Controlled
Substance Administration Log at this time.
ERAU interview with (b)(6); (b)(7)(C) April 21, 2017. ERAU was unable to establish who ordered
administration of the morphine or why.
121 See Exhibit 1: Creative Corrections Security and Medical Compliance Review.
 See LDF eClinicalWorks Telephone Encounter, dated February 2, 2017. See LDF Medication Administration Record, from February 1, 2017 through February 28, 2017.
124 See MHU Logbook, dated February 2, 2017. ERAU notes RAYSON's housing records erroneously document he
was moved to Eagle C versus Eagle A. Officers interviewed confirmed RAYSON was actually moved to Eagle A
on February 2, 2017. Both Eagle A and Eagle C units are 48-bed, general population dormitories for detainees
classified as high and medium high.
125 ERAU interview with (b)(6); (b)(7)(C) April 12, 2017.
CRALLINGWAITHMAND DATE TABLE / /III /

of an increased heart rate, and that his pain was at a level three.

examined and medically cleared RAYSON for placement in the

noted RAYSON's vital signs were within normal limits, with the exception

At 7:10 p.m., (b)(6),

SMU. 127 (b)(6);

At 8:05 p.m., (b)(6); (b)(7)(C) assigned and moved RAYSON to administrative segregation, and completed an administrative segregation order on which he noted "detainee has requested admission for protective custody." RAYSON did not sign the administrative segregation order, but did sign an administrative segregation orientation form. 128
RAYSON was placed in cell 5 of the Eagle B SMU. 129
RAYSON remained in administrative segregation for protective custody from February 2, 2017 through February 11, 2017, when he left LDF for LGH. ERAU notes cell 5, where RAYSON was housed, contained an inoperable intercom at the time of his detention. ¹³⁰ In contrast with the required nurse and provider rounds for detainees housed in the MHU, described in footnote 36, nurses are only required to make rounds in the SMU once per day and are not required to conduct assessments or take vital signs absent a provider order. Providers are not required to make rounds in the SMU. Nurses interviewed by ERAU stated SMU nursing rounds are conducted by knocking on the cell door and asking the detainee if he is alright. Vital signs and assessments are not routinely completed because officers do not open cell doors during rounds.
Nurses interviewed by <u>ERAU expressed</u> that RAYSON's placement in SMU made it difficult to monitor his condition. (b)(6); stated he did not believe housing RAYSON in SMU was appropriate as he wanted RAYSON up and moving around, and detainees in the SMU are locked in their cells 22 hours per day, but he did not intervene because he believed RAYSON wished to stay there. (b)(6); (b)(7)(C) stated he believed RAYSON should have remained in the MHU throughout his detention.
On February 3, 2017, at 9:33 a.m., (b)(6); (b)(7)(C) conducted a medical segregation round and documented RAYSON denied pain. Nursing staff reported they do not wake or disturb detainees during these rounds if they appear asleep or resting, thus a recorded denial of pain or pain at level zero should not be construed to mean the detainee experienced no pain.
At 4:30 p.m., (b)(6); (b)(7)(C) provided RAYSON with injections of Phenergan, Benadryl, and Toradol for pain, as ordered, after the detainee complained of level ten pain in his neck. (b)(6); did not record this administration on the MAR and did not document any follow-up to determine if RAYSON's pain resolved.
127 See LDF eClinicalWorks Appointment, dated February 2, 2017. 128 See Form I-886, Administrative Segregation Order, dated February 2, 2017. See Notice of Detainee Placement in the Restricted Housing Unit, dated February 2, 2017. 129 See LDF Housing History Grid, dated March 22, 2017. 130 ERAU Interview with holfor holfor and April 12, 2017. 131 See LDF eClinicalWorks Appointment, dated February 3, 2017. 132 See LDF eClinicalWorks Telephone Encounter, dated February 3, 2017.

