U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: DEAN, Jesse

General Demographic/Background Information

- **Date of Birth:** March 21, 1962
- **Date of Death:** February 5, 2021
- **Age:** 58
- **Gender:** Male
- **Country of Citizenship:** Bahamas
- **Marital Status:** N/A
- **Children:** N/A

Immigration History

- On June 10, 1995, the former Immigration and Naturalization Service (INS) admitted Mr. DEAN into the U.S. at Miami, Florida (FL), as a non-immigrant visitor, with authorization to remain in the U.S. until December 9, 1995.

- On December 31, 2019, Enforcement and Removal Operations (ERO) Detroit encountered Mr. DEAN at the North Lake Correctional Facility (CI-NLK), in Baldwin, MI, and served an Immigration Detainer, Notice of Action, form I-247.

- On December 31, 2020, CI-NLK released Mr. DEAN to ERO Detroit. On this same date, ERO Detroit served Mr. DEAN a Final Administrative Removal Order, Form, I-851A, charging removability as an alien convicted of an aggravated felony, and transferred him to Calhoun County Jail (CCJ) for housing.

Criminal History

- On April 25, 1997, the U.S. District Court, Southern District of Florida convicted Mr. DEAN of possession, with intent to distribute cocaine, and sentenced him to thirty years.

Medical History

Medical Records from CCJ

On December 31, 2020, Mr. DEAN had intake screening which documented normal vital signs (VS) except for an elevated blood pressure (BP) of 180/98 millimeters of mercury [(mmHg); normal 90/60 – 120/80 mmHg], a weight of 172 pounds (lbs.), and a medical history of hyperlipidemia (high levels of fat in the blood) and HTN, managed with medications. Mr. DEAN was referred to a provider for chronic care management. A nasal swab test for COVID-19 was completed with negative results.

On January 10, 2021, a sick call registered nurse (RN) evaluated Mr. DEAN for mild and intermittent abdominal discomfort, accompanied with nausea and vomiting. Mr. DEAN reported his

last bowel movement (BM) occurred on that same date. The RN documented a weight of 170 lbs., normal VS, positive bowel sounds (BS), and provided bismuth subsalicylate (used to treat upset stomach) 262 milligrams (mg) chewable tablets, two tablets, by mouth, two times daily, as needed (prn).

On January 12, 2021, an RN evaluated Mr. DEAN during sick call for flatulence, bloating, and ineffective bismuth subsalicylate medication. The RN provided simethicone (used to relieve painful pressure caused by excess gas in the stomach and intestines) 125 mg chewable tablets, two tablets, by mouth, two times daily, prn.

On January 14, 2021, a medical doctor (MD) evaluated Mr. DEAN for continuous abdominal pain complaints. Mr. DEAN requested a special diet and reported his dislike for the regular diet meals. The MD ordered Mr. DEAN a clear liquid diet for four days, to relieve his stomach issues.

On January 15, 2021, Mr. DEAN received a COVID-19 nasal swab test that showed negative results.

On January 19, 2021, an RN completed Mr. DEAN's physical examination, reviewed his intake screening, documented a weight of 156 lbs., normal VS, and a ten-year medical history of HTN, managed with medications. The RN did not document any abdominal complaints or findings.

On January 20, 2021, an RN evaluated Mr. DEAN during sick call for sharp abdominal pain with cramping, documented normal VS, positive BS, soft abdomen, and grimacing with ambulation. Mr. DEAN reported his last BM occurred "at least 5-6 days ago." The RN notified an advanced practice provider (APP) and received a verbal order to start an antacid and laxative.

On January 21, 2021, the MD evaluated Mr. DEAN during chronic care clinic, documented a weight of 156 lbs., normal VS, positive BS, and soft abdomen with palpation. Mr. DEAN reported poor fluid intake, last BM, four to five days ago, and constipation since his arrival to the facility, with increased cramping pain, while lying on his back at night. The MD diagnosed Mr. DEAN with constipation related to dehydration, ordered laboratory studies, magnesium citrate (laxative), continued current medications, and encouraged him to increase his fluid intake and exercise, in order to relieve his constipation.

On January 22, 2021, an APP ordered Mr. DEAN's HTN medications, which included lisinopril, triamterene/hydrochlorothiazide, metoprolol, and enteric coated aspirin.

On January 27, 2021, an APP evaluated Mr. DEAN for continuous complaints of constant, aching, non-radiating abdominal pain, located around the umbilicus (navel area), that worsened at night. Mr. DEAN reported only eating breakfast for two weeks, and last BM five days prior. Mr. DEAN denied bloating, vomiting, or dysuria (difficulty urinating). The APP documented normal VS, positive BS, soft, non-tender, non-distended abdomen, no palpable masses, and no changes in weight. The APP encouraged increased fluid intake, ordered laboratory studies, an abdominal x-ray, which showed normal results, and scheduled a follow-up appointment.

