Office of Enforcement and Removal Operations
ICE Health Service Corps

U.S. Department of Homeland Security
500 12th Street, SW
Washington, D.C. 20536

U.S. Immigration and Customs Enforcement

October 22, 2025

MEMORANDUM FOR: (b)(6),(b)(7)(C),(b)(7)(F) DHSc, FACHE
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ICE Health Service Corps
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THROUGH: CAPT (b)(6),(b)(7)(C),(b)(7)(F) MD, MPH, CCHP, FAAFP
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FROM: CAPT (b)(6),(b)(7)(C),(b)(7)(F) RN
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SUBJECT: Mortality Review – Report of Findings
Johnny NOVIELLO, (b)(6),(b)(7)(C)

Executive Summary:

On June 23, 2025, the U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) received notification of the death of alien Johnny NOVIELLO, (b)(6),(b)(7)(C). ICE detained Mr. NOVIELLO, a 49-year-old Canadian male, on May 15, 2025, at Krome Service Processing Center (KSPC), in Miami, Florida. On May 19, 2025, ICE transferred Mr.

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NOVIELLO to the Bureau of Prisons Federal Detention Center (FDC) Miami, in Miami, Florida, where he remained until his death. Mr. NOVIELLO's autopsy report is pending.

Prior to his detention, on October 12, 2023, the Seventh Judicial Circuit Court convicted Mr. NOVIELLO for the offenses of racketeering, trafficking illegal drugs, and unlawful use of a two-way communication device to facilitate commission of a crime, and sentenced him to 12 months of imprisonment. On May 15, 2025, ICE Enforcement and Removal Operations (ERO) Miami apprehended Mr. NOVIELLO at the Florida Department of Corrections Probation office, in Daytona Beach, Florida, issued him a Notice to Appear, Service Form I-862, charging removability pursuant to Section 237(a)(2)(B)(i) of the Immigration and Nationality Act, and detained him at KSPC.

On May 16, 2025, during his KSPC intake screening, Mr. NOVIELLO reported a medical history of seizures and hypertension, and presented with anticonvulsant and antihypertensive medications. A registered nurse (RN) submitted a medical referral to an advanced practice provider (APP) and a mental health referral for Mr. NOVIELLO's report of clonazepam (benzodiazepine) use for seizures. An APP prescribed Mr. NOVIELLO's reported medications, except clonazepam.

On May 19, 2025, ERO Miami transferred Mr. NOVIELLO to FDC Miami.

On May 20, 2025, during his intake screening, an FDC Miami APP documented Mr. NOVIELLO's vital signs, ordered labs, and ordered self-carry medications to continue as written by KSPC providers.

Between May 21 and June 20, 2025, health staff assessed Mr. NOVIELLO and documented his numerous refusals of care and food, and his declining health and mental status.

On June 20, 2025, a behavioral health provider (BHP) placed Mr. NOVIELLO in restrictive housing for increased observation, confiscated his self-carry medications, placed his medications in the officer's station, and sent an e-mail notification to medical staff with information on his housing status.

On June 21 and 22, 2025, a BHP evaluated Mr. NOVIELLO and documented his confused and disoriented state.

On June 23, 2025, a BHP evaluated Mr. NOVIELLO and requested an urgent evaluation by the APP. The APP documented Mr. NOVIELLO's confused and disoriented state.

- On the same date, at approximately 1:02 p.m., custody staff found Mr. NOVIELLO unresponsive in his cell and announced a medical emergency via the facility radio. At 1:04 p.m., medical staff arrived at Mr. NOVIELLO's cell. At 1:05 p.m., custody and

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medical staff carried Mr. NOVIELLO from his cell, laid him on the floor in the pod, began administering cardiopulmonary resuscitation (CPR), applied an automatic external defibrillator (AED), loaded him on a stretcher, transported him to the urgent care room, and continued life-saving measures until the City of Miami Fire Rescue Department (MFRD) personnel arrived at the scene. At 1:36 p.m., MFRD personnel pronounced Mr. NOVIELLO deceased.

Mortality Finding:

As a result of Mr. NOVIELLO's death, the IHSC Assistant Director requested a mortality review to learn from his death by reviewing the care provided and the circumstances leading up to his death. The goal of the mortality review is to determine the appropriateness of clinical care; ascertain whether changes to policies, procedures or practices are warranted; and identify issues requiring further study.