(b)(6); (b)(7)(C) completed a segregation status review and
recommended no change in protective custody status. Although the Officer in Charge, [b)(6); (b)(7)(C)
On February 4, 2017, at 9:12 a.m., (b)(6); (b)(7)(C) completed a medical segregation round and documented RAYSON reported zero pain. ERAU notes(b)(6); (b)(7)(C) did not document whether she spoke to RAYSON during the round.
On February 5, 2017, security staff completed and approved a segregation status review for RAYSON and did not recommend any change to his protective custody status. ¹³⁵
At 9:13 a.m., (b)(6); (b)(7)(C) completed a medical segregation round during which she documented RAYSON experienced no pain. ERAU notes she did not document whether she spoke to RAYSON during the round. 136
At 4:08 p.m., (b)(6), (b)(7)(C) and (b)(6); (b)(7)(C) retrieved RAYSON from the SMU after an SMU officer called (b)(6); (b)(7)(C) to let her know RAYSON was "wailing" and complaining of pain throughout his body. The nurses transported him to the clinic in a wheelchair. (b)(6); (b)(7)(C) took RAYSON's vital signs which were within normal limits, with the exception of a mildly elevated blood pressure, and noted that he complained of level ten pain. (b)(6); (b)(7)(C) documented that RAYSON described his pain as electric, frequent, knife-like, persistent and progressive, and that he complained of nausea. (b)(6); (b)(7)(C) contacted (b)(6); (b)(7)(C) who ordered Phenergan and Toradol by injection and directed that RAYSON return to the SMU once his pair level decreased. 138
At 5:30 p.m., (b)(6); (b)(7)(C) followed up with RAYSON, documented his vital signs were within normal limits, that he was weak and unsteady, and that he described his pain at a level eight. (b)(6); (b)(7)(C) notified (b)(6): the detainee's pain decreased, and (b)(6): directed his released from the clinic. An officer escorted RAYSON back to the SMU in a wheelchair. During her interview, (b)(6); (b)(7)(C) Informed ERAU she was very concerned about RAYSON after he returned to the SMU, and stated she recommended to (b)(6): that RAYSON be sent to the hospital because he was very sick and in a great deal of pain. (b)(6); (b)(7)(C) stated that the following day, she also recommended to (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) that RAYSON at least be moved back to the MHU.

¹³³ See Form I-855, Administrative Segregation Review, dated February 3, 2017.
134 See LDF eClinicalWorks Appointment, dated February 4, 2017.
135 See Form I-855, Administrative Segregation Review, dated February 3, 2017.
136 See LDF eClinicalWorks Appointment, dated February 5, 2017.

 ¹³⁸ See LDF eClinicalWorks Telephone Encounter, dated February 5, 2017.
 139 See LDF eClinicalWorks Appointment, dated February 5, 2017.

On February 6, 2017, at 10:29 a.m., (b)(6); (b)(7)(C) completed a medical segregation round and documented RAYSON complained of level ten head and neck pain and appeared ill and weak. (b)(6); (b)(7)(C) consulted with (b)(6); who ordered Percocet three times daily, as needed, and the medication was administered at 3:00 p.m. and 9:00 p.m. 141 Creative Corrections notes that nurses did not conduct a follow-up assessment to determine the effectiveness and/or adverse side of effects of the Percocet, in contravention of standard nursing practice.
At 11:34 a.m., Psychologist (b)(6); (b)(7)(C) conducted a mental health assessment and noted RAYSON's condition deteriorated since his move to the SMU. (b)(6); (b)(7)(C) diagnosed RAYSON with adjustment disorder and depressed mood and scheduled a follow-up appointment in one week. (b)(6); (b)(7)(C) stated during interview that he believed RAYSON's depression stemmed from physical pain, being in detention, and his estrangement from his sister. (143)
At 3:08 p.m., Psychiatrist (b)(6); (b)(7)(C) conducted a second mental health assessment pursuant to a request from (b)(6); (b)(7)(C) described RAYSON as calm, cooperative, and agreeable. (b)(6); (b)(7)(C) offered RAYSON psychotropic medications, which he refused, 145 so she ordered a follow-up mental health assessment in two weeks and encouraged the detainee to engage in activities like light exercise and socializing with other detainees.
On February 7, 2017, the Consulate of Jamaica issued RAYSON a travel document valid through February 23, 2017. 146
At 9:30 a.m., (b)(6); (b)(7)(C) completed a medical segregation round and documented RAYSON complained of a constant level nine pain in his lower back, persisting for two to three days. During her conversation with RAYSON, he stated the Percocet he received the day before helped his pain but that he did not receive a dose that morning. ERAU notes RAYSON'S MAR shows he received Percocet at 9:00 a.m., 3:00 p.m., and 9:00 p.m. on February 7, 2017. ERAU could not resolve the discrepancy between (b)(6); (b)(7)(C) documentation that RAYSON reported not receiving the morning dose, and the notation on the MAR that he received Percocet at 9:00 a.m.
On February 8, 2017, at 8:25 a.m., (b)(6); (b)(7)(C) completed a medical segregation round and documented RAYSON's pain level as zero. (b)(6); (b)(7)(C) did not record whether she spoke with RAYSON during the round. 148
140 See LDF eClinicalWorks Appointment, dated February 6, 2017. 141 See LDF eClinicalWorks Telephone Encounter, dated February 6, 2017; LDF Medication Administration Record, dated February 6, 2017. 142 See LDF eClinicalWorks Appointment, dated February 7, 2017 143 ERAU Interview with (b)(6); (b)(7)(C) April 11, 2017. 144 See LDF eClinicalWorks Appointment, dated February 6, 2017. 145 See IHSC Form 820-S, Refusal Form, dated February 6, 2017. 146 See ICE Significant Incident Report, dated March 13, 2017. According to (b)(6); (b)(7)(C) the first available charter flight to Jamaica was scheduled for February 23, 2017, and RAYSON was scheduled to depart on the flight. 147 See LDF eClinicalWorks Appointment, dated February 7, 2017. 148 See LDF eClinicalWorks Appointment, dated February 8, 2017.

