CBP-RELATED DEATHS

Office of Professional Responsibility

Fiscal Year 2021

Homeland Security

U.S. Customs and Border Protection

Executive Summary

Report language accompanying the Department of Homeland Security (DHS) fiscal year (FY) 2021 Appropriation Bill required Customs and Border Protection (CBP) to take certain actions with respect to the review and reporting of deaths of individuals in its custody and deaths of individuals in which CBP was involved in some way.[1] As a part of those actions CBP was required to establish standardized definitions for in-custody deaths, to carry out certain investigative activities following such incidents, and to provide detailed reporting on these deaths to Congress and the public.

This report includes statistical data on a total of 151 deaths, which occurred during FY 2021, including 55 in-custody deaths, 53 reportable CBP-involved deaths, and 43 additional deaths that Appropriations staff requested OPR to review. The report provides background information on the demographics of decedents, the locations of the deaths, and broadly categorizes the most frequent causes of death. The report also contains information on how deaths were reviewed by CBP's Office of Professional Responsibility and Office of the Chief Medical Officer. In a limited number of instances, and as required by Appropriations report language, certain in-custody deaths were reviewed by an independent clinician contracted by CBP.

[1] H. Rept. 116-458, *Department of Homeland Security Appropriations Bill, 2021.*

CBP-Related Deaths

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I. Legislative Language

The information in this document is a statistical representation of the information compiled pursuant to requirements set forth in House Report 116-458 and the Joint Explanatory Statement, which accompany the Fiscal Year (FY) 2021 Department of Homeland Security (DHS) Appropriations Act (P.L. 116-260).

Joint Explanatory Statement states:

> *Deaths in Custody.* —The Committee directs CBP to notify the applicable consulate, congressional committees with relevant jurisdiction, the Office of the Inspector General, and the Office of Civil Rights and Civil Liberties within 24-hours of the death of any individual in CBP custody or any individual not in custody if CBP personnel were involved in the death. The notification shall include the name of the individual and the circumstances of the death. For purposes of this requirement, CBP custody includes any individuals detained on CBP's behalf by another law enforcement agency or admitted to a medical facility while still in CBP's legal custody. The Committee also directs CBP to:
>
> (1) provide the same notifications to the public after the next-of-kin have been notified, or after reasonable efforts have been made to notify the next-of-kin;
> (2) preserve all video recordings of such individuals during their time in custody until the completion of all related investigations;
> (3) conduct interviews of relevant parties regarding the circumstances of the death;
> (4) conduct an autopsy as part of a review of the circumstances leading to the death; and
> (5) with the assistance of independent clinicians, conduct a prompt mortality review of each death, including a review of whether the individual's treatment in detention complied with CBP's standards on Transport, Escort, Detention, and Search (TEDS).
>
> Not later than 30 days after the end of each fiscal year, CBP shall submit a report to the Committee detailing all such deaths, including summaries of mortality reviews and compliance with TEDS. In addition, the Office of Professional Responsibility (OPR) shall brief the Committee on its findings and associated recommendations for any deaths it investigates.

House Report 116-458 states:

> *Definition of Death in Custody.* —Not later than 60 days after the date of enactment of this Act, CBP shall brief the Committee on the definition of a death ''in custody'' and a death ''not in custody'' that will be used in notifications and investigations of any deaths. The Committee expects to be notified of both types of death within 24-hours of the death.

II. Background

With the enactment of the FY 2021 DHS Appropriations Bill on December 27, 2020, U.S. Customs and Border Protection (CBP) was required to formulate definitions for deaths "in-custody" and "not in-custody" and report back to Committee staff within 60 days. CBP was also required to immediately begin reviewing these deaths and providing prompt notification to Congress and the public when they occurred. CBP's approach to this situation was to rely heavily on the established statutory definition for in-custody death set forth in the Death in Custody Reporting Act (DCRA) of 2013 (PL 113-242). Ultimately, CBP and Committee staff reached an agreement to use the existing statutory definition of an in-custody death when categorizing incidents to meet these new reporting requirements.[2]

The DCRA established a definition for use by all federal law enforcement agencies when making death-related custody determinations. The DCRA also requires all such agencies to submit data related to in-custody deaths to the Federal Death in Custody Reporting Program (FDCRP) managed by the Bureau of Justice Statistics within the U.S. Department of Justice. The FDCRP has primary responsibility for collecting, aggregating, analyzing, and reporting that information to Congress and the public on a yearly basis. Under the Act, CBP is required to report the death of any person who is:

1. Detained, under arrest, or is in the process of being arrested by any officer of such Federal law enforcement agency (or by any State or local law enforcement officer while participating in and for the purposes of a federal law enforcement operation, task force, or any other Federal law enforcement capacity carried out by such Federal law enforcement agency); or

2. En route to be incarcerated or detained or is incarcerated or detained at (A) any facility (including any immigration or juvenile facility) pursuant to a contract with such Federal law enforcement agency; (B) any State or local government facility used by such Federal law enforcement agency; or (C) any Federal correctional or Federal pre-trial detention facility located within the United States.

To ensure consistent reporting, the FDCRP provides law enforcement agencies with detailed guidance to assist them in making death-related custody determinations. CBP uses this guidance to assist in making its own determinations and for purposes of its mandatory annual submission to the FDCRP. Because FDCRP independently analyzes data submitted by CBP about each death, it is possible that an office could make a different determination resulting in a disagreement between the data presented in this report and the data published in their annual report. Harmonizing the final determinations would be impossible as CBP is required to submit

[2] Committee staff requested CBP categorize any death that occurred after an individual was admitted to a hospital while in CBP custody as in-custody regardless of whether CBP eventually terminated hospital watch in favor of requiring the individual to appear for immigration proceedings later. While this circumstance would not meet the statutory definition of an in-custody death, CBP has categorized them in that manner in this report.

its data to Congress shortly after the end of each fiscal year whereas the FDCRP reports are on a more attenuated schedule.

Terms and definitions

Cause of death—A description of the specific factors leading to the termination of the biological functions that sustain life.

Decedent—A person who died.

Federal arrest-related death—A death that occurs when the event causing the death (e.g., gunshot wound, self-inflicted injury, cardiac arrest, fall from a height, drowning) occurs while the decedent's freedom to leave is restricted by federal law enforcement personnel acting in an official capacity. Arrest-related deaths include—

- any death attributed to any use of force by federal law enforcement personnel
- any death that occurred while the decedent's freedom to leave was restricted by federal law enforcement prior to, during, or following an arrest—
  - while detained for questioning or investigation (e.g., Terry stop)
  - during the process of apprehension (e.g., pursuit of criminal suspect or standoff with law enforcement)
  - while in the custody of, or shortly after restraint by, law enforcement (even if the decedent was not formally under arrest)
  - during transport to or from law enforcement, detention, incarceration, or medical facilities
- any death while the decedent was confined in a temporary holding facility designed to hold detainees for no longer than 72 hours (e.g., booking center, holding area, or staging location)
- any death that occurred during an interaction with federal law enforcement personnel during response to medical or mental-health assistance (e.g., response to suicidal persons).

