

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

Timothy P. Fox (CA Bar 157750)
tfox@creeclaw.org
Elizabeth Jordan*
ejordan@creeclaw.org
CIVIL RIGHTS EDUCATION AND
ENFORCEMENT CENTER
1245 E. Colfax Avenue, Suite 400
Denver, CO 80218
Tel: (303) 757-7901
Fax: (303) 872-9072

Lisa Graybill*
lisa.graybill@splcenter.org
Jared Davidson*
jared.davidson@splcenter.org
SOUTHERN POVERTY LAW
CENTER
201 St. Charles Avenue, Suite 2000
New Orleans, Louisiana 70170
Tel: (504) 486-8982
Fax: (504) 486-8947

Stuart Seaborn (CA Bar 198590)
sseaborn@dralegal.org
Melissa Riess (CA Bar 295959)
mriess@dralegal.org
DISABILITY RIGHTS ADVOCATES
2001 Center Street, 4th Floor
Berkeley, California 94704
Tel: (510) 665-8644
Fax: (510) 665-8511

Attorneys for Plaintiffs (continued on next page)

**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE**

FAOUR ABDALLAH FRAIHAT, *et al.*,
Plaintiffs,
v.
U.S. IMMIGRATION AND CUSTOMS
ENFORCEMENT, *et al.*,
Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

**THIRD SUPPLEMENTAL
DECLARATION OF DR. HOMER
VENTERS**

1 William F. Alderman (CA Bar 47381)
walderman@orrick.com
2 Jake Routhier (CA Bar 324452)
jrouthier@orrick.com
3 ORRICK, HERRINGTON &
4 SUTCLIFFE LLP
405 Howard Street
5 San Francisco, CA 94105
Tel: (415) 773-5700
6 Fax: (415) 773-5759

7 Michael W. Johnson**
mjohnson1@willkie.com
8 Dania Bardavid**
dbardavid@willkie.com
9 Jessica Blanton**
jblanton@willkie.com
10 Joseph Bretschneider**
jbretschneider@willkie.com
11 WILLKIE FARR &
12 GALLAGHER LLP
787 Seventh Avenue
13 New York, NY 10019
Tel: (212) 728-8000
14 Fax: (212) 728-8111

15 Maia Fleischman*
maia.fleischman@splcenter.org
16 SOUTHERN POVERTY LAW
17 CENTER
2 South Biscayne Boulevard
18 Suite 3750
Miami, FL 33131
19 Tel: (786) 347-2056
20 Fax: (786) 237-2949

21 Christina Brandt-Young*
cbrandt-young@dralegal.org
22 DISABILITY RIGHTS
23 ADVOCATES
655 Third Avenue, 14th Floor
24 New York, NY 10017
Tel: (212) 644-8644
25 Fax: (212) 644-8636

Mark Mermelstein (CA Bar 208005)
mmermelstein@orrick.com
ORRICK, HERRINGTON &
SUTCLIFFE LLP
777 South Figueroa Street
Suite 3200
Los Angeles, CA 90017
Tel: (213) 629-2020
Fax: (213) 612-2499

Leigh Coutoumanos**
lcoutoumanos@willkie.com
WILLKIE FARR &
GALLAGHER LLP
1875 K Street NW, Suite 100
Washington, DC 20006
Tel: (202) 303-1000
Fax: (202) 303-2000

Shalini Goel Agarwal
(CA Bar 254540)
shalini.agarwal@splcenter.org
SOUTHERN POVERTY LAW
CENTER
106 East College Avenue
Suite 1010
Tallahassee, FL 32301
Tel: (850) 521-3024
Fax: (850) 521-3001

Maria del Pilar Gonzalez Morales
(CA Bar 308550)
pgonzalez@creeclaw.org
CIVIL RIGHTS EDUCATION
AND ENFORCEMENT CENTER
1825 N. Vermont Avenue, #27916
Los Angeles, CA 90027
Tel: (805) 813-8896
Fax: (303) 872-9072

26 Attorneys for Plaintiffs (continued from previous page)

27 *Admitted Pro Hac Vice

28 **Pro Hac Vice Application Forthcoming

1 **THIRD SUPPLEMENTAL DECLARATION OF DR. HOMER VENTERS**

2 I, Homer Venters, make the following declaration based on my personal
3 knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. § 1746
4 that the following is true and correct.