A mortality review committee (MRC) determined the care FDC Miami provided to Mr. NOVIELLO deviated beyond safe limits of practice. Specifically, the MRC determined, 1) FDC Miami medical staff did not administer Mr. NOVIELLO's medications while custody staff housed him in restrictive housing; 2) FDC Miami staff did not effectively communicate Mr. NOVIELLO's deterioration among the multidisciplinary team; 3) FDC Miami medical staff did not perform baseline exams, labs, or studies indicated based on his diagnoses and reported medical history; 4) FDC Miami behavioral health staff did not appropriately refer Mr. NOVIELLO to a higher level of care; 5) FDC Miami's logs contained discrepancies and omissions, and medical staff did not adequately document Mr. NOVEILLO's status based on his medical condition; 6) During Mr. NOVIELLO's medical emergency, FDC Miami staff did not provide effective CPR or secure his body to the gurney during transportation.

The MRC convened on September 15, 2025, and consisted of the following IHSC members: Dr. (b)(6),(b)(7)(C),(b)(7)(F) medical doctor, clinical director, physician reviewer; Captain (CAPT) (b)(6),(b)(7)(C),(b)(7)(F) (b)(6),(b)(7)(C),(b)(7)(F) physician assistant, IHSC chief APP, APP reviewer; and CAPT (b)(6),(b)(7)(C),(b)(7)(F) RN, IHSC chief nurse, nurse reviewer.

The following summary of events was based on: 1) Mr. NOVIELLO's KSPC and FDC Miami medical records and emergency medical services (EMS) report; 2) incident and notification reports; 3) ICE ENFORCE Alien Removal Module (EARM) and ICE ENFORCE Alien Detention Module (EADM) database records; 4) Mr. NOVIELLO's FDC Miami detention file; 5) video footage from June 23, 2025; 6) an on-site review and staff interviews conducted by CAPT (b)(6),(b)(7)(C),(b)(7)(F) and Lieutenant Commander (LCDR) (b)(6),(b)(7)(C),(b)(7)(F) at KSPC and FDC Miami from August 5 to 7, 2025; 8) applicable FDC Miami policies and procedures; and 9) applicable accreditation standards.

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Summary of Events

On May 16, 2025, at 4:03 p.m., a KSPC APP documented Mr. NOVIELLO's diagnoses of unspecified convulsions and hypertension, placed medication orders for levetiracetam (anticonvulsant), carbamazepine (anticonvulsant), lisinopril (antihypertensive), and hydrochlorothiazide (antihypertensive, diuretic), and did not perform a physical assessment.

- At 4:15 p.m., an RN completed Mr. NOVIELLO's medical intake screening, documented his current diagnoses of hypertension and seizure disorder, his blood pressure of 142/70 millimeters of mercury [(mm Hg): normal less than 120/80 mm Hg and greater than 90/60 mm Hg], his body mass index of 45 kilograms per meter squared [(kg/m^2); normal: 18.5-24.9 kg/m^2], and his reported medication list of clonazepam, levetiracetam, and carbamazepine for seizures, and lisinopril and hydrochlorothiazide for blood pressure. The RN sent a medical provider referral for Mr. NOVIELLO's abnormal intake and a mental health referral for his clonazepam. Custody staff retrieved Mr. NOVIELLO's reported medications from prescription bottles in his property. An APP prescribed and administered Mr. NOVIELLO his home medications, except clonazepam.

On May 19, 2025, ICE transferred Mr. NOVIELLO to FDC Miami.

On May 20, 2025, an FDC Miami APP evaluated Mr. NOVIELLO, documented his heart rate of 100 beats per minute [(BPM) normal: 60 – 100 BPM], blood pressure of 103/63 mm Hg, and otherwise normal vital signs, continued his medications as prescribed at KSPC, and ordered labs. FDC Miami health staff did not complete or document a reason for not completing Mr. NOVIELLO's labs, but staff reported computer issues contributed to the unfulfilled orders.

