CHILDREN IN CBP CUSTODY: EXAMINING DEATHS, MEDICAL CARE PROCEDURES, AND IMPROPER SPENDING

WRITTEN TESTIMONY

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Introduction

Good afternoon, Chairman Thompson, Ranking Member Rogers, and the members of The Committee on Homeland Security, my name is Dr. Roger A. Mitchell Jr, and I currently serve as the Chief Medical Examiner for Washington DC. It brings me no pleasure to testify today on these Deaths in Custody, but I appreciate the confidence of the Committee in asking me to do so. I take seriously the task that has been set before me. I have been asked to review the cases of **Jakelin Caal Maquin** and **Felipe Gomez-Alonso** from the medical examiner's perspective; specifically the post-mortem findings, the autopsy report, the cause of death, and the manner of death.

Before we get into the specifics of the cases, I would like to provide some foundational elements related to the role the medical examiner in the investigation, examination, certification, and reporting of Deaths in Custody.

The medicolegal death investigation (MLDI) system in the United States (US) comprises both coroners and medical examiners. The difference between these two types of systems varies based upon the jurisdiction, as there is a lack of uniformity of how the MLDI system is implemented across the nation. In general, coroners are elected officials who do not possess a medical education. In contrast, medical examiners are board-certified forensic pathologists and are appointed by governmental leadership. Both systems require that sudden and unexpected deaths be reported to ensure proper investigation, examination and certification. Types of cases include homicides, suicides, accidents, undetermined deaths, and even natural causes of death. Also, most jurisdictions require the reporting of the sudden deaths among children and those who die in the justice system's custody. We see both criteria in the cases that we will discuss today.

I have been studying Deaths in Custody for over 20 years. Deaths of men such as Amidou Diallo (NY) and Earl Faison (NJ) forced me to think about Deaths in Custody as a public health issue. Although much of what we think about when we hear the term “Deaths in Custody” are the recent, prominent cases like the deaths of George Floyd and Rayshard Brooks, we must remember that Deaths in Custody occur on a continuum. The continuum moves through four (4) distinct phases with the overlap of each period. The Deaths in Custody phases include: 1) pre-arrest related (during pursuit); 2) arrest-related (apprehension and transport); 3) in-custody (in short-term holding, detention, and jail); and 4) incarcerated (long-term jail, detention, or prison).[1,2] Additional deaths in custody can occur during judicial executions and post-custody (death within one year of release from jail or prison). Most of the Deaths in Custody occur from natural causes within the correctional system (jail, detention, or prison).[3]

In addition, I served as the Chair of the Child and Infant Fatality Review Committee for Washington DC from 2014-2019. The committee is tasked with the review of infant and child deaths for the purpose of creating system-centered recommendations intended to improve

outcomes and prevent future deaths. During my tenure the committee reviewed nearly 700 deaths.

It is with this lens that I review the following cases:

Jakelin Caal-Maquin

Materials Reviewed: Department of Homeland Security – Office of the Inspector General, Report of Investigation (I19-BP-ELP-05501).

Brief History/Timeline:

On December 6, 2018, Jakelin Caal-Maquin (Caal-Maquin), a 7-year-old female child, and her father were apprehended by US Customs and Border Patrol (US-CBP) attempting entrance into the US. During the transportation from the location of apprehension to the US Border Patrol (USBP) Station (93 miles/2 hours away), US-CBP agents were informed that Caal-Maquin complained of fever and vomiting. US-CBP Agents called ahead of their arrival to the USBP Station, informing them of a sick child on the bus. Caal-Maquin was found to have a temperature of 105.7 degrees upon arrival at the USBP station were Emergency Medical Technicians (EMT) tended to her, providing oxygen and cold compress. Caal-Maquin was witnessed to have a "seizure." She was subsequently air-lifted to an area hospital from the USBP Station. Caal-Maquin was pronounced dead on December 8, 2018.