Federal death in custody—A death that occurs while the decedent was detained or incarcerated for violating federal criminal or administrative law and was housed in any facility designed to detain or incarcerate such individuals for longer than 72 hours. This includes all detainee or inmate deaths that occurred in any federal corrections, pre-trial, or administrative detention facility or any facility under federal contract to criminally hold, detain, or imprison or administratively hold or detain individuals.

Federal detention agency—An organizational unit or sub-unit of the federal government with the principal function of detention or incarceration of alleged or convicted offenders.

Federal law enforcement agency—An organizational unit or sub-unit of the federal government with the principal functions of prevention, detection, and investigation of crime and the apprehension of alleged offenders.

Federal Law Enforcement Agency Deaths in Custody Reporting Program—A data collection of all federal agencies with arrest or detention functions.

Homicide—The willful killing of one person by another. This includes killing in performance of an official duty or in circumstances defined by law as legally justifed.

Manner of death—An explanation of how a person died, typically illustrated by a one-word description of the intentions and circumstances that led to the stated medical cause of death (e.g., accident, homicide, illness, suicide, or undetermined).

[3]

Using the statutory definition and guidance promulgated by the FDCRP, CBP's Office of Professional Responsibility (CBP OPR) led an agency-wide effort to establish criteria to differentiate between in-custody and not in-custody deaths, as they pertain to CBP operations. On March 8, 2021, CBP OPR met with House and Senate Appropriations staff and briefed them on the definitions as required by House Report 116-458. During that meeting, CBP OPR and Committee staff agreed upon the proposed CBP-specific definitions. In addition, the group also discussed several specific concerns posed by CBP regarding the expectations set forth in the appropriations report language.

Regarding Subsection 1, which originally required CBP to notify the public of all in-custody and other CBP-involved deaths, Committee staff agreed CBP would only be required to make public notifications regarding in-custody deaths. Both parties agreed that based on the broad criteria set for reportable, but not in-custody deaths, clearing public statements for each incident would be extremely challenging. Nevertheless, CBP agreed that all such deaths would still be reported to

[3] Bureau of Justice Statistics; December 2020, NCJ 252838: Federal Deaths in Custody and During Arrest, 2016-2017-Statistical Tables

Congress. Although CBP does not publicly release statements on all not in-custody deaths, the statistics for not in-custody deaths are included this report.

Regarding Subsection 4, which required CBP to conduct an autopsy related to each reportable death, Committee staff acknowledged CBP does not have the capability or authority to independently perform autopsies. CBP OPR agreed to continue the practice of requesting local authorities to conduct autopsies for all in-custody deaths and to the extent permissible by law or regulation, CBP OPR will coordinate with medical examiners (ME) to ensure autopsy-related data is available for review by CBP medical personnel as well as independent clinicians supporting CBP OPR mortality reviews.

Regarding Subsection 5, which required CBP to engage the services of an independent clinician to render an opinion as to whether CBP complied with TEDS standards in its treatment of each deceased individual, Committee staff agreed these reviews would be limited to cases in which the decedent was held in a CBP facility immediately preceding his or her death. In addition, Committee staff acknowledged that CBP would work to secure support from the U.S. Public Health Service to provide independent clinician reviews during FY 2021.

On May 3, 2021, CBP OPR once again met with Committee staff to discuss the scope of reportable not in-custody CBP-related deaths. Deaths in this category included individuals who died in the field of natural causes, frequently caused by environmental factors, shortly after being located or apprehended by Border Patrol Agents (BPAs). During March and April 2021, CBP OPR attempted to respond to each such death and experienced a significant operational strain impacting mission readiness. After discussing these concerns with Committee staff, all parties agreed to eliminate the review and reporting requirements for the following two categories of deaths (though the statistics for these two categories are included in this report):

1) Subject discovered in medical distress and dies in the field or en route to hospital; and
2) Subject discovered in medical distress and dies during initial lifesaving efforts at the hospital.

In Custody (Reportable)	Not in Custody (Reportable)	Not Reportable
Subject dies in the process of being physically detained by CBP Subject dies after being detained or arrested or while being escorted to a CBP vehicle Subject dies due to vehicle collision, is struck by a vehicle, or dies by any other means while being actively pursued by CBP Subject dies due to actions of CBP while attempting to detain or arrest subject (e.g., struck by CBP vehicle) Subject dies while being transported by, or in the custody of, a CBP contractor Subject dies in a CBP holding facility or in route to a CBP holding facility Subject dies as a result of any use of force by CBP personnel Subject dies while undergoing secondary inspection or detained by CBP personnel for any other reason Subject dies after being admitted to a medical facility while still in CBP's legal custody	Subject dies while attempting to elude CBP but not being actively pursued (including falls from border barriers) Subject dies before, during, or after primary or outbound inspection at a port of entry (unless referred to secondary or due to use of force) Subject dies before, during, or after primary inspection at a USBP checkpoint (unless referred to secondary or due to use of force) Subject that is not detained or arrested dies while being transported in a CBP-owned vehicle or other conveyance with the sole purpose of obtaining immediate medical care Subject dies while processing of import/export paperwork or while paying import/export fees	Subject discovered in medical distress and dies in the field or en route to hospital (not in a CBP vehicle) Subject discovered in medical distress and dies during initial lifesaving efforts at hospital Remains discovered by CBP personnel Discovery of deceased individuals by other agencies Deaths resulting from an enforcement action in which CBP personnel did not participate Subject found deceased by CBP personnel in connection with a search and rescue operation

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A. CBP's Proactive Measures

Because the DHS FY 2021 appropriation was not enacted until December 27, 2020, CBP OPR did not review every death prior to that date in accordance with the expectations set forth in House Report 116-458. To comply with these new requirements, CBP OPR relied on information provided by CBP components in Significant Incident Reports for deaths that occurred prior to that date.

In response to these new expectations, CBP OPR took substantial action to build its death investigations capacity including:

- Partnered with the Public Agency Training Council to provide three days of death investigations training for all CBP OPR special agents and supervisors.
- Issued a memorandum to all CBP components reminding them of their obligation to immediately reports deaths and other critical incidents to OPR in a timely manner.
- Launched a multidisciplinary working group including CBP's Laboratory and Scientific Services to develop response protocol checklists to ensure death reviews were carried out in a consistent manner. These checklists are now used in the field.

