

ICE and CBP Deaths in Custody during FY 2021





OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

Washington, DC 20528 / www.oig.dhs.gov

February 1, 2023

MEMORANDUM FOR: Tae D. Johnson
Acting Director
U.S. Immigration and Customs Enforcement

Troy A. Miller
Acting Commissioner
U.S. Customs and Border Protection

FROM: Joseph V. Cuffari, Ph.D. **JOSEPH V. CUFFARI** Digitally signed by
Inspector General JOSEPH V CUFFARI Date: 2023.02.01
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SUBJECT: *ICE and CBP Deaths in Custody during FY 2021*

Attached for your information is our final report, *ICE and CBP Deaths in Custody during FY 2021*. Your offices chose not to submit management comments to the draft report. The report contains no recommendations.

Consistent with our responsibility under the *Inspector General Act of 1978, as amended* we will provide copies of our report to congressional committees with oversight and appropriation responsibility over the Department of Homeland Security. We will post the report on our website for public dissemination.

Please call me with any questions, or your staff may contact Thomas Kait, Deputy Inspector General for Inspections and Evaluations at (202) 981-6000.

Attachment



DHS OIG HIGHLIGHTS

ICE and CBP Deaths in Custody during FY 2021

February 1, 2023

Why We Did This Inspection

Pursuant to the requirements in Department of Homeland Security FY 2021 appropriations, we conducted a review of deaths of individuals in custody during FY 2021 for both ICE and CBP. Contracted medical professionals reviewed the circumstances of each death, and we looked at the deaths overall to ascertain whether systemic factors, policies, or processes played a role.

What We Recommend

We offer no recommendations in this report.

For Further Information:

Contact our Office of Public Affairs at (202) 981-6000, or email us at DHS-OIG.OfficePublicAffairs@oig.dhs.gov

What We Found

We reviewed the deaths of five individuals in custody reported by U.S. Immigration and Customs Enforcement (ICE) and the deaths of five individuals in custody reported by U.S. Customs and Border Protection (CBP) in fiscal year 2021. We found that no underlying systemic factors, policies, or processes played a role in the deaths of 9 of these 10 individuals and that both components reported their deaths to the Office of Inspector General as required. We were unable to evaluate the remaining individual's death due to an ongoing criminal investigation.

Previously, during an unannounced inspection of the Adams County Correctional Center in Natchez, Mississippi, we identified concerns about one of the five individuals who died in ICE custody and made recommendations for corrective action. Our contracted medical team reviewed the other four deaths in ICE detention in FY 2021 and found one individual was not provided timely or appropriate care by medical staff at the Calhoun County Jail in Battle Creek, Michigan. The contracted medical team found that measures taken by detention center medical staff for the other three individuals who died were appropriate. For CBP, as noted above, the contracted medical team could not fully evaluate circumstances related to one individual's death due to an ongoing criminal investigation and insufficient medical records. For the other four individuals who died in CBP custody, the medical team concluded that all measures taken by CBP and medical staff were consistent with applicable standards.

ICE and CBP Response

ICE and CBP chose not to submit formal management comments but provided technical comments, which we incorporated in this report as appropriate.



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Department of Homeland Security

Table of Contents

Background	1
Results of Inspection	3
Review of Deaths of Detainees in ICE Custody	4
Review of Deaths of Detainees in CBP Custody	9
Analysis of Systemic Issues	12
Recommendations	13

Appendixes

Appendix A: Objective, Scope, and Methodology	14
Appendix B: ICE Health Service Corps Mortality Reviews for the Five Deaths in ICE Custody	16
Appendix C: Office of Inspections and Evaluations Major Contributors to This Report	17
Appendix D: Report Distribution	18

Abbreviations

CBP	U.S. Customs and Border Protection
CPR	cardiopulmonary resuscitation
ECG	electrocardiogram
EMS	emergency medical services
ICE	U.S. Immigration and Customs Enforcement
OPR	Office of Professional Responsibility



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Department of Homeland Security

Background

Both U.S. Immigration and Customs Enforcement (ICE) and U.S. Customs and Border Protection (CBP) detain individuals in the course of their work. As part of its immigration mandate, ICE places apprehended noncitizens who require custodial supervision in detention facilities, which is the point at which ICE considers these individuals detained and in custody. As part of securing the Nation's borders, CBP stops illegal entrants and illicit goods. CBP's definition of "in custody" is broader than ICE's, and its interactions with apprehended individuals might include transport, escort, detention, or transferring them to another agency's custody.

