U.S. Immigration and Customs Enforcement (ICE)
Detainee Death Report: WONG, Kai Yin

General Demographic/Background Information

- **Date of Birth** November 30, 1961
- **Date of Death:** October 25, 2025
- **Age:** 63
- **Sex:** Male
- **Country of Citizenship:** China

Immigration History

On December 20, 1970, the former U.S. Immigration and Naturalization Service admitted Mr. WONG into the United States, at San Francisco, California (CA), as a Lawful Permanent Resident.

On March 8, 2024, ICE Enforcement Removal Operations (ERO) Los Angeles encountered Mr. WONG at Chuckwalla Valley State Prison (CVSP), in Blythe, CA.

In April 2024, ERO Los Angeles took custody of Mr. WONG after his release from CVSP, served him with a Notice to Appear pursuant to section 237(a)(2)(A)(iii) of the Immigration and Nationality Act, as an alien convicted of an aggravated felony, to wit: sexual abuse of a minor, and transferred Mr. WONG to ERO Denver at Denver Contract Detention Facility (DCDF), in Aurora, CO.

On May 15, 2024, an immigration judge ordered Mr. WONG removed.

On May 13, 2025, ERO Denver transferred Mr. WONG to ERO San Antonio, and ERO San Antonio detained him at South Texas ICE Processing Center (STIPC), in Pearsall, Texas (TX).

Criminal Record

On March 16, 2010, the Superior Court of California, Los Angeles County, convicted Mr. WONG of lewd acts upon a child and continuous sexual abuse, and sentenced him to a combined 20 years in prison.

Synopsis of Events

On April 16, 2024, a DCDF licensed practical nurse (LPN) completed Mr. WONG's intake assessment, documented a medical history of a heart murmur, tuberculosis treatment in 2010, and an inguinal hernia (June 2023), normal vital signs, and his current medications, and scheduled a next day health assessment.

On April 17, 2024, a physician completed Mr. WONG's comprehensive health assessment, documented a medical history, noted normal lung sounds and a regularly, irregular heart rate. The

physician ordered baseline lab work, an electrocardiogram (EKG), blood pressure monitoring, weekly weight checks, and a follow-up appointment in two weeks.

Between April 17, 2024, **and May 13, 2025**, DCDF medical staff monitored and treated Mr. WONG's medical conditions, which included periodic laboratory testing, medication adjustments, diagnostic imaging, evaluations for sick call and acute health care requests, chronic care follow up, and necessary referrals for specialty care, including emergency room (ER) services, cardiology, general surgery, and urology.

On May 13, 2025, Mr. WONG was transferred to STIPC.

- **On the same day**, a licensed vocational nurse (LVN) completed Mr. WONG's intake assessment, reviewed his transfer summary, noted a medical history of mitral valve disease, atrial fibrillation, inguinal hernia, and a hydrocele, documented no current complaints of chest pain or shortness of breath, and normal vital signs, listed his current medications of a stool softener, diltiazem, apixaban, and a multivitamin, and contacted an advanced practice provider (APP). The APP provided a telephone order to continue Mr. WONG's medications, ordered an EKG, and cleared him for general population (GP).

On May 15, 2025, an APP completed Mr. WONG's comprehensive health assessment, documented no current complaints of chest pain or shortness of breath, normal vital signs, and noted his past medical history, which included an unsuccessful transesophageal echocardiography (TEE) cardioversion in 2024, and a pulmonary embolism two months ago. The APP reviewed a previous EKG that showed atrial fibrillation, ordered baseline routine lab work, including a lipid panel, comprehensive metabolic panel, complete blood count, and hemoglobin A1C, continued his current ordered medications, made referrals for cardiology, general surgery (hernia), and urology (hydrocele), and scheduled a follow-up appointment in two to three weeks.

On May 16, 2025, an RN evaluated Mr. WONG upon his return from an off-site cardiology appointment, documented TTE scheduled for July 9, 2025, no current complaints of chest pain or shortness of breath, and normal vital signs, and released him back to GP.

On May 27, 2025, an APP evaluated Mr. WONG after his recent cardiology appointment, documented no current complaints of chest pain or shortness of breath and normal vital signs, and noted Mr. WONG's report of a cardiology appointment prior to coming to STIPC, during which the cardiologist informed him he needed surgery to fix his heart valve. The APP reviewed his recent lab work, showing only an elevated glucose reading and hemoglobin A1C, continued his current medications, and scheduled a follow-up appointment in four weeks.

On June 12, 2025, an APP completed Mr. WONG's chronic care follow-up evaluation, documented his report of a cough for two weeks and shortness of breath during activity and at rest, assessed an irregular heart rate and rhythm with a murmur, and crackles to the left posterior lungs, and referred him to the University Health System (UHS) ER for further evaluation.

On June 15, 2025, an RN evaluated Mr. WONG upon his return from UHS, documented no current complaints of chest pain or shortness of breath, normal vital signs, a discharge diagnosis of bacterial pneumonia, and an order for an antibiotic, and notified an APP. The APP ordered Mr. WONG's antibiotic and placement in the medical housing unit (MHU) for observation.

On June 16, 2025, an APP evaluated Mr. WONG for his recent hospital return, documented normal heart rate and rhythm, normal lung sounds, no current complaints of chest pain or shortness of breath, normal vital signs, his report of feeling better, and his request to return to GP, and discharged him from the MHU.

On July 5, 2025, an RN evaluated Mr. WONG for complaints of shortness of breath, documented normal vital signs, his denial of chest pain, normal lung sounds, and a normal heart rate, and instructed him to increase his fluid intake and notify medical staff if symptoms continue or worsen.