[4] Term of Reportable and Not Reportable refer to the 24-hour Congressional notification set forth in the House Report 116-458

[5] CBP Death in Custody Reporting Chart; *Notification and Review Procedures for Certain Deaths and Deaths in Custody*

- Sent three CBP OPR personnel from locations with a high number of CBP-involved deaths to a two-week crime scene processing certification course at the Federal Law Enforcement Training Center.
- Established a new Death in Custody Program that is led by a GS-15 supervisory special agent and staffed by three full-time GS-14 senior special agents. While the team is a headquarters level function, the three senior special agents are assigned to field locations and provide subject matter expertise to CBP OPR units responding to critical incidents in real time.

On June 10, 2021, the acting CBP Commissioner approved the *Notification and Review Procedures for Certain Deaths and Deaths in Custody* policy. This policy fully implements the review and reporting procedures set forth in the House Report 116-458 and reflects CBP's commitment to transparency and accountability. This policy mandates that when a reportable death occurs CBP OPR will:

- Initiate a review to fully document the facts and circumstances surrounding the death including interviewing relevant witnesses, reviewing, and preserving records and video and audio evidence, and obtaining relevant information from medical personnel including autopsy results;
- Ensure agency compliance with relevant rules, regulations, and laws (including the CBP Standards for Transport, Escort, Detention and Search policy;
- Coordinate its reviews with the Office of Chief Medical Officer (OCMO) and other investigative agencies;
- Identify any potential gaps in training, policy, or procedure that could mitigate similar incidents in the future; and
- To the extent an individual dies in-custody while, or after, being detained in a CBP facility, will consult with an independent clinician who will review the facts and circumstances as documented by OPR's review to assess CBP's compliance with TEDS standards.

In accordance with this policy, CBP components notify CBP OPR field offices of incidents which result in a non-employee death. In response, the CBP OPR field office responds to document and investigate the circumstances surrounding the death. CBP OPR headquarters subject matter experts provide the responding special agents with operational support to ensure CBP OPR death reviews meet quality standards. CBP OPR also created its own database to track reportable deaths, which was used to prepare later sections of this report.

For benchmarking purposes, CBP OPR personnel met with representatives of oversight bodies within large police agencies and oversight offices including the Los Angeles Police Department, the California Highway Patrol, the New Mexico State Police, the Chicago Police Department, the Chicago Civilian Office of Police Accountability, and the Federal Bureau of Investigation.

To meet the requirement of an independent clinician review of any death of an individual in custody while, or after, being detained in a CBP facility, CBP's OCMO contracted a physician to review specific cases as determined by OPR, in consultation with OCMO, for CBP's compliance with TEDS standards. The physician has extensive experience both in full-spectrum family medicine (pediatrics, obstetrics, geriatrics, and active-duty medicine) and in operational

medicine, which makes the contracted physician uniquely qualified to serve as an independent reviewer for the multitude of cases seen by CBP.

B. CBP-Related Deaths Report Versus CBP's Rescue Beacon and Unidentified Remains Report

A distinction should be made between the CBP-Related Death Report versus CBP's Rescue Beacon and Unidentified Remains Report. The Rescue Beacon and Unidentified Remains Report provides data obtained from CBP's Missing Migrant Program (MMP), led by U.S. Border Patrol (USBP). CBP initiated the MMP in 2017 to prevent the loss of life of migrants during their journey to the United States.

MMP focuses on border safety, locating migrants reported missing, the rescue of migrants in distress, the mitigation of migrant deaths, and the identification and reunification of decedents in the border region. Included in the Rescue Beacon and Unidentified Remains Report are the number of suspected undocumented migrants who lost their lives crossing into the United States.

The MMP's statistics are pulled from designated target zones, which are comprised of 45 counties with proximity to the southwest border and are historical routes of travel for undocumented migrants. The MMP maintains the following criteria for decedents included in their report:

- A suspected undocumented migrant who died:
    - In furtherance of an illegal entry,
    - Within a designated target zone,
    - Whether or not the Border Patrol was directly involved;

or

- A suspected undocumented migrant who died:
    - In furtherance of an illegal entry,
    - Outside of a designated target zone,
    - If the Border Patrol was directly involved with the incident

The CBP-Related Death Report focuses on deaths relating to CBP operations and interactions. The focus of the CBP-Related Death Report is individuals who die after having contact with CBP employees or on CBP property, such as a fall from the border barrier (BB). Neither the immigration status of the decedent nor the location of the death is a limiting factor in this report; however, it does not include human remains or individuals discovered deceased. While these reports are both generated by CBP, the reporting requirements differ and therefore the totals are not comparable.

III. FY 2021 CBP-Related Death Data

A. Custody and Incident Type Classification

The FDCRP broadly categorizes in-custody deaths in two categories: Deaths in Custody and Arrest-Related Deaths. Both categories are reportable under the DCRA, and both count as "in-custody." FDCRP defines the two as:

- **Death in Custody:** A death that occurs while the decedent was detained or incarcerated for violating federal criminal or administrative law and was housed in any facility designed to detain or incarcerate such individuals for longer than 72 hours.

- **Arrest Related Death:** A death that occurs when the event causing the death occurs while the decedent's freedom to leave is restricted by law enforcement personnel acting in an official capacity. This category also includes any death that occurs when the decedent is detained in a temporary facility designed to hold prisoners for less than 72 hours.

Based on the above definitions, all in-custody deaths included in this report are considered arrest-related as they either occurred in the field or in temporary holding facilities, including hospitals. The non-custodial deaths in this report include deaths that occurred with CBP involvement; however, did not occur while the decedent's freedom to leave was restricted by CBP or during the process of being arrested or detained by CBP.

In addition to categorizing CBP-related deaths by custody status, this report also classifies them by incident type. These following incident type definitions were formulated by CBP to best describe the circumstances under which a death occurred.

- **Use of Force** – Death was the direct result of a use of force by CBP personnel. This category would include shooting incidents, Collapsible Straight Baton strikes, Electronic Control Weapon deployment, Offensive Driving Techniques, Vehicle Immobilization Device (VIDs), or other applications of force.

- **Distress** – Decedent discovered in medical distress and dies of natural causes in the field, en route to a hospital, during initial lifesaving efforts at a hospital, or after being admitted to a hospital. Includes search and rescue operations, lost migrants, 911 calls requesting help or reporting an individual in distress, and heat-related illness.

- **Distress at POE** - Decedent encountered in medical distress before, during, or after primary or outbound inspections at a port of entry (POE).

- **Fall** – Decedent falls from the BB or falls from other objects or structures while attempting to elude CBP on foot. This category is used if an individual is found deceased after falling from the BB.