ICE and CBP have different ways of defining "death in custody." ICE defines "death in custody" as a case in which an individual dies under ICE's supervision in a detention facility, medical facility, or in transit between facilities, or post release (within 30 days). CBP has extensive criteria to establish "death in custody" because it detains individuals in a variety of settings, including CBP vehicles, inspection locations, and holding facilities. CBP criteria categorize deaths as "in custody (reportable)," "not in custody (reportable)," and "not reportable" for the purposes of required annual reporting.¹

A July 2020 House Committee on Appropriations report regarding fiscal year 2021 Department of Homeland Security appropriations directs the DHS Office of Inspector General to "invest additional resources in assessing whether systemic factors, policies, or processes have played a role in such deaths [in ICE and CBP custody] and make recommendations for reducing the risk of future deaths."² In compliance with this committee report, we assessed ICE and CBP deaths in custody from October 1, 2020, through September 30, 2021 (FY 2021). In addition, the committee report directs CBP to notify OIG's Office of Investigations "within 24 hours of the death of any individual in CBP custody or any individual not in custody if CBP personnel were involved in the death." Similarly, ICE is required to notify OIG within 12 hours of a detainee death.³

Our objective was to review the circumstances related to each death that occurred in ICE and CBP custody in FY 2021 and determine whether systemic factors, policies, or processes played a role in the death.

¹ Under the Federal Deaths in Custody Reporting Program, Federal law enforcement agencies must report deaths that occurred under their jurisdiction to the Department of Justice on an annual basis.

² [House Report 116-458 from July 20, 2020, p. 17.](#)

³ ICE Directive 11003.5, *Notification, Review, and Reporting for Detainee Deaths*, Oct. 25, 2021.



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Department of Homeland Security

Because the two components define and categorize deaths in custody differently, we applied a common definition to the datasets from both components to provide consistency in our review. To further make the broader CBP data comparable with ICE data, we reviewed cases in which CBP had detained migrants who later died and assessed whether CBP obtained sufficient and appropriate medical care for these migrants. We contracted with a team of medical professionals, consisting of one medical doctor and one registered nurse, to assess whether the medical care provided was appropriate given the circumstances of each case.

For the purposes of this mandate, we defined “death in custody” as follows:

ICE: Death of a noncitizen at any time while in ICE custody, including in an ICE detention facility, medical facility, or in transit between facilities.

In FY 2021, ICE reported five deaths of detainees in custody to OIG. All five deaths reported to OIG met this definition and were included in this review.

CBP: Death of an individual whom CBP had placed in custody at some point, in a Government vehicle or CBP facility. We did not review cases in which an individual died before being put into custody or was in the process of being put into custody by CBP (including while being apprehended), as these cases did not fall into our interpretation of the scope of the language in the congressional mandate.

In FY 2021, CBP reported 117 deaths to OIG. We found that many of these were for individuals who were not in CBP custody at the time of their death. After reviewing all 117 deaths that CBP reported for FY 2021, we grouped the deaths into four categories:

1. On scene: 45 individuals (39 percent) died before CBP arrived or while CBP was on scene, but not as a result of apprehension.⁴
2. Medical facility or transport: 42 individuals (36 percent) were pronounced dead at a hospital or during medical transport prior to being taken into CBP custody.
3. During apprehension: 25 individuals (21 percent) died during apprehension, while fleeing, or as a result of attacking CBP personnel but were not considered to be in CBP custody.

⁴ “Apprehension” refers to the physical control or temporary detainment of a person who is not lawfully in the United States, which may or may not result in an arrest.



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

4. In CBP custody: 5 individuals (4 percent) died after having a medical emergency while in CBP custody.⁵ We determined that these five deaths met our definition of death in custody and included them in this review.

Our review of the five ICE cases was based on applicable ICE standards and the mortality reviews conducted by the ICE Health Service Corps for every detainee death.⁶ In addition, ICE's Office of Professional Responsibility (OPR) provided us reviews related to the detainee deaths.⁷ However, these reviews were more focused on the facility's adherence to standards, whereas our reviews were focused on clinical outcomes.

Our review of the five CBP cases was based on CBP's 2015 *National Standards on Transport, Escort, Detention and Search*.⁸ Our contracted medical team reviewed the cases for appropriate clinical response to detainee needs and the timeliness and appropriateness of actions taken to meet those needs.

