



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

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The Office of Inspector General Completes Investigation of the Treatment of a Non-Citizen from Russia Who Was in Immigration and Customs Enforcement Custody Prior to His Death

The Department of Homeland Security (DHS), Office of Inspector General (OIG) initiated an investigation based on an article published by the *Seattle Times* titled, "Russian immigrant's handwritten note leaves many questions about treatment at Northwest Detention Center." The article alleged questionable actions taken at the Northwest Immigration and Customs Enforcement (ICE) Processing Center (NWIPC), Tacoma, WA, in the treatment of an ICE detainee. The article reported that while the individual was on a prolonged hunger strike, ICE placed him in a cold, isolated cell without any clothes, and that he continued to be held in segregation without receiving adequate medical and mental health care. The individual attempted suicide while in ICE custody at the NWIPC on November 15, 2018. He later succumbed to his injuries at St. Joseph's Hospital, Tacoma, WA, on November 18, 2018. A few hours prior to the suicide attempt, he was notified by a NWIPC staff member that the Board of Immigration Appeals had dismissed his appeal, and arrangements would be made to proceed with his removal from the United States.

DHS OIG reviewed policies, records, memoranda, and information reports; interviewed witnesses; reviewed the Detainee Death, Root Cause Analysis, and Psychological Autopsy Reports; and coordinated with the United States Attorney's Office (USAO) and the Department of Justice's Civil Rights Division (DOJ CRD).

The investigation revealed that the individual was provided with medical and mental health care that was within ICE policy during his hunger strike and overall incarceration at the NWIPC. He was placed in a cell by himself wearing only a suicide smock with a suicide blanket and mattress for less than 24 hours while on suicide watch, as per policy.

Additionally, he was in segregation during his hunger strike as a protective measure per policy and he remained in "Segregated in Protective Custody" status at his own request. The ICE Detainee Death Report cited there were no violations of detention standards that directly contributed to the individual's death, but areas of concern were noted regarding his medical care, safety, and security at the NWIPC. The Detainee Death Report included multiple areas of concern as information only and concluded that they did not contribute to his death. The ICE Health Service Corps' Root Cause Analysis Report cited areas that were



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indirectly contributory to his attempted suicide and provided a corrective Action Plan. ICE and the GEO Group (GEO) have made changes and improvements and conducted training with regards to the corrective Action Plan, as well as the aforementioned areas of concern.

The investigation found that no ICE policies were violated, but it did determine that GEO custody staff violated GEO policy when they failed to search the individual's cell for impermissible items each time he vacated the cell. The investigation also found no discrepancies or inconsistencies with NWIPC's statement that the individual committed suicide by hanging himself. The Medical Examiner's autopsy report concluded his death was caused by anoxic encephalopathy due to hanging and the manner of death was suicide. The DOJ CRD and the local USAO were briefed on the investigation and their review determined that the investigative findings did not identify any violations of Federal law.