- **Drowning** – Decedent's death is determined to be caused by drowning. This category is used if life-saving efforts were performed or if the event is linked to a CBP enforcement action. If not, see "Found Deceased" category. If a vehicle enters the water while involved in a pursuit and occupant drowns, the "Pursuit" category is used.

- **Pursuit** – Subject dies because of a motor vehicle collision, rollover, or jumping out of a moving vehicle while CBP is actively engaged in pursuit or after pursuit is terminated and vehicle is attempting to elude CBP or another agency. Deaths associated with foot pursuits should fall under a different category. For maritime pursuits, this category is only used if the vessel collides with an object or capsizes while being pursued or after termination of CBP pursuit while still attempting to elude CBP or another agency. If death causing incident is the result of an Offensive Driving Technique or VID deployment, it would fall under the "Use of Force" category.

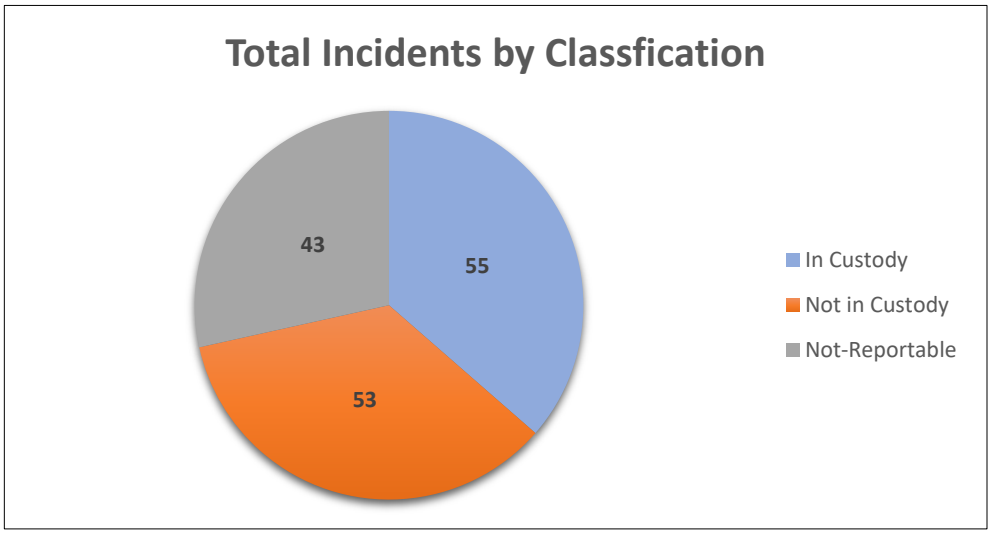
- **Struck by Vehicle** – Includes deaths caused by decedent attempting to elude CBP and struck by any motor vehicle, and deaths resulting from CBP vehicle impacting or crushing subject unintentionally. If death occurs as a result of an intentional vehicle strike, it would fall under "Use of Force."

- **Found Deceased** – Includes all instances in which the decedent is discovered after having passed away.

- **Other -** Incidents that cannot be categorized an any previous categories.

B. FY 2021 CBP-Related Deaths

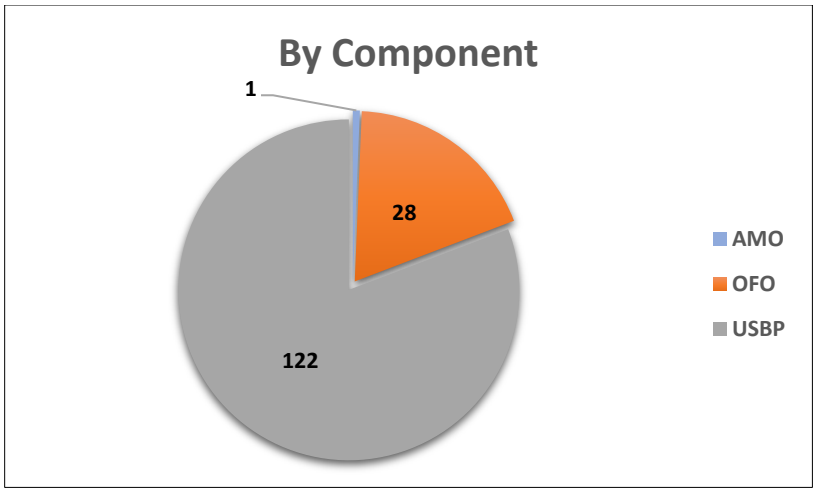
In FY 2021, CBP components conducted a combined 1,956,519 enforcement actions across the United States. From these enforcement actions, OPR reviewed 151 CBP-related deaths. The deaths were categorized into three categories: In Custody, Not in Custody, and Not Reportable. As previously mentioned, the not-reportable deaths category refers to incidents involving decedents who are found in medical distress and die during initial lifesaving efforts.



[6] [7]

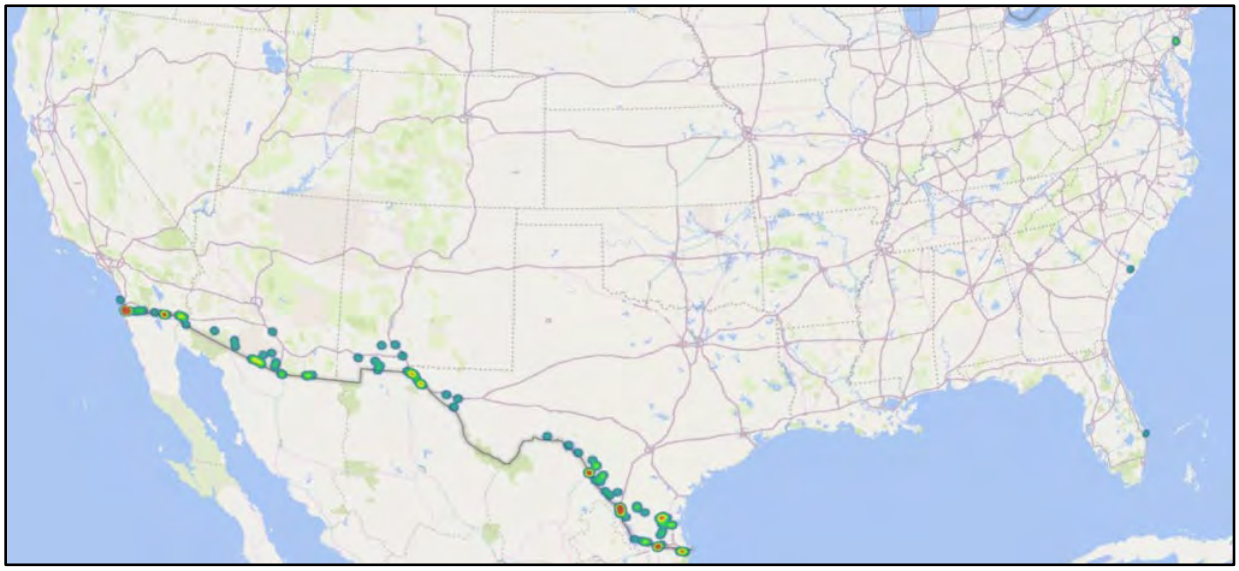
The following information is a representation of all CBP-related deaths regardless of custodial status. Of the 151 CBP-Related deaths, 122 were during USBP operations, 28 were from Office of Field Operations (OFO) activities, and one death occurred during Air and Marine Operations (AMO) activities.