5 **Background**

- 6 1. My name is Homer Venters. I am a physician, internist and epidemiologist
7 with over a decade of experience in providing, improving and leading health
8 services for incarcerated people. I have previously submitted three
9 declarations in this case in connection with Plaintiffs’ Motion for
10 Preliminary Injunction. *See* ECF 81-11, 113-2, 127-3. My extensive
11 background in correctional medicine is detailed in my first declaration and in
12 my curriculum vitae attached thereto. ECF 81-11.
- 13 2. Since the onset of the COVID-19 pandemic, in addition to my work on this
14 case, I have been involved in numerous cases evaluating COVID-19
15 responses in prisons, jails and immigration detention centers.
- 16 3. In connection with my work, I am closely and carefully evaluating best
17 practices and clinical guidance concerning treatment of and detention facility
18 responses to COVID-19, including review of new peer-reviewed
19 publications and local, state and national guidelines and recommendations
20 regarding COVID-19 response in congregate care settings including
21 detention facilities. I am in close and frequent contact with epidemiologists,
22 public health experts, and other medical providers to discuss and assess
23 medically necessary responses to COVID-19. I have been asked to provide
24 input regarding appropriate COVID-19 responses in correctional settings by
25 the National Academy of Sciences, the American Medical Association, The
26 National Association of Counties, Harvard University and other
27 organizations seeking to promote evidence-based COVID-19 care for people
28 with justice involvement.
- 29 4. I have carefully monitored ICE’s response to COVID-19. I have carefully
30 reviewed ICE’s Pandemic Response Requirements (PRR) (including its June
31 22 revisions), the declarations attached to Plaintiff’s motion, ICE’s
32 document productions in this case, and have other knowledge of ICE’s
33 response to COVID-19 through my independent research and work in other
34 cases across country.
- 35 5. Based on my expert opinion, ICE’s response to COVID-19 continues to

1 place people in its custody—particularly medically vulnerable people—at a
2 substantial risk of serious harm and even death. In this declaration, I
3 highlight some of the most dangerous aspects of ICE’s ongoing COVID-19
4 response that should be remediated immediately.

4 **Lack of Special Protections for People with Risk Factors**

5 6. Based on my review of current practices and policies of ICE, including the
6 revised PRR issued on June 22, 2020, it appears that no additional
7 meaningful steps have been taken to create heightened protections for people
8 who are at high-risk of serious illness or death from COVID-19. Detention
9 creates special risks for high-risk detainees that have not been addressed by
10 ICE. To provide but one example, high-risk detainees are often placed into
11 close contact with other detainees when receiving their medications, e.g.,
12 while waiting in ‘pill-lines.’ These lines routinely have detainees with high-
13 risk conditions standing shoulder to shoulder with other detainees. Similarly,
14 many high-risk detainees share very crowded congregate bathroom settings
15 without partitions or share a cell with a common toilet. Both types of
16 settings create repeated exposure to the fecal plume that disperses into the air
17 every time a toilet is flushed, creating a potent vector for transmission of
18 COVID-19 to high-risk patients. The primary vector for COVID-19
19 infections continues to be staff, who come and go to facilities every day, and
20 I continue to review reports from detainees that staff have stopped wearing
21 masks unless a supervisor is present, especially in housing areas in evenings
22 and over weekends. In addition, basic cleaning and disinfecting efforts
23 appear to be counterproductive in some settings where ICE is utilizing
24 agents that cause irritation of the eyes, nose and mouth of detainees and
25 where the cleaning process is done in close proximity to detainees and where
26 detainees conducting the cleaning or disinfecting may lack basic training or
27 PPE. Although cleaning and disinfecting is a crucial component of infection
28 control measures, ICE must ensure that people are not exposed to them since
they can cause health issues, such as respiratory issues, that further place
people at risk of COVID-19. Use of these harsh disinfectants in close
proximity to detained people—especially medically vulnerable people—
poses potentially grave danger.