- December 6, 2018
    - 2115 – Caal- Maquin encountered entering the US Border
- December 7, 2018
    - 0500 – Caal-Maquin identified and communicated as sick and vomiting
    - 0630 – Caal-Maquin arrives at USBP Station; met by EMT
    - 0640 – County Emergency Management Services (EMS) arrives at USBP Station
    - 0650 – Emergency air ambulance service identified and contacted
    - 0730 – Emergency air ambulance service arrives at USBP Station
    - 0745 – Emergency air ambulance service departs USBP Station with Caal-Maquin for Hospital
    - 0850 – Emergency air ambulance service arrives with Caal-Maquin at Hospital
    - 1100 – Caal-Maquin goes into cardiac arrest and is revived
- December 8, 2018
    - 0035 – Caal-Maquin pronounced dead at the Hospital

Autopsy and Post-Mortem Findings

Cause of Death: Sequelae of Streptococcal Sepsis

Manner of Death: Natural

Pathological Findings:

I. Sequelae of Streptococcal Sepsis
    a. Clinical Evidence of Disease
        i. Increased Temperature – 105.7 degrees
        ii. Disseminated Intravascular Coagulation (DIC)
        iii. Metabolic Acidosis
    b. Required Fluid Resuscitation
        i. Bilateral Pleural Effusions
            1. 160 milliliters – Right
            2. 180 milliliters – Left
        ii. Peritoneal fluid retention
            1. 210 milliliters
    c. Patchy Bronchopneumonia, bilateral, base
        i. Pulmonary Congestion
        ii. Histological evidence of acute inflammation and gram-positive cocci
            1. Immunohistochemistry staining positive for *Streptococcus* species
            2. Real-time polymerase chain reaction (RT-PCR) positive for *Streptococcus* species
    d. Splenic Involvement
        i. Histological evidence of reactive changes
        ii. Immunohistochemistry staining positive for *Streptococcus* species
    e. Hepatic Involvement
        i. Immunohistochemistry staining positive for Streptococcus species
    f. Adrenal Gland
        i. Hemorrhage and necrosis consistent with Waterhouse-Friderichsen Syndrome
        ii. Immunohistochemistry staining positive for *Streptococcus* species
        iii. Real-time polymerase chain reaction (RT-PCR) positive for *Streptococcus* species
II. Ascaris Lumbricoides Infection
    a. 2-3 dozen nematodes of different sizes in the small bowel
        i. Duodenum, proximal jejunum, near the ileocecal valve
            1. No bowel obstruction

<u>Summary Opinion</u>

The decedent is a 7-year-old female child who suffered septic complications from a bacterial infection. The subspecies of Streptococcus were unable to be determined; therefore, it is unclear the specific bacterial cause of the child's infection. Nonetheless, the clinical, laboratory, and autopsy findings are consistent with bacterial sepsis. According to the literature, sepsis is defined as a clinical syndrome resulting from a dysregulated systemic inflammatory response to infection. It is the leading cause of morbidity and mortality in children worldwide.[4] It is important to note that sepsis can progress to organ failure and shock rapidly. Therefore, early

recognition and treatment are critical. Initial treatment includes immediate fluid resuscitation. The report also describes the presence of Waterhouse-Friderichsen Syndrome (WFS). WFS is characterized by hemorrhagic necrosis of the adrenal glands accompanying vague symptoms of fever, fatigue, and weakness. According to an article in the *Pediatric Infectious Disease Journal*, WFS can be linked to streptococcal infections.[5]

Based on the review of the material available to this forensic pathologist, it is my opinion that the cause and manner of death established by the medical examiner are sufficient. It is also my opinion ~~is~~ that this death was preventable. Although the actions taken by individual US-CBP Agents seem to be appropriate and timely, the larger US-CBP system lacks adequate human resources and physical infrastructure resources to respond to medically fragile detainees, especially children. If the administration of the initial health assessment questionnaire (I-779) had been performed by a licensed medical professional (nurse practitioner, physician assistant, or nurse), the elevated body temperature would have been detected.

The above opinion is established within a reasonable degree of medical certainty.