On May 21, 2025, a BHP evaluated Mr. NOVIELLO, conducted a Psychology Services Inmate Questionnaire review, documented no mental health concerns, and referred him to an APP due to his report of clonazepam use for anxiety.

On May 29, 2025, an APP evaluated Mr. NOVIELLO for possible hunger strike when referred by a lieutenant. The APP documented Mr. NOVIELLO stated he was eating and refused the assessment. The APP notified the psychology department.

- On the same date, a BHP evaluated Mr. NOVIELLO, documented immature and slow responses, and referred him to health services and psychiatry for further follow up.

On May 30, 2025, an APP documented Mr. NOVIELLO refused a history and physical examination, and noted he refused to sign a refusal form.

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On June 8, 2025, an APP evaluated Mr. NOVIELLO, at the request of a unit officer and health services administrator (HSA), to assess his current health status. The APP requested a psychology referral and documented Mr. NOVIELLO reported he felt sad and depressed, ate and showered the day prior, and refused to go to the medical clinic for an evaluation.

On June 9, 2025, a BHP conducted a suicide risk assessment on Mr. NOVIELLO, documented unspecified depressive disorder, recommended a cellmate, scheduled a follow-up visit in a week, and notified medical services of his complaint of feeling cold and dizzy. FDC Miami custody staff did not change Mr. NOVIELLO's housing status to align with the BHP's recommendation.

- On the same date, an APP evaluated Mr. NOVIELLO, documented he maintained poor personal hygiene and denied intent to engage in a hunger strike, but had not eaten in "a while." The APP documented normal vital signs, ordered labs, and discussed the importance of self-hygiene and eating properly, but did not document when Mr. NOVIELLO last ate or follow up regarding his food consumption. Health staff did not complete or document a reason for not completing Mr. NOVIELLO's labs, but the HSA reported a "computer system error" caused Mr. NOVIELLO's missed labs.

On June 11, 2025, a BHP evaluated Mr. NOVIELLO, documented his denial of thoughts of suicide or self-harm, noted his disinterest in interventions, and recommended a cellmate and monthly psychology services. FDC Miami custody staff did not change Mr. NOVIELLO's housing status to align with the BHP's recommendation.

On June 20, 2025, a BHP evaluated Mr. NOVIELLO, documented disorientation, placed him in restrictive housing without a cellmate for increased observation, referred him to an APP, confiscated his medications, placed the medications in the officer's station, and sent an e-mail notification to medical staff with information on Mr. NOVIELLO's housing status.

On June 21 and 22, 2025, a BHP assessed Mr. NOVIELLO and documented his confused and disoriented state.

On June 23, 2025, a BHP assessed Mr. NOVIELLO, requested his immediate medical assessment, documented he had not received his medications as prescribed through the weekend, and referred him to a psychiatrist.

- On the same date, an APP evaluated Mr. NOVIELLO and documented he reportedly had a seizure; he was disoriented and confused but in no apparent distress, and had a Glasgow Coma Scale score of 12+ (tool used to assess level of consciousness based on eye, verbal, and motor responses with scores ranging from 3, indicating deep coma or death, to 15, fully alert and oriented). The APP's documentation indicated the APP administered Mr.

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NOVIELLO's medications, but the APP did not specify which medications. The APP documented instructions to continue his medications as prescribed but did not place pill line orders, obtain vital signs, conduct a physical examination, or document a follow-up plan.

- At approximately 12:40 p.m., a correctional officer rounded on Mr. NOVIELLO and saw him sitting on the floor. The correctional officer described Mr. NOVIELLO as audibly snoring, with snot dripping from his nose.

- At 1:02 p.m., a correctional officer rounded again on Mr. NOVIELLO and found him in the same position, shined a flashlight directly at him, received no response, and called a medical emergency in Hotel West, cell 4 on the 13th floor.

- At approximately 1:04 p.m., medical staff arrived at the scene, and found Mr. NOVEILLO pulseless, breathless, and unresponsive with fixed pupils. At 1:05 p.m., staff removed Mr. NOVIELLO from the cell, administered CPR, applied AED pads, called 911, and transported him on a stretcher to the medical clinic. Medical staff continued CPR, documented Mr. NOVIELLO's temperature of 95.5 degrees Fahrenheit [(°F) normal: 95.1 – 100.3 °F], blood glucose of 30 milligrams per deciliter [(mg/dL) normal: 70 – 140 mg/dL], and the continued absence of a pulse, respirations, blood pressure, and oxygen saturation.