[6] Definitions of In Custody, Not in Custody, and Not Reportable are in accordance with definitions agreed upon between CBP and the Appropriations Committees and as presented on page 5 of this report.
[7] The Not Reportable deaths represented in this graph only refer to deaths that were not in CBP custody in which: 1) the subject was discovered in medical distress and died in the field or en route to the hospital; or 2) the subject was discovered in medical distress and died during initial lifesaving efforts at hospital as mentioned on page 4 of this report.



[8]

Most of the CBP-related deaths occurred along the southwest border of the United States. Although incidents occurred in Florida, South Carolina, and Pennsylvania; southern Texas was the hardest impacted region. The heat map below depicts the location of each CBP-related death that occurred during FY 2021. Each death is represented by a dot on the map to provide a valuable visualization of where the deaths occurred. This heat map also indicates a cluster of deaths that occurred along the California/Mexico border. However, many of these were deaths categorized as *Distress at POE* deaths[9].



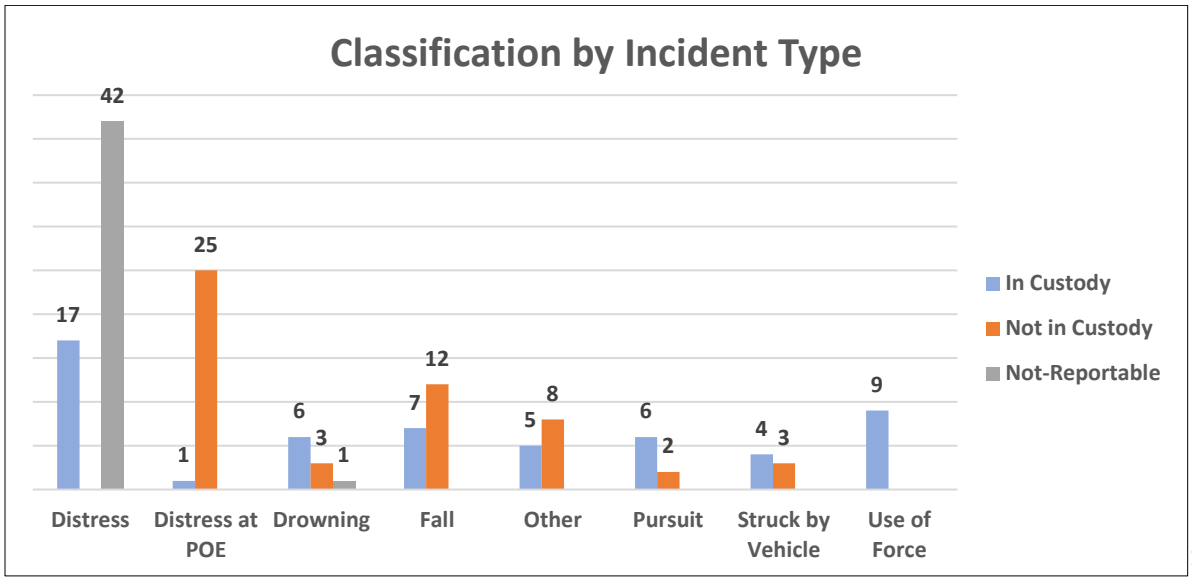
1. Incident Types

When broken down by incident type classification, *Distress* deaths were most common, accounting for 39 percent of all deaths. When combined with *Distress-related deaths of*

[8] The numbers represented in this graph include all In-Custody, Not in Custody, and Not Reportable deaths associated with each CBP component.
[9] The definitions and parameters of a Distress at POE categorized death are presented on page 8 of this report.

individuals arriving at a POE, the two categories account for 56 percent of all deaths. *Falls* and *Drownings* comprised an additional 11 percent of the deaths, including 17 documented falls from the BB, 8 of which occurred in the USBP San Diego Sector area of operations.

Throughout FY 2021, CBP employees were involved in nine *Use of Force* deaths, while performing their official duties. These include five deaths resulting from CBP involved shootings and four deaths resulting from the utilization of a VID.

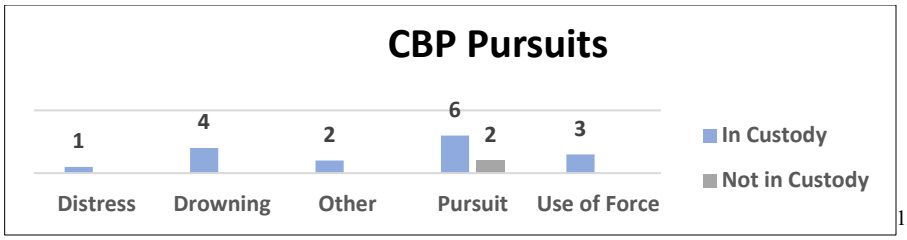


[10] [11]

Based on the CBP incident type parameters, it is possible to have a pursuit-related event that results in a death but is not categorized as a *Pursuit*. For instance, if the incident involving a pursuit also includes an application of force, the incident type is categorized as use of force. In FY 2021, three of the pursuit-related deaths involved a use of force by a CBP employee. Two of the pursuit-related *Use of Force* deaths involved the utilization of a VID during the pursuit. The third pursuit-related *Use of Force* death involved an exchange of gunfire after the pursuit concluded.

Below is a breakdown of the pursuit-related deaths during FY 2021. The non-custodial pursuit related deaths refer to an incident in which CBP discontinued the pursuit and it was taken over by another agency.

