U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: JONES, Anthony

General Demographic/Background Information

- **Date of Birth:** March 29, 1969
- **Date of Death:** December 17, 2020
- **Age:** 51
- **Gender:** Male
- **Country of Citizenship:** Bahamas
- **Marital Status:** N/A
- **Children:** N/A

Immigration History

- On March 2006, Enforcement and Removal Operations (ERO) Miami served Mr. JONES with a Notice to Appear, while in Florida's Department of Corrections' (FL DOC) custody. ERO charged Mr. JONES with inadmissibility of the Immigration and Nationality Act, as an alien present without being admitted by an Immigration officer, and as an alien convicted of a crime involving moral turpitude.
- On April 3, 2006, FL DOC released Mr. JONES to ERO Miami's custody. On November 8, 2006, an immigration judge ordered his removal from the U.S. to the Bahamas. Mr. JONES waived his right to an appeal.
- On November 13, 2007, after a Post-Order Custody Review, ERO Headquarters ordered Mr. JONES' release from ICE custody; ERO Miami released him on an order of supervision pending issuance of a travel document.
- On April 11, 2019, Broward County Jail released Mr. JONES to ERO Miami, after his charges were dropped.
- On May 21, 2019, ERO placed Mr. JONES in "failure to comply" status, due to his refusal to cooperate, provide requested information to the Consulate, and complete forms required for his travel documents.
- On October 2, 2019, ERO Miami transferred Mr. JONES to ERO New Orleans custody and housed him at ACDC.
- Between July 6 to October 23, 2020, ERO New Orleans issued Mr. JONES three "failure to comply" documents; however, Mr. JONES remained uncooperative. Mr. JONES did not report any medical conditions or concerns.

Criminal History

- On September 21, 2000 Mr. JONES was convicted of Aggravated Assault-Non-family-Strongarm in FL.
- On October 27, 2018 Mr. JONES was arrested for touch or strike battery domestic violence in Coral Springs, FL.

Medical History

Medical Records from Adams County Detention Center (ACDC)

On October 2, 2019 Mr. JONES had a medical pre-screening during which he denied any medical or mental health conditions, or current medication use. He was cleared for

admittance into ACDC, pending an intake screening. On the same day, Mr. JONES' intake screening, as well as a review of transfer summary from Krome North Service Processing, identifying his medical condition of hypertension (HTN), were complete. Mr. JONES reported having a toothache and missing/broken teeth but denied any additional medical or mental health conditions or taking current medications. Mr. JONES also reported a history of a broken leg in 2005. Mr. JONES' vital signs (VS) were normal except for an elevated blood pressure (BP) reading of 139/93 millimeter of mercury (mmHg); a normal reading is less than 120/80 mmHg. Mr. JONES was referred to a dentist and cleared for housing in general population.

On October 4, 2019 an advanced practice provider (APP) ordered the ACDC nursing staff to monitor and check Mr. JONES's BP twice a week, for four weeks.

On October 15, 2019 an APP completed Mr. JONES' initial health appraisal. Mr. JONES reported taking hydrochlorothiazide [(HCTZ); diuretic used for treatment of HTN) and an appendectomy (date unknown) but denied any other medical complaints. The APP documented normal VS, except for a BP of 135/94 mmHg. The APP ordered baseline laboratory tests and an electrocardiogram [(ECG); results: sinus rhythm with possible left ventricular hypertrophy]. The APP prescribed Mr. JONES HCTZ 25 mg, one tablet daily, and referred him to the chronic care clinic (CCC).

On October 29, 2019 an APP evaluated Mr. JONES' for a BP follow-up and noted no improvement of his BP, since starting HCTZ. Mr. JONES reported he did not take his morning medications but denied having any current complaints. The APP documented normal examination findings, except for Mr. JONES elevated BP of 135/94 mmHg. The APP continued Mr. JONES' HCTZ, discussed his laboratory results, provided education, and informed him to follow up in CCC as scheduled.

On November 12, 2019 ACDC's medical doctor (MD) evaluated Mr. JONES for his CCC visit. Mr. JONES reported a history of an appendectomy (date unknown) but denied any current complaints. The MD documented normal exam findings and VS, except for his BP readings of 133 – 149/90-98 mmHg and elevated total cholesterol results of 217 milligrams per deciliter [(mg/dL); normal: less than 200 mg/dL]. The MD diagnosed Mr. JONES with HTN and dyslipidemia (elevated cholesterol levels), ordered repeat laboratory tests, weekly BP checks for eight weeks, and a follow-up appointment in three months.

On January 13, 2020 an APP evaluated Mr. JONES for a BP follow-up. Mr. JONES denied any cardiac related symptoms. The APP noted Mr. JONES in no acute distress, documented normal exam findings, and VS, except for his BP range of 121 – 142/82-90 mmHg. The APP continued his current medications, scheduled his CCC appointment, and a prostate examination in one month.

On February 13, 2020 an APP evaluated Mr. JONES for his CCC follow-up evaluation and addressed Mr. JONES' bowel issues and request for prostate examination. The APP performed a prostate exam, ordered a prostate specific antigen [(PSA); blood test to measure the level of PSA in the blood], and diagnosed him with benign prostate

hypertrophy [(BPH); enlarged prostate], and scheduled a follow-up visit for February 17, 2020.

On February 18, 2020 an APP evaluated Mr. JONES, who denied urinary or bowel symptoms. The APP documented normal VS, normal PSA laboratory result, and ordered tamsulosin (medication used to treat an enlarged prostate) 0.4 mg one tablet, by mouth, at bedtime, and scheduled a follow-up in three months, or as needed.