<u>Recommendations</u>

- Utilize medical personnel (physician, physician assistant, nurse practitioner, or nurse) for the initial health assessment of detainees, especially children.
    - Update the initial medical assessment form (I-779) to be administered by licensed healthcare providers.
        - Accompanied by brief initial health screening including touchless temperature check, blood pressure, glucose finger stick, and COVID nasal swab.
- Develop an on-site clinic system for US-CBP that has the ability to triage pediatric patients (i.e. pediatric blood pressure cuffs)
- Establish electronic health record (EHR) for US-CBP
- Assess and reevaluate training for US-CBP
- Develop or improve emergency and acute care access standard operating procedure

Felipe Gomez-Alonso

Materials Reviewed: Department of Homeland Security – Office of the Inspector General, Report of Investigation (I19-BP-ELP-06106), Autopsy Report, Autopsy Photographs, Case Notes, Microbiology Report, Toxicology Report, and Histology Slides.

Brief History/Timeline:

On December 18, 2018, Filipe Gomez-Alonso (Gomez-Alonso), an 8-year-old male child, and his father were apprehended by US Customs and Border Patrol (US-CBP) attempting entrance into the US. They were detained at the first US-Border Patrol (USBP) station until December 20, 2018. They were transferred to a second USBP Station because of limited space. Gomez-Alonso and his father were finally moved to a third USBP Station on December 23, 2018. On December 24, 2018, Gomez-Alonso was found to have "a loud, hoarse cough," complaining of a sore throat, upset stomach, and a fever.

Alonso-Gomez was subsequently transported to the local hospital emergency room. Clinicians at the hospital saw him. He was, found to have a temperature of 103^{o}F. A pharyngeal swab was positive for influenza, and he was diagnosed with an upper respiratory infection (URI). Alonso-Gomez was prescribed acetaminophen and an antibiotic and released from the hospital.

Alonso-Gomez was transported back to the USBP Station by US-CBP agents. Reportedly, he seemed to improve over the next several hours before an acute decline in his health status. He complained of severe stomach pain and vomiting, which required urgent transportation back to the hospital. Upon arrival at the hospital, Gomez-Alonso was found to be in cardiopulmonary arrest. He was pronounced dead on December 24, 2018.

- December 18, 2018
    - 1525 – Gomez-Alonso encountered entering the US Border and transported to the first USBP Station
- December 20, 2018
    - 1200 – Gomez-Alonso transported to second USBP Station due to overcrowding
    - Remained at second USBP Station
- December 23, 2018
    - 2317 – Gomez-Alonso transported to the third USBP Station
- December 24, 2018
    - 0100-0557 – Gomez-Alonso arrival and intake process complete at the third USBP Station
    - 0900 – Gomez-Alonso requires medical attention
    - 0930 – Gomez-Alonso arrives at hospital
    - 1345 – Gomez-Alonso diagnosed with Influenza B, provided with prescriptions for acetaminophen and amoxicillin and released from the Hospital
    - 1700 – Gomez-Alonso given medications back at the USBP Station

- 1800 – Wellness Check of Gomez-Alonso by USBP Agents
- 1930 – Wellness Check of Gomez-Alonso by USBP Agents
- 2100 – Wellness Check of Gomez-Alonso by USBP Agents
- 2145 – Gomez-Alonso requests to return the Hospital
- 2200 – USBP assigned transportation
- 2258 – Gomez-Alonso transported to the hospital
- 2315 – Gomez-Alonso arrives at hospital and receives emergency treatment

2348 – Gomez-Alonso is pronounced dead

Autopsy and Post-Mortem Findings

Cause of Death: Complications of Influenza B infection with Staphylococcus aureus superinfection and sepsis

Manner of Death: Natural

Pathological Findings

I. Complications of Influenza B infection with Staphylococcus aureus superinfection and sepsis.
   a. Clinical Findings at the Initial Hospital Visit
      i. Temperature – 103.46^{o}F
      ii. Peripheral Pulse – 146 bpm
      iii. Oxygen Saturation (SpO_2) – 91%
      iv. Influenza B – Test positive (12/24/2018)
   b. Necrotizing Pneumonia (Pulmonary Hemorrhage and Edema)
      i. Bronchopneumonia, marked
         1. Diffuse alveolar damage
         2. Bacterial blood and lung cultures positive for Methicillin Sensitive Staphylococcus aureus (MSSA)
            a. Immunohistochemical and Real-Time Polymerase Chain Reaction (RT-PCR) - Positive
            b. Panton-Valentine leucocidin (PVL) – Positive
         3. Influenza B virus positive by Real-Time Polymerase Chain Reaction (RT-PCR)