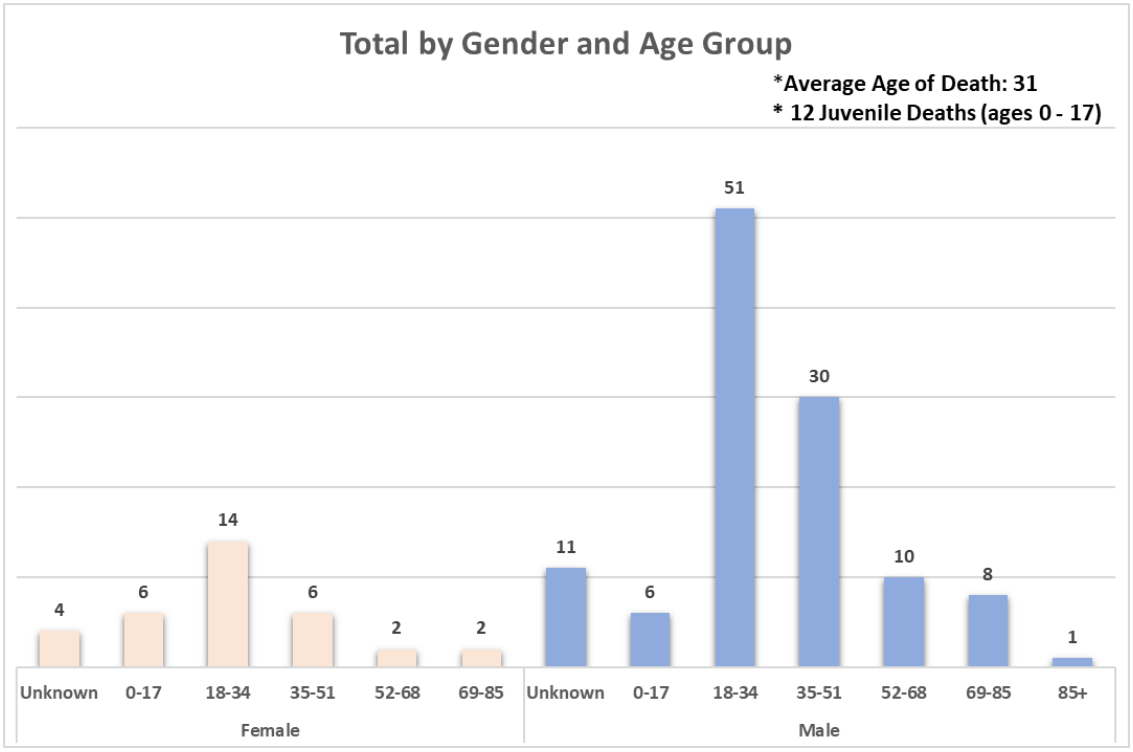
[10] Definitions of In Custody, Not in Custody, and Not Reportable are in accordance with definitions agreed upon between CBP and the Appropriations Committees and as presented on page 5 of this report.
[11] Definitions and parameters of each incident type are presented on pages 8 and 9 of this report.



[12][13]

2. Demographics

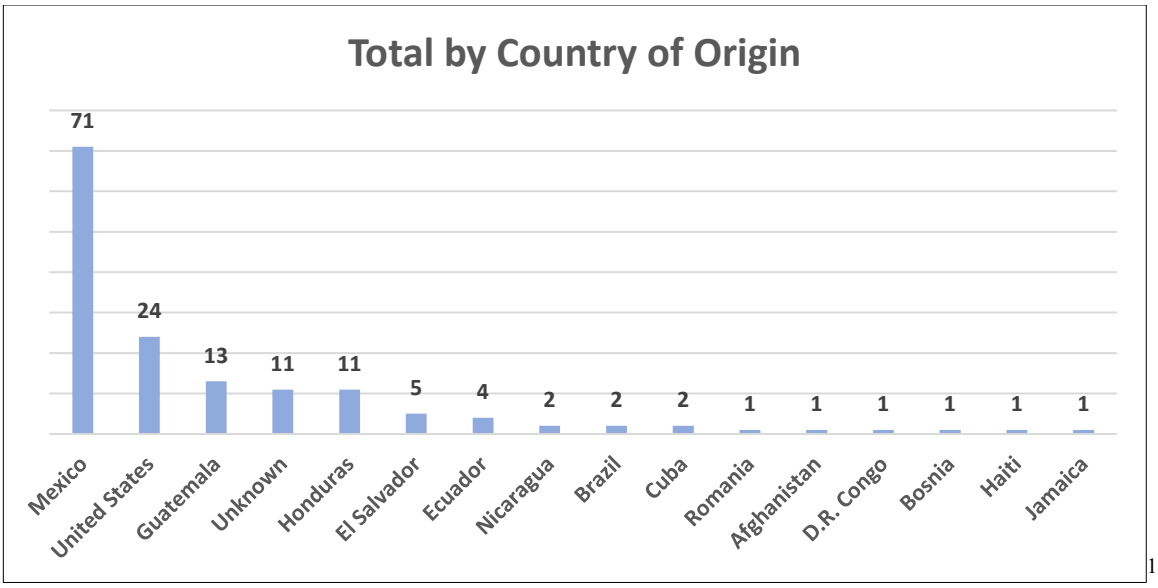
The overwhelming majority of CBP-related deaths were males, and the largest represented age group was 18-34-year-olds. CBP OPR reviewed the deaths of 12 juveniles, one of whom was in-custody. The chart below represents the age and gender of individuals involved in CBP-related deaths throughout FY 2021.



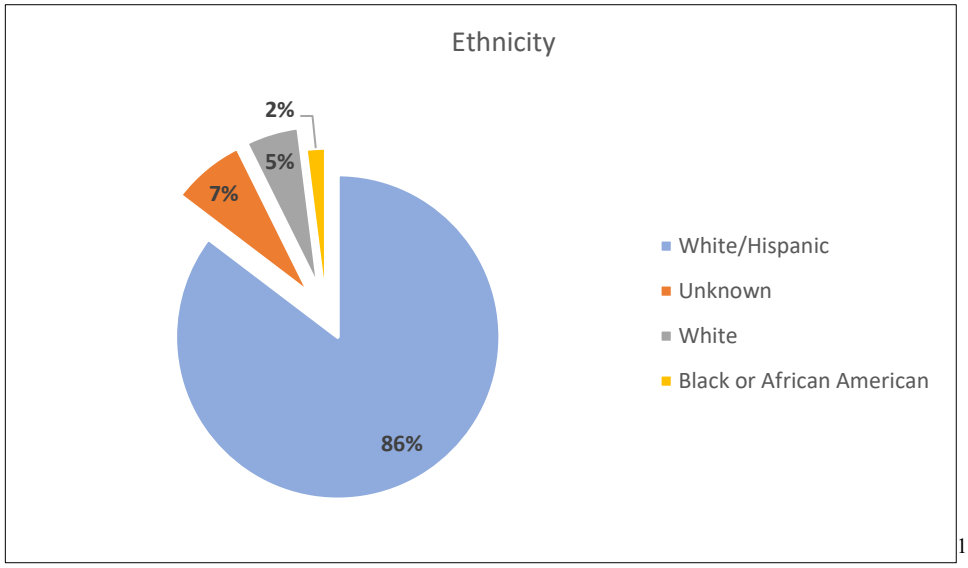
[14]

The 151 decedents hailed from 15 different countries; however, the country of origin was not identified for 11 of the decedents. The overwhelming number of the decedents were of Hispanic descent, representing 128 of the 151 reviewed deaths.