On February 9, 2017, (b)(6); (b)(7)(C) completed a segregation status review for RAYSON but did not document whether he interviewed RAYSON as part of the review, nor did he document a recommendation regarding continuation of RAYSON's placement in the SMU. 149 ERAU notes a supervisor reviewed, concurred with, and signed the review form even though it contained no recommendation. 150
At 5:47 a.m., (b)(6); (b)(7)(C) completed a medical segregation round and documented RAYSON'S pain level as zero but did not document whether she spoke with him during the round. 151
At 2:16 p.m., (b)(6); reviewed RAYSON's morning and evening blood glucose readings, which were elevated, and adjusted RAYSON's treatment plan to include an additional dose of glipizide before lunch, a decreased dosage of Tramadol, discontinuation of hydroclorothiazide and indomethacin, and administration of Fosamax every morning for thirty days to help manage elevated calcium levels. 152
On February 10, 2017, at 10:19 a.m., (b)(6); (b)(7)(C) completed the daily medical segregation round and documented RAYSON'S pain level as zero, but did not document whether RAYSON was awake or if she spoke with him during the round. 153
At 1:20 p.m., a nurse received a provider order for promethazine hydrochloride suppositories twice daily, as needed, to treat RAYSON's GERD. RAYSON's record contains no documentation concerning events that prompted the order, the order was not transcribed onto the MAR, and the record contains no documentation showing RAYSON received the suppositories.
On February 11, 2017, at 7:35 a.m., SMU (b)(6): (b)(7)(C) notified medical staff that she observed RAYSON crying in his cell and asked that they visit him right away. 154
At 7:55 a.m., (b)(6); (b)(7)(C) conducted a medical segregation round and administered RAYSON a dose of Percocet. (b)(6); (b)(7)(C) did not document whether she conducted the round in response to (b)(6); (b)(7)(C) call and did not record RAYSON's pain level.
At approximately 4:51 p.m., (b)(6); (b)(7)(C) arrived in the SMU to perform blood sugar checks. When she entered the unit, (b)(6); (b)(7)(C) found RAYSON crving and complaining of level ten pain throughout his body, as well as nausea and vomiting. (b)(6); (b)(7)(C) documented
149 See Form I-855, Administrative Segregation Review, dated February 9, 2017. 150 The supervisor's signature was illegible, and ERAU could not determine to whom it belonged. 151 See LDF eClinicalWorks Appointment, dated February 8, 2017. 152 See LDF eClinicalWorks Appointment, dated February 9, 2017. 153 See LDF eClinicalWorks Appointment, dated February 10, 2017. 154 See Eagle B Logbook, dated February 11, 2017. 155 See LDF eClinicalWorks Appointment, dated February 11, 2017. 156 See SMU surveillance video footage, February 11, 2017. 157 ERAU interview with (b)(6); (b)(7)(C) April 11, 2017.