- At approximately 1:09 p.m., MFRD personnel arrived and took over Mr. NOVIELLO's care. MFRD performed advanced cardiac life support for approximately 30 minutes with no response.

- At 1:36 p.m., MFRD personnel pronounced Mr. NOVIELLO deceased.

Mr. NOVIELLO's final autopsy report is pending.

The MRC used the following accreditation standards for this review: Performance-Based National Detention Standards, 2011 with 2016 revisions, and American Correctional Association (ACA) Adult Local Detention Facilities (ALDF) standards, 5th Edition. The following are identified program strengths, weaknesses, and recommendations found during this review.

Strengths

The MRC identified the following strengths: 1) FDC Miami psychology staff consistently assessed Mr. NOVIELLO, documented suicidal risk and disorientation, recognized he needed increased observation and specialized mental health care, and placed a referral to a psychiatrist.

2) FDC Miami medical and custody staff worked together during the emergency response and rotated giving chest compressions.

Weaknesses

1. Medication Administration.

- On June 20, 2025, FDC Miami staff confiscated Mr. NOVIELLO's self-carry medications, upon placing him in restrictive housing on increased observation, and did not ensure he received his medications as prescribed. FDC Miami lacked safeguards to prevent missed medications.

Applicable standards of care for this finding:

- ACA ALDF 5th Edition, 5-ALDF-4C-19, *Chronic Care.*
- ACA ALDF 5th Edition, 5-ALDF-4C-37, *Pharmaceuticals*.
- ACA ALDF 5th Edition, 5-ALDF-2F-11, *Restrictive Housing.*
- BOP Policy 6031_005, Patient Care, Section 9a, *Emergency/Urgent Care, Continuous Healthcare Coverage.*
- BOP Policy 6360_002, Pharmacy Services, 8j, *Administration, Dispensing, Distribution, and Prescribing- Distribution.*
- BOP Policy 6360_002, Pharmacy Services, 8i, *Administration, Dispensing, Distribution, and Prescribing-Medications for Inmate Patients in Special Housing Unit.*

2. Communication.

- FDC Miami health staff did not effectively communicate Mr. NOVIELLO's health status and the medications, care, and health assessment refusals between shifts or between the psychology and medical departments.

Applicable standards of care for this finding:

- ACA ALDF 5th Edition, 5-ALDF-4D-01, *Health Authority*.
- ACA ALDF 5th Edition, 5-ALDF-7D-09, *Policies and Procedures*.
- BOP Policy 6031_005, Patient Care, Section 14, *Alternative Restrictive Unit/Cell.*
- BOP Policy 6031_005, Patient Care, Section 20, *Chronic Care Clinics*.

3. Inappropriate medical care.

- KSPC did not conduct a comprehensive health assessment and establish a plan of care within two working days.

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- Mr. NOVIELLO arrived at FDC Miami tachycardic, and on seizure and blood pressure medications, but the medical staff did not obtain an electrocardiogram.
- FDC Miami medical staff did not document Mr. NOVIELLO's comprehensive health appraisal, vital signs, or electrolyte status, or obtain his labs.
- FDC Miami staff did not monitor Mr. NOVIELLO's medication compliance or carbamazepine level.
- FDC Miami staff did not provide timely interventions or referrals for Mr. NOVIELLO's refusals of medical procedures and food, and overall deterioration.
- FDC Miami medical staff did not screen Mr. NOVIELLO immediately upon placement, or daily while in restrictive housing.
- On June 23, 2025, an APP evaluated Mr. NOVIELLO, per the request of a BHP, and documented a Glasgow Coma Scale score, but the APP did not document a physical exam, vital signs, or a plan for follow up. FDC Miami lacked protocols on the treatment and referral of patients with neurological emergencies.
- FDC Miami staff did not stock medical equipment in the (b)(7)(E) during Mr. NOVIELLO's increased observation status.