Results of Inspection

Both components reported deaths to OIG as required. For ICE, we previously identified concerns and made recommendations for corrective action regarding ICE's handling of one death during our unannounced inspection of the Adams County Correctional Center in Natchez, Mississippi. The contracted medical team reviewed the other four deaths in ICE detention in FY 2021 and found one individual was not provided timely or appropriate care by medical staff at the Calhoun County Jail in Battle Creek, Michigan. The contracted medical team found that measures taken by detention center medical staff for the other three individuals who died were appropriate. For CBP, the contracted medical team could not fully evaluate circumstances related to one death due to an ongoing criminal investigation. For the other four CBP detainee deaths, the medical team concluded that all measures taken by CBP and medical staff were appropriate. We found that no underlying systemic factors, policies, or processes played a role in 9 of the 10 deaths in custody reported by ICE and

⁵ Individuals who are transferred to an ambulance or other medical vehicle, or who are in a hospital or other medical facility, are still considered to be in CBP custody.

⁶ For a summary of the mortality reviews for the five ICE cases in this report, see Appendix B.

⁷ ICE's Office of Professional Responsibility also reviewed the deaths of the five individuals who died in ICE custody by assessing each facility's compliance with the applicable detention center standards. These reviews also noted areas of concern that were not covered by the standards. As noted in the reports, any deficiencies or areas of concern were for informational purposes only and were not to be construed as contributory to a detainee's death. Conversely, our medical contractors took a clinical outcome approach to their review of the deaths of the five individuals who died in ICE custody, focusing on the appropriateness of the care received and whether that care contributed to the individual's death.

⁸ CBP, 2015 *National Detention Standards on Transport, Escort, Detention and Search*, Section 4.10, *Medical*.



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

CBP in FY 2021; for the remaining case, as noted above, we could not fully evaluate the circumstances due to an ongoing criminal investigation.⁹

Review of Deaths of Detainees in ICE Custody

ICE Detainee Death in Custody Case No. 1

On October 1, 2019, Anthony Jones (a citizen of the Bahamas) was transferred into ICE custody and housed at the Adams County Correctional Center (Adams) in Natchez, Mississippi. He had been detained for unlawful entry into the United States. The transfer summary paperwork indicated Mr. Jones suffered from hypertension (high blood pressure). On October 2, 2019, medical staff at Adams completed his medical intake screening, during which Mr. Jones denied any medical or mental health conditions or current medication use. His intake screening showed elevated blood pressure.

The contracted medical team's review of Mr. Jones' medical files found that he was seen by Adams medical staff on at least 20 occasions from October 15, 2019, through December 10, 2020, for medical concerns including high blood pressure, dental issues, elevated cholesterol levels, bowel issues, sinus infection, a nosebleed, and "popping" knees. On November 12, 2019, medical staff diagnosed Mr. Jones with hypertension and dyslipidemia (elevated cholesterol levels). On February 13, 2020, medical staff diagnosed Mr. Jones with benign prostate hypertrophy (enlarged prostate).

After breakfast on December 17, 2020, Mr. Jones complained of burning in his chest. The contracted medical team determined he was assessed by Adams medical staff using the proper protocols for chest pain, which included the completion of an electrocardiogram (ECG) and administration of oxygen, aspirin, and nitroglycerin. After reviewing the ECG, a doctor advised the nurse to monitor Mr. Jones for an hour before sending him back to the housing unit.

⁹ Although we found no systemic factors that played a role in these deaths, our program of unannounced inspections of ICE detention facilities continues to include extensive reviews of medical care provided to detainees. Our office also conducts unannounced inspections of CBP holding facilities, including Border Patrol stations and Office of Field Operations ports of entry, to evaluate CBP's compliance with applicable detention standards. In addition, since July 2019, we have undertaken projects that address longstanding issues in ICE detention. For example, see our reports *Many Factors Hinder ICE's Ability to Maintain Adequate Medical Staffing at Detention Facilities* (<https://www.oig.dhs.gov/sites/default/files/assets/2021-11/OIG-22-03-Oct21.pdf>) and *ICE Needs to Improve Its Oversight of Segregation Use in Detention Facilities* (<https://www.oig.dhs.gov/sites/default/files/assets/2021-10/OIG-22-01-Oct21.pdf>).