[12] Definitions of In Custody, Not in Custody, and Not Reportable are in accordance with definitions agreed upon between CBP and the Appropriations Committees and as presented on page 5 of this report.
[13] Definitions and parameters of each incident type are presented on pages 8 and 9 of this report; however, this chart represents incidents that included a pursuit across different incident types.
[14] The numbers represented in this graph include all In Custody, Not in Custody and Not Reportable deaths as defined on page 5 of this report.



[15]



[16]

3. Medical Care

To preserve lives along the border, CBP has trained a large cadre of CBP officers and BPAs as Emergency Medical Technicians (EMTs) and Emergency Medical Responders (EMRs). CBP OPR's review of CBP-related deaths revealed the number of decedents who were treated by agency personnel with advanced medical training and other medical professionals prior to death.

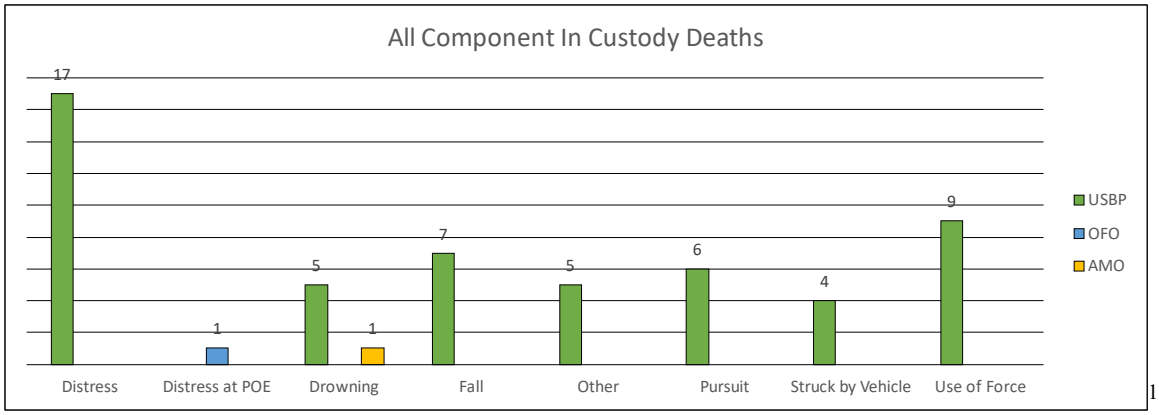
[15] The numbers represented in this graph include all In Custody, Not in Custody and Not Reportable deaths as defined on page 5 of this report.
[16] The numbers represented in this graph include all In Custody, Not in Custody and Not Reportable deaths as defined on page 5 of this report.

Percentage of Decedents who Received Medical Care Prior to Death			
	Treated by CBP EMT/EMT	Treated by Non-CBP EMT	Transported to Hospital
In Custody	30.9%	63.6%	56.3%
Not in Custody	47.1%	73.5%	33.9%
Not Reportable	79.1%	74.4%	30.2%
Total CBP-Related Deaths	50.9%	70.2%	41.0%

[17]

C. In-Custody Deaths

CBP OPR reviewed 55 in-custody deaths which occurred during FY 2021. These deaths can be broken down into eight separate incident types.



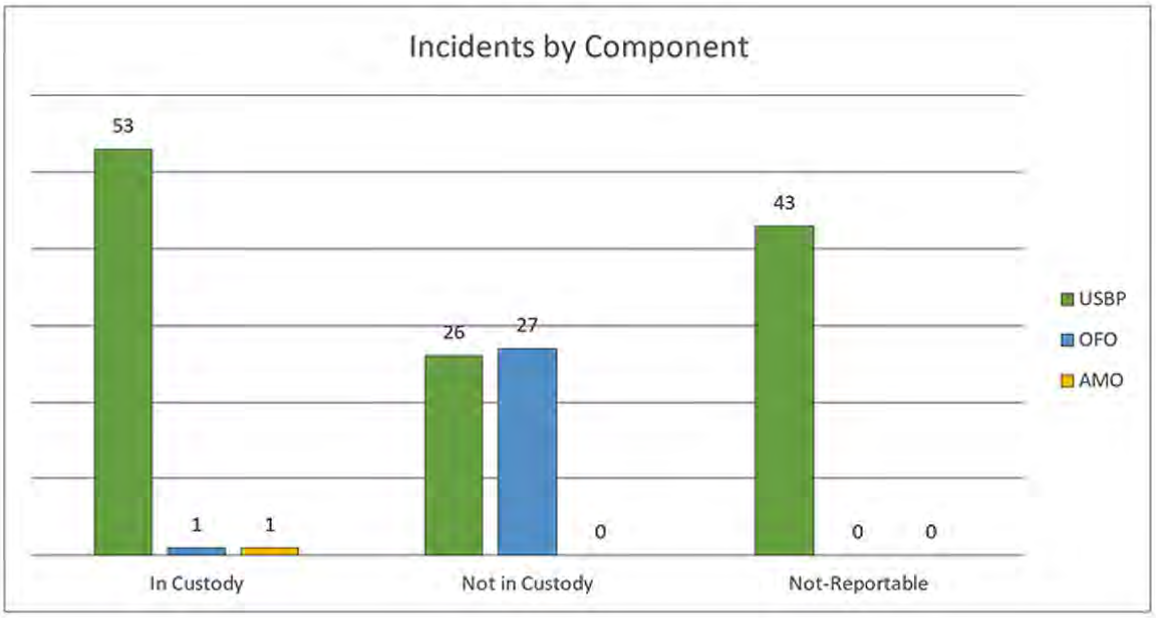
[18], [19]

[17] Definitions of In Custody, Not in Custody, and Not Reportable are in accordance with definitions agreed upon between CBP and the Appropriations Committees and as presented on page 6 of this report.
[18] Definitions of each incident type are found on pages 10 and 11 of this report.
[19] Definitions of In Custody deaths is in accordance with definitions agreed upon between CBP and the Appropriations Committees and as presented on page 6 of this report.