¹⁸

RAYSON's blood glucose level was very low and that she gave him a nutritional supplement which he did not keep it down. ¹⁵⁸ (b)(6), (b)(7)(C) called (b)(6), (b)(7)(C) and requested the nurse bring a wheelchair to transport RAYSON to the clinic. 159 (b)(6), (b)(7)(C) arrived at approximately 5:03 p.m., assisted (b)(6); (b)(7)(C) in placing RAYSON in the wheelchair, and at 5:09, (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) departed the SMU with RAYSON. 160 Both (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) reported during their interviews that they observed vomit, urine and fecal matter on RAYSON's clothes and in his cell. ERAU notes (b)(6), (b)(7)(C) did not recall that either RAYSON or his cell was soiled, and the SMU logs contain no notations of a soiled cell. ¹⁶¹ ERAU could not resolve this discrepancy.

At 5:11 p.m., (b)(6); (b)(7)(C) arrived at the medical clinic with RAYSON and took the detainee's vital signs which showed an abnormally rapid heart rate of 111, an elevated respiratory rate of 22, and an elevated temperature of 98.9. 162 (b)(6); (b)(7)(C) contacted (b)(6); (b)(7)(C) and (b)(directed (b)(6); (b)(7)(C) to transfer RAYSON to LaSalle General Hospital (LGH) by ambulance. (b)(6); (b)(7)(C) called for an ambulance immediately following her call with (b)(6); At 5:44 p.m., an ambulance arrived at LDF, 163 and at 5:45 p.m., emergency medical services (EMS) responders entered the medical clinic with a gurney. ¹⁶⁴ At 5:48 p.m., the EMS responders transported RAYSON out of the clinic on the gurney, and at 6:03 p.m., the ambulance departed LDF. 165 (b)(6); (b)(7)(C) accompanied RAYSON in the ambulance while (b)(6); (b)(7)(C) followed in a chase vehicle. RAYSON arrived at the LGH emergency room at 6:09 p.m., and at 9:07 p.m., LGH admitted him for dehydration and elevated blood calcium. 166

February 11 – March 13, 2017

RAYSON remained at LGH until his transfer to the Tulane Medical Center (TMC) on February 17, 2017. He returned to LGH on February 22, 2017, and on March 4, 2017, LGH transferred him to the Lafayette General Hospital, Lafayette, LA, where he remained until his death. As detailed by Creative Corrections, LDF medical staff obtained daily updates from all three hospitals, ¹⁶⁷ and LDF officers assigned to RAYSON maintained daily hospital logs of his activities, ¹⁶⁸ both of which document the deterioration of the detainee's health. Notable events during RAYSON's hospitalizations are summarized below.

¹⁵⁸ See LDF eClinicalWorks Appointment, dated February 11, 2017.

¹⁵⁹ ERAU interview with (b)(6); (b)(7)(C) April 11, 2017.

¹⁶⁰ See SMU surveillance video footage, February 11, 2017.

¹⁶¹ ERAU interview with (b)(6); (b)(7)(C)April 12, 2017.

¹⁶² See LDF eClinicalWorks Appointment, dated February 11, 2017.

¹⁶³ See LDF Central Control Logbook, dated February 11, 2017.

¹⁶⁴ See Medical (Main Entry) video surveillance footage, February 11, 2017.

¹⁶⁵ See LDF Central Control Logbook, dated February 11, 2017.

¹⁶⁶ See Hospital Post Log, dated February 11, 2017; See LDF eClinicalWorks Telephone Encounter, dated February 11, 2017.

¹⁶⁷ See LDF eClinicalWorks records, February 11 to March 13, 2017.

¹⁶⁸ See Hospital Post Log, dated February 11 to March 13, 2017.