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

Approximately 1 hour later, Mr. Jones was found unresponsive in the waiting room, and the medical team began cardiopulmonary resuscitation (CPR). Emergency medical services (EMS) was called, and the Adams medical team continued lifesaving measures until EMS arrived. Upon arrival, EMS staff pronounced Mr. Jones dead.

The contracted medical team determined that Mr. Jones was seen in a timely manner for his medical issues and they were appropriately addressed. The team also noted there were no delays in care for his hypertension. Chronic care visits occurred on a routine basis, and Mr. Jones' blood pressure was well managed. Medications were appropriately ordered by medical staff and delivered to Mr. Jones. He had routine laboratory studies, which showed his cholesterol was within limits that did not require medication for treatment.

However, the contracted medical team concluded that the mortality event raised some concerns regarding the handling of Mr. Jones' complaint on December 17, 2020. An autopsy conducted by the Mississippi Office of the State Medical Examiner ruled the cause of death was atherosclerotic cardiovascular disease.¹⁰ Our contracted physician noted that the Mr. Jones' ECG from December 17, 2020, showed significant changes from an ECG performed approximately 1 year prior — indicating an event that required more immediate action. Based on a review of medical records and the autopsy report, our medical contractor concluded that had the Adams medical staff compared the 2019 ECG with the one conducted on December 17, 2020, it should have prompted the medical staff to call 911 and send the detainee to the hospital, where life support care would have been readily available. The contracted medical physician found that care for this episode was not appropriate and further determined that the delay in getting the detainee to a higher level of care potentially contributed to his death.

We addressed this specific death and made recommendations for corrective action in a previous inspection report.¹¹

ICE Detainee Death in Custody Review Case No. 2

On December 28, 2020, Felipe Montes (a citizen of Mexico) was charged with inadmissibility as a noncitizen present in the United States without being

¹⁰ Arteriosclerosis is hardening and thickening of the walls of the arteries. When arteriosclerosis affects the coronary arteries that supply blood to the heart muscle, a shortage of oxygen delivered to the heart itself may lead to a heart attack.

¹¹ *Violations of ICE Detention Standards at Adams County Correctional Center*, OIG-21-46, issued July 14, 2021, <https://www.oig.dhs.gov/sites/default/files/assets/2021-07/OIG-21-46-Jul21.pdf>.



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

admitted or paroled. He was transferred into ICE custody and housed at the Stewart Detention Center in Lumpkin, Georgia.

The contracted medical team's review of Mr. Montes' medical files found that his intake process was timely and consisted of an intake screening examination and a COVID-19 test conducted by a registered nurse. Mr. Montes' screening showed no history of or current medical problems and no COVID-19 related symptoms, and he tested negative for the virus. However, per the detention center's COVID-19 protocols, Mr. Montes was quarantined for 14 days.

On January 1, 2021, Mr. Montes again tested negative for COVID-19 and was transferred to the general population. On January 4, 2021, he received an initial physical exam, which documented normal findings.

On January 9, 2021, Mr. Montes complained of a sore throat, and detention staff monitored his symptoms throughout the day, which the contracted medical team concluded was appropriate care. On January 10, 2021, Mr. Montes complained of difficulty breathing, and detention center staff immediately initiated transport to the Piedmont-Columbus Regional Hospital in Columbus, Georgia. Upon his arrival, hospital staff assumed care of Mr. Montes and diagnosed him with pneumonia related to COVID-19 and hypoxia (oxygen deficiency). Hospital staff also tested Mr. Montes for COVID-19, and the test was positive.

During his hospital stay, Mr. Montes' condition improved for some days and then worsened for some days. On January 19, 2021, Mr. Montes was placed on an airway management device to keep his lungs expanded for better oxygen absorption. He removed the device later in the day, which required hospital staff to intubate and transfer him to the intensive care unit.

On January 29, 2021, Mr. Montes' condition worsened, and he needed the support of a mechanical ventilator. On January 30, 2021, he went into cardiac arrest. Lifesaving measures performed by hospital staff were unsuccessful, and Mr. Montes was pronounced dead that morning.

The contracted medical team reviewed the medical files and determined that facility staff had performed COVID-19 screening and the emergency response at the facility was appropriate. The contracted medical team also determined the hospital staff acted appropriately in its overall care of the detainee.



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

ICE Detainee Death in Custody Review Case No. 3

On December 31, 2020, Jesse Jerome Dean (a citizen of the Bahamas) was transferred into ICE custody and held at Calhoun County Jail in Battle Creek, Michigan.