Applicable standards of care for this finding:

- KSPC Policy 8.01A, Initial Screening and Intake Reviews 4-5, *Plan of Care.*
- PBNDS 2011 with 2016 revisions: Part 4.3, Medical Care; section J. *Medical and Mental Health Screening of New Arrivals.*
- ACA ALDF 5th Edition, 5-ALDF-4C-07, *Treatment Plan.*
- ACA ALDF 5th Edition, 5-ALDF-4C-05, *Referrals.*
- ACA ALDF 5th Edition, 5-ALDF-2F-03, *Restrictive Housing.*
- ACA ALDF 5th Edition, 5-ALDF-4C-05, *Referrals.*
- BOP Policy 6031_005, Patient Care, Section 14, *Alternative Restrictive Unit/Cell.*

4. Inappropriate mental health care.

- FDC Miami mental health staff rounded on Mr. NOVIELLO while on increased observation status but did not refer him to a higher level of care when he presented with confusion, disorientation, and speechlessness, rendering the mental health staff unable to conduct an assessment.

Applicable standards of care for this finding:

- ACA ALDF 5th Edition, 5-ALDF-4C-30, *Mental Health Referrals.*

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5. Documentation.

- Facility security cameras and control computer times differ, which led to discrepancies in the reported times of the medical emergency and response.
- FDC Miami medical staff did not document Mr. NOVIELLO's food intake or hunger strike status after documenting he missed eight meals, and his blood glucose was 30 mg/dL at the time of his cardiac arrest.
- FDC Miami health staff documented Mr. NOVIELLO refused care but did not consistently complete refusal forms.
- FDC Miami staff did not document when AED pads or emergency medications get checked. The emergency bag in the urgent care room contained expired nitroglycerine.
- FDC Miami did not document annual man down drills.

Applicable standards of care for this finding:

- ACA ALDF 5th Edition, 5-ALDF-4C-33, *Health Records.*
- BOP Policy 6031_005, Patient Care, Section 20, *Chronic Care Clinics.*
- BOP Policy 6031_005, Patient Care, Section 21s, *Documentation-Clinical Encounter notes.*
- BOP Policy 6031_005, Patient Care Section 41, *Involuntary Medical Treatment/Refusal of Treatment.*

6. Inappropriate emergency care.

- FDC Miami staff did not provide prompt response or sufficient referral for Mr. NOVIELLO's emergent disoriented status.
- FDC Miami staff delivered Mr. NOVIELLO ineffective CPR. While transporting Mr. NOVIELLO to the urgent care room, FDC Miami staff did not secure his body to the gurney, or deliver oxygen or consistent rescue breaths. When FDC Miami staff administered Mr. NOVIELLO rescue breaths, they did not use the head-tilt, chin-lift maneuver, or verify chest rise and fall. FDC Miami staff delivered Mr. NOVIELLO chest compressions at a rate exceeding the recommended rate, and did not allow for full chest recoil, or use a backboard.

Applicable standards of care for this finding:

- ACA ALDF 5th Edition, 5-ALDF-4D-08, *Emergency Response.*
- ACA ALDF 5th Edition, 5-ALDF-4C-04, *Continuity of Care.*
- ACA ALDF 5th Edition, 5-ALDF-1C-15, *Emergency Power and Communication.*

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- BOP Policy 6360_002, Pharmacy Services, 8j. *Procedures and Operation Practices-Outdated Medications.*
- BOP Policy 6031_005, Patient Care, Section 9e, *Emergency/Urgent Care, Basic Lift Support.*

Recommendations

- Forward these findings to the IHSC Deputy Assistant Director (DAD) of Health Systems Support Division (HSSD), DAD of Clinical Services Division (CSD), and DAD of Health Care Compliance Division (HCCD).
- The IHSC DAD of HSSD will share these findings with KSPC's HSA for review, dissemination to ICE and KSPC's facility administrator, and any action(s) deemed appropriate.
- The IHSC DAD of HCCD will share these findings through appropriate communication channels to ICE, and FDC Miami's facility administrator and health authority, for review and any action(s) deemed appropriate.
- KSPC's HSA and the respective IHSC CSD and HCCD units will ensure KSPC's corrective action plan, if applicable, is implemented and sustained.
- The respective IHSC HCCD unit and ICE will ensure FDC Miami's corrective action plan, if applicable, is implemented and sustained.

End of report.

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