PROXY MEMORANDUM

To: The GEO Group Shareholders:

Subject: Support shareholder resolution requesting an independent annual report on company-wide human rights performance

Date: March 21, 2106

Contact(s): Father Stephen Privett, SJ at sprivett@jesuits.org and Keith Vernon at kvernon@jesuit.org

The California Province of the Jesuits recommends a vote “For” the shareholder resolution cited directly below. The proposal was filed by the California Province of the Jesuits along with the Interfaith Center on Corporate Responsibility shareholders and multiple co-filers and will appear on The GEO Group’s proxy ballot and be voted on at The GEO Group’s Annual General Meeting on April 27, 2016.

Resolved:

Shareholders request that The GEO Group provide an independent Human Rights report to its investors, published on its website annually beginning in May 2016.

The resolution’s supporting statement requests that the report include:

* Specific information on the content of the Human Rights ongoing trainings and the manner they are provided to employees;

* The number of people trained and frequency of Human Rights training;

* Metrics used to assess effectiveness of the training and outcomes of assessment; and,

* A process for identifying Human Rights shortfalls and steps taken to modify trainings and practices to improve Human Rights performance.

Background:

Proponents believe that The GEO Group faces financial and reputational risk as a result of its human rights performance. The GEO Group promotes itself as “the world’s leading provider of correctional, detention, and community reentry services with 104 facilities, approximately 87,000 beds, and 20,500 employees around the globe.” The GEO Group recognizes the importance of demonstrating respect for human rights to its business reputation, as demonstrated
by its decision to adopt a Human Rights Policy in 2013. Nevertheless, proponents note that even as of February 2016 that The GEO Group had not yet trained all 20,500 employees on the content and implications of the Human Rights Policy published three years earlier. The GEO Group relies on federal and state government contracts for the vast majority of its revenue and maintains that it is an “industry leader” in performing tasks demanded by its government clients in all areas, including human rights. Such a professed level of performance requires adhering to adequate measures to maintain requisite human rights performance. Investors and public stakeholders alike expect a “leading provider” of private prisons, detention centers, and community reentry services to demonstrate diligence in protecting and promoting the human rights of people in the company’s custody or care. Investors in The GEO Group, expect to see human rights performance that includes:

1. A robust and fully implemented human rights policy;
2. Training of all employees on the policy;
3. Examination of data collected to ensure policy effectiveness; and,
4. Disclosure of human rights relevant information to investors regarding the policy implementation and human rights performance, including the provision of data to confirm The GEO Group is maintaining quality operations in which human rights are routinely integrated into operational choices, and human rights risks are examined and mitigated. [This is precisely what shareholders’ resolution seeks in the report]

The information sought in the proponents’ resolution is long overdue when considered in the larger context of the level of information that other corporations/industries now report to investors. Currently, investors are unable to assess The GEO Group’s human rights performance without adequate disclosure related to the policy’s implementation, relevant training, and key performance indicators. Likewise, a positive human rights performance can be framed as a competitive market advantage. A report confirming human rights performance standards and successes would be a way to demonstrate a business advantage for The GEO Group.

**Human Rights Risks:**

The GEO Group’s efforts to promote itself as a leader in human rights makes perfect business sense and would improve shareholder value. Clients expect that The GEO Group respect human rights in its operations. The GEO Group’s work to adopt a Global Human Rights Policy in 2013 was a welcome first step in the direction of strengthening human rights performance. However the absence of disclosure from the company about the metrics and processes in place to measure and address human rights risks, in tandem with persistent controversies casting a negative light on The GEO Group’s operations has led to the proponents’ resolution.

The private prison industry presents inherent risks related to human rights of detainees and prisoners, by virtue of the manner in which incarcerated individuals’ physical integrity, basic

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1 The GEO Group, Inc 10-K
living conditions and access to health care, adequate food, family and legal visitation are governed by the operational decisions made by prison and detention facilities. The GEO Group’s operations are large and human rights compliance requires rigorous internal mechanisms to ensure proper treatment of people in its operational control. The private prison industry on a whole is subject to a high level of public scrutiny, all the more evident in the current political context where policy makers are weighing the societal cost of large-scale incarceration of both criminal offenders and immigrants. Non-disclosure of human rights performance, metrics, and training mechanisms can no longer be looked at as an acceptable risk for investors. With a growing number of negative reports continuing to surface in the media the need to improve human rights performance is critical. Public disclosure of negative findings in compliance reports by one of The GEO Group’s chief clients further confirms the need for greater attention to ensuring high levels of human rights performance – especially for a corporation that positions itself as the “leader” in the industry. Further, a growing number of lawsuits filed against The Geo Group represent not just a reputational cost, but also potentially a financial cost to the company.

Over the last year, subject to a Freedom of Information Act request the Department of Homeland Security’s Office of detention Oversight (ODO) made public several reports that found The Geo Group’s failure to ensure proper medical care for detained immigrants at the Adelanto Detention Facility (ADF)2 and the Denver Contract Detention Facility (DCDF-Aurora)3 resulted in the preventable deaths of two detainees. This type of negative finding presents significant reputational risk to The GEO Group and may place business contracts in jeopardy.

In 2014 The GEO Group entered into a highly controversial contract with the Department of Homeland Security’s Immigration and Customs Enforcement (DHS-ICE) agency to detain women and children ranging in age from infants to teens. The detention of young children at the Karnes County Residential Detention Center facility subjected GEO to an even higher degree of public scrutiny than usual. After months of protests and allegations of human rights violations by women and children released from the detention facility, an employee of The GEO Group, the lead clinical social worker at Karnes, Dr. Olivia Lopez, resigned her post in April 2015 and made public her own concerns about The GEO Group’s operations at the Karnes facility. In addition to her allegations that she was asked to falsify and withhold information from the DHS-ICE, that she observed that women and children placed in dark rooms as punishment for protesting the conditions of their confinement, and that mental health care for the particularly traumatized population was inadequate, Dr. Lopez disclosed that The GEO Group’s separation of teens from their mothers and poor supervision of these teens resulted in the sexual assault of a teenage minor by another teenage minor.4 These allegations were publicly disclosed to Members of Congress who called for DHS to conduct an investigation and to close the Karnes family

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detention facility. On March 18, 2016, the Guardian reported that Karnes will be converted back to an all-male detention at the end of the current Fiscal Year, an apparent result of constant Congressional pressure and persistent complaints of abuse.\(^5\) The lack of any apparent evaluation of the human rights risks inherent in operating a facility where young children and teenagers were to be detained with their mothers is further evidence of the need for The GEO Group to fully integrate its human rights policy into all levels of company operations, including into protocols for deciding whether or not to submit a bid on a particular contract.

There is also a significant divestment movement underway targeting the private prison industry. Implementation of the requests in this proposal would help to mitigate the risk of further divestment from The GEO Group.

The fact is that while The GEO Group promotes itself as having “always been committed to protecting human rights” alleged violations and lawsuits have existed in years past and continue to the present day. Attached, as “Exhibit A” is a sample of some of the alleged human rights rooted complaints and/or lawsuits that exist in the public domain. Shareholders only offer this sampling to demonstrate the need for diligence in meeting and disclosing company’s efforts to meet human rights performance standards so that informed decisions regarding human rights risks can be made.

**Conclusion:**

The GEO Group competes in a business environment with operational demands few other companies can appreciate. The company’s reputation in the public sphere is a key factor in maintaining a competitive advantage. Diligence to human rights performance needs to be at the very center of all its operations.

The report that shareholders request will make The GEO Group stronger and better in the ever increasing performance indicator of human rights. Compiling the information requested for the report, and providing it to investors will in fact be a win for both investors and The GEO Group. Proponent shareholders recommend a vote “For” this shareholder resolution.

\(^5\) “Controversial Texas family detention center to change back to all-male facility” *The Guardian*  
<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Date</th>
<th>Description</th>
<th>Human Rights Violation</th>
<th>Source/Author</th>
<th>Date</th>
<th>Web Address</th>
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<tbody>
<tr>
<td>Coke County Detention Center</td>
<td>January 30, 2008</td>
<td>The GEO Group agreed to pay $2.2 million to settle a class-action lawsuit alleging inadequate strip searches of inmates at six facilities.</td>
<td>INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT</td>
<td>Emily Ramshaw and Belly Vuckic, Dallas Morning News</td>
<td>January 30, 2008</td>
<td><a href="http://www.privateci.org/texas.htm">http://www.privateci.org/texas.htm</a></td>
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<td>Frio County Detention Center</td>
<td>August 1, 2006</td>
<td>The prison's warden said he was aware of many of the problems pointed out by auditors. He indicated that corporate didn't respond to many of his purchasing needs...</td>
<td>INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT</td>
<td>Sharon E. Haas, AP on MSNBC website</td>
<td>June 17, 2007</td>
<td><a href="http://www.mysanantonio.com/news/local-news/7/28151.htm">http://www.mysanantonio.com/news/local-news/7/28151.htm</a></td>
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<td>Newton County Correctional Center</td>
<td>July 18, 2006</td>
<td>Daniel McCallough sued Texas-based GEO Group and its top executives, all of Florida, and the warden of the jail where his father, Randall, died on Aug. 18, 2008. In his complaint in Comal County Court, Daniel McCallough says his father &quot;was found dead after supposedly being watched, and he hanged himself in his cell. Scott Browne, a Beaumont attorney representing Mr. Schulze's family, commended the TYC on Monday for its action. &quot;I would hope that changes like this by TYC would help ensure that no one else would suffer the way Robert Schulze did,&quot; Mr. Brown said.</td>
<td>INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT</td>
<td>Madison Vorens, Courthouse News</td>
<td></td>
<td><a href="http://www.courthouselnews.com/2010/06/1/8111.htm">http://www.courthouselnews.com/2010/06/1/8111.htm</a></td>
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The GEO Group Inc. entered into a corporate-wide settlement agreement with the U.S. Department of Labor that requires the company to implement comprehensive procedures and policies to better safeguard its workers against the hazards of workplace violence in every correctional and adult detention facility that it manages in the nation.

“This corporate-wide settlement agreement will have a far-reaching effect and impact on correctional officers and other staff nationwide,” said Teresa A. Harrison, OSHA’s acting regional administrator in Atlanta. “This agreement is the first of its kind in the corrections industry that addresses the hazards associated with workplace violence.”

In June 2012, the department’s Occupational Safety and Health Administration cited the company for workplace safety violations at a prison facility it managed in Meridian, Miss. These violations included a willful violation for the company’s failure to: provide adequate staffing of correctional officers; fit malfunctioning cell door locks; and provide required training and personal protective equipment to protect employees from incidents of violent behavior by inmates, including stab wounds, bites and other injuries. The company contested the citation to the Occupational Safety & Health Review Commission.

Under the three-year agreement, the willful citation has been reclassified as a serious violation and the company will pay a $13,600 fine. Additionally, the company is required to hire a third-party consultant to develop and maintain a workplace violence prevention program and conduct onsite workplace violence safety audits at each of the 42 correctional and adult detention facilities that it manages across the country. They will also need to create a corporate-level workplace violence coordinator position and develop a workplace safety committee at each of these facilities. In those unionized facilities covered under the agreement, the committee will include representatives from both labor and management.

### Sample of Media Accounts of Lawsuits and Lost Contracts Involving Possible/Alleged Human Rights Violations at GEO Facilities

<table>
<thead>
<tr>
<th>Facility(ies)</th>
<th>Date of Violation</th>
<th>Description</th>
<th>Human Rights Violation</th>
<th>Author/Source</th>
<th>Title &amp; Date</th>
<th>Web Address</th>
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<tr>
<td>Reeves County Detention Facility, Texas</td>
<td>12/12/2008</td>
<td>Months leading up to inmate’s death on 12/12/2008</td>
<td>Rights to Just and Favorable Conditions of Work, Right to Security of the Person</td>
<td>Forrest Wilder, The Texas Observer</td>
<td>The lawsuit west of the Pecos, December 8, 2010</td>
<td><a href="http://www.texasobserver.org/the-lawsuit-west-of-the-pecos">http://www.texasobserver.org/the-lawsuit-west-of-the-pecos</a></td>
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<td>Walnut Grove Youth Correctional Facility, MS</td>
<td>2010 and before</td>
<td>A federal lawsuit filed November 2010 against GEO Group claims young offenders at Walnut Grove Correctional Facility are being forced to live in “barbaric, unconstitutional conditions.” The lawsuit accuses GEO Group of perpetuating violence and corruption. Some prison staff exploit youth by selling drugs inside the facility and engaging in sexual relationships with youth in their care, the suit alleges. Many youth have suffered physical injuries, some permanent as a result of dangerously deficient security policies. The litigation came weeks after U.S. Department of Justice officials told Gov. Haley Barbour they had begun an investigation into the treatment of juveniles at the prison. Former inmate Ross Walton said, “The officers did nothing to protect kids from beat downs and sexual assaults” and that there was little time for education because the place was so disenfranchised, and “the officers did not care about our future.” [GEO took over the facility in August 2010.]</td>
<td>Right to Adequate Food and Medical Care, Inhuman and Degrading Treatment and Punishment</td>
<td>Clarion Ledger</td>
<td>November 17, 2010</td>
<td>Article no longer available on Clarion Ledger website. Site: <a href="http://www.clarionledger.com">http://www.clarionledger.com</a></td>
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<td>Walnut Grove Youth Correctional Facility, MS</td>
<td>Based on January 2011 on-site inspection</td>
<td>DOJ released scathing report of WGYCF on March 20, 2012. Found on January 2011 on-site inspection an extensive document review. We conclude that the State of Mississippi is deliberately indifferent to the constitutional rights of young men confined at WGYCF. Evidence discovered at WGYCF reveals systematic, euphemistic, and dangerous practices exacerbated by a lack of accountability and controls. We conclude that youth at WGYCF are not receiving constitutionally adequate care. Six major findings: 1) WGYCF is deliberately indifferent to staff sexual misconduct and inappropriate behavior with youth. The sexual misconduct is the worst they have ever seen in any facility in the nation. 2) WGYCF is engaged in a pattern of using excessive force against youth. 3) WGYCF is deliberately indifferent to gang affiliations within the ranks of correctional staff; 4) WGYCF is deliberately indifferent to serious risk of harm to youth posed by fellow youth. Staff fail to supervise youth. 5) WGYCF is deliberately indifferent to the suicide risks and serious mental health needs of its youth. The Facility lacks sufficient mental health professionals and current staff is not properly trained to prevent suicides; 6) WGYCF is deliberately indifferent to serious medical needs of youth. (Mental and medical health staffs are not employees of GEO). &quot;Following GEO and Cornell's merger, key personnel, policies and training at WGYCF did not change pages 33 to 47.</td>
<td>VIOLATION OF THE RIGHT OF SECURITY OF THE PERSON AND INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT</td>
<td>Margaret Winker, National Prison Project, on ACLU blog</td>
<td>Investigation of the Walnut Grove Youth Correctional Facility, March 20, 2012</td>
<td><a href="http://www.aclu.org/blog/prisoners-rights/cornell-should-be-removed-everywhere">http://www.aclu.org/blog/prisoners-rights/cornell-should-be-removed-everywhere</a></td>
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<td>Walnut Grove Youth Correctional Facility, MS</td>
<td>Based on March 22, 2012, court hearing</td>
<td>Federal Judge Calvin Hoovers entered a blistering order giving final approval to a consent decree. He wrote, &quot;The testimony established that only two days before the hearing, the facility remained so understaffed that a teenage offender was brutally attacked...[Walnut Grove] has allowed a cascade of unconstitution and inhuman acts and conditions to germinate... The sum of these actions and inactions... paints a picture of horror as should be unrealized anywhere in the civilized world. Court intervention, as proposed by the parties, is undoubtedly necessary.&quot;</td>
<td>RIGHT OF SECURITY OF THE PERSON AND INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT</td>
<td>John Burnett, NPF</td>
<td>Lawsuit filed in Mississippi after its prison is called a &quot;cesspool,&quot; April 24, 2015</td>
<td><a href="http://www.npr.org/2015/04/24/403171328/lawsuit-immigrants-moves-forward">http://www.npr.org/2015/04/24/403171328/lawsuit-immigrants-moves-forward</a></td>
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<td>Walnut Grove Youth Correctional Facility, MS</td>
<td>NA</td>
<td>On Friday, April 20, 2012 GEO announced it was pulling out all three prisons in MS that it manages by July 2012. In NPR report about the Walnut Grove, Jonathan Smith, the chief of special litigation in the civil rights section at DOJ said about Walnut Grove juvenile prison, &quot;To have a prison that's chaotic, poorly run, dangerous, didn't provide services, highly sexualized and highly violent really limits the ability of the state to turn those folks around, and to ensure public safety upon their release from prison.&quot; In response to GEO email that the abuses documented by the government occurred before GEO took over Walnut Grove in late 2010 (August 2010), Smith is paraphrased as saying he does not accept that statement. He said troubles at the prison continued after GEO stepped in.</td>
<td>RIGHT OF SECURITY OF THE PERSON AND INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT</td>
<td>Dale Daniels, Lawton Constitution</td>
<td>Lawsuit Against Lawton Prison November 25, 2015</td>
<td><a href="http://www.sokalnews.com/local/former-employee-files-lawsuit-against-lawton-prison">http://www.sokalnews.com/local/former-employee-files-lawsuit-against-lawton-prison</a></td>
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<td>Lawton Correctional Facility Oklahoma City, Oklahoma</td>
<td>9/2/14</td>
<td>Lee &quot;Allen&quot; Ziembovic had worked for The GEO Group for more than 16 years when, he said, a fellow guard repeatedly hit an inmate in the head and face while two other guards held the inmate in place. Ziembovic said in the lawsuit that he reported the Sept. 2, 2014, incident to a local prosecutor and to the Oklahoma Department of Corrections. He told investigators that the guard who allegedly assaulted the inmate ordered a video of the incident to be erased and then threatened the jobs of those who reported the incident. In November 2014, the lawsuit states, Ziembovic was placed on unpaid suspension pending an investigation. He was formally terminated in January of this year. &quot;The termination of the plaintiff was retaliatory and in violation of Oklahoma's constitution and clearly established public policy,&quot; the lawsuit states. Ziembovic has asked for compensatory damages and attorneys' fees. He now works at the Grady County jail.</td>
<td>RIGHT OF SECURITY OF THE PERSON</td>
<td>Former Employee Files Lawsuit Against Lawton Prison November 25, 2015</td>
<td>Lawsuit: immigrants get $1 a day for work at private prison: GEO lawsuit alleging forced labor of immigrant detainees moves forward</td>
<td><a href="http://blog.sokalnews.com/2015/11/18/immigrant-detainees-get-1-a-day-for-work-at-private-prison-geos-lawsuit-alleging-forced-labor-of-immigrant-detainees-moves-forward">http://blog.sokalnews.com/2015/11/18/immigrant-detainees-get-1-a-day-for-work-at-private-prison-geos-lawsuit-alleging-forced-labor-of-immigrant-detainees-moves-forward</a></td>
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The family of Nestor Garay, a federal prisoner, filed a wrongful death lawsuit on March 4, 2016, alleging that private prison operators negligently left inmates in the care of inadequately qualified medical workers who failed to respond properly to a medical emergency. Garay was 41 when he died on June 28, 2014, shackled to his bed in Midland Memorial Hospital in Midland, Texas. The cause, according to the neurologist who examined him there, was a stroke he’d suffered two days earlier and 40 miles away, in Big Spring Correctional Center. The facility is operated by the Geo Group and its medical subcontractor, Correct Care Solutions. Garay suffered the stroke in a 10-man cell in the 3,500-bed prison, one of 11 federal facilities that house only noncitizens. His cellmates were startled awake at around 3:30 a.m. on June 26 by the sounds of his pain-induced moans. When they found Garay unresponsive, nearly falling off of his top bunk, and covered in sweat and urine, they called for help. But the only medical staff member on duty that night was a licensed vocational nurse, or LVN, whose licensure required only one year of training. In most settings, LVNs typically serve as support staff for more highly trained registered nurses or medical doctors. The LVN phoned a physician’s assistant who was on call for a consult; rather than order Garay to be delivered to an emergency room, the PA ordered a dose of antiseizure meds and had Garay returned to his cell until morning. When the morning nurse found Garay on a mattress on the floor of a cell at 6:15 a.m., his face was drooping and his right arm was contracted. It was only then, roughly five hours after Garay’s cellmates first reported the stroke, that he was ordered to an ER. It took another hour before Garay was finally on the way to the hospital. The Midland neurologist said that for ischemic strokes, the window for intervention is typically three hours; after the long delay, he said, “treatment was too little too late.” In the family’s lawsuit, Garay’s parents, Baldacino and Alvarez Garay, who have lived for decades in California’s Napa Valley, allege that their son’s “life-threatening conditions were left untreated.” “The nurses on staff were severely undertrained and were not equipped to recognize, diagnose, or treat patients with serious illnesses or conditions,” the complaint reads. But Big Spring’s own mortality review faulted both the LVN and the PA for failing to alert the clinical director when Garay’s condition did not improve. The review found that the PA “did not respond correctly to the initial report from nursing describing new onset of presumptive seizure of a previously healthy 41 year old male.” It also found that neither diagnosis nor treatment was “appropriate and timely.”

Arizona State Prison- Florence West facility, Florence, AZ

From 2010 lawsuit

Sexual-harassment claims against a private prison company brought on behalf of female employees by Arizona's attorney general and a federal agency should be reinstated, the Ninth Circuit ruled Monday. The Equal Employment Opportunity Commission (EEOC) and the Arizona Law Department's Civil Rights Division sued the Florida-based Geo Group in 2010 on behalf of a number of its female employees at the Arizona State Prison-Florence West facility, including Alice Hancock. Hancock, a corrections officer, claimed she had been subjected to discrimination, harassment and retaliation by male co-workers who would comment that they wanted to "ram [them] from behind" and asking them to "suck [the alleged harasser's] dick." Callahan wrote that, while Hines' claims that a male employee of Geo "made unwanted physical contact with her by "spoon[ing]" her butt in front of inmates and a cadet" and repeatedly talked dirty to her might not "in itself be sufficient to support a hostile work environment claim, their cumulative effect is sufficient to raise material issues of fact as to whether the conduct was so severe or pervasive to alter the conditions of the workplace." This ruling allows our office to seek remedies for 25 women who were forced to accept sexual harassment by their male co-workers and supervisors as a requirement for their work at the Geo Group, a private company that contracts with the [Department of Corrections]," said Mira Garcia, spokesperson for the Arizona Attorney General's Office. "This ruling allows our office to continue to work toward ending a workplace culture of accepting and expecting physical and verbal sexual harassment against female correctional officers employed by the Geo Group.

Big Spring Correctional Center, Big Spring, Texas

Based on June 28, 2014, death

RIGHT TO JUST AND FAVORABLE CONDITIONS OF WORK WITHOUT ANY DISCRIMINATION

Jamie Ross, Courthouse News; Jonathan R. Tung, Paul Hesse

9th Circuit revives prison sex-harassment claims, March 14, 2016

Sexual harassment claims against the private prison operator over deaths at immigrant-only facilities, March 15, 2016


Lawmakers seek to halt detention center expansion

ADELANTO — A group of lawmakers have asked the federal government to halt the expansion of a High Desert correctional facility.

On Tuesday, Rep. Judy Chu, D-Monterey Park, and 28 other Congressional representatives called on the federal government to stop the expansion of the Adelanto Detention Center.

In a signed letter sent to Immigration and Customs Enforcement officials and the U.S. Justice Department, the lawmakers asked the Justice Department to begin an investigation into California’s largest immigrant detention center. They also asked to halt the expansion because of reports of “medical negligence” at the privately run facility.

The letter also asks the Adelanto Detention Facility and ICE to stop the ongoing transfer of gay and female transgender and bisexual detainees into the center.

“ICE takes very seriously the health, safety and welfare of those in our care,” ICE spokeswoman Virginia Kice informed the Daily Press via email on Tuesday. “The agency is committed to ensuring that individuals in our custody receive timely and appropriate medical treatment."

Kice said ICE’s detention standards are designed to provide onsite and remote access to quality medical health care for all detainees.

In June, the Daily Press cited an ICE spokeswoman who said the 640-bed expansion at the Adelanto facility would enable the housing of 259 women, a first for the center.

ICE officials said the Adelanto expansion will substantially increase the agency’s capacity to house female immigrant detainees in the regional, seven-county Los Angeles area, where there are just about 100 beds for women and currently under 30 available.

In the letter, lawmakers mentioned the death of two immigrant detainees and wrote that there have been consistent reports documenting “GEO’s failure to respond and to adequately address the health and mental concerns of detainees.”

According to the letter, GEO Group failed to provide adequate medical care to Fernando Domínguez, which resulted in his death in 2012. ICE’s Office of Professional Responsibility determined that Domínguez’s death was caused by “egregious errors” committed by the center’s medical staff. The letter also says that Raul Ernesto-Ramos, a detainee for five years, “died after GEO failed to diagnose and treat his intestinal cancer.”

The six-page letter also mentions many cases of alleged neglect, including that of Gerardo Corelas, a partially paralyzed 19-year-old who developed a urinary tract infection “after GEO’s failure to sanitize catheters.”

GEO Group officials could not be reached for comment.

The letter said the American Civil Liberties Union of Southern California, the American Immigration Lawyers Association, Community Initiatives for Visiting Immigrants in Confinement (CIVIC) and other organizations working with detainees at the center detailed a series of troubling medical cases at the facility.

Among them: The denial of medically-necessary headgear for a detainee with severe epilepsy and the denial of surgery to correct mobility issues in a stroke victim’s arm.

The letter closes with a request to halt the center’s expansion and any plans to transfer or detain women and LGBT individuals. It also asks for the appointment of an investigator with the Department of Justice to examine the delivery of health care at the center.

Other requests include the appointment of an investigator with the Department of Homeland Security to inspect and ensure the health and safety of current and future detainees. And finally, to provide a civil rights group with a pro bono telephone extension so the community may document and update lawmakers on problems at the center.

Christina Fialho, co-founder/executive director of CIVIC, told the Daily Press that the GEO Group has severely abused its unchecked powers at Adelanto.

“Our federal government can no longer ignore the medical failures at this facility,” Fialho said. “We join our Congressional representatives in calling on ICE to halt the expansion of this facility.”

Visit www.vvdailypress.com to read the Congressional representatives’ letter to ICE.

Rene Ray De La Cruz may be reached at 760-951-6227, RDeLaCruz@VVDailyPress.com or on Twitter @DP_ReneDeLaCruz.
DEPARTMENT OF HOMELAND SECURITY

REPORT OF INVESTIGATION

1. CASE NUMBER
201207288

PREPARED BY
(b)(6), (b)(7)(C)

2. REPORT NUMBER
002

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

4. FINAL RESOLUTION

5. STATUS
Closing Report

6. TYPE OF REPORT
Detainee Death Review

7. RELATED CASES

8. TOPIC
Detainee Death Review of Evalin MANDZA

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

On April 17, 2012, the U.S. Immigration and Customs Enforcement, Office of Professional Responsibility, Office of Detention Oversight, initiated a Detainee Death Review of MANDZA’s death. This report documents the findings of the review.
10. NARRATIVE

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

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

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

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

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

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

On October 17, 2011, MANDZA was convicted in the City of Aurora Municipal Court, Aurora, CO,
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for the offense of the unlawful selling of merchandise, and sentenced to 60 days in jail, 55 days suspended sentence, with three days to serve. On the same date, Immigration Enforcement Agent (IEA) interviewed MANDZA at the Aurora County Jail (ACJ) in Aurora, CO, pursuant to the Criminal Alien Program. Following the interview, IEA issued a Form I-247, Immigration Detainer Notice, informing ACJ that an investigation had been initiated to determine whether MANDZA is subject to immigration removal proceedings. MANDZA remained at the Aurora County Jail until his release on October 24, 2011.

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

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

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

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

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

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

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

On October 31, 2011, MANDZA submitted a sick call request for "constipation movement" (Exhibit 14). MANDZA was placed on the sick call list to be seen by Dr. [b(6), b(7)(c)] on November 3, 2011. During the ODO site visit for this review, RN [b(6), b(7)(c)] observed Detainee MANDZA's name was crossed off Dr. [b(6), b(7)(c)] sick call list with a crayon.
SA (b)(6), (b)(7)(c), RN (b)(6), (b)(7)(c), and RN (b)(6), (b)(7)(c) interviewed Acting Health Services Administrator (HSA) RN (b)(6), (b)(7)(c) on May 21, 2012, at DCDF. Acting HSA RN (b)(6), (b)(7)(c) stated names are crossed off sick call lists with crayons to signify the medical record has been removed for the appointment. There was no corresponding Progress Note or other documentation confirming that detainee MANDZA was seen by Dr. (b)(6), (b)(7)(c) on November 3, 2011. RN (b)(6), (b)(7)(c) could not explain why the sick call appointment was missed. No other significant activity occurred regarding MANDZA until November 8, 2011.

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

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

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

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

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

On November 27, 2011, MANDZA submitted a sick call request for constipation and razor burn (Exhibit 23). On November 28, 2011, MANDZA was seen by RN (b)(6), (b)(7)(c) for his complaints. RN (b)(6), (b)(7)(c)
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[MANDZA](b)(6), (b)(7)(c) provided MANDZA Milk of Magnesia, Dulcolax, and fiber for the constipation, and triple antibiotic cream for the razor burn rash (Exhibit 24). RN(b)(6), (b)(7)(c) documented MANDZA was instructed to increase fluid consumption, not use triple antibiotic cream around his eyes, and return to the medical unit if symptoms persisted or worsened (refer to Exhibit 23).

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

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

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

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

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

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

On December 25, 2011, at approximately 11:53 a.m., MANDZA was moved to the Special Management Unit for allegedly fighting with another detainee (Exhibit 33). MANDZA was placed in administrative segregation based on an allegation of "horseplay" with another detainee while...
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awaiting the outcome of a DCDF investigation (Exhibit 34). On December 27, 2011, MANDZA was released from segregation and returned to housing unit A3 (refer to Exhibit 33). ODO interviewed Lieutenant [redacted] on May 23, 2012, at the DCDF. Lieutenant [redacted] investigated the allegations that led to MANDZA being assigned to administrative segregation. Lieutenant [redacted] stated that the incident on December 25, 2011, was a result of horseplay between MANDZA and another detainee. Although the incident was downgraded from fighting to horseplay, Lieutenant [redacted] stated MANDZA was held in segregation until the investigation was complete.

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

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

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

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

On January 18, 2012, MANDZA was removed from housing unit A3 and taken to disciplinary segregation for allegedly refusing to obey a staff member and interfering with the population count. On January 20, 2012, MANDZA was issued a warning, released from segregation, and returned to housing unit A3 (Exhibit 39). The Pre-Segregation History and Physical completed by RN [redacted] documents medical clearance for housing in Administrative Segregation. "No physical confrontation just arguing" was noted. The form was signed by Dr. [redacted] but not dated (Exhibit
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40. ODO found that based on the Medical Request dated January 16, MANDZA was to be seen by Dr. on January 18, 2012. There is no documentation confirming this appointment occurred. During her interview, RN could not explain why Dr. did not see MANDZA as scheduled.