Summary Opinion

The decedent is an 8-year-old male child who suffered complications of influenza viral infection associated with a superimposed bacterial disease. According to the Infectious Disease Pathology Branch (IDPB) of the Centers for Disease Control (CDC), the bacteria isolated were methicillin-sensitive Staphylococcus aureus (MSSA) with associated Panton-Valentine leucocidin (PVL) exotoxin. It is a significant factor that led to the death. MSSA is highly contagious, particularly in close quarters or conditions of overcrowding. PVL-positive MSSA is a severe

infection, often associated with influenza disease, that leads to rapidly progressing necrotizing pneumonia.[6]

Based upon the review of material available to this forensic pathologist, it is my opinion that the cause of death should read *Necrotizing pneumonia due to methicillin-sensitive Staphylococcus aureus complicating Influenza B viral infection*. The manner of death is natural.

It is also my opinion that this death was preventable. Overcrowding is a known condition of the USBP Stations. I believe the overcrowded conditions played a significant role in the decedent developing the infections that led to his death. Although the actions taken by individual US-CBP agents seem to be appropriate and timely, the larger US-CBP system lacks adequate human resources and physical infrastructure to respond to medically fragile detainees, especially children. There were many missed opportunities to provide life-saving care to this child, namely the hospital's mismanagement of his initial presentation. However, if a licensed medical professional (nurse practitioner, nurse, or physician assistant) would have cared for this patient throughout his stay within the detention station, the patient would have had a more informed assessment before presenting to the hospital during his initial visit and beyond.

The above opinion is established within a reasonable degree of medical certainty.

<u>Recommendations</u>

- Enforce and control the population in USBP Stations to protect against overcrowding
- Utilize medical personnel (physician, physician assistant, nurse practitioner, or nurse) for initial health assessment of detainees, especially children.
    - Update the initial medical assessment form (I-779) to be administered by licensed healthcare providers.
        - Accompanied by brief initial health screening including touchless temperature check, blood pressure, glucose finger stick, and COVID nasal swab.
- Develop an on-site clinic system for US-CBP that has the ability to triage pediatric patients (i.e. pediatric blood pressure cuffs).
- Establish electronic health record (EHR) for US-CBP
- Assess and reevaluate training for US-CBP Agents.
- Develop or improve emergency and acute care access standard operating procedure

CONCLUSION

In conclusion, immediate and timely access to a healthcare assessment by licensed and trained medical professionals could have prevented the deaths of both **Jakelin Caal Maquin** and **Felipe Gomez-Alonso.** The deaths of these two children are a symptom of a more extensive system that requires much improvement. No system is perfect, but any system established by our government must have at its core the health and safety of all who come into contact with it. There is an excellent opportunity to make the necessary investment to ensure life-saving

medical care to sick men, women, and children. The cases of these two children remind us that Deaths in Custody are not merely a criminal justice issue, but a public health issue. We must treat those who die in the custody of our detention system as preventable, revealing a system that is able to improve.

In 2017, the National Institute of Justice (NIJ) in collaboration with the RAND Justice Policy Program hosted an expert panel of prison and jail administrators, researchers and health care professionals entitled, *Caring for Those in Custody: Identifying High-Priority Needs to Reduce Mortality in Correctional Facilities*.[3] I had the pleasure of serving on this panel, and what we realized is that those who find themselves incarcerated, for whatever the reason, either arrive with or acquire health conditions that become the responsibility of the institution. We have an obligation to make sure that all who come into our custody receive timely, accurate, and reliable care. We must provide reliable care in the detention centers of our borders, but also on the streets of our cities, the jails of our counties, and the prisons of our states.

I appreciate the work that this Committee is doing to solve this problem. I pray that this hearing does not only provide an "appearance" of addressing the issues that I have outlined, but is a true "call to action" with resolutions. This may require your dedication to this Nation beyond what is comfortable, but I believe it is attainable. Thank you, Chairman Thompson and Members of the Committee. I am now available to answer any questions that you may have.

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