7. These inherent and ongoing risks are merely illustrative of significant other
risks of harm threatening medically vulnerable people.¹ The easiest method
of protecting people with Risk Factors is simply to release them. While

¹ Below I address in greater detail additional deficiencies in ICE’s overall response, including its revised PRR, that further places medically vulnerable people at risk.

1 release is a primary method to reduce the risks posed by COVID-19 for
2 high-risk detainees, there are numerous other interventions that are required
3 to reduce risk for this same cohort while detained. The types of protections
4 that can make a meaningful reduction in the risk of serious illness or death
5 from COVID-19 include the following:

- 6 a. Twice daily screening of symptoms and temperature consistent with
7 CDC recommendations using a structured screening tool;²
- 8 b. Cohorting of high-risk detainees into specialized housing areas with
9 enhanced infection control measures and training among staff, who
10 are steady on these units;
- 11 c. Healthcare evaluations by appropriately trained staff to assess high-
12 risk patients' current conditions, symptoms, medications, and to make
13 a plan for COVID-19 infection;
- 14 d. Enhanced medical monitoring of medically vulnerable people when
15 they have COVID-19, as well as treatment protocols;
- 16 e. Standards and protocols to ensure that medically vulnerable people
17 are properly evaluated following their recovery from COVID-19;
- 18 f. Increased social distancing measures and PPE for high-risk people;
- 19 g. Increased medical surveillance of people with Risk Factors, including
20 contact tracing;
- 21 h. Expansion of testing to people with Risk Factors and close
22 contacts/staff;
- 23 i. Prohibitions on transfer (because transfer risks spread);
- 24 j. Clear guidance on how requisite conditions of medical isolation and
25 quarantine to ensure that conditions equivalent to solitary confinement
26 are not imposed;
- 27 k. Enhanced cleaning measures for areas occupied by medically
28 vulnerable people (and standards to ensure that people are not exposed
to harsh cleaning agents _;
- l. Increased education of people with Risk Factors;
- m. Enhanced training of staff with any responsibility over people with
Risk Factors;
- n. Audits of medical staffing ratios at facilities to ensure proper staffing
where medically vulnerable people are detained;
- o. Hospitalization protocols for people with Risk Factors;

8. Currently, the PRR fails to prescribe these basic precautionary measures that
are crucial to the health and safety of medically vulnerable people. In

² Temperature checks alone are inadequate because many people with COVID-19
do not have a fever and thermometers may be wrong. Symptom checks are an
important component of screening and should be done in conjunction with
temperature checks.

1 addition to these necessary precautionary measures, below I elaborate on
2 some of the crucial safeguards that should be implemented to protect
3 people—especially medically vulnerable people—in ICE’s care but that are
4 not addressed in the revised PRR.

5 **Need for Restriction of Transfers**

6 9. Based on reports from throughout the country, ICE unnecessarily continues
7 to transfer large numbers of people between detention facilities and between
8 prisons/jails and detention facilities. This ongoing practice contradicts CDC
9 guidance and places detained people as well as staff at substantial risk of
10 infection and death.

11 10. Detained individuals continue being transferred daily without universal
12 testing. For example, on June 16, 2020, the Director of Farmville confirmed
13 that 34 people who had been recently transferred to Farmville tested positive
14 for COVID-19 upon arrival. Feldman Decl. ¶ 27. This was not an isolated
15 incident, as transfers are occurring in and out of detention facilities
16 systemwide. *See* Doubossarskaia Decl. ¶ 34 (reports individuals being
17 transferred to and from IAH, Conroe, and South Louisiana); *See* Vosburgh
18 Decl. ¶ 17 (reports 30 individuals transferred to ICE custody at Etowah
19 within the last 2 weeks). One who tested positive for COVID-19 after his
20 transfer to Pulaski, a detention center in Chicago, describes being transferred
21 in a small, enclosed van without PEE and with multiple detained noncitizens
22 who were coughing and exhibiting other symptoms of COVID-19. *See*
23 Zwick Decl. ¶ 32. On June 10, 2020, 50 people were reportedly transferred
24 from Broward Transitional Center to Georgia, only to be brought back to
25 Miami, and then finally flown to Louisiana. In fact, a few of those 50
26 individuals were eventually brought back to BTC two days later. *See* King
27 Decl. ¶ 16. One detained individual has been transferred a shocking total of
28 18 times since April 13. *Id.* ¶ 19. These stories of “circular” transfers are not
limited to Florida. Detained individuals in Louisiana report being
transported from the facility to the airport for deportation, and when their
country of origin refuses to accept them, they are brought back to the facility
and placed in general population. Page Decl. ¶ 16.