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

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

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

On January 27, 2012, at approximately 5:48 p.m., a Progress Note by ANP documents MANDZA complained of constipation, but declined the Colace and the fiber recommended by ANP (Exhibit 42). Glycerin suppositories were renewed for three days, and MANDZA was counseled on taking the prescribed treatment for constipation. ODO found there were no refusal forms for Colace and fiber contained in the record. ANP stated it is not a customary practice to have detainees sign refusal forms for over-the-counter medications.
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On February 9, 2012, a Progress Note by RN documents MANDZA complained of constipation and had not had a bowel movement since February 3, 2012 (refer to Exhibit 42). According to the Progress Note, MANDZA's bowel sounds were decreased and his discomfort was increased. MANDZA was provided Dulcolax and Milk of Magnesia per GEO nursing protocol.

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

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

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

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

On March 21, 2012, MANDZA submitted a sick call request for constipation and razor burn (Exhibit 48). LPN documents MANDZA was seen in the medical unit, scheduled for a medical review, and provided Milk of Magnesia and Dulcolax. Dr. completed a Progress
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Note documenting MANDZA’s history of constipation with stress; Colace was ordered (Exhibit 49).

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

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

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

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

ODO interviewed Lieutenant [redacted] on May 22, 2012, at the DCDF. Lieutenant [redacted] stated that on April 12, 2012, at approximately 5:24 a.m., he was conducting rounds and speaking with GEO DO [redacted] in housing unit A4, when he heard a detainee call out for GEO DO [redacted]. Lieutenant [redacted] stated GEO DO [redacted] entered MANDZA’s cell and then instructed him to call a code blue. Lieutenant [redacted] activated the code blue, began organizing first responders, and ordered side doors to be manned and held open for the medical staff. Lieutenant [redacted] observed MANDZA holding his hand over his chest and MANDZA appeared...
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to be in pain. Lieutenant stated nursing staff arrived within four minutes and began their assessment of MANDZA. Lieutenant completed a GEO Serious Incident Report (Exhibit 55) and a GEO Supervisor Report (Exhibit 56) documenting this event. The nursing staff determined MANDZA had to be moved to the medical unit for further evaluation. Lieutenant stated MANDZA's pain appeared constant, but MANDZA stopped moaning once he arrived at the medical unit.

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

ODO interviewed RN on May 22, 2012, at the DCDF. RN stated she did not recall having any previous contact with MANDZA prior to her response to the code blue on April 12, 2012. According to RN on April 12, 2012, at approximately 5:24 a.m., she was alerted to a code blue in housing unit A4. RN and LPN responded. Upon arrival in housing unit A4, RN observed MANDZA in his bed, touching his left side, complaining of chest pain. RN recommended the patient be transferred to the DCDF trauma room for further evaluation. RN completed a GEO General Incident Report documenting this event (Exhibit 58).

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

On April 12, 2012, at approximately 5:28 a.m., MANDZA was transferred to the DCDF trauma room. At this point, no medications had been administered to the patient in an attempt to relieve
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MANDZA was taken to the trauma room where he was placed on oxygen, his vital signs were obtained, and an electrocardiogram (EKG) was performed. In her attempt to diagnose MANDZA, RN was unable to get a reading with the first EKG due to her unfamiliarity with the machine, but was able to get a reading utilizing the second EKG machine. When asked if she could interpret the EKG results, RN stated she was not trained on the use of an EKG or in the interpretation of EKG test results. RN stated she relied on "gut instinct" to send MANDZA to the hospital. A Progress Note completed by RN indicated she contacted Dr. and received the verbal order to transport him to the hospital (refer to Exhibit 57).

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

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

At approximately 6:20 a.m., Lieutenant called the nursing station to check on MANDZA. During this call, he was instructed by LPN to call 911. During his interview with ODO, Lieutenant expressed concern over the time it took for 911 to be called (refer to Exhibits 55 & 56). During the ODO interview of Dr. , Dr. stated he was unaware of any delay that resulted in EMS not being called until approximately 6:21 a.m. Dr. stated EMS should have been contacted immediately, and any GEO protocols that were followed resulting in this delay need to be modified.
ODO interviewed LPN on May 22, 2012. LPN stated it was her understanding that MANDZA would be transported by GEO personnel in a GEO van. Sometime later, she was told by RN that MANDZA needed to go to the AMCS by ambulance. LPN stated she did not call 911, and she did not instruct the GEO Control Officer to call 911. LPN stated while she continued processing the necessary paperwork to have MANDZA transferred to an off-site medical facility, she received a call from Lieutenant. While speaking to Lieutenant, LPN asked him to call 911. When asked about the delay in calling 911, LPN stated she needed to get the paperwork concerning MANDZA’s medical condition completed before making the call (refer to Exhibit 59).

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

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

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

ODO interviewed GEO DO on May 23, 2012, at the DCDF. GEO DO who was previously listed as a housing unit officer in housing unit A2, was later transferred to transportation.
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duty. According to GEO DO on April 12, 2012, while assigned to transportation duty, he responded to a code blue medical emergency requiring transportation to the AMCS. GEO DO stated he followed the ambulance to the AMCS, and his partner, GEO DO rode in the back of the ambulance with MANDZA. GEO DO completed a GEO General Incident Report documenting this event (Exhibit 62).

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

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

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

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

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

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

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

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

MEDICAL COMPLIANCE REVIEW

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

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

MORTALITY REVIEW

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

IMMIGRATION AND DETENTION HISTORY

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

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

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

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

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

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

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


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

CRIMINAL HISTORY

MANDZA was assigned State of Colorado SID# and State of New York SID#.

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

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

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

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

INVESTIGATIVE FINDINGS

Detainee MANDZA came to ICE custody on October 24, 2011, and was provided an initial medical screening and physical examination in accordance with the ICE PBNDS. During MANDZA’s initial medical screening, no medical conditions were identified, and MANDZA was housed in general...
population. On April 12, 2012, MANDZA was found in his cell complaining of chest pains. This review determined that DCDF failed to provide MANDZA access to emergent, urgent, or non-emergent medical care. As a result, his health care needs were not met in a timely and efficient manner in accordance with the ICE PBNDS.

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

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

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

AREAS OF CONCERN

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

On April 12, 2012, in response to the code blue, RN did not use the assessment criteria in the...
10. NARRATIVE

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

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

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

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

002

### Exhibit List

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<th>Number</th>
<th>Description</th>
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<td>Form I-213</td>
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<td>Nursing Incoming Screen Progress Note</td>
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<td>Mental Health Evaluation</td>
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<td>53. DCDF Log Books</td>
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<td>54. GEO Incident Report from GEO DO [(b)(6), (b)(7)(c)]</td>
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<td>55. GEO Serious Incident Report from Lieutenant [(b)(6), (b)(7)(c)]</td>
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<td>58. GEO Incident Report from RN [(b)(6), (b)(7)]</td>
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<td>60. Rural/Metro EMS records</td>
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<td>61. GEO Incident Report from GEO DO [(b)(6), (b)(7)(c)]</td>
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<td>62. GEO Incident Report from GEO DO [(b)(6), (b)(7)(c)]</td>
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<td>63. Aurora Medical Center South Medical Records</td>
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<td>65. ERO Notification and Reporting of Detainee Deaths Individual Incident Checklist</td>
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<td>66. Creative Corrections Medical Compliance Review</td>
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<td>67. IHSC Medical Record Review Report</td>
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<td>68. Creative Corrections Mortality Review</td>
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U.S. Department of Homeland Security

Record of Deportable/Inadmissible Alien

Family Name (CAPS): MANDZA, Evalin

Country of Citizenship: GABON

U.S. Address: NEW YORK, NEW YORK, 10456

Date, Place, Time, and Manner of Last Entry: Unknown Date, Unknown Time, NEW, ADMITTED B-2 VISITOR

Case No: (b)(6), (b)(7)(c)

Passport Number and Country of Issue: (b)(7)(e)

Sex: M

Height: 69

Race: BLK

Eyes: BRO

Occupation: MED

Weight: 180

Sick and Marks: None Indicated

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

Number, Street, City, Province (State) and Country of Permanent Residence: GABON

Date of Birth: 12/05/1965

Age: 45

City, Province (State) and Country of Birth: GABON

Date of Action: 10/24/2011

Location Code: DEN/DEN

Date Visas Issued: AR

Social Security Account Name:

Social Security Number:

Immigration Record

NEGATIVE - See Narrative

Criminal Record

None Known

Number and Nationality of Minor Children

See Narrative

Name, Address, and Nationality of Spouse ( Maiden Name, if Appropriate):

NATIONALITY: GABON

Daughter's Name, Maiden Name, Nationality, and Address, if Known:

Daughter's Name, Maiden Name, Nationality, and Address, if Known:

None Claimed

None Due/Property in U.S. Not in Immediate Possession:

Fingerprints:

None

Systems Checks:

None

Charge Code Word(s): (b)(7)(c)

Type of Employment:

Salary:

Employed Since:

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

FINS: 1121982592

Left Index fingerprint

Right Index fingerprint

OTHER ALIASES KNOWN BY:

MANDZA, ELALIN

MINOR CHILDREN

(Continued on I-831)

Alien has been advised of communication:

Date/Initials: 02/11

Distribution:

file

copy

sien

Form I-213 (Rev. 08/01/07)
Record of Deportable/Excludable Alien:

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

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

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

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

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

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

COURT - POLICE DEPARTMENT NEW YORK
FORGED INSTRUMENT - 3RD
...(CONTINUED ON NEXT PAGE)
CHARGES
Section 237(a)(1)(B) of the Immigration and Nationality Act (Act), as amended, in that after admission as a nonimmigrant under Section 101(a)(15) of the Act, you have remained in the United States for a time longer than permitted, in violation of this Act or any other law of the United States.

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

HEALTH, FAMILY WELFARE, AND FUNDS
MANDZA stated he was in good health and taking no medications, and appeared to be in good health.
MANDZA states he has three children which lives in New York with their mother.
MANDZA has $33.00 in U.S. funds in his possession. Check #3249
MANDZA was provided a copy of the Detainee Handbook.
MANDE (b)(6), (b)(7)(c)

MANDZA; EVALIN

DOB: 12/6/1965 Nation: GABON
Arrival Date: 10/24/2011 17:05

Detainee Name: ___________________________ Date: __________ ID# __________

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

Name/Nombre: ____________________________

Street Address/Direccion: __________________________

City/Ciudad: ____________________________ State/Estado: __________________________ ___________

Zip Code/Codigo Postal: __________________________

Telephone/Telefono: 347-657 (b)(6), (b)(7)(c) 240-857 (b)(6), (b)(7)(c) Country/Pais: __________

Detainee Signature/Firma del Detenido: __________________________

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

CLOTHING, BEDDING, LINEN, HYGIENE ISSUE RECEIPT

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<td></td>
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<tr>
<td>Gym Shorts</td>
<td>1</td>
</tr>
<tr>
<td>Undergarments</td>
<td>3</td>
</tr>
<tr>
<td>Shower</td>
<td>1 pair</td>
</tr>
<tr>
<td>Shoes</td>
<td></td>
</tr>
</tbody>
</table>

CROSS OUT ITEMS NOT RECEIVED

Discrepancies: None

WASH STREET CLOTHES / LAVAR LA ROPA DE LA CALLE? YES No

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

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

Officer Signature: __________________________

Detainee Signature: __________________________

SIGNED FORM INDICATES ACTIVATED DETENTION FILE
MANDZA, EVALIN

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

Inmate? [ ] Last

Inmate Number: ____________ Sex: _____ Date of Birth: _____/_____/

Previous Commitment? [ ] Yes [ ] No Where?

Interviewed by: [ ] (b)(6), (b)(7)(c) Facility Name ____________________________

VITAL SIGNS: Pulse _____ B/P _____/_____ Resp _____ Temp 97.1

VISUAL OBSERVATION: (Explain any “Yes” answers under “Remarks”)

1. Is inmate unconscious or have obvious pain, bleeding, injuries, illness, or other symptoms suggesting need for emergency medical referral? [ ] Yes [ ] No

2. Is inmate carrying any prescribed medication? If yes, what? ________________________________

3. Is there obvious fever or other evidence of infection? [ ] Yes [ ] No

4. Is there evidence of infestations, rashes, needle marks, bruises, lesions, jaundice or trauma markings? [ ] Yes [ ] No

5. Does inmate appear to be under the influence of, or withdrawing from drugs, alcohol or an unknown substance? [ ] Yes [ ] No

6. Does inmate exhibit any signs of abnormal behavior, tremors, sweating, persistent cough or lethargy? [ ] Yes [ ] No

7. Does inmate’s behavior or physical appearance suggest the risk of suicide or assault on staff or other inmates? [ ] Yes [ ] No

8. Is inmate’s mobility restricted in any way or has any body deformities? [ ] Yes [ ] No

9. Does inmate have Physical Aids: [ ] Glasses [ ] Hearing Aid [ ] Cane [ ] Crutches [ ] Dentures [ ] Other

10. Is inmate experiencing visual or auditory hallucinations? If yes, Explain [ ] Yes [ ] No

Inmate Questionnaire: (Explain any “Yes” answers under “Remarks”)

10. Presently taking medication under a doctor’s order? What? ________________________________ How often? ________________________________ [ ] Yes [ ] No

11. Ever had: diabetes, seizures, asthma, ulcers, high blood pressure, heart condition, or a psychiatric disorder? [ ] Yes [ ] No

12. Are you on a special diet prescribed by a physician? [ ] Yes [ ] No

13. Been hospitalized or treated by a psychiatrist or a physician within the past year? Why? ________________________________ Where? ________________________________ [ ] Yes [ ] No

14. History of or current communicable illnesses: venereal disease, TB infections, hepatitis, HIV or symptoms suggestive of such illness? (lethargy, cough, spitting up blood, weakness, weight loss, loss of appetite, fever, of appetite, fever, night sweats) [ ] Yes [ ] No

15. Allergic to anything (drugs, food plants, etc)? ________________________________ [ ] Yes [ ] No

16. Ever been treated for a mental disorder or attempted suicide? When? ________________________________ Where? ________________________________ [ ] Yes [ ] No

17. Fainted recently or had a recent head injury? ________________________________ [ ] Yes [ ] No

18. Visualize the mouth, teeth and gums. Are there any dental problems noted? [ ] Yes [ ] No

If yes, please comment: __________________________________________________________

19. Are there any other medical or mental problems you have not told me about? [ ] Yes [ ] No

20. Use alcohol? [ ] Yes [ ] No What kind? _______ How often? _______ When was the last time? _______ How much? _______

21. Use drugs? [ ] Yes [ ] No What kind? _______ How often? _______ When was the last time? _______ How much? _______

22. Ever had problem following withdrawal of alcohol or drug use? _______ What kind of problem? _______ Convulsions? _______

23. Females: Current gynecological problems? _______ Pregnant or on birth control pills? _______ Recently delivered/aborted? _______ Language: (circle one) English Other ____________________________

25. Placement recommendation: (circle one) get emergency treatment next sick call isolation

Remarks: __________________________________________________________

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

Inmate’s Signature ____________________________ Date 10-24-11
### Nurse - Incoming Screen Progress Notes

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

| Date & Time | Allergies: 
---|---
| **10/24/11** 18 05 | AKDA |

**IMMUNIZATIONS:**  
- DIPHTHERIA/TETANUS DATES: [Childhood]  
- PPD DATE:  
- RESULTS:  
- TB CLASS: [Prophylaxis: Yes/No]  
- DATE COMPLETED:  
- DATE TO COMPLETE:  
- TREATMENT: IN PROGRESS  
- SEROLOGY DATE:  
- RESULTS:  
- CHRONIC ILLNESS/DISABILITIES: ADD TO CHRONIC CLINIC  

**MEDICATION ORDERS:**
1.  
2.  
3.  
4.  
5.  
6.  
7.  

**TREATMENT/SPECIAL CARE FOLLOW-UP/REFERRALS:**

**WORK LIMITATION:**

**HOUSING & BUNK LIMITATIONS:**

**NURSE'S SIGNATURE:**

**PHYSICIAN SIGNATURE:** OCT 27 2011
**General Health Evaluation**

**MANZIA, EVALIN**

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever been hospitalized for an emotional or nervous problem?</td>
<td>No</td>
</tr>
<tr>
<td>When?</td>
<td></td>
</tr>
<tr>
<td>2. Have you ever received counseling or outpatient mental health treatment for the above?</td>
<td>No</td>
</tr>
<tr>
<td>Where?</td>
<td></td>
</tr>
<tr>
<td>3. Are you taking any medication for a nervous condition?</td>
<td>No</td>
</tr>
<tr>
<td>If yes, name of medication/dosage</td>
<td></td>
</tr>
<tr>
<td>How often?</td>
<td></td>
</tr>
<tr>
<td>Who prescribed it?</td>
<td></td>
</tr>
<tr>
<td>How long have you been taking it?</td>
<td></td>
</tr>
<tr>
<td>4. Do you use any of the following?</td>
<td>Yes</td>
</tr>
<tr>
<td>Beer?</td>
<td></td>
</tr>
<tr>
<td>How much?</td>
<td></td>
</tr>
<tr>
<td>How often?</td>
<td></td>
</tr>
<tr>
<td>How long?</td>
<td></td>
</tr>
<tr>
<td>5. Have you ever been treated for alcohol abuse?</td>
<td>No</td>
</tr>
<tr>
<td>When?</td>
<td></td>
</tr>
<tr>
<td>How long?</td>
<td></td>
</tr>
<tr>
<td>6. Have you ever used illegal drugs?</td>
<td>No</td>
</tr>
<tr>
<td>What illegal drugs have you used in the last 12 months?</td>
<td></td>
</tr>
<tr>
<td>When did you start using these drugs?</td>
<td></td>
</tr>
<tr>
<td>7. Have you ever been treated for drug abuse?</td>
<td>No</td>
</tr>
<tr>
<td>When?</td>
<td></td>
</tr>
<tr>
<td>How long?</td>
<td></td>
</tr>
<tr>
<td>8. Have you ever attempted suicide?</td>
<td>No</td>
</tr>
<tr>
<td>When?</td>
<td></td>
</tr>
<tr>
<td>9. Have you ever thought about suicide?</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you think of it often?</td>
<td>Seldom?</td>
</tr>
<tr>
<td>Sometimes?</td>
<td></td>
</tr>
<tr>
<td>9a. Have you ever hurt yourself without wanting to die?</td>
<td>No</td>
</tr>
<tr>
<td>Do you think of it often?</td>
<td>Seldom?</td>
</tr>
<tr>
<td>Sometimes?</td>
<td></td>
</tr>
<tr>
<td>10. Have you ever been suspended from school?</td>
<td>Yes</td>
</tr>
<tr>
<td>If yes, how many times?</td>
<td></td>
</tr>
<tr>
<td>11. Have you ever lost a job because of a fight?</td>
<td>No</td>
</tr>
<tr>
<td>If yes, how many times?</td>
<td></td>
</tr>
<tr>
<td>12. Have you ever had a seizure?</td>
<td>No</td>
</tr>
<tr>
<td>If yes, when?</td>
<td></td>
</tr>
<tr>
<td>13. Have you ever had a head injury?</td>
<td>Yes</td>
</tr>
<tr>
<td>If yes, when?</td>
<td></td>
</tr>
<tr>
<td>14. What grade did you complete in school?</td>
<td>7th</td>
</tr>
<tr>
<td>15. Were you in any special education classes?</td>
<td>No</td>
</tr>
<tr>
<td>If yes, what class?</td>
<td></td>
</tr>
<tr>
<td>16. Are you able to read and write English?</td>
<td>Yes</td>
</tr>
<tr>
<td>17. Have you ever been convicted of a violent crime?</td>
<td>No</td>
</tr>
<tr>
<td>If yes, When?</td>
<td></td>
</tr>
<tr>
<td>What was your sentence?</td>
<td></td>
</tr>
<tr>
<td>18. Have you ever been a victim of a violent crime or sexual abuse?</td>
<td>No</td>
</tr>
<tr>
<td>If yes, When?</td>
<td></td>
</tr>
<tr>
<td>Where?</td>
<td></td>
</tr>
<tr>
<td>19. Do people consider you a violent person?</td>
<td>No</td>
</tr>
<tr>
<td>If yes, why?</td>
<td></td>
</tr>
<tr>
<td>20. Do you have a history of sexual aggression or sexual assault?</td>
<td>Yes</td>
</tr>
<tr>
<td>If yes, When?</td>
<td></td>
</tr>
<tr>
<td>Where?</td>
<td></td>
</tr>
<tr>
<td>Have you ever been convicted of a sexual offense?</td>
<td>No</td>
</tr>
<tr>
<td>If yes, When?</td>
<td></td>
</tr>
<tr>
<td>Where?</td>
<td></td>
</tr>
<tr>
<td>21. How do you feel about your incarceration?</td>
<td></td>
</tr>
</tbody>
</table>

**Referral:** Mental health  Doctor  Next sick call  General population

**Interviewed:** 10/25/11

**Date:** 10/25/11

**Rev 11/07, 7/11**
Release of Responsibility for Medical Services

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

Inmate Number: 
Date: 10/24/11 Time: 1855

This is to certify that I, __________________________, under the care of the __________________________

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

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

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

**Undiagnosed Disease Process**

**Untreated Medical Condition**

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

Patients Signature __________________________ Date __________________________

Witness (GEO Employee) __________________________ Date __________________________

Physician Signature __________________________ Date __________________________
SITE: ICE_AURORA

NAME: MANDZA, EVALIN

ALIEN #: [redacted]

DATE OF X-RAY: 10/24/2011

DATE OF BIRTH: 12/05/1965

STUDY TYPE:

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

SIGNED BY RADIOLOGIST: [redacted]

SIGNED AT: 2011/10/24 22:19:56 EDT
Name: Mandy Lin

Date of Birth: 12/05/65

Country of Citizenship: Pabso

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

ID: 014 Date: 10/24/14

Language: (English ☑/N) Other:

(b)(7)(e)
Medical Request/
Solicited De Asistencia Medica

Date of request: 10/25/41
Feche de Solicitud

(Please check one)  
Medical Complaint
Por favor marque uno.  
- Oueja medica  
- Oueja Dental

Print: Evolin  Manduz
Letra-Molde  Inmates Name/
Nombre del Preso

A2 201
Number/
Numero

Housing Location/
Sito de Vivienda

Job Assignment/
Asignacion de Trabajo

Duty Hours/
Horas de Trabajo

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

Explique brevemente la razón de su solicitud. Permítan varios días para que su solicitud sea procesada. Una copia de su solicitud será archivada en sus registros. Prisioneros de habla hispana pueden solicitar dicha asistencia en español.

PROBLEM/QUEJA: Bad movement

Inmate's Signature/Firma del Preso

---DO NOT WRITE BELOW THIS LINE/NÖ ESCRIBA DEBAJO DE ESTA LINEA---

Date Received: (Stamp Date)

Date Reviewed: 
□ Written Response (see below)  
☑ Seen in Medical

ACTION TAKEN: 

□ Placed on sick call list

Date of Appointment: __/__/____

□ Placed on Dental list

Date of Appointment: __/__/____

□ Other (Explain):
### Medical History and Physical Assessment

**Site:**
- Mental Health Assessment: N
- Orientation (person, place, time): 
- General appearance: 
- Motor behavior, mannerisms: 
- Affect (mood): 
- Content of thought, history of suicide, present thoughts of suicide: 

**Health Assessment:**
- Age: 47
- Sex: M
- Race: 
- Height: 5', 8" 
- Weight: 141
- Temp: 99.5°F
- Pulse: 73
- Resp: 
- B/P 104/47

<table>
<thead>
<tr>
<th>Medical History</th>
<th>Allergy</th>
<th>Abnormal - Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems</td>
<td>Y</td>
<td>Problems</td>
</tr>
<tr>
<td>Head trauma</td>
<td>/</td>
<td>Back/neck problem</td>
</tr>
<tr>
<td>Loss of consciousness</td>
<td>/</td>
<td>Kidney stones/disease</td>
</tr>
<tr>
<td>Severe headaches</td>
<td>/</td>
<td>Bladder/kidney infection</td>
</tr>
<tr>
<td>Vertigo/dizziness</td>
<td>/</td>
<td>Alcoholism</td>
</tr>
<tr>
<td>Vision problems</td>
<td>/</td>
<td>Drug abuse</td>
</tr>
<tr>
<td>Hearing problems</td>
<td>/</td>
<td>Tobacco abuse</td>
</tr>
<tr>
<td>Dental problems/dentures</td>
<td>/</td>
<td>Psychiatric hx</td>
</tr>
<tr>
<td>Seizures</td>
<td>/</td>
<td>Suicidal</td>
</tr>
<tr>
<td>Strokes</td>
<td>/</td>
<td>Communicable/contagious</td>
</tr>
<tr>
<td>Nervous disorders</td>
<td>/</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>DTs</td>
<td>/</td>
<td>HIV/AIDS</td>
</tr>
<tr>
<td>Heart condition</td>
<td>/</td>
<td>Hepatitis</td>
</tr>
<tr>
<td>Angina/heart attack</td>
<td>/</td>
<td>V.D. - gonorreaa</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>/</td>
<td>V.D. - syphilis</td>
</tr>
<tr>
<td>Anemia/blood</td>
<td>/</td>
<td>Lice - crabs - scabies</td>
</tr>
<tr>
<td>Lung condition</td>
<td>/</td>
<td>OB/GYN</td>
</tr>
<tr>
<td>Asthma</td>
<td>/</td>
<td>LPM date</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>/</td>
<td>Duration</td>
</tr>
<tr>
<td>Emphysema</td>
<td>/</td>
<td>LMP normal</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>/</td>
<td>Regularity</td>
</tr>
<tr>
<td>Diabetes</td>
<td>/</td>
<td>Gravida/para</td>
</tr>
<tr>
<td>Hay fever/allergies</td>
<td>/</td>
<td>AB/miscarriage</td>
</tr>
<tr>
<td>Gastritis</td>
<td>/</td>
<td>Last pap</td>
</tr>
<tr>
<td>Ulcers</td>
<td>/</td>
<td>Contraception</td>
</tr>
<tr>
<td>Bleeding</td>
<td>/</td>
<td>LAB tests - dates</td>
</tr>
<tr>
<td>Gallbladder/pancreas</td>
<td>/</td>
<td>RPR</td>
</tr>
<tr>
<td>Liver problems</td>
<td>/</td>
<td>FFPD</td>
</tr>
<tr>
<td>Arthritis</td>
<td>/</td>
<td>Other:</td>
</tr>
</tbody>
</table>

**Mandza, Evalin**
- DOB: 12/5/1985
- Nation: GABON
- Arrival Date: 10/24/2011 17:05
- RN Signature: (b)(6), (b)(7)(c)
- Date: 10/24/2011
- Physician Signature: (b)(6), (b)(7)(c)
- Date: 10/24/2011

**Comments:**

- Inmate Name: 
- Inmate Number: 10/24/2011
- RN Signature: (b)(6), (b)(7)(c)
- Date: 10/24/2011
- Physician Signature: (b)(6), (b)(7)(c)
- Date: 10/24/2011
**Site:** Aurora / ICE Processing Center

**Detainee Name:** [Redacted]

<table>
<thead>
<tr>
<th>DATE/TIME</th>
<th>PROGRESS NOTE</th>
<th>ORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/26/11</td>
<td>Return to medical cp not having bowel movements. Told 1x day fluid intake verbalized understanding.</td>
<td>[Redacted]</td>
</tr>
<tr>
<td>10/26/11</td>
<td>DE completed</td>
<td>[Redacted]</td>
</tr>
<tr>
<td>10/26/11</td>
<td>[Note: 10/26/11]</td>
<td>[Redacted]</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>HEALTH SERVICES</strong></td>
<td>NURSING ASSESSMENT PROTOCOLS</td>
<td></td>
</tr>
<tr>
<td><strong>ABDOMINAL PAIN/CONSTIPATION/DIARRHEA/INDIGENCE/VOMITING/PROTOCOL</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DATE/TIMESTAMP**: 10/21/11 00:03

**S. CHIEF COMPLAINT**: Constipation

**ALLERGIES**: NKDA

**History ofolec / gallbladder disease / appendicitis / recent abdominal surgery / recent weight change (if any):**

**Time/Activity at onset**: 3-4 days after eating, does pain increase / decrease / remain same:

**Pain location**: Radiation yes/no:

**Radiation yes/no**: Constant or intermittent:

**Current medications**: No

**Character**: Cramping / stabbing / burning / sharp / dull

**Status**: Pain Intensity Scale 1-10:

**Last BM**: 3-4 days

**Consistency**: A L M

**Blood** (if yes, red / black / or maroon, and amount):

**Ostomia**

**Ostomia output**: Frequency / Occasionally / N/A

**Degrees mild / mod / severe**

**Urinary frequency**: 4-6

**Burning**: Yes

**Frequent micturition**: No

**Low back pain**: No

**Dietary habits**: Fat intake:

**Alcohol intake**: Yes

**Smoking habits**: Caffeine intake:

**O2 BP**: 107/64

**R: 70 Normal rhythm /bounding**

**P: 97**

**WT: 143 lbs**

**Bowel sounds**: Normal / hypo / hyper / absent

**Heard in all 4 quadrants**:

**Guarding**:

**Rebound tenderness**: No

**Jaundice**: No

**If states blood in stool, do hemocult. Results**: No

**Pain location**

**Description of observed vomiting / stool**:

**More comfortable position**: Lying / sitting / standing:

**Sick call**

**Character**: Cramping / stabbing / burning / sharp / dull

**Status**: Pain Intensity Scale 1-10:

**Last BM**: 3-4 days

**Consistency**: A L M

**Blood** (if yes, red / black / or maroon, and amount):

**Ostomia**

**Ostomia output**: Frequency / Occasionally / N/A

**Degrees mild / mod / severe**

**Urinary frequency**: 4-6

**Burning**: Yes

**Frequent micturition**: No

**Low back pain**: No

**Dietary habits**: Fat intake:

**Alcohol intake**: Yes

**Smoking habits**: Caffeine intake:

**O2 BP**: 107/64

**R: 70 Normal rhythm /bounding**

**P: 97**

**WT: 143 lbs**

**Bowel sounds**: Normal / hypo / hyper / absent

**Heard in all 4 quadrants**:

**Guarding**:

**Rebound tenderness**: No

**Jaundice**: No

**If states blood in stool, do hemocult. Results**: No

**A. CONSULT**

**Pr: The nurse may offer the patient the choice of Antacid, Milk of Magnesia, Kapectate, Emisine, Pepto Bismol, Dicyclomine, bulk laxative**