The contracted medical team's review of Mr. Dean's medical files found that upon transfer to the Calhoun County Jail, he received a timely intake screening, which documented normal vital signs, except for elevated blood pressure. Mr. Dean's medical history also showed a history of hyperlipidemia (high levels of fat in the blood) and hypertension (high blood pressure). He was referred to a provider for chronic care management. Mr. Dean also took a COVID-19 test, which was negative.

For approximately 5 weeks while in custody, Mr. Dean had recurring gastrointestinal complaints. Mr. Dean was seen and treated with several different medications, but his symptoms did not resolve. He was seen by nursing and provider staff on numerous occasions. His symptoms got progressively worse, until he was no longer eating and had lost 17 pounds since his point of intake into the facility. Abdominal x-rays and bloodwork were ordered and returned results with non-specific findings.

On February 2, 2021, Mr. Dean reported losing consciousness due to his abdominal pain. Based on his reports of anxiety, the nurse referred Mr. Dean to a behavioral health provider. Facility medical staff noted that he should no longer be allowed on the upper tier of the housing unit.

On February 5, 2021, medical staff observed Mr. Dean having difficulty getting up to take his medication. He was transferred to the medical unit for observation. Mr. Dean's condition worsened, and his files noted he fell on a few occasions and struggled to get up. Shortly before his death, Mr. Dean became hypotensive (had abnormally low blood pressure) and was given IV fluids. A few hours later, Mr. Dean became unresponsive, and EMS was called. When EMS staff arrived, they transferred Mr. Dean to the ambulance and requested additional assistance from Calhoun County Jail medical staff. Lifesaving measures were performed for approximately 30 minutes but were unsuccessful, and Mr. Dean died. Mr. Dean's autopsy report showed the cause of death was a gastrointestinal hemorrhage due to an ulcer in his small intestine, with hypertensive cardiovascular disease as a contributory cause of death. The autopsy indicated that his cause of death was natural.

The contracted medical team reviewed the medical files and autopsy report and determined that Calhoun County Jail medical staff should have acted more swiftly to meet Mr. Dean's needs after correlating his complaints of worsening



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

symptoms, significant weight loss, hypotension, and fall events. They did not take the appropriate actions to address his continued gastrointestinal complaints, and thus the contracted medical team determined the care provided was not appropriate.

ICE Detainee Death in Custody Review Case No. 4

On March 2, 2021, Diego Fernando Gallego-Agudelo (a citizen of Colombia) was apprehended and arrested by CBP for unlawful entry into the United States. He was sent to the Rio Grande Valley Sector Centralized Processing Center in McAllen, Texas. On March 3, 2021, Mr. Gallego-Agudelo was transferred into ICE custody and housed at Port Isabel Detention Center in Los Fresnos, Texas.

The contracted medical team's review of Mr. Gallego-Agudelo's medical files found that on March 6, 2021, he complained of chest pains. Facility staff promptly escorted him to the medical clinic, where he said that he did not have a history of cardiac issues or hypertension. The facility's medical staff contacted EMS for emergency transport to the hospital for a higher level of care, which the contracted medical team concluded was an appropriate response for Mr. Gallego-Agudelo's clinical presentation. Medical staff continued to provide supportive care until EMS arrived on the scene, at which time EMS staff took over the care of Mr. Gallego-Agudelo and transported him to the hospital. Mr. Gallego-Agudelo remained in the hospital from March 6, 2021, through March 15, 2021, when he went into cardiac arrest and lifesaving measures were unsuccessful. Mr. Gallego-Agudelo died the evening of March 15, 2021.

The contracted medical team reviewed the medical files and determined that the detainee had reported no history of cardiac disease nor ever experienced cardiac symptoms in the past. Therefore, the facility staff had no reason to take action prior to his cardiac event. The contracted medical team determined that facility staff had responded appropriately and in a timely manner to Mr. Gallego-Agudelo's medical emergency. The contracted medical team also determined the hospital staff acted appropriately in its overall care of the detainee.

ICE Detainee Death in Custody Review Case No. 5

On July 26, 2021, Elba Maria Centeno-Briones (a citizen of Nicaragua) entered the United States near Brownsville, Texas, without inspection and admission or parole by an immigration officer. CBP arrested Ms. Centeno-Briones and issued her a notice and order of expedited removal. On July 27, 2021, Ms. Centeno-Briones was transferred into ICE custody and housed at the El Valle Detention Facility in Raymondville, Texas.