11. Transfer of detainees in and out of ICE facilities represents a significant
potential source of COVID-19 infection for staff and detained people alike.
Indeed, the CDC has identified detainee transfers as a significant risk for the
spread of infection.³ Increased transfers pose a special risk of infection for

³ <https://www.cdc.gov/coronavirus/2019-ncov/downloads/guidance-correctional-detention.pdf>.

1 medically vulnerable individuals. Accordingly, the CDC has emphasized
2 that transfers of detained people must be restricted to abate the spread of
3 COVID-19 and should only be used when necessary for medical evaluation,
4 medical isolation/quarantine, clinical care, extenuating security concerns, or
5 to prevent overcrowding.⁴ Notably, however, ICE could achieve many of
6 these goals, e.g., preventing overcrowding and medical isolation/quarantine,
7 simply by releasing people rather than transferring them.

- 8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
12. Since the onset of COVID-19, ICE’s unnecessary transfer of individuals between facilities has resulted in the preventable spread of the virus between facilities. Indeed, Dr. Scott Allen, who serves as a medical subject matter expert for the Department of Homeland Security, recently observed that “[t]here have been multiple examples of ICE’s active transfer of detainees being a source of spread of the virus, causing outbreaks in detention facilities.”⁵ The spread of COVID-19 from transfers is highly foreseeable given that ICE systemically fails to test people prior to transfer.⁶

⁴ CDC at 9 <https://www.cdc.gov/coronavirus/2019-ncov/downloads/guidance-correctional-detention.pdf>.

⁵ See Written Statement of Dr. Scott A. Allen, MD, U.S. Senate Committee on the Judiciary, *Examining Best Practices for Incarceration and Detention During COVID-19* (June 2, 2020), <https://www.judiciary.senate.gov/imo/media/doc/Scott%20Allen%20Testimony.pdf> (citing Lisa Riordan Seville and Hannah Rappleye, “ICE keeps transferring detainees around the country, leading to COVID-19 outbreaks,” NBC News (May 31, 2020), available at <https://www.nbcnews.com/politics/immigration/ice-keeps-transferring-detainees-around-country-leading-covid-19-outbreaks-n1212856>; Hamed Aleaziz, “ICE Moved Dozens Of Detainees Across the Country During the Coronavirus Pandemic. Now Many Have COVID-19.” BuzzFeed News (April 29, 2020), available at <https://www.buzzfeednews.com/article/hamedaleaziz/ice-immigrant-transfer-jail-coronavirus>; Yeganeh Torbati, Dara Lind and Jack Gillum, “In a 10-Day Span, ICE Flew This Detainee Across the Country — Nine Times,” ProPublica (March 27, 2020), available at <https://www.propublica.org/article/coronavirus-ice-flights-detaineesirous-asgari>; Monique Maden, “Coronavirus cases skyrocket at ICE detention center in Broward after transfer from Miami,” Miami Herald (May 19, 2020), available at <https://www.miamiherald.com/news/local/immigration/article242844451.html>.)

⁶“During a June 10 Senate Judiciary Committee oversight hearing on COVID-19 in ICE and Bureau of Prisons facilities, Executive Associate Director of Enforcement and Removal Operations Henry Lucero stated that the agency does not conduct universal testing of COVID-19 during transfers, but is considering expanding testing in relation to transfers.” *COVID-19 IN ICE CUSTODY Biweekly Analysis & Update* FREEDOMFORIMMIGRANTS (June 18, 2020) at 2 <https://static1.squarespace.com/static/5a33042eb078691c386e7bce/t/5eebc846c4275f35d9c6c110/1592510535009/FFI+June+18+COVID-19+update.pdf>.