**Type does**

**Give according to label instructions**

**If vomiting or diarrhea, give clear liquid diet x 24 hrs and key in pass, unless otherwise ordered**

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

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

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

**Instructed not to lie down at least 2 hrs after eating**

**Caution to quit smoking**

**MANDZA, EVALIN**

**DOB: 12/5/1965**

**Nation: GABON**

**Arrival Date: 10/24/2011 17:05**
Medical Request / Solicited De Asistencia Medica

Date of request: 10/31/11

Medical Complaint ☑ Ouestra medica ☐ Ouestra Dental

Print: Evalin Ali Mandza

Letra – Molde Inmates Name / Nombre del Preso

Number Housing Location Job Assignment Duty Hour

Problem / Queja: Constipation

Evalin Ali Mandza
Inmate’s Signature / Firma del Preso

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

Date Received: (Stamp Date)

Date Reviewed: Written Response (see below) ☑ Seen in Medical

Action Taken: per protocol / scheduled for exam

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

☐ Placed on Dental List Date of Appointment: 

☐ Other (Explain):

(b)(6), (b)(7)(C)
Medical Request /
Solicited De Asistencia Medica

Date of request: 11/06/11
(Please check one) Medical Complaint Dental Complaint
( Por favor marque uno) □ Oueja medica □ Oueja Dental

Print /: Evalin Manda
(a)(6), (b)(7)(c) AZ-261

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

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

Explique brevemente la razón de su solicitud. Permita varios días para que su solicitud sea procesada. Una copia de su solicitud se archivará en sus registros. Prisioneros de habla hispana pueden solicitar dicha asistencia en esas

PROBLEM / QUEJA: 

POOMPS SHAVING, NEED MEDICAL

Evalin Manda
Inmates Signature / Firma del Preso

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

Date Received: (Stamp Date)

Date Reviewed: 11/9/11 06:00 □ Written Response (see below) □ Seen in Medical

ACTION TAKEN: T.A.D. APPLY DAILY X 7 DAYS

Placed on Sick Call List Date of Appointment: ______/_____/______

Placed on Dental List Date of Appointment: ______/_____/______

Other (Explain):
<table>
<thead>
<tr>
<th>DATE / TIME</th>
<th>PROGRESS NOTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/9/11</td>
<td>Act. 90% pagon bumps. Air skin. T.A-O apply daily X 7 days</td>
</tr>
<tr>
<td>0600</td>
<td>Protocol</td>
</tr>
</tbody>
</table>
# CONTACT DERMATITIS / ECZEMA PROTOCOL / ALLERGIC SKIN RASH

**DATE/TIME:**

<table>
<thead>
<tr>
<th>S.C. CHIEF COMPLAINT</th>
<th>ALLERGIEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knorr Bumps</td>
<td></td>
</tr>
</tbody>
</table>

**Chief Complaint:**

Course and onset of symptoms:

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/16</td>
<td>2:00</td>
</tr>
</tbody>
</table>

Where did it start:

- Fuzzy춘

Did it spread (where):

- All over face, extremities

Exposure to allergen, poison ivy, poison oak, or chemicals:

- Yes

Pain Intensity Scale 1-10:

- 5-6

History of:

- Hay fever
- Asthma
- Eczema
- Other Skin Conditions: acne

**Temperature:**

<table>
<thead>
<tr>
<th>Temperature</th>
</tr>
</thead>
<tbody>
<tr>
<td>96.9</td>
</tr>
</tbody>
</table>

**Height:**

<table>
<thead>
<tr>
<th>Height</th>
</tr>
</thead>
<tbody>
<tr>
<td>1'4'</td>
</tr>
</tbody>
</table>

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

- Color / shape of rash / lesions: none

- Describe rash: Macules, Papules, Pustules, Vesicles, Open excoriation, Weeping, Peeling, Dry/flaking, Crusting lesions, Hives, Burning, Itching

- Thickening of Skin: Yes
- Pigmentation changes: Yes

- Are the palms of the hands affected?: Yes
- Are the soles of the feet affected?: Yes

**Signs of secondary infection:**

- Purulent drainage
- Redness
- Edema
- Heat

**Eliminate contact with allergen, if known:** N/A

**Wash well with soap and water / dry well:**

- The Nurse may offer the choice of an anti-itch lotion (Calamine) applied topically 2% 2 weeks: Yes
- Hydrocortisone cream 1% bid pm x 3 days: Yes
- The Nurse may also offer Benadryl 25 mg, 2 tabs p.o., 6.13.4 for itching: Yes

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

**The apply daily x 7 days:**

**Instructions:**

- Instructed to bathe daily, rinse & dry thoroughly, and use only his own towels / linens etc.: Yes
- Instructed to keep hands off the affected areas and avoid scratching: Yes
- Instructed to avoid contact with lotion/ointment in or around the eyes: Yes
- Instructed to return to medical if symptoms persist: No

**Understanding of above instructions:**

- Yes

**NURSING SIGNATURE:**

- [Signature]

**NAME:** MANDZA, EVALIN

**DOB:** 12/5/1965

**NATION:** GABON

**Arrival Date:** 10/24/2011 17:05
Medical Request /
Solicited De Asistencia Medica

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

(Please check one) Medical Complaint Dental Complaint
Por favor marque uno) Ouestra medica O Ouestra Dental

Print: Ekin Monda
Letra - Molde Inmates Name /
Nombre del Preso

Number Housing Location Job Assignment Duty Hours

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

Explique brevemente la razón de su solicitud. Permíta varios días para que su solicitud sea procesada. Una copia de su solicitud se archivará en sus registros. Prisioneros de habla hispana pueden solicitar dicha asistencia en español.

PROBLEM / QUEJA: Constipation Movement

Ekin mark
Inmate’s Signature / Firma del Preso

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

Date Received: (Stamp Date)
Date Reviewed: 11 / 11 / 11 Written Response (see below) Seen in Medical
ACTION TAKEN: Per protocol

[ ] Placed on Sick Call List Date of Appointment: ______ / ______ / ______
[ ] Placed on Dental List Date of Appointment: ______ / ______ / ______
[ ] Other (Explain): ____________________________

(b)(6), (b)(7)(C)
MANDZA, EVALIN
DOB: 12/5/1965 Nation: GABON
Arrival Date: 10/24/2011 17:05

HEALTH SERVICES
ABDOMINAL PAIN/CONSTITUTION/DEATH/HEALTH/INDUCTION/VOMITING/PROTOCOL

TIME/DATE
11/11/11
DOE:

CHIEF COMPLAINT: Constipation

ALLERGIES: N/A

History of ulcers / gallbladder disease / appendicitis / recent abdominal surgery / recent weight change (pounds): N/A

Time Activity at onset: N/A

Pain location: N/A

Radiation: N/A

Duration: N/A

Current medications: N/A

Allergen factors: N/A

Character: Cramping / stabbing / burning / sharp / dull

Flatus: N/A

Pain Intensity Scale 1-10: N/A

Sick call

Last BM: N/A

Consistency: N/A

Amount: N/A

(Blood (Hb, red / black / or maroon, and sim) N/A

Diarrhea (frequency/quantity): N/A

Frequency / Occasional / N/A

Urinary frequency: N/A

Burning: N/A

Penile discharge: N/A

Low back pain: N/A

Dietary habits: Fat intake: N/A

Alcohol intake: N/A

Caffeine intake: N/A

Smoking habits: N/A

BP: 104/74 R=U T=98.3 W=145

Heart rate in all 4 quadrants: N/A

Guarding: N/A

Rebound tenderness: N/A

Jaundice: N/A

Irritation in stool, fever, hemoctot. Results: N/A

Pain location: N/A

Description of observed, stool: N/A

More comfortable: Lying / sitting / standing: N/A

Able to sit still: N/A

Skin color: Normal / dry / pale / flushed / cyanotic / diaphoretic

Abdomen soft / rigid: N/A

Degree of distended: N/A

Evidence of dehydration / oral bleeding: N/A

Overall appearance: Acute distress / mild distress / severe distress: Obvious anxiety: N/A

P. The Name may offer Patient the choice of Antacid, Milk of Magnesia, Kappacete, Rectoxol, Pepto bismol (Dulcolax, lactogenic) Type / dose:

Give according to label instructions.

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

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

If fever above 100.4 F, nausea or vomiting accompanying constipation, absent bowel sounds, blood in stool, all H/P + treatment or if H/P does appear ill, and there is pain upon palpation, the physician must be notified for specific orders.

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

Instructed not to smoke.

Caution to quit smoking:

II-1-11
Medical Request /
Solicited De Asistencia Medica

Date of request: Nov / 17 / 11

Medical Complaint: Dental Complaint
(Por favor marque uno) □ Oueja medica □ Oueja Dental

Print /: Evalin Mendoza

Letra – Molde Inmates Name /
Nombre del Preso

Number Housing Location Job Assignment Duty Hours
Numero Sitio de Vivienda Asignacion de Trabajo Horas de Trabajo

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

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PROBLEM / QUEJA:

Dental hurt, couldn’t go to sleep.

Inmate’s Signature / Firma del Preso

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

Date Received: ________________________ (Stamp Date)

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

ACTION TAKEN: Given Tylenol and scheduled for dentist
Instructed on proper oral hygiene. Return to medical if symptoms persist/worsen.

□ Placed on Sick Call List

□ Placed on Dental List

□ Other (Explain): ____________________________

Date of Appointment: __/__/____
HEALTH SERVICES
NURSING ASSESSMENT PROTOCOLS
DENTAL - TOOTHACHE PROTOCOL

DATE/TIME

CHIEF COMPLAINT: Toothache

Pain Intensity Scale 1-10: 9/10

Time of onset: 2 days ago

Contributing factors related to pain (eating, drinking, chewing, hot/cold air): None

Allaying factors: Tylenol

Current medications: Fiber

circle one:

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

Sick call:

O2 BP: 108/70 P= 74 R= 18 99.0° F = 91.6 Wt=

declared

Bleeding: No

E.R.

true E.R.

Redness or Swelling: Yes

Injury to mouth/ gums/ teeth:

Identity of the tooth: Upper right third molar

Is tooth positive to percussion: No

Visible signs of decay: Yes

Loose, e.g.

A.

I.

B.

C.

D.

E.

P.O. x 3 days

Secondary infection, or temp > 100.4:

If none of the above symptoms are present: The Nurse may offer Patient the choice of Ibuprofen 200 mg, two tablets 6-8 times/day, or Metamucil 325 mg. 2 tbs. p.o. and pain x 3 days or until seen by dentist:

Schedule for next dental call: Yes 11-31-11

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

Instructed to return to medical if symptoms persist/worsen:

Immediate verbalized understanding of above instructions: Yes

MANDZA, EVALIN

DOB: 12/5/1985 Nation: GABON

Arrival Date: 10/24/2011 17:05
<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Services Rendered</th>
<th>P</th>
<th>Dentist (Signature)</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/21/11</td>
<td>S: Complaint of TA LL. Has court tomorrow so he wants to reschedule</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/15/11</td>
<td>O: #18 has deep occlusal caries. @ percussion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11/21/11</td>
<td>A: Irreversible Pulpitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>P: Ext #18 RTC next week?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/20/11</td>
<td>S: Wants teeth cleaned and complaint of pain LL.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/20/11</td>
<td>O: #18 still has deep caries, mobility of 1/2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A: Irreversible Pulpitis #18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>P: He refuses ext.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/20/11</td>
<td>RX: IBP 400 mg Bid x 5 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/16/12</td>
<td>S: Pain LL x 3 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/16/12</td>
<td>O: #18 is tender to percussion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A: I/P #18</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>P: Refused ext.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>RX: Amoxicillin 1000 mg Bid x 7 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>TYLENOL 1000 mg Bid x 7 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DC: TYLENOL 1000 Bid x 7 days</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>orders noted 1/17/12 0550</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>14 Chart Complete 1/17/200400 in Queue</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Aurora/ICE Processing Center

Rev 01/05
Medical Request /
Solicited De Asistencia Medica

Date of Request: 11/27/11
(Please check one)
Medical Complaint  Dental Complaint
Por favor marque uno) □ Oueja medica □ Oueja Dental
Print /: Evalin Mandza  A3-109
Letra – Molde Inmates Name / Number Housing Location Job Assignment Duty Hours
Nombre del Preso Numero Sitio de Vivienda Asignacion de Trabajo Horas de Trabajo

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

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PROBLEM / QUEJA: Constipation Movement & Shaving Pump MEd

Evalin Mandza
Inmate’s Signature / Firma del Preso

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

Date Received: ___________________________ (Stamp Date)

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

ACTION TAKEN: Given mom and Dulcolax X1. Fiber bid x10 days. Also given TIAO for razor burn rash on face. Instructed to drink a lot of water, do not use TIAO around eyes, and return to medical if symptoms persist/worsen.

□ Placed on Sick Call List  Date of Appointment: ___/___/____
□ Placed on Dental List  Date of Appointment: ___/___/____
□ Other (Explain): RN

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

(b)(6), (b)(7)(c)
HEALTH SERVICES
ABDOMINAL PAIN/CONSTIPATION/DIARRHEA/INDIGESTION/VOMITING PROTOCOL

S) CHIEF COMPLAINT: Constipation

ALLEGIES: N-V-D-A

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

Time/Activity at onset: Stress / Romero / Rising back

Pain location: No / Radiation: None

Duration: NIAB Constant or Intermittent: NIAB

Current medications: Treated: None

Character: Cramping / stabbing / burning / sharp / dull: None

Flatus: Yes

Pain Intensity Scale 1-10: None

Last BM: 11/23/11

Consistency: hard

Amt: Little

Blood (if yes, red / black / or maroon, and aml): NO

Constipation: Yes

Diarrhea (Frequency/amt): NO

Urinary frequency: NA

Heartburn or indigestion: No

Describe frequency/amt/color: NA

Frequently / Occasionally (NA)

Degree: mild / mod / severe (NA)

Diabetic habits: Fat intake: Normal

Alcohol intake: None

Smoking habits: None

Burning: No

Penile discharge: No

Low back pain: No

Caffeine intake: 1-2 cups/2 days

Rebound tenderness: None

Jaundice: No

Heard in all 4 quadrants: YES

Guarding: NO

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

Description of observed vomitus/stool: NA

More comfortable: Diagnosing / Sitting / Standing

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

Abdomen: Soft / rigid

Degree: Mild / Moderate / Severe (NA)

Bowel sounds: Normal / hypo / hyper / absent

Evidence of dehydration / GI bleeding: No

Bladder distended: No

Overall appearance: No acute distress / Mild distress / Severe distress

If yes, orthostatic BP = NIAB

If at rest: YES

A.)

P. The Nurse may offer Patient the choice of Antacid / Milk of Magnesia, kapectate, Emetrol,

Pepto Bismol (Quilolax, bulk laxative) Type/dose: No

Give according to label instructions.

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

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

Fiber po BID x 10 days

*If fever above 100.4 F, nausea or vomiting accompanying constipation, absent bowel sounds, blood in stool, all HCP + inmates with diarrhea,

diarrhea that lasts longer than 24 hrs after treatment, or if pts does appear ill, and there is pain upon palpation, the physician must be notified for

specific orders:

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

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

Caution to quit smoking: NO

Instructed on stress relief measures, high fiber diet, and adequate exercise: YES

Aggregate verbalized understanding of above instructions: YES
# Health Services
## Nursing Assessment Protocols
### Contact Dermatitis / Eczema Protocol / Allergic Skin Rash

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>S.J. Chief Complaint:</th>
<th>Allergies:</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/26/19</td>
<td>Razor burn</td>
<td>NEFA</td>
</tr>
</tbody>
</table>

- **Course and onset of symptoms:** After shaving, got hair bumps
- **Where did it start?:** Face + neck
  - Did it spread (where?): No
- **Exposure to allergens, poison ivy, poison oak, or chemicals:** Yes
- **Pain Intensity Scale 1-10:** 5/10
- **History of:**
  - Hay fever: No
  - Asthma: No
  - Eczema: No
  - Other Skin Conditions: No

- **Declared E.R.:**
  - BP: 108/72
  - P: 70
  - R: 17
  - T: 97.1
  - WT: 147 lbs
  - 98.00

- **True E.R.:**
  - Location / size of rash / lesions (face, neck, trunk, folds of skin, behind the knees, elbows, and body):
    - Small red bumps
  - Color / shape of rash / lesions:
    - Red, round
  - Describe rash:
    - Macules
    - Papules
    - Pustules
    - Vesicles
    - Open excoriation
    - Swelling
    - Peeling
    - Dry / flaking
    - Crusting lesions
    - Hives
    - Burning
    - Itching
  - Thickening of Skin:
    - Yes
  - Pigmentation changes:
    - Yes
  - Are the palms of the hands affected:
    - No
  - Are the soles of the feet affected:
    - No
  - Signs of secondary infection:
    - Purulent drainage: No
    - Redness: No
    - Edema: No
    - Heat: No

### A.

- Eliminate contact with allergen, if known: Yes
- Wash well with soap and water / dry well: Yes
- The Nurse may offer the choice of an antihistamine (Calamine) applied topically qid pm x 2 weeks:
  - Yes
  - No
- Hydrocortisone cream 1% bid pm x 3 days:
  - Yes
  - No
- The Nurse may also offer Benadryl 25 mg, 2 tabs p.o., b.i.d. x 3 days for itching:
  - Yes
  - No
- Call physician for specific orders if secondary infection is present, Temp > 100.4, or if lesions are present on the eyes or genitalia:
  - TAO x 7 days

### B.

- Fasses / Referrals given:
  - Instructed to bathe daily, rinse & dry thoroughly, and use only his own towels / linens: Yes
  - No
  - Instructed to keep hands off the affected areas and avoid scratching: Yes
  - No
  - Instructed to avoid contact with lotion / ointment in or around the eyes: Yes
  - No
  - Instructed to return to medical if symptoms persist / worsen: Yes
  - No

### Name: MANDZA, EVALIN

### Number / DOB / Nation:
- 12/6/1965
- GABON
- Arrival Date: 10/24/2011 17:05

### DOB / Nursing Signature:
- 10/24/2011 17:05
- RN
<table>
<thead>
<tr>
<th>DATE/TIME</th>
<th>PROGRESS NOTE</th>
<th>ORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/2/11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10/4, 11/3/09</td>
<td>% legion to oral peri</td>
<td>Adult Colace 100mg x 3 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/2/11</td>
<td>Noted 1422 metastatic supp ordered 100mg</td>
<td></td>
</tr>
<tr>
<td>12-03-11</td>
<td>24 hr x 5 0/25</td>
<td></td>
</tr>
</tbody>
</table>
Medical Request /
Solicited De Asistencia Medica

Date of request: 12/11/11
Feche de Solicitud: 12/11/11

(Print/ Inmates Name / Nombre del Preso)
Evelin Mandza

43-266

Medical Complaint: []
Dental Complaint: [x]

Por favor marque uno

(Please check one)

Dueja medica
Dueja Dental

Duty Hours

Letra - Molde
Inmates Name /
Nombre del Preso

Number
Numero

Housing Location
Sitio de Vivienda

Job Assignment
Asignacion de Trabajo

Duty Hours
Horas de Trabajo

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

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

Evelin Mandza
Inmate's Signature / Firma del Preso

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

Date Received: __________________________ (Stamp Date)

Date Reviewed: __________________________
[ ] Written Response (see below) [x] Seen in Medical

ACTION TAKEN: __________________________

[ ] Placed on Sick Call List

[ ] Placed on Dental List

[ ] Other (Explain): __________________________

Date of Appointment: ______/_____/_____

Date of Appointment: 12/12/11
<table>
<thead>
<tr>
<th>DATE/TIME</th>
<th>PROGRESS NOTE</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/2/11</td>
<td>Detainee &amp; medical of toothache, (4) Fist cream 6125348</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td>06:40</td>
<td>lower teeth with decay, detainee has been scheduled to see dentist re: teeth.</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td>12/3/11</td>
<td>Lying, standing</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td>Wt-145 lbs</td>
<td>105/70, 102/166</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td>70/18</td>
<td>69/72</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td>10/2/65</td>
<td>Pt examined by Doc</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td>5/4/11</td>
<td>No new orders made</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>(b)(6), (b)(7)(c)</td>
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<tr>
<td></td>
<td>24°C/104F on 12/15/11 at 1530</td>
<td>(b)(6), (b)(7)(c)</td>
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<tr>
<td>1-3-12</td>
<td>½ pt of 1st MP</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td></td>
<td>Burns RT foot also</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td></td>
<td>Stilts use against soccer ball</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td></td>
<td>O. W. Noted N/A</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td></td>
<td>Ex: Gagging, nausea</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td></td>
<td>Mt. Jowl</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td></td>
<td>1) Hyperglycemia</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td></td>
<td>No grain of family</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td></td>
<td>800 mg - po</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td></td>
<td>2) Amoxicillin 600 x 60</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td></td>
<td>It's tender 3/4th days</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td></td>
<td>WBC 14000</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td></td>
<td>2) Lower back bed, please</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td>1/3/12</td>
<td>1250 Noted Med to MR + Bunk A'd</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td>1/4/12</td>
<td>24°F/1530</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
</tbody>
</table>

Rev: 01/05

HS-166
HEALTH SERVICES
NURSING ASSESSMENT PROTOCOLS
DENTAL - TOOTHACHE PROTOCOL

DATE/TIME: 05/20

S.) CHIEF COMPLAINT: Toothache

ALLERGIES: N/A

Time of onset: 12 hr

Pain Intensity Scale 1-10: 7

Any trauma or injury: No

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

Alleviating factors:

Current medications:

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

sick call

walk-in O.) BP: 108/68 F= 74 R= 16 T= 97 Wt= 150

declared

e.R.

Bleeding: No

true E.R.

Redness or Swelling: No

Injury to mouth/gums/teeth: No

Identity of the tooth: Lower tooth

Visible signs of decay: Yes Loose: Yes

Is tooth positive to percussion: Yes

Oral hygiene:

White patches/discharge: No

Earache or sore throat (examination if positive): No

A.) Ibuprofen 200 mg PO BD X3d / tooth x 3

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

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

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

Schedule for next dental call:

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

Instructed to return to medical if symptoms persist/worsen:

Inmate verbalized understanding of above instructions:

MANDZA, EVALIN

DOB: 12/5/1986 Nation: GABON

NUMBEI: 10/24/2011 17:05

NURSING SIGNATURE:
Medical Request /
Solicitada De Asistencia Medica

Date of request: 12/14/11
(Please check one) Medical Complaint \ Dental Complaint
(Por favor marque uno) \ Oueja medica \ Oueja Dental

Print / : A3-206
Letra – Molde
Inmates Name / Nombre del Preso

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

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

PROBLEM / QUEJA:
I fell from the hospital bed, hurt my foot

\[Signature\]
Inmate’s Signature / Firma del Preso

\[Stamp\]
Date Received: 12/15/11 (Stamp Date)

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

ACTION TAKEN: Returned to for further evalution

Placed on Sick Call List

\[Stamp\]
Date of Appointment: 12/15/11

\[Stamp\]
Date of Appointment: 12/15/11

\[Stamp\]
Other (Explain): Seem long walk orders made 12/15/11
# MUSCULOSKELETAL TRAUMA PROTOCOL

**DATE/TIME**

<table>
<thead>
<tr>
<th>S.</th>
<th>CHIEF COMPLAINT:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pain to great for</td>
</tr>
</tbody>
</table>

### Allergies: 

- PCDA

**Time of onset: 2000**  
**Activity at onset: fell**  
**History of ulcers: NO**

**Pain location:** (O) great toe  
**Constant/intermittent:**

**Circle one:**
- Character: cramping / stabbing / burning / sharp / dull

**Sick call:**
- Radiation: yes/no  
- History of previous injury to same site: yes/no  
- When:

**Walk in**
- Most comfortable lying / sitting / standing / rocking?
- Able to sit still: yes/no

**Self ER**
- Numbness / tingling: yes/no  
- Location:
- Loss of consciousness: yes/no  
- If so, how long:

**True ER**
- Last tetanus date: (if > 5 yrs & skin broken, notify physician for order for booster)

**OS! 30**

### Does anything help? yes/no what: 

**Heart sounds:** regular / irregular

**Gait:** steady / slightly unsteady / unable to stand

**Arrived at medical via:** walk / wheelchair / stretcher

**Skin:** normal / pale / flushed / diaphoretic  
**Describe location / degree:**

**Abnormalities / incision:** location:

**Sign of infection:** yes/no

**Swelling:** yes/no site:

**Bruising:** yes/no site:

**Redness:** yes/no site:

**Range of motion:** full / decreased:

**Capillary refill:** distal to injury < 3 sec / sluggish / absent  
**Skin temp distal to injury:**

**Peripheral pulses distal to injury:** strong / weak / unable to palpate

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

A.)

P.) **Applied ice x 24 hours (on 45, off 15)** yes/no  
**Elevated extremity:** yes/no

**Apply warm compress x 48 hrs (after ice x 24):** yes/no

**Immobilization:** ace wrap applied (sprains only): yes/no  
**If no fracture:** sturdy splint

**Applied:** yes/no  
**Type:** 
**Steri-strips applied:** yes/no  
**Dressing applied:** yes/no

**Physician notified:** yes/no time:  
**Orders received:** yes/no time: 
**List:**

| - | - |

- **Compression:** yes/no  
- **Type / exp. date:**

**Disposition:** dorm / infirmary / transfer to E.R.  
**Condition:** stable / guarded / critical

E.) **Instructed to resume activity gradually:**

- **If ankle / foot involved:** stay off x 48 hrs: yes/no  
**Instructed to use ice pack / warm:**

- **Compresses:** yes/no  
**Instructed to return to medical if symptoms persist / worsen:** yes/no

**Inmate verbalized understanding:** yes

---

**NAME:** Mandza, Evalin

**NUMBER:** 12/5/1965

**DOB:** 12/5/1965

**ASING SIGNATURE:**

45
Medical Report on Injuries/Non-Injuries

Last Name: MANDZA, EVALIN
First Name: ____________________ Middle Name: __________
DOB: 12/5/1965 Nationality: GABON
Date of Birth: 12/25/2011 17:05
Date Number: ____________________

Date of Incident: 12-25-11 Time: 11:40 AM
Place: ____________________

Was it necessary to notify physician? ☐ Yes ☐ No
Time of notification: __________

Name of physician: N/A

Type of incident: ☐ Fighting ☐ Use of Force

Other: ____________________

Injuries/Non-Injuries:

Head Area Examined: NO INJURY

Face Area Examined: NO INJURY

Chest Area Examined: Tiny Scratches

Back Area Examined: NO INJURY

Arms Area Examined: Tiny Scratches at wrist area

Legs Area Examined: NO INJURY

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

THIS INJURY IS: (CIRCLE ONE)
REPORTABLE NON-REPORTABLE

LAY-IN DATE:
START _____ STOP _____

Date of Exam: 12/25/11 Time: 11:40 AM
INMATE NAME: [REDACTED]
INMATE NUMBER: [REDACTED]
D.O.B: [REDACTED]
PRESENTLY ON MEDS: YES / NO
CHRONIC CLINICS: [REDACTED]
WEIGHT: 151
TEMP: 97.5
PULSE: 89
RESP: 20
B/P: 151/83

CIRCLE APPROPRIATE RESPONSE

PHYSICAL OBSERVATIONS

GENERAL APPEARANCE
Clean Neat Dirty Disheveled

SKIN
Turgor
Lacerations
Contusions
Bruises

RESPIRATORY
Breath Sounds
Dyspnea
Cough/Congestion

CARDIOVASCULAR
Rhythm
Edema
Chest Pain
Bleeding Tendencies

GASTROINTESTINAL
Distention
Constipation/Diarrhea
Nausea/Vomiting
Abdominal Pain

GENITOURINARY
Pain
Burning/Frequency
Urination
Discharge

CYN
Pregnant
Menses

COMMENTS REQUIRED ON ABNORMALITIES

NEUROLOGICAL
1. Headache/Dizziness
2. Speech
3. Pupils
4. Gait

PSYCHIATRIC
1. Orientation
2. Coherence of Thought Process
3. Emotional State

MUSCULOSKELETAL
1. Range of Motion
2. Upper Extremities
3. Lower Extremities

CLEARED FOR AD. SEG. (Yes/No)

REFFERED FOR FURTHER EVALUATION
Psych. Services

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

ALL FORMS MUST BE COUNTERSIGNED WITHIN SEVENTY-TWO HOURS

PHYSICIAN: [REDACTED]
DATE/TIME: 12-27-11
# Special Management Unit Housing Record

**Name of Detainee:** Mendoza Erwin Garcia

**Room #:** 117

**Violation or Reason:** 201 Fighting/Harassment

**Date Received:** 12/25/11  
**Time Received:** 153

**Date Released:** 12/26/11  
**Time Released:** 20:17

**Admittance Authorized by:** Lt.

**Pertinent Information:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Shift</th>
<th>B</th>
<th>L</th>
<th>D</th>
<th>Sh</th>
<th>Rec</th>
<th>Medical Officer</th>
<th>Housing Officer</th>
<th>Comments- Use Reverse side if required</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/25/11</td>
<td>2nd</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>(b)(6), (b)(7)(c)</td>
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<td></td>
<td>3rd</td>
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<td>(b)(6), (b)(7)(c)</td>
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<tr>
<td>12/26/11</td>
<td>2nd</td>
<td>Y</td>
<td>R</td>
<td>N</td>
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<td>N</td>
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<td>R</td>
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<td>1st</td>
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<td></td>
<td>(b)(6), (b)(7)(c)</td>
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</table>

**Pertinent Information:** Epileptic, Diabetic, Suicidal, Assaultive, etc.

**B (Breakfast) L (Lunch) D (Dinner) Shower—indicate Yes (Y); No (N); Refused (R)**

**Rec (Recreation) — log in actual time, i.e., 0900/1000**

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

Comments: i.e., Conduct, Attitude, etc. Additional comments on reverse side must include date, signature, and title.

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

Date: Dec 25, 2011

To: Warden

From: Shift Supervisor

RE: ADMINISTRATIVE SEGREGATION ORDER

Mandaz, Evalin-Ali

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

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

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

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

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

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

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

Detainee Signature

ID# Date

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

Record a brief outline of the circumstances and names of any witnesses to events leading to this placement:

Detainee placed in Administrative Segregation for]  and another detainee

Medical Staff Signature: ____________________________ Date: 12/25/11

Supervisor Signature: ____________________________ Date: 12/25/11

Admitted by: ____________________________ Date: 12/25/2011

Released by: ____________________________ Date: 12/25/2011

Reviewed by: ____________________________ Date: 12/25/2011

I have received a copy of this Administrative Segregation Order

Detainee Signature / ID# / Date
INCIDENT OF PROHIBITED ACTS AND NOTICE OF CHARGES

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

ID#: ____________________________ Nationality: ____________________________

Date & Time of Incident: 12/25/11 11:05 Housing Assignment: A3

Incident Location: A3 - 206 Work Assignment: ____________________________

Classification Level: ____________________________

PROHIBITED ACTS:

1. Fighting, boxing, wrestling, sparring, and any Code: 201
2. Other form of physical encounters, including Code: ____________________________
   horseplay
3. ____________________________
   Code: ____________________________
4. ____________________________
   Code: ____________________________

Description of Incident:

On 12-25-11 at approx. 1105, detainee [b](6), [b](7)(c) had brought to D/C [b](6), [b](7)(c) attulin that he is been pushed around in cell 206 by Mandza Evalin Ali. Detaine Mandza Evalin Ali responded that he also been pushed around in the cell 206 by detainee [b](6), [b](7)(c) that both detainee were transferred to E1 Segregation. End of the report.