On January 28, 2021, Mr. DEAN received a COVID-19 nasal swab test that showed negative results.

On January 30, 2021 at approximately 12:10 a.m., an RN documented Mr. DEAN's continued complaint of abdominal pain, which he reported as the cause of his difficulty breathing.

- **At approximately 10:47 p.m.**, a CCJ custody officer requested medical staff evaluate Mr. DEAN for reported having severe abdominal pain and difficulty breathing. An RN evaluated Mr. DEAN, documented normal bowel sounds in all four quadrants, upon auscultation (the action of listening to organ sounds with a stethoscope), normal VS, oxygen saturation level at 98% on room air, excessive belching, and no signs of respiratory distress.

On January 31, 2021 at approximately 8:54 a.m., an RN evaluated Mr. DEAN during sick call for abdominal pain. The RN documented Mr. DEAN's pain level of six (on a ten-point scale), and normal VS, but did not complete an abdominal assessment. The RN explained to Mr. DEAN, his symptoms may be related to his "state of mind" and referred him to a behavioral health provider.

- **At approximately 8:30 p.m**., an RN evaluated Mr. DEAN in his housing unit for persistent abdominal pain. The RN documented Mr. DEAN's normal VS and unchanged symptoms, from previous medical staff evaluations. The RN did not complete an abdominal assessment.

On February 2, 2021, medical staff responded to a medical emergency in Mr. DEAN's housing unit, due to Mr. DEAN's reported loss of consciousness. Mr. DEAN denied any injuries, dizziness, nausea, vomiting, or visual disturbance, but complained of moderate, constant, dull achy abdominal pain, and associated cramping near the umbilicus. The RN evaluated Mr. DEAN, observed him alert and oriented, documented normal VS, full range of motion to all extremities, and positive BS. Mr. DEAN reported having anxiety, difficulty with his thoughts but denied suicidal ideations, and the RN referred him to a behavioral health provider (BHP).

On February 4, 2021, Mr. DEAN reported severe abdominal pain with associated dizziness, causing him to fall. An RN evaluated Mr. DEAN and documented normal VS. He expressed feeling anxious and requested a BHP evaluation. The medical staff switched Mr. DEAN's housing assignment to the intake area for monitoring, due to his continued complaints of abdominal pain. An RN evaluated Mr. DEAN and documented normal VS and findings.

On February 5, 2021 at approximately 7:40 a.m., during Mr. DEAN's medication administration, a licensed practical nurse (LPN) observed Mr. DEAN struggling to get up to take his medications and Mr. DEAN reported not feeling well. The LPN noted Mr. DEAN's low BP of 88/48 mmHg, and requested additional assistance. An APP observed Mr. DEAN as alert and oriented, well nourished, documented a soft, non-tender, non-distended abdomen, and no palpable masses. Mr. DEAN denied chest pain or shortness of breath. The APP transferred Mr. DEAN to the medical unit for observation, initiated intravenous fluids, and held his medications.

- **At approximately, 10:45 a.m.**, during an RN evaluation, Mr. DEAN became unresponsive and the RN notified the APP. The APP evaluated Mr. DEAN, documented the following VS: BP of 90/50 mmHg, a heart rate of 80 beats per minute [(bpm); normal range 80 – 100 bpm], elevated blood sugar of 203 milligrams/ deciliter [(mg/dl); normal range 70- 100 mg/dl], a normal electrocardiogram, and variable respirations, ranging from five to twenty breaths per minute [(bpm); normal respirations 12- 20 bpm], ordered supplemental oxygen at 10 liters per and activated the emergency medical services (EMS)
- **At approximately 10:53 a.m.**, EMS arrived at CCJ.

- **At approximately 11:07 a.m**., EMS transferred Mr. DEAN to the ambulance and shortly after requested additional assistance from CCJ's medical staff.
- **At approximately 11:10 a.m.**, EMS and CCJ staff initiated cardiopulmonary resuscitation; however, Mr. DEAN never regained consciousness. After approximately thirty minutes of life saving measures, CCJ medical staff pronounced Mr. DEAN deceased at 11:38 a.m.
- Mr. DEAN's autopsy report showed his cause of his death was gastrointestinal hemorrhage, due to a duodenal (first part of the small intestines) ulcer, and a contributory cause of death, of hypertensive cardiovascular disease. The coroner determined Mr. DEAN's manner of death, as natural.