- 1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
13. There are several approaches that ICE should implement in order to mitigate the risk of spreading COVID-19 between facilities, and from one region or state of the U.S to another. First, while it is true that the CDC contemplates that transfer can be utilized as a last resort to effectuate certain needs (e.g., for quarantining and overcrowding), the safest thing for ICE to do to achieve those actions is simply to release people rather than transfer them between facilities. For example, release would permit ICE to reduce detention facility populations to mitigate spread without incurring the significant risk of cross-contamination between facilities as a result of transfer. Likewise, release would permit people to self-quarantine at a home or with a sponsor without increasing the probability of spread via transfer. From both a public health perspective and an institutional management perspective, releases are absolutely safer than transfer not only for detained people but also for facility staff who undergo substantial risk of infection during transfer.
 14. Second, any facility with active COVID-19 cases (including people in medical isolation or quarantine) should halt inter-facility transfers into and out of the facility until a 14 day period has passed since the last medical isolation or quarantine has ended. Importantly, in order to ensure that there are no additional positive cases during this period, mass testing and symptom checks are crucial. Third, each facility should maintain a new admission roster that ensures that every newly admitted detainees will be held in a quarantined housing area, without contact with other detainees, for a full 14-day period. New admission quarantine, as well as other forms of medical quarantine, should not be administered as solitary confinement (isolation inside a cell for 22 or more hours per day with material deprivations). The purpose of quarantine, as described by the CDC, is to ensure that people with a potential exposure to COVID-19 are kept physically apart from other people who are not suspected of having the same exposure. Thus, the objective is to maintain a physical separation of the quarantine cohort from other detained people for the duration of 14 days or until the concern for potential exposure has been eliminated. During quarantine, all detainees should be screened at least once per day (but preferably more) for symptoms and signs of COVID-19 and these screenings should not rely solely on temperature checks because people with COVID symptoms often have symptoms other than fever.
 15. A structured screening tool, with symptoms of COVID-19, as well as temperature, should be utilized to check newly admitted people for potential COVID-19 at least once daily. During this period, the chronic health problems of every newly admitted detainee should be assessed and a

1 COVID-19 plan should be created in their medical record, identifying any
2 clinical issues that elevate their risk of serious illness or death from COVID-
3 19, and what measures will be taken to create protections or increased
4 surveillance. The new admission housing period can be shorter when newly
5 arrived detainees are offered testing on days 4-7 and test negative. This same
6 tool should be utilized to conduct twice daily screenings of all high-risk
7 detainees. A COVID-19 plan must also be created for all medically
8 vulnerable people currently in detention (and not just new admissions).

7 16. In the event that transfers are absolutely necessary, any detained person who
8 is being considered for transfer to another facility or release should similarly
9 be offered testing. No person with a positive test result should be transferred.
10 If the test is negative but the detainee reports symptoms of COVID, then the
11 detainee likewise should not be transferred and an additional test should be
12 administered to rule out false negatives, which are frequent. No individual
13 should be transferred until and unless they test negative for COVID-19.
14 Further, between the time of testing and transfer, precautions must be made
15 to ensure that transmission does not occur within the window between
16 testing and results, but those precautions must not include imposition of
17 conditions equivalent to solitary confinement. Because transfers of ICE
18 detainees are often conducted to accommodate overcrowding, release of
19 detainees will be critical to reducing inter-facility transfers and spread of
20 COVID-19.

17 17. Although ICE's PRR provides that transfers should be limited only to the
18 circumstances prescribed by the CDC "where possible," the declarations of
19 legal service providers and detainees demonstrates that ICE is not ensuring
20 that unnecessary transfers are not occurring. The revised PRR fails to
21 provide additional protections to ensure that transfers are not limited,
22 thereby further magnifying the risk of infection to medically vulnerable
23 people.