Staff Witnesses: Y [ ] Evidence Attached: Y N N/A

Supporting Reports: Y N N/A
(b)(6), (b)(7)(c)

Name of Reporting Officer ____________________________ Date & Time ____________________________
12-15-11 12:30 ____________________________
(b)(6), (b)(7)(c)

Reviewed for accuracy prior to investigation by: ____________________________
Supervisor ____________________________
Date and Time 1105 Hours

Classification Level Change: ( ) N Level change from 2 to 3
# HEALTH SERVICES
**NURSING ASSESSMENT PROTOCOLS**

## MUSCULOSKELETAL PAIN PROTOCOL

<table>
<thead>
<tr>
<th>TIME</th>
<th>CHIEF COMPLAINT</th>
<th>ALLERGIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/30/11</td>
<td>Left big toe</td>
<td>NKDA</td>
</tr>
</tbody>
</table>

### Time of onset: 11:05
Activity at onset: **Playing soccer**
Radiation: **Up foot**

**Character of pain:** Sharp pain

**Type of pain:** Constant or intermittent

**Cause of injury:** Fall playing soccer

**Medications:**

<table>
<thead>
<tr>
<th>NUMBNESS OR TINGLING</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

### BP: 120/81, P: 71, R: 17, T: 96.3, WT: 145

- **Respiratory rhythm:** Even, regular
- **Lung sounds:** Clear
- **Method of arrival to medical:** Walking
- **Heart sounds:** Regular rhythm
- **Gait:** Normal, no shaving
- **Able to get on and off table:** Yes

### Skin (distal to injury):
- Normal (warm/pink/dry)
- Pale / flushed / cyanotic / mottled / diaphoretic / cool / dusky

### Capillary refill distal to injury: < 2 seconds

### Peripheral pulses distal to injury: Normal

### Overall appearance:
- No acute distress
- Mild distress
- Moderate distress
- Severe distress

### Instructions:

1. **Elevate extremity** and apply cold compresses for 24 hrs (on 45 min off 15)
2. Use local heat after acute phase is over (warm compresses)
3. If again: give Ace wrap or splint
4. If leg/foot involved: issue crutches & pass
5. Give recreation restriction pass to rest affected muscles/joints

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

- Ibuprofen 200 mg, two tablets bid p.o. x 3 days:

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

### Instructed:
- Patient to avoid heavy lifting, strenuous work/sports activity until problem resolved, to resume activity gradually, and return to medical if problem persists or worsens: Yes
- Instructed to keep extremity elevated and use cold/warm compresses in dorm: Yes
- Instructed to avoid contact with balm/ointment in or around the eye: Yes
- Instructed on benefits of regular exercise, slowly progressing to 20 minutes QD 3x weekly after clearance from physician: Yes

---

**SIGNATURES**

- **MANZAZA, EVALIN**
- **DOB: 12/5/1965 Nation: GABON**
- **Arrival Date: 10/24/2011 17:05**
Medical Request/Solicitud De Asistencia Medica

Date of request: 01/12/12

(b)(6), (b)(7)(C)

Medical Complaint □
Dental Complaint □

(Please check one)
(Para favor marque uno)

Dentist

Print:
Letra-Molde
Inmates Name/Nombre del Preso

Number/Numero
Housing Location/Siio de Vivienda

Job Assignment/Asignacion de Trabajo
Duty Hours/Horas de Trabajo

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

Explique brevemente la razón de su solicitud. Permita varios días para que su solicitud sea procesada. Una copia de su solicitud será archivada en sus records. Prisioneros de habla hispana pueden solicitar dicha asistencia en español.

PROBLEM/QUEJA:
Dental Problem

Inmate's Signature/Firma del Preso

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

Date Received: (Stamp Date)
Date Reviewed: 11/15/12  □ Written Response (see below)  X Seen in Medical

ACTION TAKEN: Referred to Dental 11/16/12

□ Placed on sick call list
Date of Appointment: ______ / ______ / ______

□ Placed on Dental list
Date of Appointment: ______ / ______ / ______

□ Other (Explain):

Medical Staff Signature

Date: 11/15/12
Medical Request/
Solicited De Asistencia Medica

Date of request: 01/15/12

(Please check one)
(Por favor marque uno)

Medical Complaint
Ojea medica

Dental Complaint
Ojea Dental

Print: Evalin Mandza

Letra-Molde Nombres del Preso

Inmates Name/Numero

Number/Housing Location/Sitio de Vivienda

(b)(6), (b)(7)(c) A3-105

Job Assignment/Asignacion de Trabajo

Duty Hours/Horas de Trabajo

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

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

PROBLEM/QUEJA: Dental Problem. I need to keep taking the constipation supp. that help. Thanks

Inmate's Signature/Firma del Preso

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

Date Received: ____________________ (Stamp Date)

Date Reviewed: 1/10/12 □ Written Response (see below) □ Seen in Medical

ACTION TAKEN: Not given anything for dental b/c already on ibuprofen 800 mg prn. Scheduled to see Dr. 1/18/12 to discuss glycerine supp. Scheduled to see Dr. 1/16/12 to discuss dental problem.

Placed on sick call list Date of Appointment: 1/18/12

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

Other (Explain):

Medical Staff Signature

Date
# Health Services

## Nursing Assessment Protocols

**Abdominal Pain/Constipation/Diarrhea/Indigestion/Vomiting Protocol**

<table>
<thead>
<tr>
<th>Time/Date</th>
<th>Complaint</th>
<th>Allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/17/17</td>
<td>Constipation</td>
<td>No</td>
</tr>
</tbody>
</table>

- History of ulcers / gallbladder disease / appendicitis / recent abdominal surgeries / recent weight change (lbs): No
- Time/Activity at onset: After eating, does pain increase / decrease / remain same
- Pain location: Abdomen
- Radiation: yes
- Duration: Constant or Intermittent
- Current medications: Motrin, Colace, Fiber
- Alleviating factors: None

<table>
<thead>
<tr>
<th>Character</th>
<th>Flatus</th>
<th>Pain Intensity Scale 1-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cramping / stabbing / burning / sharp / dull</td>
<td>Yes</td>
<td>3</td>
</tr>
</tbody>
</table>

- Last BM: 1/11/17
- Consistency: Hard
- Amount: 1
- Blood (if yes, red / black / maroon, and amount): None

- Constipation: Yes
- Diarrhea (Frequency/Amount): No
- Nausea/vomiting: No
- Describe frequency/amount/color: N/A
- Urinary frequency: None
- Burning: No
- Penile discharge: No
- Low back pain: No
- Dietary habits: Fat intake: N/A
- Alcohol intake: No
- Caffeine intake: Cup/day
- Smoking habits: None
- O2 BP: 105/60
- P: 75
- Normal/Weak/bounding
- R: 17
- T: 96.5
- WT: 154

- Bowel sounds: Normal / hypo / hyper / absent
- Heard in all 4 quadrants: Yes
- Guarding: No
- Jaundice: No
- Rebound tenderness: No
- Pain location: N/A
- If states blood in stool, do hemocult. Results: N/A
- Description of observed vomitus/stool: N/A
- More comfortable: Lying / sitting / standing: N/A
- Able to sit still: Yes
- Skin: Normal / warm & dry / pale / flushed / cyanotic / diaphoretic
- Abdomen: Soft / rigid
- Degree: mild / moderate / severe / n/a: Bladder distended: No
- Evidence of dehydration / GI bleeding: No
- If yes, orthostatic BP: N/A
- P: N/A

**Overall appearance:**
- no acute distress / mild distress / severe distress
- Obvious anxiety: No

---

**A.)**

- The Nurse may offer Patient the choice of Antacid, Milk of Magnesium, Kapectate, Emetrol, Peptobismuth, Dulcolax, bulk laxative) Type/dose: No
- Give according to label instructions.
- If vomiting or diarrhea, give clear liquid diet x 24 hrs and lay-in pass, unless otherwise ordered: No
- If blood in stool, vomiting, or severe diarrhea, place in infirmary/observation, unless otherwise ordered: No
- *If fever above 100.4 F, nausea or vomiting accompanying constipation, absent bowel sounds, blood in stool, all HIV + inmates with diarrhea, diarrhea that lasts longer than 24 hrs after treatment, or if pt does appear ill, and there is pain upon palpation, the physician must be notified for specific orders.*

**Scheduled to see Dr. [b](b),(7)(c) 1/18/12.**

**E.)** Instructed to avoid spicy foods, eat small meals, chew slowly & thoroughly, and drink 6-8 glasses water daily: Yes
- Instructed not to lie down at least 2 hrs after eating: No
- Caution to quit smoking: No
- Instructed on stress relief measures, high fiber diet, and adequate exercise: Yes
- Return if symptoms persist/worsen: Yes
- Inmate verbalized understanding of above instructions: Yes

---

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

**Signature:** [Signature]
INVESTIGATION REPORT

Detainee Name: **Mandza-Evalin - A61**

Date & Time of Incident: **1/18/13 06:20** Place of Incident: **A3-unit**

Housing Assignment: **A3-165** Date of Investigation: **01-18-12** Code(s): **307-314**

Name of Investigating Officer: **LT**

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

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

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

Investigator's Comments and Conclusions: **Detainee guilty of 307 and 314 based on his oral self-admission to charges. Refer to JDC.**

Date and Time Investigation Began: **1-18-13** 11:05 hours

Date and Time Investigation Ended: **1-18-13** 11:10 hours

Signature of Investigating Officer

Reviewed for Accuracy by Supervisor
INSTITUTION DISCIPLINARY PANEL REPORT

Detainee Name: Maudza, Evulina-Ali  A-Number: (b)(6), (b)(7)(C)

Date of Incident: 1/16/2012  Code(s): 307, 314

I. Notice of Charge(s):
   A. Advance written notice of charge(s) (copy of Incident Report) was given to the detainee on ___________________________ at ___________________________.
   (Date)  (Time)
   B. The IDP hearing was held on ___________________________ at ___________________________.
   (Date)  (Time)
   C. The detainee was advised of his/her rights before this IDP by ________________ on ___________________________ and a copy of the advisement of rights form is attached.
   (Officer)  (Date)

II. Staff Representative:
   A. Detainee waived his/her rights to staff representative: ___________________________.
   B. Detainee requested staff representative and ________________ appeared.
   (Staff Representative)
   C. Requested staff representative declined or could not appear but detainee was advised of option to postpone hearing to obtain an alternative staff representative with the following result: ___________________________.

III. Presentation of Evidence:
   A. Detainee has been advised of his/her right to present a statement or to remain silent, to present documents, including written statements of unavailable witnesses, and for relevant and material witnesses to appear on his/her behalf.
   B. Summary of detainee's statement: ___________________________.

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

______ a. The Act was Committed as Charged

______ b. The Following Act was Committed:

______ c. No Prohibited Act was Committed

V. Specific Evidence Relied on to Support Findings:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

VI. Sanctions or Action Taken: Offense Severity:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

VII. Reason for Sanction or Action Taken:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Hearing Board Chairperson ___________________________ Date ____________

Hearing Board Member ___________________________ Date ____________

Hearing Board Member ___________________________ Date ____________

VIII. Review and Concur:
   A. Concur with findings: ___________________________
   B. Proceedings terminated: ___________________________
   C. Discipline Imposed: ___________________________

Findings Administrator’s Signature: ___________________________ Date/Time: ___________________________

Copy delivered to detainee by: ___________________________ on ___________________________ (Signature and Title) (Date)
Incident of Prohibited Acts
and Notice of Charges
Aurora/I.C.E. Processing Center

Detainee Name: Mandza Evalin-Ali
ID#: N/A
Date & Time of Incident: 1-18-12 0620
Incident Location: Cell 105
Classification Level: level 2

A-Number: (b)(6), (b)(7)(c)
Nationality: Gabon
Housing Assignment: A-3
Work Assignment: none

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

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

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

SUPERVISOR'S REMARKS:
N/A

Evidence Attached?: □ Yes No □ N/A Supporting Reports?: □ Yes □ No □ N/A

Staff Witnesses?: □ Yes □ No

Reporting Officer: D/O (b)(6), (b)(7)(c)

Date & Time: 1-18-12 0734

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

Classification Level Change?: □ Yes □ No

Level change from level 2 to level 3.

1/19/2012
NOTICE OF INSTITUTION DISCIPLINARY PANEL HEARING

AVISO DE LA AUDIENCIA DISCIPLINARIA DEL PANEL DE LA INSTITUCION

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

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

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

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

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

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

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

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

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

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

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

Usted también tiene la derecha de llamar testigos en la audiencia y de presentar certificado justificativo en su favor; con tal que, eso que llama sus testigos no comprometa seguridad de facilidad. Los nombres de testigos que usted desea llamar se deben enumerar abajo. El estado debajo de cual podría cada testigo propuesto atestiguar (sea específico):
The chairperson of the Institution Disciplinary Panel will call those listed above as witnesses (staff or detainee) who are reasonably available, and who are determined by the chairperson to be necessary for an appreciation of all the circumstances surrounding the charge(s). Representative witnesses need not be called. Unavailable witnesses may be asked to submit written statements. If additional space is required, use the reverse side of this form.

El presidente del panel disciplinario de la institución llama a esos enumerados arriba como testigos (personal o detinente) que estén razonablemente disponibles, y que son determinados por el presidente para ser necesarios para un aprecio de todas las circunstancias que rodean las cargas. Los testigos repetidores no necesitan ser llamados. Los testigos inasistentes se pueden someter declaraciones escritas. Si se requiere el espacio adicional, utilícese el dorso de esta.
DETAINEE RIGHTS AT THE INSTITUTIONAL DISCIPLINARY PANEL HEARING
(IDP)

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

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

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

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

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

Signed: ___________________ A#: ___________________ Date: 11/19/2012

Notice of Rights given to detainee by: ___________________

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

Staff Member and Date: ____________________________

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

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

Detainee Signature/Date and Time: ____________________________
UNIT DISCIPLINARY COMMITTEE REPORT OF FINDINGS AND
ACTIONS

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

Date of Incident: 01/18/2012

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

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

It is the Finding of the Unit Disciplinary Committee that:
1. You committed the Prohibited Act as Charged: Code(s): 307, 314
2. You committed the following Prohibited Act: Code(s): 307, 314
3. You did not commit a Prohibited Act as charged: N/A

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

Committee Action:
[ ] Refer to IDP  Date & Time: January 19, 2012 / 1310
[ ] Loss of Privileges  [ ] Loss of Job
[ ] Restrict to Dorm  [ ] Remove from Program
[ X] Warning  [ ] Reprimand
[ ] Confiscate Contraband  [ ] Impound Personal
     Property

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

UDC Chairperson's Signature:  Date/Time: 01/19/2012/1330

UDC Member’s Signature:  Date/Time: N/A

Copy delivered to detainee by  Date: 20/12

Rev. 3/05
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<td>SKIN</td>
<td>Turger / Lacerations / Contusions / Bruises</td>
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<td>Breath Sounds / Wheezing / Cough / Congestion</td>
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| CLEARED FOR AD. SEG. | Yes / No |
| REferred for Further Evaluation | Psych. Services M.D. |

| EXAMINER: | (b)(6), (b)(7)(c) |
| DATE: | (b)(6), (b)(7)(c) |
| TIME: | (b)(6), (b)(7)(c) |
| ALL FORMS MUST BE COUNTERSIGNED WITHIN SEVENTY-TWO HOURS | (b)(6), (b)(7)(c) |
| PHYSICIAN: | (b)(6), (b)(7)(c) |
| DATE/TIME: | (b)(6), (b)(7)(c) |
## DETAINEE CLASSIFICATION SYSTEM - SECONDARY ASSESSMENT FORM

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<th>MANDZA, FJALIN-ALL</th>
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</tr>
<tr>
<td>Date of Birth</td>
<td>12/05/65</td>
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<tr>
<td>Country of Citizenship</td>
<td>GAB</td>
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<td>Classified By</td>
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<td>Language</td>
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<tr>
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<td>1/20/12</td>
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(b)(6), (b)(7)(C)

(b)(7)(C)
From: (b)(6), (b)(7)(c)
Sent: Tuesday, May 22, 2012 5:53 PM
To: (b)(6), (b)(7)(c)
Subject: FW: mandza

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

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<th>Removed</th>
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<td>01/18/2012 06:47:00</td>
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<td>01/18/2012 06:25:00</td>
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<td>105</td>
<td>01</td>
<td>12/29/2011 04:00:00</td>
<td>01/03/2012 13:06:00</td>
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<td>110</td>
<td>1HC</td>
<td>12/29/2011 03:43:00</td>
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<td>109</td>
<td>01</td>
<td>12/27/2011 17:17:00</td>
<td>12/29/2011 03:43:00</td>
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<tr>
<td>E1</td>
<td>NA</td>
<td>E</td>
<td>117</td>
<td>01</td>
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<td>A3</td>
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<td>206</td>
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<td>11/28/2011 16:05:00</td>
<td>12/25/2011 13:00:00</td>
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<tr>
<td>A3</td>
<td>NA</td>
<td>A</td>
<td>109</td>
<td>03</td>
<td>11/15/2011 19:06:00</td>
<td>11/28/2011 16:05:00</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td>A2</td>
<td>NA</td>
<td>A</td>
<td>201</td>
<td>03</td>
<td>10/24/2011 18:41:00</td>
<td>11/15/2011 19:06:00</td>
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</tbody>
</table>
**Progress Notes**

**Site:** Aurora / ICE Processing Center

<table>
<thead>
<tr>
<th>Detainee Name:</th>
<th>#</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DATE / TIME</th>
<th>PROGRESS NOTE</th>
<th>ORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/27/12 17:48</td>
<td>S+ NY Compl -</td>
<td>Glycine Supp.</td>
</tr>
<tr>
<td>WT 156.2</td>
<td>Nurse ongoing detainee care</td>
<td>Initially Bid</td>
</tr>
<tr>
<td>96.5, 16</td>
<td>decline color + fiber</td>
<td>X 3 cl</td>
</tr>
<tr>
<td>1/28/69 67</td>
<td>WDN X-Ray</td>
<td></td>
</tr>
<tr>
<td>&amp; 5th &amp; 7th</td>
<td>constipation non constp h Overlay</td>
<td>not noted at 0200</td>
</tr>
<tr>
<td></td>
<td>GLYCINE SUPPORT rectally</td>
<td>Bid x 3 cl</td>
</tr>
<tr>
<td></td>
<td>Counsel on fac present</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TY to constipation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>24° elevation V 1</td>
<td>30 (18) 0700</td>
</tr>
<tr>
<td>1/9/12 0900</td>
<td>Det c/o constipation - Last BM</td>
<td></td>
</tr>
<tr>
<td></td>
<td>was 2/3/12, + bowel sounds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>↑ discomfort - Given Dulcolax 10mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>po 1x dose, mom 30cc po 1x close</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and discharged back to dorm</td>
<td></td>
</tr>
</tbody>
</table>

Rev 01/05
Medical Request /
Solicited De Asistencia Medica

Date of request: 2/14/12
(Date favor marque uno)  
Medical Complaint  
Dental Complaint
Queja medica  
Queja Dental

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

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

Explique brevemente la razon de su solicitud. Permítan varios dias para que su solicitud sea procesada. Una copia de su solicitud se archivar en sus reorcrds. Prisioneros de habla hispana pueden solicitar dicha asistencia enespanol.

PROBLEM / QUEJA:
A Problem with my teeth

Inmate’s Signature / Firma del Preso

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

Date Received:  
(Stamp Date)

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

ACTION TAKEN:
YOU SEE DENTIST 2/14/12

Place on Sick Call List  
Date of Appointment:

Place on Dental List  
Date of Appointment:

Other (Explain):


Consent to Dental Procedures

Inmate Name: Evalin Mandza
Date of Birth: 12/5/65

I hereby authorize The GEO Group, Inc. and Dr. [Signature] his/her assistant(s) to treat me as is necessary in his/her judgment.

The procedure(s), Ext tooth # 18 necessary to treat my condition has been fully explained to me by Dr. [Signature] and I understand the nature of, and risks associated with, this procedure(s). Briefly stated, they are:

(Benefits)

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

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

Evalin Munanda
Signature of Inmate

D.O.M.D.
### Medical Request/
**Solicitada De Asistencia Medica**

<table>
<thead>
<tr>
<th>Date of Request:</th>
<th>3/1/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fecha de Solicitud:</td>
<td>3/1/12</td>
</tr>
</tbody>
</table>

(Please check one)

- [X] Oujea medica
- [ ] Oujea Dental

<table>
<thead>
<tr>
<th>Print:</th>
<th>EVELIN MANDZAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letra-Molde:</td>
<td>AB-110</td>
</tr>
<tr>
<td>Inmates Name/Nombre del Preso:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Complaint</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number/Numero:</td>
</tr>
<tr>
<td>Housing Location/Sitio de Vivienda:</td>
</tr>
<tr>
<td>Job Assignment/Asignacion de Trabajo:</td>
</tr>
<tr>
<td>Duty Hours/Horas de Trabajo:</td>
</tr>
</tbody>
</table>

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

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**PROBLEM/QUEJA:** Eyes problem, burning/congestion

---

**EVELIN MANDZAG**
Inmate’s Signature/Firma del Preso

---

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

<table>
<thead>
<tr>
<th>Date Received:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Stamp Date)</td>
<td></td>
</tr>
</tbody>
</table>

Date Reviewed: 3/3/12
- [ ] Written Response (see below)
- [X] Seen in Medical

**ACTION TAKEN:** Given Dulcolax, milk of magnesia, and artificial tears. Return to medical if symptoms persist/worsen

- [X] RN

- [ ] Placed on sick call list
- [ ] Placed on Dental list
- [ ] Other (Explain):

<table>
<thead>
<tr>
<th>Date of Appointment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/5/12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Appointment:</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Medical Staff Signature: RN

[3/3/12]

Date
HEALTH SERVICES
NURSING ASSESSMENT PROTOCOLS

ABDOMINAL PAIN/CONSTIPATION/DIARRHEA/INDIGESTION/VOMITING PROTOCOL

Chief Complaint: Constipation

Past Medical History:
- History of ulcers/ gallbladder disease/ appendicitis/ recent abdominal surgeries/ recent weight change (# lbs):
- No
- Time/Activity at onset: After eating, does pain increase/ decrease/ remain same:
- N/A
- Pain location:
- Amb/ Uncomfortable
- Radiation: Yes/No
- Duration: N/A
- Constant or intermittent:
- Alleviating factors:
- Colace

Circle one:
- Character: Cramping/ stabbing/ burning/ sharp/ dull
- Flatus: Yes
- Pain Intensity Scale 1-10: 7/10
- Last BM: Last Friday
- Consistency: Hard
- Amt: 5m
- Blood (if yes, red/ black/ or maroon, and amount): No

Self declared ER:
- Constipation: Yes
- Diarrhea (Frequency/ amount): No

true ER:
- Nausea/ vomiting: No
- Describe frequency/ amount/color: N/A
- Heartburn or indigestion: No
- Frequently/ Occasionally: N/A
- Degree: mild/ mod/ severe: N/A
- Urinary frequency: No
- Burning: No
- Penile discharge: No
- Low back pain: No
- Dietary habits: Fat intake:
- No more than: N/A
- Alcohol intake: No
- Caffeine intake: N/A
- Smoking habits: None
- O2 BP: 108/70
- P= 107
- R= 17
- T= 98.6
- WT: 160
- Bowel sounds: normal/ hyper/ absent
- Heard in all 4 quadrants: Yes
- Guarding: No
- Rebound tenderness: No
- Jaundice: No
- If states blood in stool, do hemocult. Results: N/A
- Pain location:
- Abdom: N/A
- Description of observed vomitus/stool: N/A
- More comfortable:
- Lying/ sitting/ standing: N/A
- Able to sit still: Yes
- Skin:
- Normal (warm & dry)/ pale/ flushed/ cyanotic/ diaphoretic
- Abdomen:
- Soft/ rigid
- Degree: mild/ moderate/ severe: No/Yes
- Bladder distended: No
- Evidence of dehydration/ GI bleeding:
- No
- If yes, orthostatic BP:
- N/A
- P= N/A
- Overall appearance:
- Acute distress/ mild distress/ severe distress:
- Obvious anxiety: N/A

A.)

P.) The Nurse may offer Patient the choice of Antacid, Milk of Magnesia, Kapectate, Emotrol,
- Peptobismuth, Dulcolax/ bulk laxative
- Type/ dose:
- Give according to label instructions.
- If vomiting or diarrhea, give clear liquid diet x 24 hrs and lay-in pass, unless otherwise ordered:
- No
- If blood in stool, vomiting, or severe diarrhea, place in infirmary/ observation, unless otherwise ordered:
- No

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

E.) Instructed to avoid spicy foods, eat small meals, chew slowly & thoroughly, and drink 6-8 glasses water daily:
- Yes
- Instructed not to lie down at least 2 hrs after eating:
- No
- Caution to quit smoking:
- No
- Instructed on stress relief measures, high fiber diet, and adequate exercise:
- Yes
- Return if symptoms persist/ worsen:
- Yes
- Innate verbalized understanding of above instructions:
- Yes

NAME: MANDZA, EVALIN
DOB: 12/5/1965
Nation: GABON
Arrival Date: 10/24/2011 17:05
Nursing Signature: (b)(6), (b)(7)(c)
### Progress Notes

**Site:** Aurora / ICE Processing Center  
**Detainee Name:** MANDZA, EVALIN  
**DOB:** 12/5/1965  
**Nation:** GABON  
**Arrival Date:** 10/24/2011 17:05

<table>
<thead>
<tr>
<th>DATE/TIME</th>
<th>PROGRESS NOTE</th>
<th>ORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/3/12</td>
<td>OS30. Det clo eyes burning. They are red with brown spots underneath the iris. He says have grown bigger. Pupils 2-3mm in size, equal and reactive to light. No vision changes. Given Artificial Tears KOP Return to medical if symptoms persist/worsen.</td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
</tbody>
</table>
| 3/5/12    | 1. Fiber optic BID (b)(7)(c) QD  
2. Cefzile 150mg PO BID (b)(7)(c) QD  
3. Cefzile 150mg PO BID (b)(7)(c) QD | (b)(6), (b)(7)(c) |
| 3/7/12    | MD Signature  
Date | (b)(6), (b)(7)(c) |

**Physical Exam:**  
- **Abdomen:** Soft, nontender  
- **Vaginal:**  
- **BP:** 120/80  
- **Ht:** 5'8"  
- **Wt:** 153 lbs  
- **Pct:** 72  
- **R:** 18  

**Laboratory:**  
- **CBC:**

<table>
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<th>ORDER</th>
<th>DATE</th>
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<tbody>
<tr>
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</table>
Medical Request/
Solicitado De Asistencia Medica

Date of request: 3/26/12
Fecha de Solicitud

(Please check one)
(Por favor marque uno)
Medical Complaint
□ Oueja medica
Dental Complaint
□ Oueja Dental

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

Housing Location/
Sitio de Vivienda

Job Assignment/
Asignacion de Trabajo

Duty Hours/
Horas de Trabajo

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PROBLEM/QUEJA: bad More problems / bumps Shower Problems

Evalin Manda
Inmate’s Signature/Firma del Preso

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

Date Received: ___________ (Stamp Date)
Date Reviewed: 3/26/12 04/15 □ Written Response (see below) □ Seen in Medical

ACTION TAKEN: M.O.M. 30cc po every X1 dose. Breakfast take:
po (now) X1 dose: M.O.M. 30cc po 4/5s X3 days po
(start 3/26/12) set: scheduled for mid: review

□ Placed on sick call list Date of Appointment: ___ / ___ / ___
□ Placed on Dental list Date of Appointment: ___ / ___ / ___
□ Other (Explain):

Medical Staff Signature

Date 3/26/12
Progress Notes

Site: Aurora
MANDZA, EVALIN
DOB: 12/5/1966 Nation: GABON
Arrival Date: 10/24/2011 17:05

DATE / TIME      PROGRESS NOTE      ORDERS

3/21/12  len. of "constipation" see med.  M.O.M. see
O 6/5 gain protocol. Med. current on  see Dr. 5/10 for constipation.  PROV.

3/21/12  Hx: constipation & stress. Rx well goals.

3/21/12  Q.N.V. Q.B. Blood Labs

3/21/12  Gen. med. ABG 3

3/21/12  ABG S/A P.R.S. 4

3/21/12  Constipation w/ palp.  TRIAL CL 100 mg

3/21/12  Chart

3/21/12  PRN 30 days

LE:  100 mg  P.O. q HS 7-7 days

LE:  100 mg  P.O. q HS 7-7 days

LE:  100 mg  P.O. q HS 7-7 days

LE:  100 mg  P.O. q HS 7-7 days
<table>
<thead>
<tr>
<th>DATE/TIME</th>
<th>PROGRESS NOTE</th>
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<tbody>
<tr>
<td>3/25/10 09:30</td>
<td>Made work, well on canteen. Recorded B/P of 118/70</td>
</tr>
<tr>
<td>3/25/10 9:30</td>
<td>VSS</td>
</tr>
<tr>
<td>3/25/10 9:30</td>
<td>Ab/P cast re pln lgt of</td>
</tr>
<tr>
<td>3/25/10 9:30</td>
<td>problems</td>
</tr>
<tr>
<td>3/25/10 12:05</td>
<td>1005 Noted</td>
</tr>
<tr>
<td>3/26/10 01:00</td>
<td>Male</td>
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</table>
**Medical Request/ Solicidad De Asistencia Medica**

<table>
<thead>
<tr>
<th>Date of request: 3/31/12</th>
<th>(Please check one)</th>
<th>Medical Complaint</th>
<th>Dental Complaint</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fecha de Solicitud</td>
<td>(Por favor marque uno)</td>
<td>Ojea medica</td>
<td>Ojea Dental</td>
</tr>
</tbody>
</table>

**Print:** Evalin Mandeza  
Letra-Molda  
Inmates Name/ Nombre del Preso: AY-110

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

Explique brevemente la razón de su solicitud. Permite varios días para que su solicitud sea procesada. Una copia de su solicitud será archivada en sus records. Prisioneros de habla hispana pueden solicitar dicha asistencia en español.