- RAYSON exhibited vomiting and a significantly elevated temperature upon his
 admission to LGH. LGH placed RAYSON on IV antibiotics, and by the following day,
 February 13, 2017, his vomiting abated and his temperature normalized. Over the next
 five days, RAYSON remained stable, although he complained of significant pain and
 continued to vomit intermittently.
- On February 17, LGH completed a CT scan of RAYSON's head after the detainee exhibited confusion. Because the CT scan showed a large subdural hematoma, ¹⁶⁹ LGH transferred RAYSON to the TMC for treatment.
- TMC performed a successful subdural hematoma draining procedure ¹⁷⁰ on February 18, 2017, and RAYSON remained at TMC for four days to recover. TMC discharged RAYSON to LGH on February 21, 2017, with instructions for continuation of antibiotic treatment.
- On February 23, 2017, (b)(6), (b)(7)(C) visited RAYSON at LGH. During their visit, they informed RAYSON he would not depart for Jamaica on that day's scheduled charter flight as he needed to first complete a course of antibiotics and potentially undergo another CT scan. 171
- In the days following his readmission to LGH, RAYSON remained stable, but continued to complain of significant pain, vomited intermittently, refused many of his meals, and became increasingly confused.
- On February 28, 2017, RAYSON underwent a second CT scan after exhibiting signs of confusion. The CT scan showed re-accumulation of blood related to the previously treated subdural hematoma.
- On March 1, 2017, LGH updated the neurosurgeon who treated RAYSON at TMC on the detainee's symptoms, as well the results of the second CT scan, to determine whether the detainee required transfer back to TMC. The TMC neurosurgeon did not respond prior to RAYSON's transfer to Lafayette General Hospital.
- On March 4, 2017, LGH transferred RAYSON to the Lafayette General Hospital after the detainee exhibited significant deterioration including increasing pain, weakness, lethargy, mental confusion, a persistent fever, and development of sepsis. ¹⁷² Lafayette General Hospital admitted RAYSON to the Intensive Care Unit (ICU) that same day, and he remained there in stable but critical condition until his death.

¹⁶⁹ A subdural hematoma is a collection of blood below the outer membrane covering the brain.

Hematoma evacuation is the removal of the blood collection, in this case by drilling a hole into the cranium.

Per (b)(6); (b)(7)(C) the next scheduled charter flight was scheduled for March

^{23, 2017.}

¹⁷² Sepsis is a life-threatening complication of an infection.

• On March 13, 2017, RAYSON stopped breathing at approximately 3:12 p.m., and a Lafayette General Hospital physician pronounced RAYSON dead at 3:20 p.m.

ERO New Orleans notified the Consulate of Jamaica in Miami, FL of RAYSON's death on March 13, 2017, and consular officials notified RAYSON's next of kin. 173

¹⁷³ See ICE Significant Incident Report, dated March 13, 2017.

^{174 &}lt;u>See Exhibit 6</u>: Report of the Forensic Pathologist, Louisiana Forensic Center, LLC, dated July 10, 2017.
175 (b)(6); noted the subdural hemorrhages likely led to a traumatic brain injury which ultimately caused the detainee's death, and that he could not determine a definitive cause of the subdural hemorrhages but did rule out a possible fall. ERAU notes there is no documentation RAYSON sustained a head injury during his detention at LDF.
176 See Exhibit 7: Certification of Death, State of Louisiana, dated August 4, 2017.

MEDICAL CARE AND SECURITY REVIEW

ERAU reviewed the medical care RAYSON was provided by LDF, as well as the facility's efforts to ensure that he was safe and secure while detained at the facility. ERAU found LDF deficient in its compliance with the following requirements in 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: Medically necessary and appropriate medical, dental and mental health care and pharmaceutical services."
 - On January 30, 2017, RAYSON reported level seven pain but was given no pain medication for over seven hours.
 - On February 1, 2017, an RN did not contact a provider for a pain medication order after RAYSON reported level seven pain. RAYSON received no medication for seven hours.
- 2. ICE PBNDS 2011, *Medical Care*, Section (V)(D), which states, "Consent forms and refusals shall be documented and placed in the detainee's medical file."
 - On February 1, 2017, RAYSON refused a cane to assist in ambulation, but he did not sign a refusal form.
- 3. ICE PBNDS 2011, *Medical Care*, Section (V)(J), which states, "If, at any time during the screening process, there is an indication of need of, or a request for mental health services, the HSA must be notified within 24 hours. The CMA, HSA or other qualified licensed health care provider shall ensure a full mental health evaluation, if indicated."
 - The NP who conducted RAYSON's initial health assessment did not did not refer him for a mental health assessment, despite her note of his depressed mood and sad affect.
- 4. ICE PBNDS 2011, *Medical Care*, Section (V)(S), which states, "Distribution of medication (including over the counter) shall be performed in accordance with specific instructions and procedures established by the HSA in consultation with the CMA. Written records of all prescribed medication given to or refused by detainees shall be maintained."
 - On January 31, 2017, an RN did not document an administration of Tramadol to RAYSON.
 - On February 2, 2017, an RN administered morphine, a controlled substance, to RAYSON and notated on the MAR that order in the record.