23 **Need for Expanded Testing**

24 18. To date, ICE has conducted only 8,858 tests for a total population of 24,041.
25 This represents only about one third of the detained population. The overall
26 lack of testing by ICE, combined with the fact that many people show no or
27 few symptoms, means that the current number of infected detainees are
28 likely just a small fraction of overall positive cases. As a result, ICE's
meager testing numbers threaten to further spread the virus and also to
prevent people who are positive from obtaining necessary medical attention
before complications occur. Indeed, failure to expand testing increases the

1 likelihood that asymptomatic individuals who are not tested will transmit the
2 virus to medically vulnerable people.⁷ In order to protect medically
3 vulnerable people, ICE's revisions to the PRR should have mandated
4 universal and ongoing testing.⁸

5 19. Declarations of providers and detained individuals show that testing remains
6 inadequate throughout the country. For example, at ICA Farmville, over 100
7 detained individuals participated in a hunger strike, in part, to demand
8 testing symptomatic people. Feldman Decl. ¶ 31. At Pulaski, an individual
9 had to wait 13 days after demonstrating symptoms such as severe chest pain
10 to get tested. Zwick Decl. ¶ 21. According to service providers from NIJC,
11 who represent individuals in detention centers across the country, very little
12 testing has been conducted, "even if detained individuals report having
13 symptoms of COVID-19 and specifically request to be tested." *Id.* at ¶ 31.
14 Indeed, in some instances, ICE has placed people in punitive segregation
15 following a return from the hospital but did not test them for COVID-19.
16 *See, e.g.,* Mencias-Soto Decl. ¶¶ 7, 14 (Adelanto, California). And although
17 ICE should be testing all detained individuals, and not just those exhibiting
18 symptoms, in many facilities, ICE is not regularly checking people for
19 symptoms. Rios Decl. Ex. C ¶14. These examples demonstrate that ICE's
20 testing continues to be deficient, thereby exposing medically vulnerable
21 people to avoidable infection.

22 20. ICE should follow the lead of many large State and Federal Prisons as well
23 State and national public health agencies and dramatically expand COVID-
24 19 testing. For example, as of June 22, 2020, the Federal Bureau of Prisons
25 had tested over 19,000 detainees, whereas ICE had tested less than 9,000

26 ⁷ *See, e.g.,* See D. Sutton, K. Fuchs, M. D'Alton, D. Goffman, Universal screening
27 for SARS-CoV-2 in women admitted for delivery N ENGL J MED, (May 28, 2020),
28 pp. 2163-2164, <https://www.nejm.org/doi/full/10.1056/NEJMc2009316> (87% of
all patients who tested positive had no symptoms of COVID-19 upon entry. "The
potential benefits of a universal testing approach include the ability to use Covid-
19 status to determine hospital isolation practices and bed assignments... guide the
use of personal protective equipment); *see also* Dr. Eduardo Sanchez, *COVID-19
Science: Why Testing is so Important*, HEART.ORG (April 2, 2020)
[https://www.heart.org/en/news/2020/04/02/covid-19-science-why-testing-is-so-
important](https://www.heart.org/en/news/2020/04/02/covid-19-science-why-testing-is-so-important).

⁸ *A Systematic Approach To Mitigate The Spread Of COVID-19 In Immigration
Detention Facilities* HEALTHAFFAIRS (June 17, 2020)
https://www.healthaffairs.org/doi/10.1377/hblog20200616.357449/full/?utm_medium=social&utm_source=twitter&utm_campaign=blog&utm_content=erfani&
(urging ICE to increase COVID-19 screening and mass testing).

1 detainees.⁹ It is critical to recognize that expansion of testing does not
2 represent a one-time testing of many or all detainees, but an expansion of
3 *ongoing* testing until the prevalence of COVID-19, as well as the positivity
4 of tests, is low. Because of the numerous transfers between ICE facilities up
5 to this point, every ICE detainee in custody should be offered COVID-19
6 testing. ICE has taken this approach in two facilities where cases of COVID-
7 19 have been reported, but the ongoing transfer of detainees in between ICE
8 facilities has created a situation that limits the value of expanded testing in
9 limited facilities.¹⁰