On July 7, 2025, an RN evaluated Mr. WONG for complaints of a cough with blood-tinged sputum on two occasions, shortness of breath upon exertion, mid-epigastric pain, and difficulty breathing when taking a deep breath. The RN documented an elevated pulse with exertion, abnormal oxygen saturation levels, and normal lung sounds, instructed him to increase his fluid intake and to notify medical if symptoms continue or worsen, and scheduled a next-day, APP follow-up appointment.

On July 8, 2025, an APP evaluated Mr. WONG and documented Mr. WONG reported increased shortness of breath when lying and current shortness of breath with mid-epigastric pain. The APP noted Mr. WONG 's offsite TTE had to be rescheduled and documented a normal oxygen saturation, heart rate, and lung sounds, and referred him to the UHS ER for further evaluation.

- **On the same day**, an APP evaluated Mr. WONG upon his return, noted a diagnosis of congestive heart failure (CHF), documented normal vital signs, ordered furosemide, noted an upcoming cardiology follow up in two weeks, and scheduled a follow-up appointment in one week.

On July 9, 2025, an RN evaluated Mr. WONG upon his return from a TTE procedure, documented no current complaints of chest pain or shortness of breath, a pulse ranging between 99 – 114 bpm, and otherwise normal vital signs, provided education to notify medical if any symptoms occur, and notified an APP of his return.

On July 14, 2025, a physician documented UHS admitted Mr. WONG after a TEE procedure, with an admitting diagnosis of mitral valve insufficiency with volume overload, and a reported assessment of crackles throughout the lung bases and shortness of breath.

On August 6, 2025, an RN evaluated Mr. WONG after he returned from the hospital and documented a discharge diagnosis of non-rheumatic mitral valve regurgitation, his denial of any

chest pain or shortness of breath, normal vital signs, and his reports of mild dizziness and weakness, contacted an APP, and placed Mr. WONG in the MHU for observation.

Between August 6 and 18, 2025, STIPC medical staff monitored Mr. WONG's medical conditions daily in the MHU, ordered laboratory testing, adjusted his medications as needed, ordered diagnostic imaging, conducted appropriate MHU rounds, and made referrals for specialty appointments as needed.

On August 18, 2025, an APP evaluated MR. WONG during MHU rounds, documented normal lung sounds and a regularly irregular heart rate, and noted his blood pressure was lower over the past two days but would improve with repositioning and walking. The APP observed Mr. WONG's blood pressure remained low, consulted with an MD, and referred Mr. WONG to UHS ER for further evaluation.

On August 21, 2025, an RN evaluated Mr. WONG upon his return from UHS, documented a discharge diagnosis of inflammation of the small intestine, no current complaints of chest pain, normal vital signs, and no acute distress, notified a provider of his return, and placed him back in the MHU.

Between August 21 and October 11, 2025, STIPC medical staff monitored Mr. WONG's medical conditions daily in the MHU, ordered appropriate laboratory testing, adjusted his medications as needed, ordered diagnostic imaging, conducted appropriate MHU rounds, and made referrals for specialty appointments as needed.

On October 11, 2025, an APP evaluated Mr. WONG after he reported feeling hot and nauseated but felt better after consuming a liquid diet. A few hours later, an RN reported to the APP that Mr. WONG reported feeling worse and appeared ill. The APP observed Mr. WONG lying in bed, noted labored breathing and complained of shortness of breath, abdominal pain, and nausea, elevated pulse, low blood pressure reading, elevated respiration rate, difficulty obtaining an oxygen saturation reading, and crackles to the left lower lobe. The APP activated emergency medical services (EMS), ordered supplemental oxygen, and documented Mr. WONG reported he felt better with oxygen.

- **At approximately 2:02 p.m**., EMS arrived, completed an EKG, which showed abnormal results, and transferred Mr. WONG to Frio Regional Hospital (FRH), in Pearsall, TX.

On October 11, 2025, **at approximately 3:00 p.m.**, FRH transferred Mr. WONG to the Christus Santa Rosa Hospital (CSRH) – West Over Hills, in San Antonio, TX, for a higher level of care due to heart failure, possible pneumonia, and possible fluid collection in the abdomen. FRH medical staff intubated Mr. WONG and connected him to a ventilator prior to his transfer.

On October 12, 2025, CSRH transferred Mr. WONG to Methodist Metropolitan Hospital (MMH) for surgery to repair his heart valve. On the same day, MMH medical staff performed a right and left

heart catheterization and returned Mr. WONG to the intensive care unit (ICU) on temporary ventricular support, still intubated.

Between October 13 and 14, 2025, Mr. WONG remained in a guarded condition, intubated and on temporary ventricular support.

Between October 15 and 22, 2025, Mr. WONG's status improved to a more stable condition. Mr. WONG became alert and oriented, and he remained on supplemental oxygen and temporary ventricular support.

On October 23, 2025, **at approximately 10:00 p.m.**, MMH performed surgery on Mr. WONG to remove the mitral valve, inserted a balloon pump catheter, and placed him on extracorporeal membrane oxygenation (ECMO).

On October 25, 2025, **at approximately 12:53 p.m.**, MMH medical staff informed ERO San Antonio Mr. WONG's family requested to withdrawal of all lifesaving measures/treatment and the implementation of hospice protocols.

- **At approximately 1:25 p.m.**, MMH staff informed ERO San Antonio of Mr. WONG's official time of death was 1:14 p.m.