- On February 3, 2017, an RN did not document the administration of Benadryl and Toradol in the MAR.
- On February 10, 2017, nurses failed to transcribe a provider order for promethazine hydrochloride suppositories onto the MAR and did not document whether the suppositories were given to RAYSON.
- 5. ICE PBNDS 2011, *Medical Care*, Section (V)(U), which states, "Consistent with the IHSC Detainee Covered Services Package, detainees will be provided medical prosthetic devices or other impairment aids, such as eyeglasses, hearing aids, or wheelchairs, except when such provisions would impact the security or safety of the facility."
 - Although medical staff interviewed described RAYSON as weak and unstable, they did not offer him a cane, walker, or wheelchair upon his discharge from the MHU on February 2, 2017, or upon his return to the SMU on February 5, 2017.
- 6. ICE PBNDS 2011, *Custody Classification System*, Section (V)(A)(4), which states, "Each detainee's classification shall be reviewed and approved by a first-line supervisor or classification supervisor."
 - A supervisor did not approve RAYSON's January 28, 2017 classification, which also violates LDF policy and procedure 12.1.4, section (III)(A)(3), which states, "the first-line supervisor will review and approve each detainee's classification."
- 7. ICE PBNDS 2011, Environmental Health and Safety, Section (V)(A)(3), which states, "The facility administrator shall ensure that staff and detainees maintain a high standard of facility sanitation and general cleanliness."
 - LDF medical staff reported that on February 11, 2017, RAYSON's cell contained vomit, urine, and feces. Additionally, the ERAU review team observed a significant amount of graffiti in RAYSON's SMU cell during the onsite review.
- 8. ICE PBNDS 2011, Special Management Units, Section (V)(A)(1)(c)(9), which states, "Use of administrative segregation to protect vulnerable populations shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing options exist, and as a last resort. Detainees who have been placed in administrative segregation for protective custody shall have access to programs, services, visitation, counsel and other services available to the general population to the maximum extent possible."
 - Although RAYSON chose protective custody rather than moving to an alternate general population unit or returning to the MHU, and his medical condition well qualified him as a vulnerable detainee, security staff did not appropriately

document his request for protective custody. Additionally, although only medical providers have the authority to place detainees in the MHU, security staff made no attempt to explore returning RAYSON to the MHU despite his deteriorating condition.

- 9. ICE PBNDS 2011, *Special Management Units*, Section (V)(A)(2)(e), which states, "If the segregation is ordered for protective custody purposes, the order shall state whether the detainee requested the segregation, and whether the detainee requests a hearing concerning the segregation."
 - RAYSON's segregation order did not document whether he requested protective custody or if he requested a hearing regarding the assignment. This deficiency also violates LDF Policy and Procedure 10.4.1, Restricted Housing Units, Section (II)(B)(7), which states, "If the restriction housing is ordered for [protective custody] purposes, the order will state whether the detainee requested the restriction housing; also, whether the detainee requests a hearing concerning the restriction housing."
- 10. ICE PBNDS 2011, Special Management Units, Section (V)(A)(3)(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."
 - RAYSON's record contains no evidence a security supervisor interviewed him as part of his 72 hour segregation review. Further, the record does not demonstrate that the reviewing supervisor considered RAYSON's suitability for continued segregation, given his medical conditions.
- 11. ICE PBNDS 2011, Special Management Units, section (V)(A)(3)(b), which states, "A supervisor shall conduct an identical review after the detainee has spent seven days in administrative segregation, and every week thereafter, for the first 30 days and every 10 days thereafter, at a minimum."
 - RAYSON's record contains no evidence a security supervisor interviewed him as part of his seven day segregation review.
- 12. ICE PBNDS 2011, Special Management Units, Section (V)(A)(3)(c), which states, "The review shall include an interview with the detainee, and a written record shall be made of the decision and its justification."
 - RAYSON's record contains no evidence a security supervisor interviewed him as part of his seven day segregation review.

- 13. ICE PBNDS 2011, *Telephone Access*, Section (V)(E)(3), which states, "The indigent detainee may request a call to immediate family or others in personal or family emergencies or on an as-needed basis."
 - Security staff denied RAYSON's request for a free call to family despite his indigent status at the time of the request.