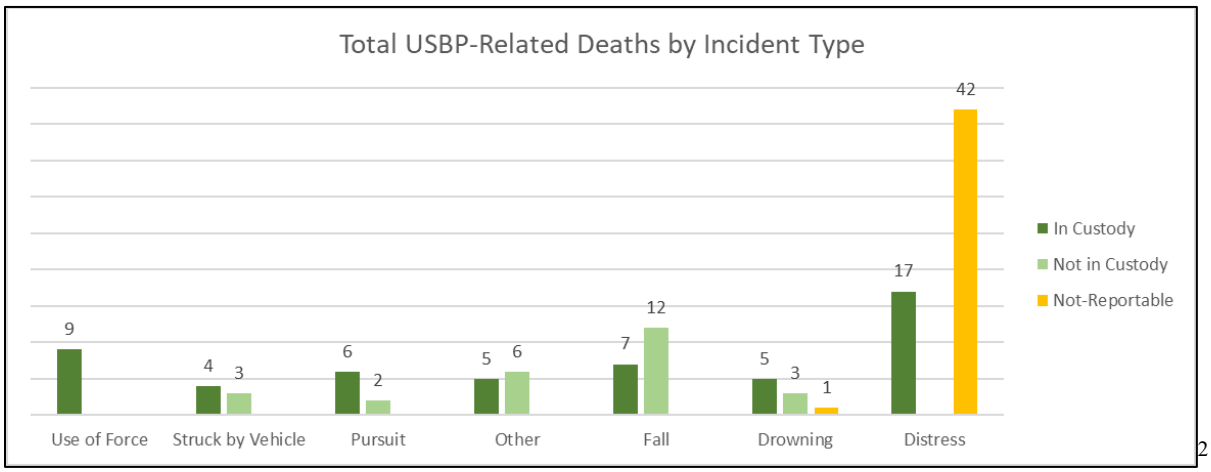
D. Component Breakdown

1. U.S. Border Patrol

The USBP is the CBP component tasked with securing the nation's borders in areas between the POEs. The areas patrolled by the USBP are often remote and harsh. Most in-custody deaths that took place in FY 2021 were connected to USBP operations.



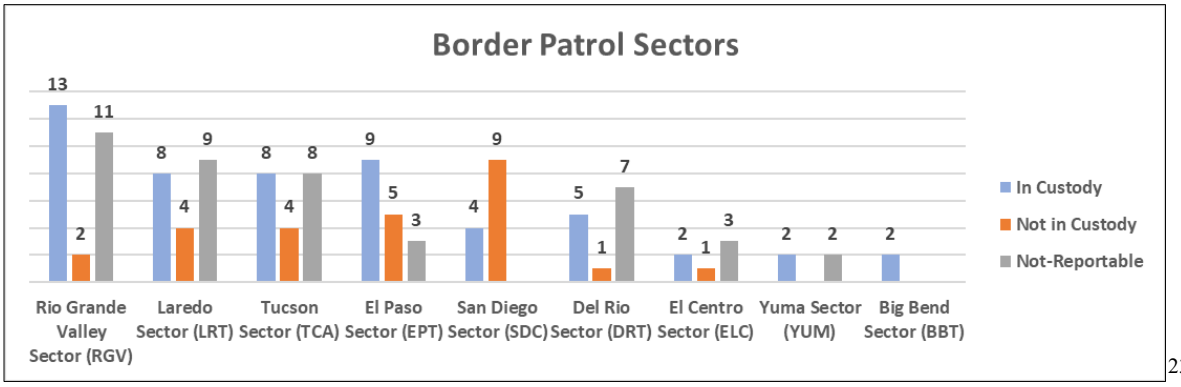
In FY 2021, distress-related deaths were most common and all 17 of these decedents were under hospital care at the time of death.



[21], [22]

[20] Definitions of In Custody, Not in Custody, and Not Reportable are in accordance with definitions agreed upon between CBP and the Appropriations Committees and as presented on page 5 of this report.
[21] Definitions and parameters of each incident type are presented on pages 8 and 9 of this report.
[22] Definitions of In Custody, Not in Custody and Not Reportable are in accordance with definitions agreed upon between CBP and the Appropriations Committees and as presented on page 5 of this report.

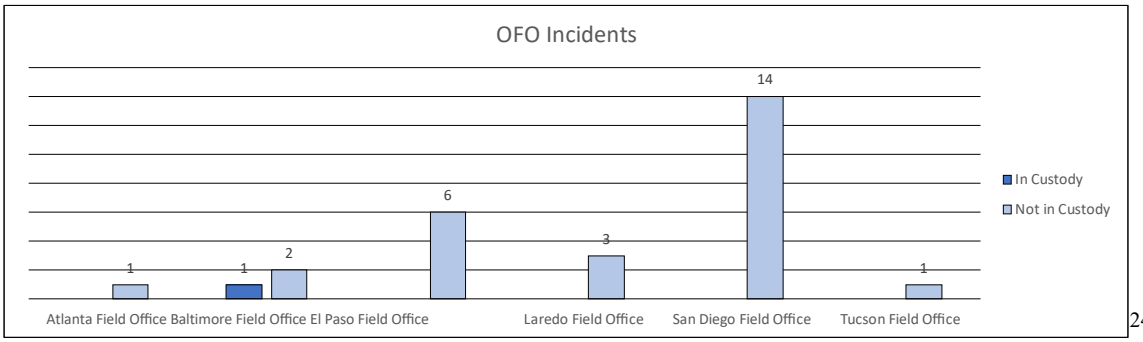
All nine USBP sectors on the southwest border experienced a CBP-related death during FY 2021. Rio Grande Valley Sector experienced the highest number of deaths and experienced the largest number of encounters throughout the year.



[23]

2. Office of Field Operations

In FY 2021, OFO experienced 28 CBP-related deaths, including one in-custody death that occurred when a medical emergency occurred during an agriculture inspection.



[24]

3. Air and Marine Operations

One death occurred during AMO operations in FY 2021. This in-custody death occurred at the onset of a maritime pursuit when an occupant jumped from the subject vessel.

[23] Definitions of In Custody, Not in Custody, and Not Reportable are in accordance with definitions agreed upon between CBP and the Appropriations Committees and as presented on page 5 of this report.
[24] Definitions of In Custody, Not in Custody, and Not Reportable are in accordance with definitions agreed upon between CBP and the Appropriations Committees and as presented on page 5 of this report.

IV. Appendix- List of Abbreviations

Abbreviation	Definition
AMO	Air and Marine Operations
BB	Border Barrier
BPA	Border Patrol Agent
CBP	Customs and Border Protection
DCRA	Death in Custody Reporting Act
DHS	Department of Homeland Security
EMR	Emergency Medical Responder
EMT	Emergency Medical Technician
FDCRP	Federal Death in Custody Reporting Program
FY	Fiscal Year
ME	Medical Examiner
MMP	Missing Migrant Program
OCMO	Office of the Chief Medical Officer
OFO	Office of Field Operations
OPR	Office of Professional Responsibility
POE	Port of Entry
TEDS	Transportation, Escort, Detention and Search
USBP	U.S. Border Patrol
VID	Vehicle Immobilization Device