**PROBLEM/QUEJA:** NO MOVEMENT all weak, const.

**Evalin Mandeza**  
Inmate’s Signature/Firma del Preso

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

<table>
<thead>
<tr>
<th>Date Received:</th>
<th>(Stamp Date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Reviewed:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>X Written Response (see below)</td>
</tr>
<tr>
<td></td>
<td>X Seen in Medical</td>
</tr>
</tbody>
</table>

**ACTION TAKEN:** 
30cc PO OD pm x 1 - Mom
Dextrex tabs 15mg po bid x 1 - Mom

- [ ] Placed on sick call list  
- [ ] Placed on Dental list  
- [ ] Other (Explain): 

<table>
<thead>
<tr>
<th>Date of Appointment:</th>
<th>/   /</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Appointment:</th>
<th>/   /</th>
</tr>
</thead>
</table>

**Medical Staff Signature**

Date
**Health Services: Nursing Assessment Protocols**

**Abdominal Pain, Constipation, Diarrhea, Nausea, Vomiting Protocol**

<table>
<thead>
<tr>
<th><strong>TIME</strong></th>
<th><strong>ABDOMINAL PAIN/CONSTIPATION/DIARRHEA/NÜSSION/VOMITING PROTOCOL</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHIEF COMPLAINT:</strong> Constipation</td>
<td><strong>ALLERGIES:</strong> NA</td>
</tr>
<tr>
<td><strong>History of illness:</strong> Gallbladder disease/appendicitis/ Recent abdominal surgery/recent weight change (if any):**</td>
<td></td>
</tr>
<tr>
<td><strong>Patient's Activity at onset:</strong> After eating, does pain increase/decrease/remain same: <strong>NA</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Pain Location:</strong> N/A</td>
<td><strong>Radiation:</strong> yes/no</td>
</tr>
<tr>
<td><strong>Current medications:</strong></td>
<td><strong>Constant or intermittent?:</strong></td>
</tr>
<tr>
<td><strong>Complications:</strong></td>
<td><strong>Alleviating factors:</strong></td>
</tr>
<tr>
<td><strong>Diagnosis:</strong></td>
<td></td>
</tr>
</tbody>
</table>

| **CHARACTER:** | | |
| **Stools:** | | |
| **Consistency:** | | |
| **Blood:** | | |

| **SIMILARITY:** | | |
| **Last BM:** | | |
| **Consistency:** | | |
| **Blood:** | | |

| **SICK/ILL:** | | |
| **Constipation:** | | |
| **Diarrhea (Frequency/Amount):** | | |

| **WALKING:** | | |
| **Constipation:** | | |
| **Diarrhea (Frequency/Amount):** | | |

| **GI TRACT:** | | |
| **Fever:** | | |
| **Severe:** | | |

| **Diabetic:** | | |
| **Urinary frequency:** | | |
| **Burning:** | | |
| **Painful discharge:** | | |

| **DIET:** | | |
| **Fat intake:** | | |
| **Alcohol intake:** | | |
| **Caffeine intake:** | | |

| **SMOKING:** | | |
| **Nasty:** | | |
| **Normal:** | | |

| **BP:** | 130/80 | **P:** 68 | Normal/risk/bounding | **R:** | 80 | **T:** 98 | **WT:** 15.7 |

| **SICK/ILL:** | | |
| **Bowel sounds:** | | |
| **Normal:** | | |
| **Hypo:** | | |
| **Hyper:** | | |
| **Absent:** | | |

| **Rebound Tenderness:** | | |
| **Jaundice:** | | |
| **Abdominal distention:** | | |
| **Blood in stool:** | | |

| **PAIN LOCATION:** | | |
| **Location:** | | |

| **Description of observed symptoms/physical:** | | |
| **More uncomfortable:** | | |
| **Lying:** | | |
| **Sitting:** | | |
| **Standing:** | | |

| **More comfortable:** | | |
| **Sitting:** | | |
| **Standing:** | | |

| **Skin:** | | |
| **Normal:** | | |
| **Damp:** | | |
| **Painful:** | | |
| **Cyanotic:** | | |
| **Diaphoretic:** | | |

| **Abdominal:** | | |
| **Hard:** | | |
| **Soft:** | | |
| **Moderate:** | | |
| **Severe:** | | |

| **SICK/ILL:** | | |
| **High fever:** | | |
| **Fever:** | | |
| **Diabetes:** | | |

| **Evidence of dehydration:** | | |
| **Skin bleeding:** | | |
| **Overall appearance and acute distress:** | | |
| **Mild distress:** | | |
| **Severe distress:** | | |

| **A:** | | |
| **The Nurse may offer Patient the choice of Antacid, Milk of Magnesia, Kapectate, Evacetol,** | | |
| **Pepto Bismol, Dulcolax, bulk laxative** | | |

| **Abdominal pain, nausea, or vomiting:** | | |
| **Giving instructions:** | | |
| **If vomiting or diarrhea:** | | |
| **Give clear liquid diet x 24 hrs and lay-in peas, unless otherwise ordered:** | | |
| **If blood in stool, vomiting, or severe diarrhea, please keep N/A, unless otherwise ordered:** | | |

| **TREATMENT:** | | |
| **Do not feed:** | | |
| **Chow slowly & thoroughly:** | | |
| **Drink 6-8 glasses water daily:** | | |

| **Instructed not to lie down:** | Least 2 hrs after eating | **Caution to quit smoking:** | | |

**MANDZA, EVAHIN**

**DOB:** 12/5/1955  **Nation:**  **GABON**

| **Arrival Date:** | 10/24/2011 17:05 | **Signature:** | 4/11/12 | **(b)(6), (b)(7)(c)*** | **(b)(6), (b)(7)(c)*** |
Control Shift    Thursday

3:00:00  4/12/72
05:32 Standdown Code Black
05:41 Moving B/A & B from Intake
05:26 Emit on-site
06:13 Ent out site
06:50 1 A to Corros and Count remains the same 417
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>0100</td>
<td>Security check - All appear safe</td>
</tr>
<tr>
<td>0116</td>
<td>Count class with 420</td>
</tr>
<tr>
<td>0145</td>
<td>Work in to return for lunch break</td>
</tr>
<tr>
<td>0155</td>
<td>Do exits instead</td>
</tr>
<tr>
<td>0200</td>
<td>Security check - All safe and secure</td>
</tr>
<tr>
<td>0205</td>
<td>Security check - All safe and secure</td>
</tr>
<tr>
<td>0210</td>
<td>Security check - All appear safe</td>
</tr>
<tr>
<td>0220</td>
<td>Security check - All appear safe</td>
</tr>
<tr>
<td>0230</td>
<td>Security check - All appear safe</td>
</tr>
<tr>
<td>0240</td>
<td>Security check - All appear safe</td>
</tr>
<tr>
<td>0300</td>
<td>Security check - All appear safe</td>
</tr>
<tr>
<td>0310</td>
<td>Security check - All appear safe</td>
</tr>
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<td>0320</td>
<td>Security check - All appear safe</td>
</tr>
<tr>
<td>0330</td>
<td>Security check - All appear safe</td>
</tr>
<tr>
<td>0345</td>
<td>Security check - All appear safe</td>
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<tr>
<td>0415</td>
<td>Matron, Enron - A - return to B - B - 2</td>
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<tr>
<td>0500</td>
<td>Security check - All appear safe</td>
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<tr>
<td>0515</td>
<td>Matron, out to hospital</td>
</tr>
<tr>
<td>0600</td>
<td>Security check - All appear safe</td>
</tr>
<tr>
<td>0625</td>
<td>8 return to B - B - 2</td>
</tr>
<tr>
<td>0700</td>
<td>Matron, out to hospital</td>
</tr>
<tr>
<td>0800</td>
<td>Security check - All appear safe</td>
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Note: (b)(6), (b)(7)(c)
General Incident Report

The GEO Group, Inc. - Aurora/L.C.E. Processing Center

Subject: Please check one of the appropriate boxes
- Security Breach
- Rules Violation
- Detainee on Detainee Assault
- Detainee on Staff Assault
- Major Fire
- Minor Fire
- Self Harm
- Detainee Injury
- Maintenance
- Major Disturbance
- Minor Disturbance
- Contraband
- Hunger Strike
- Other: ________________________

To: MAJOR (b)(6), (b)(7)(c) Title: MAJOR Date: 4/12/12 Time: 0525
From: D/O (b)(6), (b)(7)(c) Title: D/O Location: A4 - 110/2

Detainee: MENDZA, EVALIN-ALI (b)(6), (b)(7)(c) Detainee: ________________________
Print Name ________________________ ID# ________________________ Dorm ________________________

Details of Incident

I D/O (b)(6), (b)(7)(c) was talking with Lt (b)(6), (b)(7)(c) while he was making
his rounds and the other Detainees in A4-110 got my attention
that in Detainee MENDZA, EVALIN-ALI (b)(6), (b)(7)(c) needed help
when I arrived at Room 110 A1J was complaining of chest pains
I instructed Lt (b)(6), (b)(7)(c) to call the Code Blue.

Code Blue called at 0525
Medical Arrived at 0528
Stand down from Code Blue 0533
Medical Departs with Detainee Mendza 0534

Supervisor's Assessment
(Please Print and Include: Date/Time, if AOD was notified, when and by whom)

REFER TO SUPERVISOR'S REPORT

Use of force Report submitted? [ ] Yes [ ] No

D/O (b)(6), (b)(7)(c)
Staff Signature And Printed Name and Title

Supervisor's Signature, Printed Name and Title, Date And Time
# SERIOUS INCIDENT REPORT

**04/12/2012 - 04/12/2012**

<table>
<thead>
<tr>
<th>Incident Date / Time:</th>
<th>4/12/2012 7:00:09AM</th>
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<tbody>
<tr>
<td>Facility:</td>
<td>Aurora/ICE Processing Center</td>
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<tr>
<td>Region:</td>
<td>Western Region</td>
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<td>Incident number:</td>
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<table>
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<tr>
<th>Assaults</th>
<th>Disturbances</th>
<th>Health Services</th>
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<tbody>
<tr>
<td>A1: Inmate/Staff</td>
<td>D1: Major Disturbance</td>
<td>H1: Death</td>
</tr>
<tr>
<td>A2: Inmate/Inmate</td>
<td>D2: Organized Inmate Resistance</td>
<td>H2: Inmate Suicide</td>
</tr>
<tr>
<td>A3: Minor Fight</td>
<td>D3: Inmate Hunger Strike</td>
<td>H3: Attempted Suicide</td>
</tr>
<tr>
<td></td>
<td>D4: Minor Disturbance</td>
<td>H4: Inmate Self Harm</td>
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<table>
<thead>
<tr>
<th>Escapes</th>
<th>Fire</th>
<th>Other</th>
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<tbody>
<tr>
<td>E1: Escape</td>
<td>F1: Major Fire</td>
<td>O1: Weapon Discharge</td>
</tr>
<tr>
<td>E2: Attempted Escape</td>
<td>F2: Minor Fire</td>
<td>O2: Serious Contraband</td>
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<tr>
<td>E3: Failure To Return</td>
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<tr>
<td>E4: Walk Away</td>
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<table>
<thead>
<tr>
<th>Use Of Force</th>
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<tbody>
<tr>
<td>U1: Major Use Of Force</td>
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<tr>
<td>U2: Minor Use Of Force</td>
<td>EMERGENCY MEDICAL TRANSPORT</td>
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<table>
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<tr>
<th>Number of Staff Involved:</th>
<th>5</th>
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<tbody>
<tr>
<td>Staff:</td>
<td>LT(R), (b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td></td>
<td>LPN, (b)(6), (b)(7)(c)</td>
</tr>
<tr>
<td></td>
<td>D/O, (b)(6), (b)(7)(c)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Inmates Involved:</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inmates:</td>
<td>MANDZA, EVALIN-ALI</td>
</tr>
<tr>
<td></td>
<td>(b)(6), (b)(7)(c)</td>
</tr>
</tbody>
</table>

## Incident Description:

At about 0525 hours, a Code Blue (medical emergency) was called by Lt (b)(6), (b)(7)(c) at A-4 Unit due to detainee Mandaz, Evalin-Ali (b)(6), (b)(7)(c) complaining of chest pains. Medical staff responded transporting detainee Mandaz, Evalin-Ali (b)(6), (b)(7)(c) via wheel chair to medical. Nurse (b)(6), (b)(7)(c) advised the detainee needed to be transported to the Aurora South Hospital for further medical examination.

## Immediate Action Taken:

Upon arrival in the medical department an assessment by RN (b)(6), (b)(7) was conducted. The determination to call 911 (ambulance) was requested and EMS arrived on site at about 0625 hours. Detainee was taken to the Aurora South Hospital ER for additional treatment.

## Follow-Up Information:

---

Report Created By: Lt (b)(6), (b)(7)(c)  
Report Transmitted On: 4/12/2012 12:02:03PM  
Reviewed By: Warden (b)(6), (b)(7)(c)
SUPERVISOR REPORT

Date: April 12, 2012

To: (b)(6), (b)(7)(c)
   Major
   Ward
   (b)(6), (b)(7)(c) AFA

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

From: (b)(6), (b)(7)(c) Lieutenant

RE: CODE BLUE IN A-4 UNIT

Detainee: Mandela Evalus-Ali
A # : (b)(6), (b)(7)(c)
DOB : 12-05-65
Country : GAB
Received Date: 10-24-11

At about 0525 hours a Code Blue (medical emergency) at A-4 Unit due to above listed detainee complaining of chest pains that would not stop.

Upon medical and additional staff support on scene, detainee was secured and moved to the medical unit via wheelchair for additional assessment by nurses.

At 0620 hours medical informed that 911 needed to be called in order to have detainee taken to Aurora South Hospital ER for additional treatment.

GEO Nurses (b)(6), (b)(7)(c) attended to the detainee's treatment.
EMS departed to hospital from the facility at 0644 hours.

ICE notifications were made by Nurse (b)(6), (b)(7)(c) to inform them of the emergency details.

GEO notifications were made by Lt. (b)(6), (b)(7)(c).

This report generated and S.I.R. filed by me.
<table>
<thead>
<tr>
<th>DATE / TIME</th>
<th>PROGRESS NOTE</th>
<th>ORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/12/12 05:25</td>
<td>Responded to code blue at housing unit 4. A found detainee lying on back (impaired) touching left chest area. Detainee alert and oriented, answers all questions appropriately. Skin wt, color, adequate, no respiratory distress noted. Reports chest pain 3-4/10, pain worse in respiration. Pulse ox on 2L 99%. Decided to move for transfer to medical unit.</td>
<td></td>
</tr>
<tr>
<td>05:28 Transfer to trauma room. On assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>154.84-68</td>
<td>Skin wt, color adequate, bilateral breath sound clear to base. All peripheral pulses palpable. 02 placed at 4L July 82-92%. Abdomen soft. Flat x-rays negative.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Last BM was on 4/19/10.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PIP 86 chest pain remains unchanged.</td>
<td></td>
</tr>
<tr>
<td>05/20 Dr. notified of detainee's medical status. Orders received on 06/02, IVS notified of detainee status.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/03</td>
<td>HSA notified of detainee status.</td>
<td></td>
</tr>
</tbody>
</table>
### Progress Notes

**Site:** Aurora / ICE Processing Center

<table>
<thead>
<tr>
<th>Detainee Name:</th>
<th>#</th>
<th>DOB</th>
<th>ORDERs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE / TIME</th>
<th>PROGRESS NOTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/10/02</td>
<td>Report called to medical center by attending physician.</td>
</tr>
<tr>
<td></td>
<td>MEDS given, EKG done by EMT. Transferred to MCA (ER).</td>
</tr>
<tr>
<td>0630-0640</td>
<td>EMS requested report given, EKG done by EMT. Transferred to MCA (ER).</td>
</tr>
</tbody>
</table>

**Rev 01/05**

HS-166
**General Incident Report**
The GEO Group, Inc. – Aurora/I.C.E. Processing Center

**Subject:** Please check one of the appropriate boxes
- Security Breach
- Rules Violation
- Detainee on Detainee Assault
- Detainee on Staff Assault
- Major Fire
- Minor Fire
- Detainee Injury
- Maintenance
- Self Harm
- Major Disturbance
- Contraband
- Hunger Strike
- Other: 

**To:** Warden
**From:**
**Title:**

**Date:** 4/12/12
**Time:** 09:30
**Location:** Medical

**Detainee:** MANZANA EVA
Print Name
ID#
Dorm

**Detainee:**
Print Name
ID#
Dorm

**Details of Incident**

- Detainee was found unresponsive in cell C9. He was later pronounced dead at 10:56 AM. The cause of death is currently under investigation.
- The medical examiner was notified at 11:23 AM.
- The scene was secured and the cell was evacuated.

**Supervisor's Assessment**
(Please Print and Include: Date/Time, if AOD was notified, when and by whom)

- The scene was secured and the cell was evacuated.
- The medical examiner was notified at 11:23 AM.

**Use of Force Report submitted?:** Yes
General Incident Report

Subject: Manza Evalin

Date: 4/12/12 Time: 0930

Details of Incident (Continued)

0600 Hrs, HSA notified of detainee status. Report called to Medical Director at Aurora E.R. 0630 Vs 19181-NR67
0630 EMS arrived. Report given. EMS doing their assessment. E.R. done by EMT. All care transfer
0632 Detainee transferred to MCA E.R. by EMS.

Supervisor's Assessment (Continued)
(Please Print and Include: Date/Time, if AOD was notified, when and by whom)
General Incident Report
The GEO Group, Inc. – Aurora/I.C.E. Processing Center

Subject: Please check one of the appropriate boxes
- Security Breach
- Rules Violation
- Detainee on Detainee Assault
- Detainee on Staff Assault
- Major Fire
- Minor Fire
- Self Harm
- Detainee Injury
- Med. Emergency
- Maintenance
- Major Disturbance
- Minor Disturbance
- Contraband
- Hunger Strike
- Other: ____________________________

To: (b)(6), (b)(7)(c)
From: (b)(6), (b)(7)(c)
Title: Warden
Date: 4-17-12
Time: 0930
Location: Medical Dept.

Detainee: MANDA EVELIN A
Print Name: ____________________________
ID#: ____________________________
Dorm: ____________________________

Detainee: ____________________________
Print Name: ____________________________
ID#: ____________________________
Dorm: ____________________________

Details of Incident

This writer, Nurse LPN responded to code blue in housing unit A-4 Det # (b)(6), (b)(7)(c) was laying in bed on back holding left chest area with complaints of chest pain. Det was alert oriented. Pulse at 94, BP 0, Res 20 on room air at that time (0925)

0925 Detaine # (b)(6), (b)(7)(c) was transferred by W/O to medical unit trauma room for assessment. Respiratory assessment done by Nurse (b)(6), (b)(7)(c) R.N. Det. then started on ne humeral canula at 4 liters. EKG done by Nurse (b)(6), (b)(7)(c) R.N. Det# (b)(6), (b)(7)(c) was noted to have chest pain 8/10 Dr (b)(6), (b)(7)(c) pulled report on Detaine's status given - orders received per MD to send to hosp. At this time I nurse (b)(6), (b)(7)(c) completed transfer form & notified watch commander (b)(6), (b)(7)(c) of transfer to hosp. per M.D. orders.

0120 W.V.S. 139, 81 Heart rate 67 pulse of 100, 02/11 11:41

Supervisor's Assessment
(Please Print and Include: Date/Time, if AOD was notified, when and by whom)

Use of force Report submitted?: □ Yes □ No
**Details of Incident (Continued)**


<table>
<thead>
<tr>
<th>(b)(6), (b)(7)(c)</th>
<th>(b)(6), (b)(7)(c)</th>
<th>(b)(6), (b)(7)(c)</th>
<th>(b)(6), (b)(7)(c)</th>
<th>(b)(6), (b)(7)(c)</th>
<th>(b)(6), (b)(7)(c)</th>
<th>(b)(6), (b)(7)(c)</th>
<th>(b)(6), (b)(7)(c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0630 EMS arrived - report given on detainee # (b)(6), (b)(7)(c)</td>
<td>0632 Detainee # (b)(6), (b)(7)(c) transferred by EMS per stretch</td>
<td>0633 Detainee was notified. Major will notify warden (b)(6), (b)(7)(c)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Supervisor's Assessment (Continued)**

(Please Print and Include: Date/Time, if AOD was notified, when and by whom)
ICE/ERO/IHSC
CDR (b)(6), (b)(7)(c)
Field Medical Coordinator – Denver Field Office
12445 E. Caley Avenue
Centennial, CO 80111
720-873- (office)
202-321- (BB)
8-66-311-0973 (Secure Fax)
(b)(6), (b)(7)(c)

fax

TO: Rural/Metro
FROM: CDR (b)(6), (b)(7)(c)

FAX: 
PAGES: 2

PHONE: 303-321- (e)(4)
DATE: 5/14/2012

RE: Mandza, Evalin-Ali
DOB: 12/05/1965

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments: Please provide copies of the ambulance report. Transport took place 4/12/2012. Thanks
**RURAL METRO OF CNTRL COLORADO**
P O BOX 52202
PHOENIX AZ 85072-2202

**MENDICINO, EVELYN**
1419 DETROIT ST APT 24
DENVER CO 80206-2441

**AMOUNT COLLECTED:**
$1,316.31

**FROM:** 3130 OAKLAND ST
**TO:** AURORA SOUTH CAMPUS

**Federal Employer ID:**
(b)(6), (b)(7)(c)

---

**INVOICE DATE:** 5/14/12

<table>
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<tr>
<th>CALL SOURCE</th>
<th>AURORA FIRE DEPARTMENT</th>
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<tbody>
<tr>
<td>PROM</td>
<td>3130 OAKLAND ST</td>
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<tr>
<td>TO</td>
<td>AURORA SOUTH CAMPUS</td>
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<td>PULSE OXIMETER PROBE</td>
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**TOTAL PAID:** $0.00
**TOTAL CHARGES:** $1,316.31

**AMOUNT DUE:** $1,316.31

---

**INQUIRIES CALL:** 303/367-7169, 888/876-1814

**NOTE:** PLEASE READ FINANCIAL POLICY ON BACK

**Federal Employer ID:**
(b)(6), (b)(7)(c)
**Patient Care Report**

Run Number: 20263
Date of Service: 05/12/2012
Patient Name: Evalin Manza
Triage Tag #:  

**Chief Complaint**
- Chest Pain
- Note: History during ambulanc travel

**Medication**
- Other: None Listed
- None

**Past Medical History**
- Other: None
- None

**ASSESSMENTS**

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<thead>
<tr>
<th>Body Area</th>
<th>Assessment</th>
<th>Body Area</th>
<th>Assessment</th>
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</thead>
<tbody>
<tr>
<td>Airway</td>
<td>Patent</td>
<td>Breathing</td>
<td>Normal Respirations</td>
</tr>
<tr>
<td>Central Nervous System</td>
<td>Nausea, Vomiting and Malfunction Normal</td>
<td>Blood-Pressure</td>
<td>None Noted</td>
</tr>
</tbody>
</table>
| ALS Assessment | ALS Assessment Performed for Chest Pain/Dizziness  

**IMPRESSION**
- Chest Pain/Discomfort
- Pain moves from upper chest through the chest into the arms; Possible indications

**TREATMENT**

<table>
<thead>
<tr>
<th>Time</th>
<th>PTA</th>
<th>BP</th>
<th>Pulse</th>
<th>Respiratory</th>
<th>TPower</th>
<th>FGPO</th>
<th>Glucose</th>
<th>JU</th>
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<tr>
<td>05:20</td>
<td>140/90</td>
<td>72, Normal</td>
<td>22, Normal</td>
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<tr>
<td></td>
<td>Auscultated</td>
<td>Regular</td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Complaint**
- Aurora Fire

05:44 | 142/90 | 72, Normal | 30, Normal | NPO, Seated |        |       |         |     |
|      | Machine | Regular |          |            |        |      |         |     |


**Complaint**
- (b)(4), (b)(7)(b)
**Patient Care Report**

**Run Number:** 29253  
**Date of Service:** 04/12/2012  
**Patient Name:** Evelyn Mauta  
**Trip Tag #:**

**Treatment Summary**

<table>
<thead>
<tr>
<th>Time</th>
<th>PTA</th>
<th>Treatment</th>
<th>Who performed</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>08:00</td>
<td>PTA</td>
<td>Triage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>08:30</td>
<td>PTA</td>
<td>Oxygen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>08:30</td>
<td></td>
<td>Euvacutar Carvera</td>
<td></td>
<td></td>
</tr>
<tr>
<td>08:30</td>
<td></td>
<td>Indication: Related to chief complaint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>08:30</td>
<td></td>
<td>Patient LPN</td>
<td></td>
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<tr>
<td>08:30</td>
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<td>Could pt self administer G27000</td>
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<tr>
<td>08:31</td>
<td>PTA</td>
<td>TEE/ECG Monitor</td>
<td></td>
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<tr>
<td>08:31</td>
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<td></td>
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<tr>
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<td>ECG Artifact</td>
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<tr>
<td>08:31</td>
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<td>Indication: Chest Pain</td>
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<td>08:31</td>
<td></td>
<td>12-Lead Performance: Yes</td>
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**Treatments**

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<td>SpO2 Monitor</td>
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<td>08:31</td>
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<td>SpO2 Monitor: Related to chief complaint</td>
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<td>Aspirin</td>
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<td>Dosage: PO 30 mg chewable ASA</td>
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<td>08:47</td>
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<td>Result: No Change</td>
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<tr>
<td>08:55</td>
<td>PTA</td>
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<tr>
<td>08:55</td>
<td></td>
<td>ECG Artifact</td>
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<td>Indication: Chest Pain</td>
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<tr>
<td>08:55</td>
<td></td>
<td>12-Lead Performance: Yes</td>
<td></td>
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</tr>
</tbody>
</table>

**Narrative**

At 08:00 dispatch to chest pain, 08:30 pt found lying supine on exam table in facility (E.M.). Pt: chest pain.

Pt states he feels a pain this morning. Pt describes that pain as a burning sensation that moves from his upper abdomen through his chest and up into his throat. Pt states that he did eat soup and hot peppers last night. Pt denies any recent trauma or illness. Pt denies any drug or alcohol use.

Pt: AAD (personal, place, time, events). CMCLE: Breath sounds clear and equal bilaterally. Chest wall intact, increased pain on palpation of chest. No cardiac murmur. IPT: ECG and intubation. Pt: PPE, PA, CHEST X-RAY, EKG, and UA. No abdominal or right, increased pain on palpation of bilateral upper quadrants.

**Charges**

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<td>PPE On Monitor 11812875</td>
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### Patient Care Report

**Rural/Metro Ambulance**
3250 Peoria Street, Suite 100
Aurora, CO 80010
303 241-5878

**Prado's Emergency Service**
520 W 5th Ave
Aurora, CO 80012
303 438-5920

---

**Run Number:** 20243
**Date of Service:** 04/12/2012
**Patient Name:** Evelyn Minna
**Triage Tag #:**

---

**Medical Necessary**

- Prescribed by: ____________
- Given By: ____________
- Patient accepted on own power
- Patient refused: ____________

---

**PHN:**

**Time** | **Type**  | **Who signed** | **Who refused did not sign** | **Received Facility Signature**
---|---|---|---|---
04/12/2012 07:00 | Facility Acceptance | (b)(6), (b)(7)(c) | (b)(6), (b)(7)(c) | (b)(6), (b)(7)(c)

---

**Patient Unable to Sign/CHEWS Auth Rep**

**Time** | **Type**  | **Crew Member #:** | **Chefs #:** | **Refused** | **Chefs #:** | **Signature:** | **Date:** | **Chefs #:** | **Signature:**
---|---|---|---|---|---|---|---|---|---
04/12/2012 07:13 | Patient Unable to Sign/CHEWS Auth Rep | (b)(6), (b)(7)(c) | (b)(6), (b)(7)(c) | Refused | (b)(6), (b)(7)(c) | (b)(6), (b)(7)(c) | (b)(6), (b)(7)(c) | (b)(6), (b)(7)(c) | (b)(6), (b)(7)(c)

---

**Crew Information**

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<th>Crew #</th>
<th>Name</th>
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<td>(b)(6), (b)(7)(c)</td>
<td>00021553 - EMT</td>
<td>(b)(6), (b)(7)(c)</td>
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---

**Page 4 of 4**
Incident Information

Incident Location 3130 N Oakland Street (80011)
Incident Date 04/12/2012
Time of Call 08:21:46
Shift B Shift

Incident Time Log

<table>
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<tr>
<th>Unit</th>
<th>Dispatched</th>
<th>Responding</th>
<th>On Scene</th>
<th>To Hospital</th>
<th>At Hospital</th>
<th>In Service</th>
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</thead>
</table>

Patient Information

Age 46 Years
Gender Male
Ethnicity Black, non-Hispanic

Patient Hx

History Source Patient
Patient Weight 150 Pounds (Approx)

Current Medications
The patient denies taking any medications currently.

Allergies
The patient denies having any known allergies.

Medical History
The patient has a history of constipation.

Barriers to Patient Care
None

Advance Directives
None

Alcohol / Drug Use Indicators
None

This Encounter

Classification Medical
Onset of Symptoms 2 Hours
1st Patient Contact 04/12/2012 08:28

Provider's Impression
Chest pain and Heartburn / Indigestion

Disposition Transported by Rural/Metro, no AFD
Initial Condition Green (Good)

Cardiac Arrest No

Printed on 05/04/2012 at 15:00:49
PE3 was dispatched to chest pain.

C-- U/a at the immigration detention facility, we located the Pt in an examination room lying supine on an examination table. Scene secure. Pt is a 46 y/o male who is conscious and alert. Pt states a CC of midline chest pain.

H-- Pt states medical hx, no current medications and nkda's. Pt states he hasn't had a bowel movement in the past four days. Pt states he ate a bowl of soup last night, that contained a large amount of hot chilli peppers. O- Two hours ago, Pt woke up from sleep with current pain. P- pain is reproducible upon movement, and chest wall palpation. Q- Pt states it is a burning sensation. R- Pt states the burning travels from his upper abd, to his esophagus. S- 9 out of 10. Pt denies nausea/vomiting. Pt states no diaphoresis.

A-- General Impression: Pt is conscious and is responsive to verbal questioning. Pt is showing no
signs of pain or respiratory distress. ABC’s open/patent, increased/unassisted, skin warm and dry, radial pulse strong and regular, heent clear, chest wall stable rise and fall equal, breath sounds clear and equal bilateral, abd soft non-tender, pelvis stable, moex4, gcs=15, vitals as recorded. Pt was placed onto 4 ipm O2 prior to our arrival by facility nurse. 12 lead ECG revealed a Sinus Rhythm, no ST segment elevation or ectopic beats observed. Pt was packaged onto the pram and removed from the facility. Pt was secured into RM 101 for non-emergent transport to TMCA South due to AIP diversion. Immigration detention officer accompanied RM 101. Pt states no further complaints.

R-- See Treatment.

T-- See Encounter. Upon release of care Pt’s condition had remained unchanged.