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

The contracted medical team's review of Ms. Centeno-Briones' medical files found that during the intake screening process on July 27, 2021, she complained of shortness of breath, coughing, and fatigue for the past week. The nurse found that Ms. Centeno-Briones had abnormal lung sounds, along with wheezing, low blood oxygen level, and discoloration of the skin. She was tested for COVID-19, and the results were positive. The nurse immediately contacted EMS for emergency transport. While awaiting transport, medical staff gave Ms. Centeno-Briones a nebulizer treatment and oxygen.

EMS transported Ms. Centeno-Briones to the Valley Baptist Medical Center. Although she showed some improvement with treatment, Ms. Centeno-Briones ultimately required intubation and was moved to the intensive care unit. Even with ventilator support, Ms. Centeno-Briones died on August 3, 2021. The hospital's attending doctor determined Ms. Centeno-Briones' cause of death was COVID-19, with secondary complications of viral influenza and obesity. An autopsy was not performed.

The contracted medical team reviewed the medical files and determined that facility staff had performed COVID-19 screening and the emergency response at the facility was appropriate. The contracted medical team determined the hospital staff also acted appropriately in its overall care of the detainee.

Review of Deaths of Detainees in CBP Custody

CBP Detainee Death in Custody Review Case No. 1

On March 25, 2021, Lorenzo Bartolo-Cardona (a citizen of Guatemala) was apprehended and arrested by CBP for unlawful entry into the United States. He was sent to the Border Patrol Station in Casa Grande, Arizona. On March 26, 2021, Mr. Bartolo-Cardona was transferred to the Border Patrol Station in Tucson, Arizona.

The contracted medical team's review of Mr. Bartolo-Cardona's medical files found that upon arrival at the Tucson Border Patrol Station, he reported pain in his lower extremities. He then collapsed and went into cardiac arrest. CBP staff responded immediately by transporting Mr. Bartolo-Cardona to the emergency room.

After Mr. Bartolo-Cardona was transferred to the care of hospital staff, he was treated for several issues and admitted to critical care. He underwent surgery on March 26, 2021, for issues with his appendix and the formation of an ulcer. On March 27, 2021, he again underwent surgery for a bacterial infection



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

throughout his entire leg and lower extremity. The hospital staff determined that Mr. Bartolo-Cardona should be moved to comfort measures only with instructions not to resuscitate in the event of cardiac or respiratory arrest. He died on March 27, 2021.

The contracted medical team had no concerns with the care Mr. Bartolo-Cardona received from CBP personnel, concluding that CBP staff took appropriate action by immediately transferring him to the emergency room. The contracted medical team also concluded that hospital staff at Banner-University Medical Center Tucson provided the appropriate care to Mr. Bartolo-Cardona for his diagnosis and condition.

CBP Detainee Death in Custody Review Case No. 2

On March 10, 2021, Carlos Silva (a U.S. citizen) was stopped at a checkpoint within the United States. The vehicle Mr. Silva was in was referred for further screening due to the occupant's nervous behavior and inconsistent responses to questions from Border Patrol agents. During transportation to the port of entry via a Government vehicle, Mr. Silva complained that he was not feeling well but declined medical attention. At the port of entry, agents opened the rear door of the Government vehicle and found Mr. Silva convulsing and foaming at the mouth in seizure-like activity. EMS and the fire department responded to the scene, at which point Mr. Silva was transferred to their care. EMS staff provided medical attention and loaded Mr. Silva into an ambulance. He stopped breathing shortly thereafter. EMS staff performed CPR and lifesaving measures, but they were unsuccessful, and Mr. Silva was pronounced dead.

The contracted medical team reviewed Mr. Silva's medical files. His autopsy revealed that the cause of death was accidental due to an overdose of methamphetamine and cardiomegaly (enlarged heart). The contracted medical team had no concerns with the care Mr. Silva received. The team concluded that CBP personnel took appropriate action by immediately contacting emergency assistance. The team also concluded that EMS staff took appropriate actions based on Mr. Silva's condition.