AREAS OF CONCERN

Although not reflective of any violation of the requirements of the detention standards, ERAU noted the following areas of concern related to LDF's processing of referrals for specialty consultations and hospitalizations.

- Although (b)(6); (b)(7)(C) documented that RAYSON required a referral for an infectious disease consultation, she never completed the referral request form to initiate approval for and scheduling of the consultation. Additionally, RAYSON's medical record contains no evidence that an LDF provider ever reviewed the recommendations of IHSC's infectious disease specialist.
- LDF sent RAYSON to RRMC on January 29, 2017, the day following his admission, but RRMC declined to admit him to the hospital. LDF made no further attempts to hospitalize RAYSON even though (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) both recommended that RAYSON be sent to a hospital. During their interviews, both (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) and (c)(6); (c)(7)(C) expressed RAYSON required tertiary care, or consultative care by specialists working in a facility outfitted to accommodate the investigation and treatment of complex conditions, and that the area surrounding LDF has few specialty clinics.

ERAU noted the following area of concern pertaining to RAYSON's discharge from the MHU.

• On the morning of February 2, 2017, [b)(6) ordered RAYSON discharged from the MHU after reviewing the detainee's lab studies from RRMC and determining he was stable and would benefit from a less restrictive general population housing environment. At the time of his discharge from the MHU, RAYSON's pain level was consistently between levels seven and ten, and he had a standing order to receive pain medication on an as-needed basis. As noted by Creative Corrections, RAYSON's medical record does not articulate a plan for effectively managing his pain with as-needed medications in a general population housing unit. Further, security staff, including officers assigned to general population housing units, are not trained or expected to manage the needs of a seriously ill detainee suffering from mobility challenges, nausea, vomiting, and receiving narcotic medication for widespread and frequent pain.

ERAU noted the following area of concern pertaining to RAYSON's placement in SMU.

• Because RAYSON's placement in general population prompted objections from other detainees in the unit, security staff decided to move him for his own safety. When given the option to return to the MHU or move to the SMU where he could watch television, RAYSON opted to move to the SMU. A nurse subsequently cleared RAYSON for housing in the SMU, documenting that RAYSON did not appear to have any acute or unresolved medical conditions that might worsen in segregation. As noted by Creative Corrections, not only was the nurse's determination not supported by RAYSON's medical record, but the nurse did not notify the provider of the decision to clear RAYSON for housing, which was warranted given RAYSON's advanced illness.

ERAU noted the following area of concern pertaining to medication administration.

- On February 3 and 6, 2017, nurses did not follow up to assess the effectiveness of the pain medication administered to RAYSON.
- Nurses did not consistently document a pain assessment for RAYSON prior to administering him narcotics: on January 31, 2017, RAYSON received Tramadol without a documented pain assessment; and, on February 2, 2017, he received morphine without a pain assessment just 30 minutes after he received a dose of Tramadol. Per Creative Corrections, assessing and documenting a patient's pain level before administering as needed medication is standard nursing practice.

ERAU noted the following areas of concern pertaining to the SMU.

- The intercom in SMU cell #5, where RAYSON was housed, was inoperable during the period he was detained there.
- The SMU Confinement Record contained inaccurate information. Specifically, although RAYSON departed LDF on February 11, 2017, SMU logs recorded activities for RAYSON on February 12, 2017.
- LDF Post Orders for Restricted Housing Unit Officers provide inconsistent requirements with respect to security rounds. Section (12) states, "The officer shall be responsible for checking detainees in RHU four times per hour on an irregular basis," while section (13)(e) states, "Rounds must be made to ensure the health, safety and welfare of all subjects at least every 30 minutes on an irregular schedule."

EXHIBITS

- 1. Creative Corrections Security and Medical Compliance Review.
- 2. LDF eClinicalWorks Appointment (Intake prescreening), dated January 28, 2017.
- 3. LDF eClinicalWorks Appointment (Intake screening), dated January 28, 2017.
- 4. LDF eClinicalWorks Appointment (initial health assessment), dated January 29, 2017.
- 5. ICE Custody Classification Worksheet, dated January 28, 2017.
- 6. Report of the Forensic Pathologist, Louisiana Forensic Center, LLC, dated July 10, 2017.
- 7. Certification of Death, State of Louisiana, dated August 4, 2017.