--END OF STATEMENT--

Submitted by:

Fire Medic: (b)(6), (b)(7)(C)

OIC:

Capt. (b)(6), (b)(7)(C)

Report completed by: (b)(6), (b)(7)(C) on 04/12/2012 at 08:24:48
General Incident Report
Aurora/I.C.E. Processing Center

Subject: Please check one of the appropriate boxes
- Security Breach
- Major Fire
- Minor Fire
- Major Disturbance

- Rules Violation
- Contraband
- Maintenance
- Minor Disturbance

- Hunger Strike
- Self Harm
- Detainee Injury
- Medical Emergency

To: (b)(6), (b)(7)(c)
From: (b)(6), (b)(7)(c)
Title: Major
Title: Transport Officer
Date: 04/12/12
Location: The Medical Center of Aurora
Time: 0633

Detainee: Mandza, Evalin
Name: (b)(6), (b)(7)(c)
ID: Dorm

Detainee: 
Name: ID: Dorm

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

On the above date and approximate time this Transport Officer (b)(6), (b)(7)(c) and Transport Officer (b)(6), (b)(7)(c) were notified by Lt. (b)(6), (b)(7)(c) to go on a emergency medical transport for detainee#A (b)(6), (b)(7)(c) Mandza Evalin. I rode in the ambulance (Aurora Metro) with detainee Mandza Evalin. Transport Officer (b)(6), (b)(7)(c) followed the ambulance in vehicle 69806. At approximate 0657 hours, we arrived at The Medical Center of Aurora. Detainee mandza was moved to emergency room #17. Detainee Mandza was examined by medical staff and Dr. (b)(6), (b)(7)(c). At approximately 0735 hours, detainee Mandza was moved to Cath Lab #4 for a Cardiac Catheterization procedure. At 0755 hours medical staff started giving Mandza chest compressions with negative results. At 0833 hours, nurse (b)(6), (b)(7)(c) and Dr. (b)(6), (b)(7)(c) pronounced detainee Mandza Evalin dead. At 0940 hours, detainee Mandza Evalin was moved to the mortuary of the hospital. End of report.

Supervisor’s Assessment
Please Print and Include: Date/Time, whether AOD was notified, when, and by whom.

Use of Force Report submitted?: □ Yes ☑ No

Signature and Printed Name and Title

Page 1 of 1
General Incident Report
Aurora/I.C.E. Processing Center

Subject: Please check one of the appropriate boxes
- Security Breach
- Major Fire
- Minor Fire
- Major Disturbance
- Rules Violation
- Contraband
- Maintenance
- Minor Disturbance
- Hunger Strike
- Self Harm
- Detainee Injury
- Detainee on Detainee Assault
- Detainee on Staff Assault
- Other

To: (b)(6), (b)(7)(c)
Title: Major
Date: 4/12/12
Time: 0633

FROM: (b)(6), (b)(7)(c)
Title: T/O
Location: The Medical Center of Aurora

Detainee: Mandza, Evalin
Name
ID
Dorm

Detainee
Name
ID
Dorm

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

On 04/12/12 at approximately 0633 myself and T/O (b)(6), (b)(7)(c) where notified by Lt. (b)(6), (b)(7)(c) of an emergency medical transport to The Medical Center of Aurora for detainee Mandza, Evalin (b)(6), (b)(7)(c). Detainee was transported via ambulance (Aurora Metro). Officer (b)(6), (b)(7)(c) rode in the ambulance with him, while I followed in vehicle 69806. Upon arrival at the hospital detainee was moved to emergency room #17. Dr. (b)(6), (b)(7)(c) conducted several medical evaluations and moved detainee Mandza to Cardiac Cath Lab #4 for a Cardiac Catheterization. While being worked on at approximately 0755 hours, a team of medical staff began to conduct chest compressions with negative results. At 0833 hours detainee Mandza, Evalin was pronounced dead by medical personnel (Nurse (b)(6), (b)(7)(c) and Dr. (b)(7)). At 0940 the body of detainee Mandza was moved to the mortuary of the hospital. ///End of Report///.

Supervisor's Assessment
Please Print and Include: Date/Time, whether AOD was notified, when, and by whom.

Use of Force Report submitted?: □ Yes ☑ No

Transport Officer

Staff Signature and Printed Name and Title

Supervisor's Signature, Printed Name and Title, Date & Time

Page 1 of 2
LEADING HOSPITALS, TRUSTED CARE.

RELEASE OF INFORMATION

303-695 - MEDICAL CENTER OF AURORA
303-450 - NORTH SUBURBAN
303-839 - PRESBYTERIAN/ST. LUKES
303-320 - ROSE MEDICAL CENTER
720-225 - SKY RIDGE
303-363 - SPALDING REHAB
303-788 - SWEDISH/SOUTHWESTER
720-279-6593 - FAX

FACSIMILE TRANSMITTAL SHEET

TO: CDR    FROM: (b)(6), (b)(7)(c)
COMPANY:    DATE: 05/04/2012 11:38
FAX NUMBER: 18663110973    TOTAL NO. OF PAGES INCLUDING COVER:
RE: SENDER'S REFERENCE NUMBER:

NOTES/COMMENTS:
☐ REQUESTOR VERIFIED
☐ PATIENT VERIFIED
☐ FAX NUMBER VERIFIED

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THE MEDICAL CENTER OF AURORA
South Campus  
1501 South Pontiac  
Aurora, CO 80012  

North Campus  
700 Pontiac  
Aurora, CO 80011  

Centennial Medical Plaza  
14200 East Arapahoe Road  
Englewood, CO 80112  

PATIENT NAME: MANDZA, EVALIN  
ACCT #: E40000734489  
MR #: E0011113503  
LOCATION: E.SURGIN  

ATTENDING PHY:  
ADMITTING PHY:  

CARDIAC CATH LAB  

Case No.: 42299  
ADMISSION DATE: 04/12/2012  
PROCEDURE DATE: 04/12/2012  

CARDIOLOGIST:  

PROCEDURE:  
Coronary catheter insertion, coronary cineangiogram, drug-eluting stent to the left main coronary artery and PICA of the left anterior descending artery.  

INDICATION:  
Acute anterior myocardial infarction.  

Procedure as an emergency.  

DESCRIPTION OF PROCEDURE:  
The patient was brought to the cardiac catheterization laboratory and quickly prepped and draped in the usual sterile fashion. A 6-French sheath was placed in the right femoral artery, a 6-French XB 3.5 guiding catheter was positioned. A Prowater flex guidewire was positioned down the left anterior descending artery. A 2.5 x 12 mm TRED angioplasty catheter was positioned across the total occlusion and inflated to 12 atmospheres for 10 seconds. The angioplasty catheter was then removed. The patient then went into ventricular tachycardia and then a PEA arrest. ACLS protocol was begun, including CPR cardioversion. Of note is that the patient had received an Angiomax bolus and infusion prior to the balloon inflation. The patient received 3 mg of epinephrine IV. The guiding catheter was pulled back. The patient then developed a blood pressure of close to 200 and a heart rate of at least 140. This was transient. The guiding catheter was then removed and a 6-French JL4 guiding catheter was positioned in an effort to try and not have the guiding catheter into the left main as it was realized this was the source of the embolus to the left anterior descending artery and there was a severe stenosis there. We were not able to visualize the left main with this catheter and this had to be removed. An aortic root shot injection was performed which still did not show any filling into the left coronary artery. This guiding catheter was then removed and an XB 3.5, 6-French guiding catheter was then repositioned. During this time, the patient received continued CPR. He required multiple defibrillations at 360 joules in an attempt to revive him.  

PATIENT NAME: MANDZA, EVALIN  
ACCOUNT #: E40000734489  

Denver Patient Care Inquiry (PCI: OE Database COCAA)  
Run: 05/04/12-11:35 by  
Page 1 of 3
Also of note is that a 7-French sheath was placed in the left femoral vein in an attempt to access the artery and place a balloon pump. The artery was never able to be accessed on that side and the balloon pump was unable to be placed. A temporary pacemaker wire was positioned.

A second 6-French XB 3.5 guiding catheter was then positioned to replace the Judkins catheter, and the Prowater flex guidewire was positioned down the left anterior descending artery, and a Runthrough guidewire was positioned down the circumflex artery which now also had an embolus in it, presumed from the left main ostium. A Xience 3.5 x 12 mm stent was positioned across the ostium with restoration of patency; however, by this point the distal arteries had at best TIMI 1 flow and ultimately had TIMI 0 flow. No further interventional maneuvers were then able to be performed. The patient received a final defibrillation of 360 joules but had no electrical activity. Because of the embolization into 2 arteries and now the TIMI 0 flow throughout the whole left coronary system despite a patent left main coronary artery, it was felt he had microvascular thrombosis and there was no hope for resuscitation. The patient was then pronounced dead at 8:38 am on 04/12/2012.

Procedure time: 52 minutes
Fluoro time: 11.5 minutes
Contrast: 100 mL Iovue
Fluids: 1000 mL normal saline

MEDICATIONS ADMINISTERED:
Fentanyl 50 mcg IV
Versed 1 mg IV
Benadryl 25 mg PO
Epinephrine 1 mg IV x6
Angiomax bolus 11 mL, plus drip 250 mg/50 mL NS @ 26 mL/hr
Sodium Bicarbonate 1 mEq x2
Calcium Chloride 1 mg IV
Amiodarone 150 mg IV

FINAL DIAGNOSES:
1. Successful stent placement to the left main coronary artery.
2. Unsuccessful percutaneous intervention of the left anterior descending artery, which was felt to have been occluded from an embolization from the left main.
3. Unsuccessful resuscitation of the patient due to no flow into the entire left coronary circulation due to a combination of embolization from the left main and thrombosis of the microcirculation due to no flow and prolonged CPR.
THE MEDICAL CENTER OF AURORA

South Campus
1501 South Potomac
Aurora, CO 80012

North Campus
700 Potomac
Aurora, CO 80011

Centennial Medical Plaza
14200 East Arapahoe Road
Englewood, CO 80112

PATIENT NAME: MANDZA, EVALIN
ACCT #: E40000734489 MR #: E001113503
LOCATION: E.ERHOLD

ATTENDING PHY: (b)(6), (b)(7)(c)
ADMITTING PHY: (b)(6), (b)(7)(c)

HISTORY & PHYSICAL REPORT

ADMISSION DATE: 04/12/2012

REASON FOR ADMISSION:
Acute anterior MI.

HISTORY OF PRESENT ILLNESS:
The patient is a 46-year-old gentleman whose history was limited as the patient was in severe pain and not very communicative. He apparently had chest pain starting at 4 o'clock this morning while he was in the detention center. The pain was obviously severe and an EKG was eventually done there at 5:45. He was transported here because of ongoing pain. Upon arrival here, he was found to have evidence of an acute anterior MI and a cardiac alert was called.

The patient's history again is very limited. He denies having similar chest pain or any heart problems. He denies any medical problems.

MEDICATIONS:
He takes no medications.

ALLERGIES:
NONE.

REVIEW OF SYSTEMS:
Cannot be done.

PHYSICAL EXAMINATION:
GENERAL: He is a well-nourished gentleman. He is in extreme chest pain.
VITAL SIGNS: 149/97, pulse is 53 plus metoprolol.
HEENT: Normal.
SKIN: Warm and dry. JVP is 5.
CHEST: Clear to auscultation.
CARDIAC EXAM: Revealed a 4th heart sound, without murmurs or gallops.
ABDOMINAL: With no masses, tenderness or organomegaly.
NEURO: Good pulses in his feet, groin and hands. They were all equal.

PATIENT NAME: MANDZA, EVALIN
ACCOUNT #: E40000734489

Denver Patient Care Inquiry (PCI: OE Database COCAA)
Run: 05/04/12-11:35 by (b)(6), (b)(7)(c)
LABORATORIES:
Potassium of 3, BUN of 7, creatinine 1.

IMPRESSION:
The patient is a 46-year-old gentleman with no apparent risk factors. He is
having an acute anterior myocardial infarction. He will report to the Cath
Lab. We will treat it with beta blockers, aspirin, statin and a platelet
inhibitor.

CONDITION AT THE TIME OF ADMISSION:
Guarded.

D: 04/12/2012 07:40:04 / T: 04/12/2012 08:19:23
Job #: 863240/509465129

Electronically Signed by on 04/20/12 at 0656

PATIENT NAME: MANDZA, EVALIN
ACCOUNT #:E400000734489

Denver Patient Care Inquiry (PCI: OE Database COCAA)
Run: 05/04/12-11:35 by
THE MEDICAL CENTER OF AURORA

South Campus North Campus Centennial Medical Plaza
1501 South Potomac 700 Potomac 14200 East Arapahoe Road
Aurora, CO 80012 Aurora, CO 80011 Englewood, CO 80112

PATIENT NAME: MANDZA, EVALIN
ACCT #: E40000734489 MR #: E001113503
LOCATION: E.SURGIN

ATTENDING PHY: (b)(6), (b)(7)(c)
ADMITTING PHY:

ED TSYSTEMS DOCUMENTATION

Patient: MANDZA, EVALIN  Clinical Report - Physicians/Mid Levels
MRN: E001113503 The Medical Center of Aurora
VisitID: E40000734489 1501 South Potomac St., Aurora, CO 80012 303-695-2628
46y, M Arrival Date/Time: 04/12/2012 6:58
DOB: 12/05/1965

Arrived- By private vehicle. Historian- patient.

HISTORY OF PRESENT ILLNESS
CHEST PAIN. This started 4:00 and is still present. It was abrupt in onset.
Onset during light activity. It is described as "pain" and it is described
as located in the central chest area. No radiation. At its maximum,
severity described as 10 / 10. When seen in the E.D., severity described as
10 / 10. Modifying factors- Not worsened by anything. Not relieved by
anything. He has had difficulty breathing. No nausea, vomiting or
diaphoresis.

Similar symptoms previously: None.

Recent medical care: Not recently seen/assessed.

REVIEW OF SYSTEMS
No chills, fever, decreased vision, hearing loss or nasal congestion. No
runny nose, sore throat, calf pain, chest pain or cough.

PAST HISTORY
Negative.

Denies the following risk factors for heart disease - hypertension, smoking,
diabetes, elevated cholesterol and family history of heart disease. Denies
the following risk factors for DVT/PE - history of DVT and pulmonary embolism
and recent surgery.

Medications:
None..
Allergies:
No Known Drug Allergy..

PATIENT NAME: MANDZA, EVALIN  ACCOUNT #:E40000734489

Denver Patient Care Inquiry (PCI: OE Database COCAA)
Run: 05/04/12-11:35 by (b)(6), (b)(7)(c)
SOCIAL HISTORY
Never smoked. No alcohol use or drug use.

ADDITIONAL NOTES
The nursing notes have been reviewed.
Weight: 79.3 kg estimated. Height: 72 inches Estimated. BMI: 23.7.

PHYSICAL EXAM
Appearance: Alert. Appears to be in pain.
Eyes: Pupils equal, round and reactive to light.
ENT: Pharynx normal.
Neck: Neck supple.
CVS: Normal heart rate and rhythm. Heart sounds normal.
Respiratory: No respiratory distress. Breath sounds normal.
Abdomen: Soft and nontender.
Back: Normal external inspection.
Skin: Skin warm and dry. Normal skin color.
Extremities: Extremities exhibit normal ROM.
Neuro: Oriented X 3. No motor deficit. No sensory deficit.

LABS, X-RAYS, AND EKG
EKG: EKG time (7:10). Rate: 96. Normal P waves. Normal QRS complex. ST elevation in lead V2, V3, V4 and V5. The study has been interpreted contemporaneously by me. The study has been independently viewed by me. The EKG appears to be a good tracing.
Laboratory Tests: 0412:AA:BG00055R: (COLL: 04/12/2012 07:21) (MagRcvd 04/12/2012 07:34) Final results

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0412:AA:BG00054R: (COLL: 04/12/2012 07:26) (MagRcvd 04/12/2012 07:29) Final results

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<td>GFR NON-AFRICAN AMER. PATIENT</td>
<td>&gt;60</td>
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0412:AA:CG00059S: (COLL: 04/12/2012 07:15) (MagRcvd 04/12/2012 07:42) Final results

<table>
<thead>
<tr>
<th>Laboratory Test</th>
<th>Value</th>
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<tbody>
<tr>
<td>PATIENT NAME: MANDZA, EVALIN</td>
<td>ACCOUNT #:E40000734489</td>
</tr>
</tbody>
</table>
PROTHROMBIN TIME PATIENT 10.9
INTERNATIONAL NORMAL RATIO 1.0
PARTIAL THROMBOPLASTIN TIME 22

0412: Aa: H00140R: (COLL: 04/12/2012 07:15) (MsgRcvd 04/12/2012 07:28)
Final results

Laboratory Test Value
SPECIMENS REC'D-NO ORDERS

PROGRESS AND PROCEDURES
Course of Care: Pt arrived by EMS as abdominal pain, neg EKG in ICE
detention. EKG done at facility reported as neg..

7:11 EKG shown to me by Nursing staff. I immediately go to the bedside. Pt
is not answering questions. Is writhing in pain, pointing to his chest.
After several minutes of questions pt is still not answering questions.
There are no language barriers.

Cardiac alert called by me at 7:17. Pt is finally answering questions after I
told him that he is having a heart attack, and I need him to answer my
questions in order for me to help him. At this time pt is providing minimal
history. Pt has received ASA and metoprolol. Discussed with Dr. .
One of his partners will see Pt in ER.

Dr. at bedside. i-stat noted, not hyperkalemic.

Pt to cath lab..

Critical care performed (35 minutes). Time is exclusive of separately
billable procedures. Time includes: direct patient care, patient
reassessments, interpretation of data (chest x-rays), review of patient's
medical records, medical consultation and documentation of patient care- see
progress notes.

Clinical Review This patient definitively has Acute Coronary Syndrome.
ECG interpretation documented.
Antiplatelet medications administered.
Reperfusion therapy initiated.
Consultation obtained from cardiologist.
Chest pain precautions provided to patient.

Disposition: Admitted.

CLINICAL IMPRESSION
Acute myocardial infarction with ST elevation (STEMI). Aspirin administered
in ED.
Any laboratory data incorporated in this document has been entered by the emergency clinician and may have been summarized or otherwise modified. The original full report is available in Meditech. Please refer to PCI for the performing site information.

Patient: MANDZA, EVALIN Clinical Report - Nurses
MRN: E001113503 The Medical Center of Aurora
VisitID: E40000734489 1501 South Potomac St., Aurora, CO 80012 303-695
46y, M Arrival Date/Time: 04/12/2012 6:58
DOB: 12/05/1965

TRIAGE

Triage time 0659. Acuity: LEVEL 2.
Chief Complaint: ABDOMINAL PAIN and NAUSEA and (chest pain).

Pain level now: 10/10. --07:40 RN.
Weight: 79.3 kg estimated. Height: 72 inches Estimated. BMI: 23.7. --07:23
04/12/2012 RN

Medications
None. --0720 (04/12/12)

Allergies
No Known Drug Allergy. --0720 (04/12/12)

History
This started last night. (based on pt writhing in pain in bed).

Treatment PTA:

PAST MEDICAL HX: Immunizations: status is unknown.

SURGERY HX: No history of previous surgery.

PATIENT NAME: MANDZA, EVALIN
ACCOUNT #: E40000734489

Denver Patient Care Inquiry (PCI: OE Database COCAA)
Run: 05/04/12-11:35 by
The patient has had vomiting (green bile looking on arrival to unit). --07:24 (b)(6), (b)(7)(c) RN

SOCIAL HX: (Is at ICE facility). --07:24 (b)(6), (b)(7)(c) RN

Treatment PTA:
ASA 325 mg chewed given by EMS. --07:25 (b)(6), (b)(7)(c) RN

06:59 late entry -. (Uta assess full level of complaints. Pt will not answer any ?s will only thrash around in bed in pain). --07:49 (b)(6), (b)(7)(c) RN.

ADDITIONAL PROBLEMS:
None. --07:20 (b)(6), (b)(7)(c)

ADDITIONAL SURGERIES:
None. --07:20 (b)(6), (b)(7)(c)

Assessment
The patient states feels the same. --07:23 (b)(6), (b)(7)(c) RN.

Interventions
ID band on patient. --07:23 (b)(6), (b)(7)(c) RN.

PHYSICAL ASSESSMENT
To room via stretcher. Alert. Oriented X 4. Appears in pain and in distress. Respiration not labored. Breath sounds within normal limits. Abdomen soft and nontender. Bowel sounds within normal limits. Capillary refill less than 2 seconds. Mucous membranes are pink. Skin is warm and dry. --07:25 (b)(6), (b)(7)(c) RN.

NURSING PROGRESS NOTES
Patient identifiers checked. The initial plan of care for this patient includes an assessment with efforts to address the presence of pain. Call light placed in reach. Side rails up x 2. Bed placed in lowest position. Brakes of bed on. --07:25 (b)(6), (b)(7)(c) RN

Care transferred and report given (b)(6), (b)(7)(c) RN). --07:26 (b)(6), (b)(7)(c) RN

EKG time (0710). EKG was performed by a nurse and shown to the ED physician. Dr (b)(6), (b)(7)(c). --07:26 (b)(6), (b)(7)(c) RN
(cardiac alert called at 0717). --07:26 (b)(6), (b)(7)(c) RN

07:18. IV access: site #1, left antecubital space, 18g angiocath, with aseptic technique and good blood return; blood drawn: rainbow set. Sent to the lab. Lock flushed with 5 ml saline. --07:27 (b)(6), (b)(7)(c) R.N.

07:20. BP: 131/86. HR: 91. RR: 38. O2 saturation: ~100 percent on nasal cannula at 2 liter/minute. --07:28 (b)(6), (b)(7)(c) R.N.

METROPROLOL 5 mg slow IVP over 1 minute. IV patency established. IV site checked: no pain, redness, or swelling. IV flushed thoroughly pre- and post-medication administration. --07:28 (b)(6), (b)(7)(c) R.N.

PATIENT NAME: MANDZH, EVALIN ACCOUNT #: E40000734489

Denver Patient Care Inquiry (PCI: OE Database COCAA)
Run: 05/04/12-11:35 by (b)(6), (b)(7)(c)

07:20 late entry -. IV access: site #2, right antecubital space, 18g angiocath, with aseptic technique and good blood return; one attempt. Lock flushed with 5 mL saline. --07:46 R.N.

DISPOSITION / DISCHARGE
07:28. BP: 145/89. HR: 90. RR: 28. O2 saturation: -100 percent on nasal cannula at 2 liter/minute. FLACC pain scale; face: 2-frequent to constant frown, clenched jaw, quivering chin; legs: 2-kicking or legs drawn up; activity: 2-arched, rigid or jerking; cry: 2-crying steadily, screams or sobs, frequent complaints; consolability: 2-difficult to console or comfort. Condition at departure: critical. Transported via stretcher by tech and nurse with defibrillator, IV and O2. Admitted to the Cath Lab. Patient has no belongings. --07:47 R.N.

Departure time: 0728. --07:47 R.N.

Locked/Released at 04/12/2012 15:35 by R.N.
THE MEDICAL CENTER OF AURORA

South Campus  
1501 South Potomac  
Aurora, CO 80012

North Campus  
700 Potomac  
Aurora, CO 80011

Centennial Medical Plaza  
14200 East Arapahoe Road  
Englewood, CO 80112

PATIENT NAME: MANDZA, EVALIN  
ACCT #: E40000734489 MR #: E001113503

LOCATION:  
ATTENDING PHY:  
ADMITTING PHY:  
ELECTROCARDIOGRAM

Test Reason: 28  
Blood Pressure: ***/*** mmHg  
Vent. Rate: 096 BPM  
Atrial Rate: 096 BPM

P-R Int: 182 ms  
QRS Dur: 098 ms

QT Int: 378 ms  
P-R-T Axes: 081 052 071 degrees

QTc Int: 477 ms

Normal sinus rhythm  
Right atrial enlargement  
ST elevation consider anterolateral injury or acute infarct  
ST elevation consider inferior injury or acute infarct  
** ** ** * ACUTE MI ** ** **

Abnormal ECG  
No previous ECGs available  
Confirmed by: MD (121) on 4/13/2012 7:44:11 AM  
Referred By: SELF REFERRED  
Overread By: MD

PATIENT NAME: MANDZA, EVALIN  
ACCOUNT #: E40000734489

Denver Patient Care Inquiry (PCI: OE Database COCAA)  
Run: 05/04/12-11:35 by MD  
Page 1 of 1
PATIENT NAME: MANDZA, EVALIN
UNIT NO: E001113503

EXAMS: 002432047 CHEST SINGLE VW PORT AP
REASON FOR EXAM: CP - CHEST PAIN
CPT CODE: 
CHEST SINGLE VIEW RADIOGRAPH
VIEWS: One  POSITION: Upright
EXAM DATE AND TIME: 4/12/2012 7:31 AM
INDICATION: Chest pain.
COMPARISON: None.

FINDINGS:
Lungs: The lungs are well-expanded and clear. There is no consolidation or effusion.
Heart: The cardiac silhouette is normal in size. The thoracic aorta is normal in caliber.
Osseous Structures: The osseous structures are unremarkable.
Support Catheters: None.
There is no pneumothorax.

IMPRESSION:
1. No radiographic evidence for acute cardiopulmonary disease.

** Electronically Signed by MD on 04/12/2012 at 0743 **
Reported and signed by: MD

CC:

TECHNOLOGIST: BATCH NO: 
TRANS: DR SYS D/TM: 05/04/2012 (1136)
ELECTRONIC SIGNATURE DATE/TIME: 04/12/2012 (0743)

Signed Report Printed From PCI

South ED
Medical Center of Aurora
1501 S. Potomac
Aurora, CO 80012
PHONE #: 303-695-4880
FAX #: 303-873-5592

NAME: MANDZA, EVALIN
HP: (303)361-5980   AGE: 46   S:M
DOB: 12/05/1965   LOC: E.CCL A
PHYS: 
EXAM DATE: 04/12/2012 STATUS: DIS IN
A#: E40000734489   U#: E001113503
**Patient:** MANDZA, EVALIN  
**ACCT #:** 240000734489  
**LOC #:** E.SURGIN  
**U #:** E00113503  
**DOCTOR:** *(b)(6), (b)(7)(c)*  
**AGE/SX:** 46/M  
**ROOM:** E.CCL  
**REG:** 04/12/12  
**PHONE:** (303) 450-**  
**STATUS:** DIS INK  
**BED:** A  
**DIS:** 04/12/12

---

**Specimen:** 0412:AA:BG00087R  
**Collected:** 04/12/12-0718  
**Status:** COMP  
**Reg #:** 05215267  
**Received:** 04/12/12-0846  
**Sub Dr:** *(b)(6), (b)(7)(c)*  
**Verified:** 04/12/12-0846

---

**Patient Id:**  
**Ordered:** ABGPOC

---

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<th>Result</th>
<th>Flag</th>
<th>Reference</th>
<th>Site</th>
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<tr>
<td>POC PH</td>
<td>7.16</td>
<td>LC</td>
<td>7.35-7.45</td>
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<tr>
<td>POC PCO2</td>
<td>27.2</td>
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<td>POC PO2</td>
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POC - POINT OF CARE TESTING

---

**Patient:** MANDZA, EVALIN  
**Age/Sx:** 46/M  
**Acct #:** 240000734489  
**Unit #:** E00113503
Patient: MANDZA, EVALIN

**Specimen:** 0412:AA:BG00055R  **Collected:** 04/12/12-0721  **Status:** COMP  **Req#:** 05215191

**Received:** 04/12/12-0734  **Sub Dr:** Carepoint, Physician  **Verified:** 04/12/12-0734

**Test:** TROFONIN ISTAT

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<td>TROFONIN ISTAT</td>
<td>0.03</td>
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</table>

ISTAT Troponin I Interpretation:

ISTAT results greater than 0.08 ng/ml should be considered Positive for Myocardial Injury.

Interpretation of Cardiac Troponin I results should be done only in the context of the overall clinical picture, e.g., clinical history, EKG, and other laboratory tests indicative of cardiac damage.

POC - POINT OF CARE TESTING
**PT**

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<td><strong>INR</strong></td>
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**THE INR TARGET RANGE FOR ORAL ANTICOAGULANTS:**

| VENOUS THROMBOSIS | 2.0-3.0 | |
| ARTERIAL THROMBOSIS & HEART VALVE PROPHYLAXIS | 2.5-3.5 | |
| ATRIAL FIBRILLATION | 2.0-3.0 | |
| **PTT** | 22 | 22-30 SECONDS | AR | |

***NEW PTT THERAPEUTIC RANGE FOR HEPARINIZED PATIENTS***

**EFFECTIVE 6/27/2011**

The therapeutic range is 38 - 62 seconds for unfractionated heparin, as measured by the aPTT, which roughly corresponds to the recommended heparin concentrations of 0.3 - 0.7 U/mL, as measured by the activated factor X assay. If the patient's clinical situation warrants greater accuracy in the monitoring of the anticoagulation, consider measuring the actual heparin level.