CBP Detainee Death in Custody Review Case No. 3

On July 24, 2021, Nolvin Bejarano-Corea (a citizen of Honduras) was arrested by CBP and taken into custody. Shortly after being taken into custody, CBP staff noticed he was displaying flu-like symptoms. Mr. Bejarano-Corea was transported and admitted to a local hospital, and hospital staff took over his care. Mr. Bejarano-Corea was diagnosed with acute respiratory distress syndrome due to COVID-19. During the next 8 days, Mr. Bejarano-Corea



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

maintained a fever and his condition worsened. He was also diagnosed with pneumonia. Hospital staff intubated Mr. Bejarano-Corea on July 30, 2021. He went into cardiac arrest and died on July 31, 2021.

The contracted medical team reviewed Mr. Bejarano-Corea's medical files and determined that CBP staff appropriately reacted to Mr. Bejarano-Corea's condition by transporting him to the emergency room for a higher level of care. The contracted medical team also concluded that care by hospital staff was appropriate, based on the information reviewed.

CBP Detainee Death in Custody Review Case No. 4

In the early morning hours of September 20, 2021, a juvenile (citizen of Honduras) was in the custody of her mother when she was detained by CBP.

CBP officials noted the child was in physical distress while she was in a group processing center and contacted EMS. Before EMS arrived, the child went into cardiac arrest. When EMS staff arrived on scene, they initiated lifesaving measures and continued doing so during transport to a local hospital. The emergency room staff continued lifesaving measures, but they were unsuccessful. The child died on September 20, 2021. The only information CBP staff were able to obtain from the child's mother was that she had been ill for approximately 7 days prior to her presentation to CBP and subsequent cardiac arrest. The mother also informed CBP that her daughter had gone without food and water for 20 hours.

The contracted medical team reviewed the child's medical files and determined that CBP staff reacted appropriately by recognizing the child's condition and arranging for transport to the hospital. The hospital staff also acted appropriately in its care of the child. The cause of death in the preliminary autopsy report was noted as dehydration and pneumonia.

CBP Detainee Death in Custody Review Case No. 5

On August 2, 2021, a group of migrants including Jason Gonzalez-Landaverde (a citizen of El Salvador) was spotted on a Border Patrol camera inside a ranch near Eagle Pass, Texas. Border Patrol agents located and apprehended seven migrants while several others fled. Agents continued to search for the individuals, and shortly thereafter apprehended five more migrants, including Mr. Gonzalez-Landaverde. He was initially handcuffed together with two other migrants, using two sets of handcuffs. According to CBP reports, Mr. Gonzalez-Landaverde became unruly and began causing discomfort to the other two individuals. When agents removed the handcuffs to separate him from the others, he attempted to escape and managed to run a short distance



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

before being apprehended again. Agents reportedly restrained him with his hands behind his back and secured him on the hood of a nearby Border Patrol vehicle. Agents secured two other migrants on the front bumper of the vehicle and two in the back seat of the vehicle and then drove back to the location where the first group was apprehended. Upon arrival at that location, the Border Patrol agents removed Mr. Gonzalez-Landaverde from the hood of the vehicle and placed him on the ground; he remained restrained. Agents likewise removed the other migrants from the vehicle and then directed all migrants to sit on the ground nearby to await the arrival of a transport vehicle. When the Border Patrol transport vehicle arrived, approximately 1 hour later, agents discovered Mr. Gonzalez-Landaverde was unresponsive. The agents removed his restraints, began chest compressions, and requested EMS. When the Eagle Pass Fire Department arrived on the scene, medical personnel determined that Mr. Gonzalez-Landaverde was dead.

CBP's OPR responded to the scene, interviewed migrants involved in the incident, and subsequently notified the Federal Bureau of Investigation, DHS OIG, and the local sheriff's department. CBP OPR and the Webb County Medical Examiner's Office are reviewing this incident, which is under investigation by the Texas Rangers. At this time, the criminal investigation is ongoing.

The contracted medical team reviewed Mr. Gonzalez-Landaverde's medical files, which were limited, and confirmed that CBP officials contacted EMS. Medical reports indicate that lifesaving measures were performed before EMS arrived. However, upon the arrival of EMS, Mr. Gonzalez-Landaverde was pronounced dead and no further medical intervention was made. He died on August 2, 2021.

Due to the limited information available for review, the contracted medical team could not comment on the medical circumstances surrounding Mr. Gonzalez-Landaverde's death. The autopsy reported the cause of death was acute renal failure, which the medical examiner believed was most likely due to a combination of dehydration and hyperthermia (abnormally high body temperature).