On April 6, 2020 Mr. JONES' repeat laboratory studies showed abnormal Hgb, WBC, RBC, cholesterol (HDL and LDL) and elevated triglycerides**.**

On April 28, 2020 ICE completed Mr. JONES' coronavirus (COVID-19) and the *Fraihat* COVID-19 high risk factor classification review. The *Fraihat* class action is a lawsuit filed against ICE and DHS wherein the court ordered the federal government to identify and track all ICE detainees with risk factors for serious illness from COVID-19 and make timely custody determinations. Mr. JONES classified into subclass two due to HTN.

On May 1, 2020 an APP evaluated Mr. JONES due to bowel issues. The APP documented normal examination findings, VS, and ordered continuation of current medication, plan to consult with the MD, and instructed Mr. JONES to notify medical if he experienced worsening symptoms.

On May 21, 2020 and July 1, 2020 an APP evaluated Mr. JONES for nasal congestion, sinus pressure under his right eye, with nasal discharge. The APP diagnosed Mr. JONES with acute sinusitis, ordered antibiotics for Mr. JONES, and scheduled him for a one-week follow-up.

On July 30, 2020 An MD evaluated Mr. JONES for his HTN CCC visit, the MD documented no new events since his last CCC appointment and noted Mr. JONES met his BP goal (less than 120/80 mmHg). The MD reviewed Mr. JONES' laboratory results dated, April 6 and May 12, 2020, ordered additional laboratory testing, weekly BP monitoring, every two weeks, and a follow-up appointment in three months.

On August 3, 2020 an APP re-evaluated Mr. JONES for his acute sinus infection and ordered another 7-day course of antibiotics.

On August 26, 2020 ICE completed a Fraihat custody review, consulted with the ACDC health authority regarding Mr. JONES' COVID-19 risk factors, and determined Mr. JONES' risk factors were manageable for continued custody.

On September 4, 2020 Mr. JONES had a routine screen for severe acute respiratory syndrome coronavirus (SARS-CoV-2), which showed negative results.

On September 8, 2020 an APP evaluated Mr. JONES due to a sick call referral. Mr. JONES complained of right sinus pressure, having a nosebleed, and nasal drainage. He denied having any additional symptoms. The APP prescribed levofloxacin (antibiotic) for ten days, saline nasal drops, and scheduled a follow up in two weeks.

On September 28, 2020 during the APP's follow up visit for acute sinusitis, Mr. JONES verbalized resolution of his symptoms.

On October 6, 2020 the APP evaluated Mr. JONES after he presented (unscheduled) to the clinic for "sinus symptoms returning," and a BP check. The APP documented normal VS results unsuccessful resolution of Mr. JONES acute sinusitis with antibiotic therapy, and intent to start a trial of daily cetirizine (antihistamine). The APP instructed Mr. JONES to return to the clinic in two to three weeks if no resolution of symptoms.

On October 19, 2020 an APP completed Mr. JONES' annual health appraisal. Mr. JONES denied any medical complaints. The APP noted, Mr. JONES history of HTN, seasonal allergies, acute sinusitis, nosebleed, BPH, appendectomy, and his current medications, which included: a laxative, HCTZ, tamsulosin HCL, and anti-allergy medication. The APP documented Mr. JONES' normal exam findings, VS, and his wt. of 162.4 lbs. The APP instructed Mr. JONES to follow up at next CCC appointment, or as needed.

On October 27, 2020 the MD evaluated Mr. JONES during his CCC visit. Mr. JONES denied any complaints, except for "his knees are popping." The MD documented normal VS, except for a BP reading of 133/90, and ordered a blood chemistry panel, bi-weekly BP monitoring, and a three-month follow-up.

November 11 to December 10, 2020, Mr. JONES' BP ranged from 104-120/70-73 mmHg which met his BP goal (less than 120/80 mmHg).

Synopsis of Death

On December 17, 2020 Mr. JONES ambulated to the clinic and reported "burning in my chest and both arms" that started three hours after consumption of his meal. Mr. JONES rated his pain a 0/10 [1-10 pain scale] and denied having shortness of breath, lightheadedness, nausea, or vomiting.

From 7:40 a.m. to 8:25 a.m. Mr. JONES' VS, as well as his temperature were regularly completed with normal findings. The MD documented clear lung sounds, skin warm and dry, capillary refills (time taken for color to return to an external capillary bed after pressure applied) less than three seconds, ordered oxygen at two liters (L) per nasal canula; administered one nitroglycerine (treatment of chest pain) 0.4 mg tablet, sublingual, aluminum-magnesium hydroxide (antacid) 30cc, one aspirin 325 mg, and ordered an ECG that showed: "mild sinus bradycardia (52 bpm), moderate ST depression in V3, V4, but no reciprocal changes, pathological Q waves, or signs of heart block."

8:15, 8:20, and 8:25 a.m**.** The RN documented Mr. JONES had normal VS and reported "feeling much better." He denied having chest pain or shortness of breath but reported burning sensation in his right arm at.

9:13 – 9:14 a.m. Mr. JONES was noted seated slumped over in his chair at the medical unit custody officer (CO) assigned to the medical unit noted, Mr. JONES was seated slumped over in his chair, unresponsive to verbal commands, and requested Mr. JONES receive an RN evaluation. The RN and MD assessed Mr. JONES, noted him as unresponsive, not breathing, and pulseless. The RN instructed the custody officer (CO) to call 911 and requested a stretcher.

9:17 – 9: 49 a.m. Medical staff transported Mr. JONES to the clinic's emergent care and initiated life saving measures. 9:50 a.m. Emergency medical service (EMS) personnel arrived at the scene.
9:56 a.m. A paramedic arrived on scene and continued life-saving measures; however, efforts were unsuccessful, and EMS pronounced Mr. JONES dead at 9:59 a.m.

Mr. JONES' remains were transported to the Adams County Coroner office, pending an autopsy.