**VERIFIED: 6/10/2011 - NEW REFERENCE RANGE FOR HEPARINIZED PATIENTS**

AR - THE MED CTR OF AURORA, SOUTH CAMPUS
1501 S. POTOMAC, AURORA, CO. 80012
**Specimen:** 0412:AA:H001415  | **Collected:** 04/12/12-0715  | **Status:** COMP  | **Reqd:** 05215186

**Received:** 04/12/12-0730  | **Sub Dr:** (b)(6), (b)(7)(c)  | **Verified:** 04/12/12-0742

**Patient Id:** 0412:AA:H001415  | **Status:** COMP  | **Reqd:** 05215186

**Ordered:** CBC W/AUTO DIFF  | **Verified:** 04/12/12-0742

**Comments:** Campus: S  
DISCHARGE PENDING? N

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<td>WBC</td>
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<td>RBC</td>
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<td>0.7-5.2 %</td>
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</table>

AR - THE MED CTR OF AURORA, SOUTH CAMPUS  
1501 S. POTOMAC, AURORA, CO. 80012
CERTIFICATION OF VITAL RECORD

STATE OF COLORADO
COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
HOLD TO LIGHT TO VIEW WATERMARK

AMENDED

STATE OF COLORADO
CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last)
   Evalin MANDZA

2. SOCIAL SECURITY NUMBER (a) (b) (c)
   46
   Dec. 5
   1065

3. DATE OF DEATH (Month, Day, Year)
   April 12, 2012

4. SEX
   Male

5. PLACE OF DEATH (City and State or Foreign Country)
   Unknown

6. METHOD OF DISPOSITION
   Human Services

7. MEDICAL EXAMINER, AUTHORIZED TO SIGNED CERTIFICATE
   Unknown

8. PHYSICIAN/ATTENDING PHYSICIAN
   Unknown

9. MANNER OF DEATH
   Accidental

10. PLACE OF DEATH
    Wheat Ridge, Colorado

11. CERTIFICATE OF DISPOSITION
    Yes

12. DATE OF ISSUANCE
    May 24, 2012

13. AUTHORIZED TO SIGN
    Sterling Corin

14. DATE SIGNED
    May 24, 2012

15. INJURY AT TIME OF CAUSE
    Heart Attack

16. IMMEDIATE CAUSE
    Heart Attack

17. OTHER SIGNIFICANT CONDITIONS
    Heart Attack

DATE ISSUED
MAY 24, 2012

THIS IS A TRUE CERTIFICATION OF NAME AND FACTS AS
RECORDED IN THIS OFFICE. DO NOT ALTER, DESTROY OR
SMUDGE. PENALTY BY LAW, Section 25-2-118, Colorado
Revised Statutes, 1982. IF A PERSON ALTERS, USES, ATTEMPTS TO
USE OR FURNISHES THIS CERTIFICATE IN ANY DECEPTIVE MANNER, IT IS
INVALID.
**U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT**

**DIRECTIVE TITLE: NOTIFICATION AND REPORTING OF DETAINEE DEATHS**

**INDIVIDUAL INCIDENT CHECKLIST**

<table>
<thead>
<tr>
<th>Status:</th>
<th>Date:</th>
<th>Time:</th>
<th>Time Zone:</th>
<th>Person making Notification:</th>
<th>Person Notified:</th>
<th>Manner:</th>
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<td>DFOD (b)(6), (b)(7)(c)</td>
<td>JIC: (b)(6), (b)(7)(c)</td>
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<td>4/12/2012 1200 MST</td>
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</table>

- **a) Immediately following the death** of a detainee:
  - i) Enforcement and Removal Operations (ERO) Field Office Director (FOD) shall:
  - Contact the ERO Assistant Director for Field Operations.
  - Joint Intake Center (JIC) by telephone to report the death.
  - The Assistant Director for Field Operations shall notify the Executive Associate Director by telephone.
  - Report the detainee death as a “significant incident” to the ICE Reporting and Operations Center (IROC) using the electronic ICE Significant Event Notification (SEN) system.
  - The Executive Associate Director shall provide telephonic notification to the Office of the Director.
  - The JIC, upon being notified, shall provide telephonic notification to the DHS Office of the Inspector General (OIG).
**U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT**

**DIRECTIVE TITLE: NOTIFICATION AND REPORTING OF DETAINEE DEATHS**

**INDIVIDUAL INCIDENT CHECKLIST**

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<th>Person making Notification:</th>
<th>Person Notified:</th>
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<td>DFOD(b)(6, b)(7)(c)</td>
<td>Chief Counsel (b)(6, b)(7)(c)</td>
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<td>MST</td>
<td>Senior Attorney (b)(6, b)(7)(c)</td>
<td>Supervisory Legal Assistant (b)(6, b)(7)(c)</td>
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<td>4/12/2012</td>
<td>0630</td>
<td>MST</td>
<td>GEO Medical Staff</td>
<td>Unknown</td>
<td>Telephonic</td>
</tr>
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</table>

**ii) The Executive Associate Director of ERO shall:**

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<tr>
<th>Status:</th>
<th>Date:</th>
<th>Time:</th>
<th>Time Zone:</th>
<th>Person making Notification:</th>
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<tr>
<td>N/A</td>
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<td>Provide email or telephonic notification to the DHS Office of Health Affairs.</td>
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<td>Provide email or telephonic notification to the Civil Rights and Civil Liberties.</td>
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<td>Provide written notification to OAD via a Director's Note.</td>
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<td>Provide written notification to the Office of Professional Responsibility via a Director's Note.</td>
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</table>
c) **Within 48 hours** of the death of a detainee, the **Executive Associate Director of ERO** shall:

- Ensure that copies of all available medical reports are provided to the DHS Office of Health Affairs (OHA) in order to provide OHA the ability to initiate a proper mortality review. *(All other relevant documents shall be provided to OHA in accordance with section 8.)*

**NOTE:** All notifications provided in accordance with this section, along with an acknowledgment that the notification was received (if possible), shall be documented and maintained in the decedent’s alien file (A-file).
### 7.2 Notification to Consulate and Detainee’s Next-of-Kin.

#### a) Within 24 hours of the death of a detainee:

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<th>Status</th>
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<tbody>
<tr>
<td>COMPLETED</td>
<td>4/12/2012</td>
<td>0937</td>
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<td>Carter (203)</td>
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<td>1027</td>
<td>MST</td>
<td>SDDO</td>
<td>Embassy of Gabon</td>
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- The **FOD** shall telephonically notify the applicable consulate of the death and coordinate with consular officials, as necessary, to locate the next-of-kin.
- The **FOD** shall ensure that, unless consular officials are unwilling to do so, all notifications to next-of-kin are made by consular officials.
- If consular officials are unwilling to notify next-of-kin, the **FOD** shall telephone the person named as the next-of-kin to inform them of the death in a language they can understand.

#### b) Within 48 hours of the next-of-kin being notified:

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<th>Person making Notification</th>
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<tbody>
<tr>
<td>4/17/2012</td>
<td>0730</td>
<td>MST</td>
<td>SDDO</td>
<td>(b)(6), (b)(7), (c)</td>
<td>USPS mail</td>
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- The **FOD** shall send a condolence letter to the next-of-kin (see attached template), with a copy to the applicable consulate.

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**Name of Next-of Kin:** [Redacted]

**Address:** [Redacted], Aurora, CO 80016

**Relation:** Brother
7.3. Notification to Congress, the Media and Nongovernmental Organizations.
   a) **Within 24 hours** of the death of a detainee, the ICE Office of Congressional Relations shall provide e-mail notification to the Chair and Ranking member of the following Committees:

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<th>Person making Notification</th>
<th>Person Notified</th>
<th>Manner</th>
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**NOTE:** OCR shall coordinate with the ICE Office of the Chief Financial Officer before sending notifications to House and Senate Appropriations Committee staff.

- The Office of Public Affairs shall provide a media release to the local press and the Associated Press, and post the media release on ICE’s Internet website. (After notification of the next-of-kin, or when the next-of-kin cannot be located but reasonable efforts have been made by DRO (in coordination with the consulate) to locate the next-of-kin.)

**COMMENTS:**
**DIRECTIVE TITLE:** NOTIFICATION AND REPORTING OF DETAINEE DEATHS

**INDIVIDUAL INCIDENT CHECKLIST**

- The ICE Office of Policy shall provide a copy of the media release to nongovernmental organizations (NGOs) via the ICE/NGO working group co-chairs.
- In instances where the consulate has been notified of a detainee’s death but the next-of-kin have not been located yet efforts to locate them continue, notifications to Congress, the media or NGOs shall include information that efforts to reach next-of-kin are ongoing.

### 8 ONGOING REPORTING REQUIREMENTS.

#### 8.2. Detention Management Division.
Upon the death of a detainee in a detention facility, the ERO Assistant Director for Management (ADM) shall require:

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<th>Status</th>
<th>Date</th>
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<th>Manner</th>
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- In coordination with OPR, an internal review of all facility inspection records for the detention facility at which the death occurred.
- A review of all contract documentation for the detention facility where the death occurred.
- If the death occurs at a medical facility or while the detainee is in transit, the ADM shall require such review at the facility where the decedent was last held in custody.
b) The ADM shall submit the records within **14 calendar days** of the death of the detainee to:

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<thead>
<tr>
<th>Status</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>✓ ICE senior management</td>
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<tr>
<td>N/A</td>
<td>✓ OPR</td>
</tr>
<tr>
<td>N/A</td>
<td>✓ OHA for inclusion in OHA’s mortality review</td>
</tr>
<tr>
<td>N/A</td>
<td>✓ CRCL</td>
</tr>
<tr>
<td>N/A</td>
<td>✓ OIG (if the investigation is being conducted by the OIG).</td>
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<th>Status</th>
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<tbody>
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<tr>
<td>N/A</td>
<td>✓ CRCL</td>
</tr>
<tr>
<td>N/A</td>
<td>✓ OIG (if the investigation is being conducted by the OIG).</td>
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</table>

c) The ADM shall provide autopsy and toxicology results (if applicable), a copy of all treatment authorization requests (TAR), a copy of the death certificate and all other relevant documents (i.e., state and local law enforcement investigatory information), as soon as they become available to:

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<tr>
<th>Status</th>
<th>Action</th>
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<tr>
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<td>✓ OHA for inclusion in OHA’s mortality review</td>
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</tr>
<tr>
<td>N/A</td>
<td>✓ OIG (if the investigation is being conducted by the OIG).</td>
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Detainee Death Review
Medical Record Review
MANDZA, Evalin Ali, A #

DENVER CONTRACT DETENTION FACILITY, DENVER, CO

Section 1: Medical Compliance Review
As requested by the ICE Office of Professional Responsibility, Office of Detention Oversight, Creative Corrections (CC) participated in a review of detainee Evalin Ali MANDZA’s death at the Denver Contract Detention Facility (DCDF) in Denver, CO. CC accompanied Special Agents (b)(6), (b)(7)(c) and (b)(6), (b)(7)(c) on a site visit May 21-23, 2012, and participated in interviews of ICE, correctional and medical staff. Additionally, CC reviewed the medical record of detainee MANDZA, and relevant policies and procedures. CC’s participation was requested to determine compliance with the ICE Performance Based National Detention Standards governing medical services.

The following chronicles detainee MANDZA’s period of detention at DCDF based on documented and reported information. CC’s observations and compliance findings appear in commentary. Medical terminology is defined in parentheses and brackets.

Medical Encounters Timeline
October 17, 2011
Record of Deportable/Inadmissible Alien Form I 213 completed by Immigration Enforcement Officer documents detainee MANDZA, 46 years old, was arrested and charged with resisting an officer and detained at the Aurora County Jail. The form further documents the detainee “states he is in good health and is taking no medications;” further, “appears to be in good health.” He was subsequently transferred to the Denver Enforcement & Removal Operations (ERO) Field Office for processing.

October 24, 2011
5:05 pm
The detainee arrived at the DCDF. The Order to Detain listed his nationality as Gabon, a country in west central Africa.

6:45 pm
Intake Screening was conducted by Licensed Practical Nurse (LPN). Vital signs (VS) were documented as follows: pulse (P) 81, blood pressure (BP) 101/62, respirations (R) 14, temperature (T) 97.1, all within normal limits (WNL). No chronic care issues were identified, and the form documented negative responses to all health history questions. His placement recommendation was recorded as “General Population.” A consent for treatment form was signed and dated. On interview LPN stated she always asks more questions than listed on the form and seeks to identify possible signs or symptoms of anything abnormal. She stated she found “nothing out of the ordinary.”
The Nursing Incoming Screen Progress Note form documents no medications were ordered, no special treatments or follow-up referrals, no work limitations, and no housing or bunk limitations. CC was informed this form is designed to focus on chronic conditions requiring follow up and/or medications. MD reviewed and signed the form on October 27, 2011.

The Mental Health Intake Screen completed by LPN documents negative responses for all items. The form was signed by MD on the same date.

The detainee refused syphilis testing and signed a refusal form.

A chest x-ray was performed with the results documented as “Negative except for calcified granuloma [small area of inflammation of benign calcification] less than 2 cm.”

October 25, 2011
Detainee MANDZA submitted a sick call request stating he had “bad movement.”

October 26, 2011
6:00 pm
A physical examination and health appraisal was performed by Adult Nurse Practitioner (ANP). Height: 5 feet 8 inches; weight: 141 pounds. VS: T 98.6, P 78, R 18, BP 104/64, and all WNL. All history and systems items were documented as normal. Dr. signed the physical examination on October 27, 2011.

Progress Note by , Registered Nurse (RN) documents detainee MANDZA was seen for sick call complaining of not having a bowel movement in three to four days. He was instructed to increase his fluid intake. The detainee verbalized understanding and was given Ducolax and Milk of Magnesia (MOM) (laxatives to relieve constipation) in accordance with GEO nursing protocols.

October 31, 2011
Detainee MANDZA submitted a sick call request for “constipation movement.” He was placed on the sick call list to be seen by Dr. on November 3, 2011.

During site visit, CC learned Detainee MANDZA’s name was crossed off Dr. sick call list with a crayon. Acting HSA RN stated names are crossed off sick call lists with crayons to signify the medical record has been pulled for the appointment. There was no corresponding Progress Note or other documentation supporting detainee MANDZA was seen by Dr. on November 3, 2011; in fact, he was not seen by a physician until December 2, 2011. RN could not explain why the sick call appointment was missed.

COMMENT: CC cites non-compliance with ICE PBNDS, Medical Care, section (II)(2), requiring that health care needs be met in a timely and efficient manner.
**November 8, 2011**
Detainee MANDZA submitted a sick call request for, “bumps shaving, need medical.”

**November 9, 2011**
The medical record documents the sick call request was reviewed and the detainee was seen by LPN. Per GEO nursing protocol, he was given TAO (triple antibiotic cream) to be applied daily for seven days.

**November 10, 2011**
Detainee MANDZA submitted a sick call request for “constipation movement.”

**November 11, 2011**
The medical record documents the sick call request was reviewed by LPN. Per GEO nursing protocol he was given Ducolax again and fiber was added.

**November 17, 2011**
Detainee MANDZA submitted a sick call request for “dental hurt, couldn’t go to sleep.” RN gave him Tylenol (for pain) and scheduled him to see the dentist on November 21, 2011. He was instructed on proper dental hygiene and advised to return to the clinic if symptoms persisted or worsened.

**November 21, 2011**
Detainee MANDZA was seen by DDS. Per Progress Note, detainee complained of lower level toothache. “The tooth has deep cavities and needs to be extracted. The detainee has court tomorrow, so will reschedule the extraction.”

**COMMENT:** The record includes no documentation the extraction was rescheduled.

**November 27, 2011**
Detainee MANDZA submitted a sick call request for “constipation movement with shaving bumps.”

**November 28, 2011**
RN gave detainee MANDZA MOM, Ducolax, and fiber for the constipation and TAO for razor burn rash. RN documented he was instructed to “drink a lot of water, don’t use TAO around the eyes, and return to medical if symptoms persist or worsen.”

**December 2, 2011**
Dr. evaluated detainee MANDZA for constipation and folliculitis (inflammation of hair follicles). He prescribed glycerin suppositories, increased fiber, and Colace for the constipation, and a triple antibiotic cream for his neck rash.
December 11, 2011
Detainee MANDZA submitted a sick call request for “dental complaint, need to be cleaned but not to take out.”

December 12, 2011
Detainee MANDZA was seen by RN and was given Ibuprofen per GEO nursing protocol. A dental appointment was scheduled for December 20, 2011.

December 14, 2011
Detainee MANDZA submitted a sick call request stating “I fall from top bed hurt my foot.”

December 15, 2011
Dr. documented he evaluated detainee MANDZA; no new orders were issued.

December 20, 2011
Dr. (DDS) documented the detainee asked to have his teeth cleaned and complained of pain in his lower level. He refused extraction and was given Ibuprofen.

COMMENT: No refusal form was found in the medical record.

December 25, 2011
11:40 am
Medical Report on Injuries/Non-Injuries documents detainee MANDZA was evaluated due to his involvement in “horseplay” with other detainees. Tiny scratches on his chest and left wrist area were noted by LPN. No other apparent injuries.

The Pre-Segregation History and Physical by LPN documents clearance for placement in administrative segregation. The form was signed by Dr. on December 27, 2011.

December 30, 2011
RN documented detainee “fell playing soccer.” She gave him Ibuprofen and ice packs for his left big toe.

January 3, 2012
Dr. documented the detainee complained of a sore foot from striking it against a soccer ball. He was noted to be in no apparent distress with any swelling, tenderness or gross deformity. He was prescribed Ibuprofen and a lower bunk was ordered.

January 13, 2012
Detainee MANDZA submitted a sick call request for a “dental problem.” The request was reviewed on January 15, 2011 and an appointment was scheduled for January 16, 2012.
January 15, 2012  
Detainee MANDZA submitted a sick call request for a “dental problem/I need to keeping taking the constipation suppositories that help. Thanks.” The request was reviewed and LPN saw the detainee. He was reminded of his dental appointment on January 16, 2012.

January 16, 2012  
RN documented the detainee was seen in medical for his constipation and dental issues. He was scheduled to see the dentist the same day and to see Dr. on January 18, 2012.

Per Progress Note by Dr. the detainee again refused the extraction. He was given Amoxicillin (antibiotic) and Tylenol.

COMMENT: No refusal form was found in the medical record.

January 18, 2012  
7:08 am  
An entry in the Segregation/Special Management Unit (SMU) log book documents detainee MANDZA was “escorted to seg/SMU.”

The Pre-Segregation History and Physical completed by RN documents medical clearance for housing in Administrative Segregation. “[N]o physical confrontation just arguing” was noted. The form was signed by MD, but not dated.

COMMENT: Per January 16 Progress Note, detainee MANDZA was to be seen by Dr. this date. There is no documentation this appointment occurred. RN could not explain why Dr. did not see the detainee.

January 27, 2012  
Progress Note by ANP documents the detainee was complaining of constipation and was declining the Colace and fiber. The glycerin suppositories were renewed for three days, and he was counseled on taking the prescribed treatment for constipation.

COMMENT: There were no refusal forms for Colace and fiber in the record. CC was informed it is not customary practice to have detainees sign refusal forms for over-the-counter medications.

February 9, 2012  
Progress Note by RN documented the detainee complained of constipation and had not had a bowel movement since February 3, 2012. His bowel signs were decreased and discomfort was increased. He was given Ducolax and MOM per GEO nursing protocol.

February 14, 2012  
Detainee MANDZA submitted a sick call request for a “problem with my teeth.” A note (illegible initials) documents he was to see the dentist that day.
March 1, 2012
The detainee submitted a sick call request complaining of burning eyes and constipation. RN reviewed the request, saw the detainee and gave him Ducolax, MOM and artificial tears per GEO nursing protocol. He was to return to medical if symptoms persisted or worsened. He was placed on the physician sick call list for March 5, 2012.

March 5, 2012
Physician Assistant (PA) documented the detainee presented with complaints of constipation; “no dumping (when food passes too rapidly from the stomach into the upper intestine), H2O, on meds.” Observations: “Lungs clear, heart-no [illegible], abdomen soft, visceromegaly[abnormal enlargement of the soft internal organs];” Assessment: “Constipation, no water;” Plan: “Increase fiber, increase water, increase exercise.”

March 21, 2012
Detainee MANDZA submitted a sick call request for “bad move problems/bumps shaver problems.” LPN documents he was seen in medical and given MOM, Ducolax and was scheduled for a medical review.

Progress Note by Dr. documents the detainee has a history of constipation and a stress fracture; Colace ordered again.

March 25, 2012
Progress Note by Dr. documents medications are working well, no nausea, vomiting, diarrhea; no complaints; vital signs stable; continue medications. Detainee to submit a sick call request if problems.

March 31, 2012
Detainee MANDZA submitted a sick call request for “no movement all week.”

April 1, 2012
LPN documents the detainee was seen in medical and given Ducolax and MOM per GEO nursing protocol.

April 12, 2012
5:24 am

5:25 am
Per General Incident Report authored by Detention Officer (DO), “I D/O was talking with Lt. while he was making rounds on unit A-4 when the other detainees got my attention that detainee Mandza Evalin-Ali needed help. When I arrived at A-110, Ali was complaining of chest pains. I instructed Lt. to call Code Blue.” DO documented on the report Code Blue was called at 05:25, Medical arrived at 05:28, “Stand down from Code Blue” at 05:33, “Medical departs with detainee Mandza” at 05:34. On interview, DO stated he normally makes rounds every 30 minutes and that during his 5:00 a.m. round, “everything was fine.” When he was summoned by the other detainees and went over to detainee MANDZA’s bed, he found the detainee “rocking and rolling” in bed with his hands on his chest complaining of chest pain. He also stated nursing staff who responded had a wheelchair, crash bag (containing ammonia, a manual breathing bag, gloves, spill kit), and a pulse oximeter (measures the oxygen level in the blood). He did not remember an AED automated external defibrillator (AED) being brought to the housing unit.

Per GEO Serious Incident Report, Incident Description, written by Lt, he called a Code Blue due to the detainee “complaining of chest pains.” On interview, Lt. stated he found the detainee in a “fetal position grasping his chest and groaning.” He called the “Code Blue” over the radio and proceeded to open the side door to expedite medical staff’s arrival. He stated nursing staff brought with them a wheelchair, crash bag, and oxygen tank, but no AED.

Medical record Progress Note by RN documented, “Responded to Code Blue at housing unit 4A. Found detainee lying on back (in bed) touching left chest area. Detainee alert and oriented, answers all questions appropriately. Skin w/d color adequate, no respiratory distress noted. Reports chest pain 8-9/10 on a pain scale of 0 to 10, with 10 being worst, pain worse with inspiration, pulse ox: 94%. Assisted to wheelchair for transfer to medical unit.”

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

RN stated during interview she responded immediately to the Code Blue, taking with her the wheelchair, oxygen tank, crash bag and the AED. LPN did not document in the medical record, however, on interview, she stated she responded with RN to the “Code Blue” with a wheelchair, crash bag, oxygen tank and AED. As noted, DO and Lt. reported that they did not observe an AED.
**COMMENT:** Whether an AED was brought to the scene cannot be confirmed. While use of an AED on detainee MANDZA would not have been appropriate because he was found alert, responsive, breathing and with a pulse, code blue response equipment should always include an AED in the event it is needed.

**COMMENT:** CC verified current CPR certification for all responding correctional and medical staff.

**5:28 am**
Per Progress Note by RN “Transfer to trauma room. VS 154/84 -68-18; On assessment skin (warm and dry) color adequate, bilateral breath sounds clear to auscultation. All peripheral [areas of the arm, wrist, legs and feet] pulses palpable. O2 [oxygen] placed at 4 L [liters], pulse ox 92-94%, abdomen soft, flat with hypoactive bowel sounds [normal during sleep, but can also indicate constipation]. Reports last [bowel movement] was on 4-8. Chest pain remains unchanged. BP 144/85, 71 [pulse] rr [regular rhythm] 18 [respirations]. 3 lead EKG [electrocardiogram] done.”

**COMMENT:** VS were not documented again until 6:20 am. Per GEO nursing protocol for chest pain, VS are to be taken every five minutes.

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

During interviews, both RN and LPN stated they had not received formal training in reading EKGs. They stated in the past, results from the Schiller AT-102 machine were faxed to the on-call physician or a cardiology practice for interpretation; however, faxing results from the Welch Allyn machine was not possible because the machine has not been programmed the same way as the Schiller AT-102. Asked about maintenance of the EKG machines, RN indicated she had previously reported the Schiller AT-102 memory issue to Acting HSA. According to LPN, the EKG machines are checked daily for operability, though the memory is not always checked. HSA was able to produce documentation of checks for the clinic’s other emergency equipment, including oxygen tank, oxygen mask and tubing, Ambu-Bag, pulse oximeter, and AED; however, there was no record documenting EKGs are checked.
**COMMENT:** ODO cites non-compliance with ICE PBNDS, Medical Care, section (V)(O) requiring that medical and safety equipment be available and maintained, and that staff be trained in proper use of the equipment.

Per interview with DCDF’s new physician, Doctor of Osteopathy, he supports documentation by RN. However, after reviewing the GEO nursing protocol for chest pain, he stated it is flawed because the EKG should not be used as an “acute tool” in this setting; further, that this may have delayed sending the detainee to the hospital up to “ten minutes.” He would like to see the protocol revised to call for an immediate 911/EMS response to chest pain along with the administration of aspirin. He stated, “We are putting the facility at risk” by not sending detainees to the hospital in this situation. He further stated he does not need to be contacted for an order to do so.

During interview, LPN stated RN instructed her to “get the paperwork started” when detainee MANDZA was in the trauma room. She stated this instruction meant the physician was to be called for an order, the HSA was to be notified, and the Shift Commander (Lt) was to be contacted for an “order for transport.” She indicated she was under the impression the detainee would be transported by GEO transport van rather than ambulance because she thought at the time the detainee “wasn’t in dire distress.”

**5:50 am**
Per medical record documentation by RN “Dr. notified of detainee status. Orders received.” A verbal order was given to “transfer the detainee to hospital for chest pain evaluation.” On interview, RN stated it was her understanding a doctor’s order was required to send a detainee to an outside hospital. However, RN stated during interview she would use her “nursing discretion” to send a detainee to an outside hospital if needed and notify the physician later. In addition, as noted, Dr. stated it was not necessary to obtain a physician’s order in this situation. CC notes that according to GEO policy “Emergency Services,” 4-Triage,(a), Immediate Life Threatening Emergency, dated 6/13/2011, “If the Response Team Leader determines a life threatening emergency exists, Emergency Medical Services (EMS) will be summoned immediately.”

**COMMENT:** CC cites non-compliance with ICE PBNDS, Medical Care, section (II)(7) requiring that detainees who need health care beyond facility resources to be transferred in a timely manner to an appropriate facility where care is available.

RN stated she instructed LPN to call EMS, however, she did not document this instruction. It is further noted Lt. Supervisor’s Report and the Aurora Fire Department EMS Patient Care Report (see below) document the time as 6:20 am and 6:21 am, respectively. During interview, LPN stated that she was still under the impression detainee MANDZA would be going to the hospital via GEO transport van. In her General Incident Report, LPN writes “orders received per Dr. to send to hosp. At this time I Nurse completed transfer form and notified watch commander of transfer to hosp per MD orders.”

DETAINEE DEATH REVIEW: Evalin Ali MANDZA
Medical Compliance Summary
Creative Corrections, LLC
Per GEO Serious Incident Report authored by Lt. **(b)(6), (b)(7)\textsuperscript{(c)}**, LPN **(b)(6), (b)(7)\textsuperscript{(c)}** “advised the detainee needed to be transported to the Aurora South Hospital for further medical examination.”

**6:00 am**
Per Progress Note authored by RN **(b)(6), (b)(7)\textsuperscript{(c)}**, “Ms. **(b)(6), (b)(7)\textsuperscript{(c)}** notified of detainee status.”

**6:20 am**
Per Serious Incident Report by LPN **(b)(6), (b)(7)\textsuperscript{(c)}**, detainee Evalin Ali MANDZA “VS-\textit{BP} 139/81, \textit{P} 67, pulse ox 100% on 4 liters.”

Per Supervisor Report by Lt. **(b)(6), (b)(7)\textsuperscript{(c)}**, “At 0620 hours medical informed that 911 needed to be called in order to have detainee taken to Aurora South Hospital ER for additional treatment.” On interview, he stated this direction was given when he called the nursing station to get a status update on the transport of detainee MANDZA to the ER. He stated he spoke with LPN **(b)(6), (b)(7)\textsuperscript{(c)}** who instructed him to call 911. This was 30 minutes after an order was obtained from Dr. **(b)(6), (b)(7)\textsuperscript{(c)}** to send the detainee to the emergency room and approximately 50 minutes after the detainee arrived in the trauma room. Lt. **(b)(6), (b)(7)\textsuperscript{(c)}** stated in retrospect it “bothered” him it took so long to send the detainee out.

Per GEO Serious Incident Report, Immediate Action Taken, by Lt. **(b)(6), (b)(7)\textsuperscript{(c)}**, “Upon arrival in the medical department an assessment by RN **(b)(6), (b)(7)\textsuperscript{(c)}** and LPN **(b)(6), (b)(7)\textsuperscript{(c)}** was conducted. The determination to call 911 (ambulance) was requested and detainee was taken to the Aurora South Hospital ER for additional treatment.” The report by Lt. **(b)(6), (b)(7)\textsuperscript{(c)}** does not state who made the determination to call 911, when 911 was called, nor by whom.

**COMMENT:** The decision to call EMS versus transport the detainee by van is not documented in the medical record. Interviews with staff point to poor communication resulting in a delay in getting him to the ER. CC cites a second deficiency in the ICE PBNDS, Medical Care, section (II)(7) requiring timely transfer to off-site care facilities.

**6:21 am**
Per the Aurora Fire Department EMS Patient Care Report, a call came in from DCDF for emergency response.

**6:25 am**
Per GEO Serious Incident Report by Lt. **(b)(6), (b)(7)\textsuperscript{(c)}**, “EMS arrived on site about 0625 hours.” The Aurora Fire Department EMS Patient Care Report confirms this time.

**6:29 am**
Per the Aurora Fire Department EMS Patient Care Report, VS were “BP 135/85, P 80-regular, R 20-increased but not labored, perceived pain 9/10, O2 level 100 %, movement of extremities X 4\textit{is able to move all four extremities}, level of consciousness 15 \textit{out of 15}, EKG interpretation –normal sinus rhythm taken by automated device.”
6:30 am
Per the Transport/Escort Log, “EKG done by EMT.”

Aurora Fire Department EMS Patient Care Report documents impression as “Chest pain and Heartburn/Indigestion;” Cardiac Arrest was answered as “No.” “The patient is conscious and alert” and complains of “midline chest pain.” The EMS report further documents:

“History: Pt [patient] states no medical history, no current medications, no nkdas/no known drug allergies]. Pt states he hasn’t had a bowel movement in the last 4 days. Pt states he ate a bowl of soup last night that contained a large amount of hot chili peppers. Onset: Two hours ago pt awoke with current pain. Provocation [Does anything make the pain worse?]: Pain is reproduce able upon movement and chest wall palpitation. Quality of Pain: Pt states it is a burning sensation. Region and radiation: Pt states the pain travels from his upper abdomen to his esophagus. Severity: 9/10; pt denies nausea and vomiting; pt states no diaphoresis.

Assessment: General Impression-Pt is conscious and is responding to verbal questioning. Pt is showing no signs of pain or respiratory distress. ABC’s [airway, breathing, circulation] open/patent, increased/unassisted, skin warm and dry, radial pulse strong and regular, heent [head, ears, eyes, nose, throat] clear, chest wall stable rise and fall equal, breath sounds clear and equal bilateral, abd [abdomen] soft non-tender, pelvis stable, vitals as recorded. Pt was placed onto 4 L O2 prior to our arrival by facility nurse. 12 lead ECG revealed a Sinus Rhythm, no ST segment elevation or ectopic beats observed [indications of an abnormal EKG].” Pt was packaged onto the pram and removed from the facility. Pt states no further complaints.

Upon release of care pt’s condition remained unchanged.”

6:35 am
Per the Transport/Escort Log, Commander (Immigration Health Services Corps) and Warden (b)(6), (b)(7(c) notified.

6:43 am
Per Control Emergency Log book, EMT offsite.

6:57 am
General Incident Report authored by DCDF Medical Transport Officer, documents arrival at Aurora South Medical Center. Officer (b)(6), (b)(7(c) accompanied the ambulance to the ER.

COMMENT: The detainee was transported as a non-emergent case, therefore, it took 14 minutes to get to the hospital.
Per Aurora H&P [*history and physical*], “The patient is a 46 year old gentleman with no apparent risk factors. He is having an acute anterior myocardial infarction. He will report to the Cath Lab. Condition at time of admission: guarded”

7:35 am
Per General Incident Report detainee moved to the “Cath Lab for Cardiac Catheterization.”