Analysis of Systemic Issues

We did not identify any underlying systemic issues related to the deaths of 9 of the 10 individuals. The death of one individual in CBP custody is the subject of an ongoing criminal investigation, and we were unable to do a comprehensive review of the facts while the case is being investigated.



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Department of Homeland Security

Recommendations

We previously identified concerns regarding ICE's handling of the death of Anthony Jones in our unannounced inspection report of the Adams County Correctional Center and made recommendations to address the handling of emergency care at the correctional center in our 2021 report issued to ICE.¹² The facility addressed these concerns in its corrective action plan to improve medical response to emergency situations.

For all deaths we reviewed, we did not identify systemic issues warranting corrective action across ICE or CBP. Because there were no systemic issues, we make no recommendations in this report.

¹² *Violations of ICE Detention Standards at Adams County Correctional Center*, OIG-21-46, issued July 14, 2021.



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Appendix A

Objective, Scope, and Methodology

The Department of Homeland Security Office of Inspector General was established by the *Homeland Security Act of 2002* (Pub. L. No. 107-296) by amendment to the *Inspector General Act of 1978*. In 2021, H.R. 116-458, *DHS Appropriations Bill for 2021*, was passed, which directed DHS OIG to “invest additional resources in assessing whether systemic factors, policies, or processes have played a role in [deaths of individuals in the custody of ICE and CBP] and make recommendations for reducing the risk of future deaths.”

Our review of the five ICE cases was based on applicable ICE detention standards. Our review of the five CBP cases was based on CBP’s 2015 *National Detention Standards on Transport, Escort, Detention, and Search*. A contracted medical team reviewed the cases for appropriate clinical response to detainee needs and the timeliness and appropriateness of actions taken to meet those needs.

Our objective was to analyze the circumstances surrounding each detainee death that occurred in CBP and ICE custody during FY 2021. To accomplish this, we took a two-pronged approach. First, our contracted medical team reviewed the medical files for each death that occurred in custody at CBP and ICE. The medical files included all medical information, including medical records and autopsy reports, when available.

ICE and CBP are required to notify OIG Investigations of all reportable deaths of detainees in custody. Our Office of Inspections and Evaluations coordinated with OIG Investigations to identify all reported detainee deaths in custody at ICE detention facilities and at CBP facilities for FY 2021. The inspection team also received notifications of all deaths in custody from both ICE and CBP to ensure the review included a complete count of all detainee deaths in custody occurring in FY 2021.

The inspection team requested medical records and any internal reviews from ICE and CBP for all deaths of detainees in custody being reviewed by contracted medical staff. Both ICE and CBP indicated that they do not always have access to the medical records in these cases, as not all local hospitals will provide copies of individual medical records to ICE or CBP. In these cases, we were not able to complete a review of the medical records to assess the medical care provided.

We conducted this inspection under the authority of the *Inspector General Act of 1978, as amended*, and according to the *Quality Standards for Inspection*



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Appendix B

ICE Health Service Corps Mortality Reviews for the Five Deaths in ICE Custody

The ICE Health Service Corps conducts mortality reviews for every detainee 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 mortality reviews for the five deaths in ICE custody examined in this report identified strengths and weaknesses in patient care and made recommendations that ICE and the facility can take to improve compliance with standards and facility policies, procedures, and practices. Our contracted medical team reviewed the medical files at each facility for all cases in this report, as well as these mortality reviews for ICE cases, to form the professional medical opinion described for each case as to whether appropriate medical action was taken.

All five reviews identified weaknesses in communication related to the overall care and response to the detainees' conditions and mortality events. The specific communication weaknesses ranged greatly, from unprofessional communication by medical staff and the absence of interpretation services to lack of records of calls between staff or of conditions identified by different staff members.

Weaknesses in emergency response, documentation, and patient care were each noted three times across the five cases. Emergency response weaknesses included staff delay in responding to the detainees and one instance when the detainee was not provided the appropriate breathing treatment for the displayed symptoms. Weaknesses in documentation encompassed an absence of consistent and accurate medical documentation throughout the course of the detainees' care. Finally, weaknesses in patient care included instances when staff did not adequately assess or treat a detainee's repeated complaints, staff did not appropriately use emergency oxygen, and staff did not properly apply COVID-19 guidelines when they comingled detainees who had COVID-19 symptoms with detainees who did not exhibit the symptoms.



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Appendix C

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Appendix D

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