Per Aurora Hospital Cardiac Catheterization Report “Ventricular tachycardia [*fast heart rhythm that originates in the ventricles of the heart*] and PEA arrest (pulseless electrical activity), [there is electrical activity, but the heart does not contract. The heart rhythm observed on EKG looks like the heart is producing a pulse, but is not]; CPR cardioversion [*procedure to restore normal heart rhythm*]; continued CPR and multiple defibrillations.”

7:55 am
Per General Incident Report “[hospital] medical staff started giving Mandza chest compressions with negative results.”

**COMMENT:** On interview with Transport Officer who remained with the detainee at the hospital, “The whole cardio department was here to try to save his life.”

8:38 am
Per the Cardiac Catheterization Report Detainee Evalin Ali MANDZA expired due to “unsuccessful resuscitation of the patient.”

12:49 pm
GEO Serious Incident Report transmitted by Warden. In compliance with current ICE standards the onsite staff is handling the details of the autopsy.”

1:00 pm
ICE Removal proceeding hearing scheduled.

Per Serious Incident Report authored by Warden, “In compliance with current ICE standards the onsite staff is handling the details of the autopsy.”

**May 24, 2012**
Per the Death Certificate, Immediate Cause of Death was listed as “Anterior MI [*myocardial infarction or heart attack*] due to or as a consequence of “Severe left main coronary artery stenosis [*abnormal narrowing*].”
MEDICAL COMPLIANCE REVIEW CONCLUSIONS

The ICE PBNDS, Medical Care, requires that detainees have access to emergent, urgent, or non-emergent medical care so that their health care needs are met in a timely and efficient manner. As discussed in the above timeline, deficiencies were found in the following:

- ICE PBNDS Medical Care, section (II)(2) requiring detainees to have healthcare needs met in a timely and efficient manner.
  
  o There was no documentation to support Dr. evaluated the detainee for his complaint of constipation as scheduled on November 3, 2011. He was not seen by the physician until December 2, 2011.

- ICE PBNDS Medical Care, section (II)(7) requiring a detainee who needs health care beyond facility resources will be transferred in a timely manner to an appropriate facility where care is available.
  
  o A total of 56 minutes elapsed between the Code Blue emergency and activation of 911. Thirty minutes elapsed after Dr. ordered transfer to the ER.

- ICE PBNDS Medical Care, section (V)(O) requiring medical and safety equipment to be available and maintained and staff to be trained in proper use of the equipment.
  
  o There was no documentation EKG machines were checked daily to determine if they were in working order and for memory capacity.
  o Neither RN nor LPN had documented formal training on the EKG machines used at DCDF medical clinic, or in recognizing lethal rhythms.

Submitted:

Creative Corrections, LLC
ADDENDUM

IHSC MEDICAL RECORD REVIEW/INVESTIGATION

Detainee: MANDZA, Evalin-Ali

Alien Number: (b)(6), (b)(7)(c)                  DOB: 12-05-1965

EXECUTIVE SUMMARY

On 04-12-2012, U.S. Immigration and Customs Enforcement (ICE), Health Service Corps (IHSC) received notification of the death of Evalin-Ali MANDZA, an individual in the custody of ICE at the Denver Contract Detention Facility, Aurora, Colorado. The Assistant Director for IHSC requested a review of MANDZA's medical records to determine the appropriateness of the medical care he received while in ICE custody.

Cause of Death: Anterior myocardial infarction
Severe left main coronary artery stenosis

Conclusion: This additional information does alter the initial observations, conclusions and recommendations that appeared in the 05-09-2012 report.

MANDZA did not have access to appropriate medical care while detained in the Denver Contract Detention Facility (DCDF). On 04-12-2012 he received appropriate emergent medical care at the DCDF; however, there was an approximate 30 minute delay from when the physician ordered MANDZA transferred to the hospital for evaluation of chest pain, to when EMS received a call to respond to the facility. At present, IHSC has not received a death certificate; however, based upon a review of the hospital records, MANDZA apparently had an acute myocardial infarction (heart attack) and expired as a result of an inherent potential complication of a lifesaving procedure called emergency angioplasty. Prior to the morning of 04-12-2012, MANDZA did not have a history of any significant medical problems, nor did he complain of any symptoms that demonstrated an increased risk for cardiac problems.

DETAILS OF INQUIRY

ISSUE

—For Official Use Only—
On 04-12-2012, U.S. Immigration and Customs Enforcement (ICE), Health Service Corps (IHSC) received notification of the death of Evalin-Ali MANDZA, a(n) individual in the custody of ICE at the Denver Contract Detention Facility, Aurora, Colorado. The Assistant Director for IHSC requested a review of MANDZA’s medical records to determine the appropriateness of the medical care he received while in ICE custody.

PURPOSE

Review MANDZA’s medical records and prepare a formal statement regarding the standard of health care he received while in ICE custody.

BACKGROUND

MANDZA was a 46 year old male from Gabon, on the date he expired.

ICE Custody History

- 10-24-2011 to 04-12-2012 Denver Contract Detention Facility, CO
- 04-12-2012 Expired

Medical and Mental Health Conditions:

- No medical diagnoses
- Irreversible pulpitis tooth #18 – extracted
- Acute anterior myocardial infarction

ADDITIONAL INFORMATION RECEIVED

Aurora Fire Department (04-12-2012)

"C— U/a at the immigration detention facility, we located the Pt in an examination room lying supine on an examination table. Scene secure. Pt is a 46 y/o male who is conscious and alert. Pt states a CC of midline chest pain.

H—Pt states medical hx, no current medications and nkda’s. Pt states he hasn’t had a bowel movement in the past four days. Pt states he ate a bowl of soup last night, that contained a large amount of hot chili peppers. O—Two hours ago, Pt woke up from sleep with current pain. P—pain is reproducible upon movement, and chest wall palpation. Q—Pt states it is a burning sensation. R—Pt states the burning travels from his upper abd, to his esophagus. S—9 out of 10. Pt denies nausea/vomiting. Pt states no diaphoresis.

A— General Impression: Pt is conscious and is responsive to verbal questioning. Pt is showing no signs of pain or respiratory distress. ABC’s open/patent, increased/unassisted, skin warm and dry, radial pulse strong and regular, heent clear, chest wall stable rise and fall equal, breath sounds clear and equal bilateral, abd soft non-tender, pelvis stable, moex4, gcs=15, vitals as recorded. Pt was placed onto 41pm O2 prior to our arrival by facility nurse. 12 lead ECG revealed a Sinus
Rhythm, no ST segment elevation or ectopic beats observed. Pt was packaged onto the pram and removed from the facility. Pt was secured into RM 101 for non-emergent transport to TMCA South due to AIP diversion. Immigration detention officer accompanied RM 101. Pt states no further complaints.

R- See Treatment

T- See Encounter. Upon release of care Pt’s condition had remained unchanged.”

0621 Time call received.

0628 Patient contact.

0629 (Paramedic) “Position: Supine; Blood Pressure: 135/85; Pulse: 80 (Regular); Respirations: 20 (Increased, not labored); Perceived Pain: 9/10; Pulse Oximetry: 100 (On Oxygen); Movement of Extremities: x4; Level of Consciousness: 15 (4+5+6); EKG Interpretation: Normal Sinus Rhythm; Taken by automated device.”

~0630 “Oxygen, 4 l/m – nasal cannula; Response: No change; Authorization: Protocol (standing order); administered by Rural/Metro Employee”

0632 “12 Lead Cardiac Monitor; Authorization: Protocol (standing order); performed by [paramedic] COMMENT: NSR, no ST segment elevation, no ectopic beats observed”

Rural Metro Ambulance (04-12-2012)

Crew: #1 Paramedic, #2 EMT
“Dispatch to chest pain. UA pt found lying supine on exam table in facility clinic. Pt CC chest pain.

Pt states he awoke c the pain this morning. Pt describes that pain as a burning sensation that travels from his upper abd through his chest and up into his throat. Pt state that he did eat soup c hot peppers last night. Pt denies any recent trauma or illness. Pt denies any drug or alcohol use.

Pt AAOx4 (person, place, time, event). CMSx4. Breath sounds clear and equal bilaterally. Chest wall intact. Increased pain on palpation of chest. No trauma noted. HEENT clear and intact. Pupils 4, PEARL. Skin WPD. Abd non distended or rigid, increased pain on palpation of bilateral upper quadrants. No trauma noted.

Pt placed on 3L via NC. SpO2 monitor applied, 12 lead acquired – sinus rhythm c artifact. Pt scooted to pram by own power. Pt secured to pram with straps. Pt began hyperventilating en route. Pt would not talk c crew but appeared as if the pain had become worse. Pt given 324mg ASA PO. Pt would not follow directions to chew the pills so they sat in his mouth for a few minutes. Pt would not cooperate to get a third set of vitals en route. Pt vomited UA to ED. ASA pills present in vomit. Pt care transferred to nurse at receiving facility.”
0627  At patient.

0630  O2 3L nasal cannula applied by Aurora Fire Department (AFD)

0631  Cardiac monitor and 12 lead EKG performed by Rural Metro Paramedic; interpreted by AFD as sinus rhythm with ectopy and artifact.

0631  SpO2 monitor applied by Rural Metro Paramedic.

0643  Transport to ED.

0647  Four 81mg chewable ASA administered by Rural Metro Paramedic.

0655  Cardiac monitor and 12 lead EKG; interpreted by Rural Metro Paramedic as sinus rhythm with ectopy and artifact.

0700  Arrived ED and transferred care.

**Death Certificate**

**Cause of Death:**
- Anterior myocardial infarction
- Severe left main coronary artery stenosis

**Autopsy**

Coroner did not perform an autopsy.

**OBSERVATIONS**

The Denver Contract Detention Facility nurse received a physician’s order at 0550 to transfer MANDZA to the hospital for evaluation of chest pain. The Aurora County Fire Department did not receive a call until 0621.

**CONCLUSIONS**

This additional information does alter the initial observations, conclusions and recommendations that appeared in the 05-09-2012 report.

MANDZA did not have access to appropriate medical care while detained in the Denver Contract Detention Facility (DCDF). On 04-12-2012 he received appropriate emergent medical care at the DCDF; however, there was an approximate 30 minute delay from when the physician ordered MANDZA transferred to the hospital for evaluation of chest pain, to when EMS received a call to respond to the facility. At present, IHSC has not received a death certificate; however, based upon a review of the hospital records, MANDZA apparently had an acute myocardial infarction (heart attack) and expired as a result of an inherent potential complication of a lifesaving procedure called emergency angioplasty. Prior to the morning of 04-12-2012,
MANDZA did not have a history of any significant medical problems, nor did he complain of any symptoms that demonstrated an increased risk for cardiac problems.

RECOMMENDATIONS

- The findings of this review should be forwarded to the DCDF Health Authority for review, comment and corrective action plan(s) as indicated.
- During the next scheduled NDS/PBNDS review of the DCDF, the reviewers should focus on the length of time it takes the facility to arrange for emergent transport of detainees.

NOTE: recommendations applicable to non-IHSC staffed facilities will be shared with the facility by the appropriate Field Office. Follow-up on implementation of the recommendations will be conducted by the appropriate IHSC Field Medical Coordinator.

RECORDS REVIEWED

Other Information Received/Reviewed:

- 04-12-2012 Aurora Fire Department EMS report
- 04-12-2012 Rural Metro Ambulance report
- State of Colorado Certificate of Death

Note: The information and conclusions conveyed in this report are based upon the medical records and other sources of information made available to the reviewers as of 05-14-2012.

Date of Report: 05-24-2012

End of report

Reviewers:

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Detainee Death Review
Medical Record Review
MANDZA, EVALIN ALI

Section 2: Mortality Review

This mortality review was prepared by MD, Creative Corrections’ Chief Medical Officer, based on medical records from the Denver Contract Detention Facility (DCDF) and information obtained during on-site interviews by RN, Health Care Subject Matter Expert.

AUTOPSY FINDINGS
None. Autopsy not conducted.

CHRONOLOGICAL SUMMARY

October 17, 2011
Patient was processed at the Denver Field Office and Form 1213 documents the patient “states he is in good health and is taking no medication” and “appears to be in good health.” He was 46 years old.

October 24, 2011
Patient arrived at the Denver Contract Detention Facility (DCDF) and listed his nationality as Gabon, a country in west central Africa.

Intake screening was conducted by Licensed Practical Nurse (LPN). Vital signs were all within normal limits. Patient denied having any chronic care problems and it was documented he was not currently taking any prescribed medication. Spanish was documented as his primary language, as circled on the Receiving Screening Form, Line # 24. It was not documented whether he spoke and understood English. Patient was recommended to be placed in the general population. Document was signed by MD on this date.

A chest x-ray was performed with the results documented as “Negative except for calcified granuloma (small area of inflammation that has calcified) less than 2cm.” The location of the granuloma in the lungs was not documented by the radiologist.

October 25, 2011
Patient complained of having “bad movement,” which could be referred to as difficulty with movement of his bowels.

October 26, 2011
Physical examination was performed by Adult Nurse Practitioner (ANP). The progress note documented physical examination was completed, however, it did not confirm if
there were any significant findings on exam. Patient complained of having difficulty with movement of his bowels for several days in duration as stated on the progress note. Patient was prescribed Milk of Magnesia (MOM, laxative to relieve constipation) and was instructed to increase his fluid intake. Patient was also given Ducolax (a stool softener). This was the patient’s second complaint for having difficulty with movement of his bowels. The patient initially complained of difficulty with movement of his bowels on October 25, 2011.

October 31, 2011
Patient submitted a Sick Call Request complaining of constipation. This was patient’s third complaint of constipation. Patient was scheduled to be seen by Dr. [redacted] on November 3, 2011. However, the appointment did not occur. Patient was not evaluated by Dr. [redacted] until December 2, 2011 for this complaint of constipation. Patient should have been scheduled to be evaluated earlier by a physician for this complaint.

November 8, 2011
Patient submitted a Sick Call Request complaint requesting to be seen with a complaint of bumps (on his face, secondary to shaving). Patient was given topical antibiotic ointment to be applied to his face daily for seven days.

November 10, 2011
Patient submitted a Sick Call Request continuing to complain of constipation. This was the fourth complaint for this malady. Patient was evaluated by [redacted] LPN, for this complaint. Patient was given Ducolax and recommended to add fiber to his diet. Patient should have been evaluated by a physician since this has been a persistent complaint.

November 17, 2011
Patient submitted a Sick Call Request, complaining of dental pain. Patient was scheduled to be seen by the dentist on November 21, 2011 and was instructed to take Tylenol as needed for pain.

November 21, 2011
Patient was evaluated by the dentist who recommended a tooth extraction.

November 27, 2011
Patient continued to complain of having constipation. This was the fifth complaint for this ongoing problem. Despite the recommendations given by the nurses, there was no improvement in his condition.

November 28, 2011
Patient was evaluated by an RN (medical staff’s signature was illegible) and was given MOM, Ducolax and fiber. Patient had been given these same recommendations in the past, without an effective resolution. Patient was also instructed to return to health services if his symptoms worsened.
December 2, 2011
Patient was evaluated by Dr. for constipation, as well as having a rash involving his neck. Physical examination was deferred by Dr. Dr. recommended the following for treatment: (1) adult glycerin suppositories (medication used to stimulate the bowels) to be administered rectally twice a day for 3 days. (2) add fiber to his diet twice a day for 90 days (60 cc) (3) Colace (stool softener) twice a day for 90 days. Stool softener and fiber had been previously recommended by other clinical providers. This treatment had proven to be ineffective. (4) Triple antibiotic ointment cream to the neck area twice a day for 90 days.

Dr. progress note documented the patient was having abdominal pain. The examination of the abdomen was deferred by Dr. The physician should have ordered abdominal x-rays, labs, and performed an abdominal exam, as well as rectal exam for this chronic complaint.

December 11, 2011
Patient submitted a Sick Call Request with a complaint of having dental pain.

December 12, 2011
Patient was seen by RN for this dental complaint, and was given Ibuprofen and scheduled to be evaluated by the dentist on December 20, 2011.

December 14, 2011
Patient submitted a Sick Call Request complaining of pain involving his right great toe secondary to falling off the top bunk.

December 15, 2011
Patient was evaluated by Dr.; however, his progress note did not indicate a physical examination was performed for an injury involving his right great toe. In addition, no x-rays of his right great toe were ordered. No recommendations and/or orders were given by the physician.

December 20, 2011
Patient was seen by Dr. (dentist) and it was recommended to extract the tooth. Patient refused the extraction; however, there was no refusal form documented in patient’s medical record. The provider should always complete a refusal form if the patient refuses the recommended treatment.

December 25, 2011
An injury report was completed by LPN, for evaluation of abrasions on the patient’s chest and left wrist due to a physical altercation described as “horseplay” with other detainees. Patient was cleared to be placed in administrative segregation. The History and Physical exam performed by LPN was signed by Dr. on December 27, 2011.
**December 30, 2011**
Patient was evaluated by RN, with a complaint of an injury involving his right great toe. Patient stated he “fell playing soccer.” The health assessment performed by RN indicated injury to his right great toe. Ice packs and Ibuprofen were recommended.

**January 3, 2012**
Patient was examined for injury to his right great toe (secondary to playing soccer). Author’s signature on progress note was illegible. The physical exam was negative. Patient was prescribed Ibuprofen as well as authorized to have a lower bunk. The duration of patient requiring to have a lower bunk was not documented by author. In addition, a diagnosis of the injury was not documented by the author. During site visit for this review, the author was determined to be Dr.

**January 13, 2012**
A Sick Call Request was submitted for complaint of a “dental problem.” Patient was scheduled to be seen by the dentist on January 16, 2012.

**January 15, 2012**
Patient submitted a Sick Call Request, continuing to complain of constipation. This was the sixth complaint of patient informing health services of this problem. Per patient, the suppositories were helping with this condition. Patient also continues to complain of dental problem and as previously advised his appointment for the dentist was scheduled for January 16, 2012.

**January 16, 2012**
Patient was seen by Dr. (dentist) and was prescribed Amoxicillin (antibiotic) and Tylenol. Dr. recommended an extraction of the involved tooth; however, patient refused. No refusal form was found in the patient’s health record. Patient was scheduled to be evaluated by Dr. on January 18, 2012 to discuss the use of glycerin suppositories.

**January 18, 2012**
Patient was “escorted to seg/SMU.” History and Physical form was completed by RN which cleared the patient to be admitted in Administrative Segregation. Patient voiced having no physical complaints to RN. Physical examination was performed by RN was unremarkable. It was signed by MD., but not dated. The date of the signature should have been documented by the Practitioner. The patient was scheduled to be seen by Dr. however, this appointment did not occur.

**January 27, 2012**
Patient continued to complain of constipation and refused to take Colace and fiber. This was the patient’s seventh complaint of this issue. ANP renewed patient’s treatment of Glycerin suppositories for three days and the patient was counseled to take the previously prescribed treatment for constipation. According to the progress note, documented that the patient was noncompliant with the full prescribed treatment for constipation.
February 9, 2012
Progress note by RN documented the eighth complaint of patient complaining of constipation. Patient stated his last bowel movement was on January 23, 2012. Patient also had generalized abdominal discomfort associated with decreased bowel sounds. Decreased bowel sounds upon examination could have indicated a bowel obstruction was ensuing and could have necessitated a medical emergency. Patient was given a Ducolax and MOM, 30cc, one dose. It was imperative that the patient be seen immediately by a physician.

February 14, 2012
Patient submitted a Sick Call Request complaining of dental pain. Patient was seen by DMD (doctor of medical dentistry) and tooth # 18 was extracted.

March 1, 2012
A Sick Call Request was submitted by the patient with his ninth complaint of constipation. Patient also complained of his eyes burning.

March 3, 2012
RN reviewed the request and gave Ducolax and artificial tears. Patient was placed on the physician’s sick call list for March 5, 2012. Patient was instructed to “return if symptoms persisted/worsened.”

March 5, 2012
Patient was evaluated by PA (physician’s assistant) with his tenth complaint of having constipation. The progress note was written by (penmanship was illegible). The PA documented on examination visceromegaly (abnormal enlargement of the soft internal organs). It was difficult to ascertain which internal organs were enlarged, by the provider’s progress note. The provider documented “no water.” Increased water consumption is recommended for a patient who complains of being constipated. Again, the patient should have been scheduled to be evaluated by a physician for this chronic complaint. In addition, due to the chronicity of this complaint, a gastroenterology consult should have been considered for evaluation of this condition with appropriate treatment.

March 7, 2012
Patient was seen by a provider; however, the note was illegible.

March 21, 2012
Patient submitted a Sick Call Request complaining of “bad move problems/bumps shaver problems.” This was the patient’s eleventh complaint of being constipated. Patient denied having abdominal pain. RN reiterated to the patient that he needed to continue the same treatment as previously prescribed. It was quite obvious that this treatment was ineffective. At this time, the patient should have been scheduled to be evaluated by the physician and/or a referral submitted for a gastroenterology consult. Topical antibiotic ointment was prescribed to be applied twice a day for seven days to the facial area for his rash.
A progress note by (LPN) documented the patient had a stress fracture. The progress note did not indicate location of fracture, or how the diagnosis was determined. In addition, there was no evidence that x-rays were taken of the involved area.

March 25, 2012
The author (illegible signature) of the progress note stated previously prescribed medications for treatment of constipation was working. Patient stated he had normal bowel movements. Patient was instructed to continue prescribed treatment for constipation as needed. During site visit for this review, the author was determined to be Dr. .

March 31, 2012
A Sick Call Request was submitted by the patient for “no movement all week.” This was the patient’s twelfth complaint of constipation. Ducolax was prescribed one dose twice a day and MOM was prescribed, one dose per day as needed for constipation. Signature of provider was not documented on the Sick Call Request.

April 1, 2012
The patient was evaluated by LPN and was given Ducolax and MOM.

April 12, 2012
Detention Officer (DO), was making rounds on the A-4 Unit at 05:25 and was informed by other detainees that Evalin Mandza Ali was complaining of chest pains. (DO) instructed Lt. to “call Code Blue.” The Code Blue was called at 05:25. stated the patient was “rocking and rolling” in bed with his hands on his chest complaining of chest pain. The nurses on duty, RN and LPN , responded with a wheelchair, and a crash bag, which contained various medical equipment. It was unclear whether an AED (automated external defibrillator) was brought to the housing unit by the nurse. An AED should be taken to the housing unit when the patient is complaining of chest pain, because a cardiac arrest (abnormal rhythm of the heart muscle) may ensue. This equipment is necessary in an attempt to restore the normal function of the heart muscle.

Patient rated his chest pain, on a scale of 1 to 10, as an 8-9/10. Blood pressure was mildly elevated with remaining vital signs within normal limits. Patient also stated chest pain worsened upon inspiration (increase pain with breathing). RN recommended the patient be transferred to the institution’s trauma room for further evaluation. Patient was transferred to the trauma room within the institution at 05:28. At this point, no medications were administered to the patient in an attempt to relieve his chest discomfort. It is standard protocol to administer Nitroglycerin (medication given to relieve chest discomfort) and Aspirin (medication used to dilate the heart arteries). EMS (Emergency Medical Services) should have been activated immediately when nurses became aware that the patient was complaining of chest pain. RN attempted to perform an EKG using the Schiller AT-102 machine (an EKG is used as a standard assessment to determine if there is any injury to the patient’s heart muscle); however she realized the memory of the machine was full, thus the machine was inoperable. There should be a log book in the trauma room which documents that the EKG machine has been checked on a daily
basis by clinical staff which insures the equipment is functional. Also, the memory should be cleared after each use.

RN stated she had not performed a “12 lead EKG in years;” therefore, a 3 lead EKG was performed using the Welch Allyn EKG machine. A 3 lead EKG monitors only two areas of the heart. A 12 lead EKG assesses the entire function of the patient’s heart to determine if there was any direct injury to the heart muscle, which could cause a myocardial infarction (death of the heart muscle, hence a heart attack). RN also stated she had not had any formal training from the institution on the use of the two EKG machines available in the trauma unit. This is not medically acceptable, especially since she is a clinical health services provider.

RN stated she could not interpret the findings on the EKG performed on the Welch Allyn machine. Clinical health services staff should be able to interpret any abnormalities on the tracing of the EKG which could identify a patient was having an acute heart attack. RN also stated in the past the EKG could be faxed to the institution’s physician on call and/or a cardiologist for interpretation of the EKG. RN stated that presently no provision had been made to proceed with this process of faxing the EKG. Therefore, RN stated she just relied on her “gut instinct” to send the patient to the hospital. Dr. DO (doctor of osteopathic medicine) stated he would like to revise “Chest Pain Protocol” to reflect an immediate EMS response to chest pain along with administration of Aspirin. This is a very good recommendation made by Dr. to revise the “Chest Pain Protocol.”

At 05:50, Dr. was notified that the patient was complaining of chest pain. Dr. recommended the patient be transferred to the local community hospital for further evaluation. It is also noted that LPN stated the patient “wasn’t in dire distress,” and they didn’t “need to rush” (unclear who LPN was referring to as “they”). LPN recommended the patient be transported to the local community hospital by GEO van. A complaint of chest pain from a patient requires emergent evaluation and if necessary immediate transport to a higher level medical facility for evaluation and treatment. This transport to this higher level medical facility should occur expeditiously, by an ambulance. The decision to transport a patient via institutional van with a complaint of having severe chest pain was medically inappropriate.

It is so noted RN failed to follow the institution’s “Chest Pain Protocol.” Vital signs were taken twice during this encounter and not documented between 5:50 and 06:20 am. Per Institution’s “Chest Pain Protocol,” vital signs are to be taken every five minutes. In addition, no completed Chest Pain Protocol Form was located in the patient’s health record.

RN instructed LPN to “get the paper work started.” When an emergency exists within the detention center, there should be a protocol whereby having to notify various staff should not cause a delay in transporting the patient to a hospital. LPN advised Lt. that “the Patient needed to be transported to Aurora South Hospital for further medical examination.” There was confusion as to who activated the EMS (Emergency Medical Services). The staff designated in orchestrating the emergency should be the individual notifying the custodial staff in charge of activating EMS. EMS was activated at 06:21. EMS arrived at the institution at 06:30. Patient continued to complain of chest discomfort, rating pain as 9 out of 10. A 12 lead
EKG was performed by EMS, which revealed the patient had “normal sinus rhythm taken by automated device.” Normal sinus rhythm means the patient’s heart beat was beating at a normal rate. There were no acute findings seen on the EKG tracing which indicated the patient was having an acute heart attack. Upon departure from the institution, patient continued to rate his chest pain as a 9 out of 10.

At 06:57, patient arrived at Aurora South Medical Center. Per Aurora H & P (history and physical), “The patient is a 46 year old gentleman with no apparent cardiac risk factors. He is having acute anterior myocardial infarction. He will report to the Catherization Lab. Condition at time of admission was “guarded.” Patient was diagnosed with having an acute heart attack. During the cardiac catheterization (a procedure used to identify if there was blockage of the heart arteries), patient went into cardiac arrest (no contraction of the heart muscles). Advanced Cardiac Life Support Measures (medication used in an attempt to restore function of the heart) was unsuccessful. Patient expired at 08:38 on April 12, 2012.

**May 24, 2012**

Per the Death Certificate, Immediate Cause of Death was listed as “Anterior MI (myocardial infarction or heart attack) due to or as a consequence of “Severe left main coronary artery stenosis (abnormal narrowing).”

**FINDINGS**

Based on documentation in the medical record as summarized above, the reviewer finds the following:

**Timeliness of Care**

A. **Evaluation of chest pain**
   
   It took approximately 50 minutes from the onset of the patient’s complaint of chest pain for the patient to be transferred to a higher level facility for further evaluation. A complaint of chest pain requires emergent evaluation and immediate transport to a hospital. This delay in deciding to transport patient to a higher level care facility can be deleterious to patient’s condition. EMS should have been activated immediately when medical staff was notified that the patient was having chest pain. The institution’s “Chest Pain Protocol” should be revised to include the immediate administration of Nitroglycerin and Aspirin provided patient has no contraindications for these medications.

B. **Notification of appropriate staff**
   
   There was a delay in transporting the patient to the hospital because various staff, as well as signatures had to be obtained. The clinical staff should be familiar with the protocol for “Emergency Services,” which mandates which staff should be notified in a medical emergency.
D. **Scheduling of patients**
Frequently there were instances wherein the patient was not scheduled for the physician and/or dentist due to the lack of proper scheduling procedures. Procedures should be in place for scheduling patients to be seen by the clinical staff in a timely manner.

E. **Persistent complaint of constipation**
Patient submitted numerous Sick Call Requests for being constipated. The same treatment was offered repeatedly without an effective resolution. Patient was seen by the physician; however, no physical examination was performed for this ongoing complaint. In addition, there were no labs, x-rays or documentation of consideration for a specialty consult (gastroenterology) to be placed for further evaluation for this condition. Patient also complained of having abdominal pain and decreased bowel sounds were detected. This could have indicated an obstruction of his intestinal tract.

Quality of Care

A. **Use of medical equipment**
The two nurses on duty at the time of the medical emergency were unable to operate the EKG machine. Medical staff should be comfortable and knowledgeable in the operation of various medical equipment, i.e. EKG machines. Training should be performed with documentation that the clinical staff are familiar with the use of the medical equipment.

B. **Chest Pain Protocol**
Nitroglycerin and Aspirin is standard medical practice to be administered immediately to any patient when the chest pain appears to be cardiac in origin. Dr. stated that the “Chest Pain Protocol” would need to be revised to include this measure. Also, chest pain should necessitate emergent transport outside the institution if the pain appears to be cardiac in nature.

C. **Legibility of progress notes**
It was difficult to read the progress notes due to poor penmanship of the providers. The date and signature of the provider should be legible.

D. **In house training**
It was quite evident with this patient that the nurses were not trained properly to understand the nature and seriousness of this medical emergency. Interpretation and recognition of an acute myocardial infarction (heart attack) on an EKG tracing should be recognizable to the clinical staff. Continuing medical education should be a consideration in educating the clinical staff on the latest updates in the assessment and treatment of medical emergencies. Training by the staff physicians should be conducted on a regular basis to familiarize the medical staff in dealing appropriately with medical emergencies.

E. **Diagnostic Screening**
A drug screen should have been considered by the physician(s) in determining a possible cause for patient’s persistent complaint of constipation. For example, if the patient had...
been taking non-prescribed narcotics/substances, this could have been a cause for his being constipated.

CONCLUSION
It was obvious the medical staff was unfamiliar with the institution’s “Chest Pain Protocol.” Appropriate cardiac medication was not administered to this patient. This medication was critical in reducing the workload of the heart as well as preventing the death of the muscle of the heart (hence a heart attack). Also, time was of the essence in transporting the patient to a higher level care facility for prevention of further destruction of the heart wall muscle which could have contributed to the patient’s demise.

An autopsy was not ordered; reasons not documented. An autopsy would have been helpful to ascertain the pathology (abnormality) of the patient’s heart arteries. Toxicology was not ordered, which would have been beneficial in determining if the patient was taking any illicit/recreational drugs which could have also contributed to his demise.

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