- 10 21. CDC guidance on the need for expanded COVID-19 testing in congregate
11 settings, including prisons, makes clear that the approach to testing should
12 be linked to the overall infection control plan. In the case of ICE, the
13 repeated and ongoing practice of transferring detainees around their network
14 of facilities represents a departure from CDC and basic infection control
15 guidance. As a result, the ICE approach to testing must necessarily be
16 as broad and inclusive as possible, involving an initial offer of testing for
17 each detained person, together with subsequent testing based on specific
18 criteria.
- 19 22. In addition, there are multiple other circumstances under which testing
20 should be implemented.
- 21 23. Updated guidelines from the CDC make it clear that ICE must expand
22 ongoing testing for COVID-19 among detained people to prevent new
23 outbreaks in individual facilities. CDC guidance lists people who are at high
24 priority for testing, including “[r]esidents in long-term care facilities or other
25 congregate living settings, including prisons and shelters, **with** symptoms.”¹¹
26 This includes all ICE detainees and thus, ICE must establish a mechanism to
27 screen every detainee on a daily basis for symptoms of COVID-19, as well
28 as respond to detainees with one or more symptoms or sign of COVID-19
with testing. While some facilities may conduct temperature checks, the
practice of only checking the temperatures of detainees as a means to detect
COVID-19 infections is not supported by the CDC and a recent assessment
of the infrared noncontact type of thermometers being used in many ICE
facilities revealed concerns about consistently low temperature readings.

⁹ Compare <https://www.bop.gov/coronavirus/> with <https://www.ice.gov/coronavirus> (last visited June 22, 2020).

¹⁰ <https://www.ice.gov/news/releases/ice-offers-voluntary-covid-19-testing-all-detainees-2-facilities#wcm-survey-target-id>

¹¹ <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html>

1 Indeed, through my work, I have observed systematic lower readings in
2 detention settings.

3 24. Beyond testing of symptomatic individuals, ICE should decide whether a
4 new positive COVID-19 test in a facility will result in testing (or re-testing)
5 the entire facility or simply close contacts of the new case. CDC guidelines
6 state that to slow the spread of COVID-19 in nursing homes, new cases
7 should result in testing of either the entire facility, or in cases where testing
8 supplies are limited, all close contacts of the new case.¹² The more limited
9 approach, only testing close contacts of an index COVID-19 case, may
10 prove more difficult for ICE since it requires a commitment to contact
11 tracing utilizing trained staff and utilizing the core principles identified by
12 the CDC.¹³ The plan for testing, including these decisions, should be
13 identified for every facility, along with quality assurance metrics. Simply
14 providing universal ongoing testing will likely obviate some of the logistical
15 hurdles of limiting testing on the basis of contact tracing.

16 25. Because COVID-19 testing may cause apprehension about the implications
17 of testing for a detained person's immigration or detention status, health
18 staff must ensure that COVID-19 testing is explained and offered in the
19 language of the detained patient's choosing and that patients are informed
20 that the decision to accept a COVID-19 test is unrelated to their immigration
21 or detention status. The most effective way to promote acceptance of testing,
22 as well as other basic COVID-19 measures in the CDC guidelines, is to
23 establish a weekly COVID-19 briefing for each housing area by a health
24 professional, both to answer questions and explain priorities for preventing,
25 detecting and treating COVID-19. In my experience managing outbreaks in
26 detention settings, this approach has proved to be extremely valuable for
27 both the functioning of the health service and engagement of patients. The
28 revised PRR lacks such measures.

29 26. I am aware of detained people reporting that swab samples are collected by
30 non-health staff and that the techniques utilized do not appear to be
31 standardized, including nasal swabs of the outside of the nose or very
32 proximal area of the nostril. Health staff should be conducting these tests
33 and a standard amount of training should be ensured and monitored. Part of
34 this testing must include informing all detainees of the results of their tests
35 withing 24 hours of the test results becoming available.

36 ¹² <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html>

37 ¹³ <https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/principles-contact-tracing-booklet.pdf>

1
2
3
4
5
6
7
27. An additional issue for ICE is whether tests have already been performed using tests with unacceptably high false-negative rates such as the Abbott ID Now test. The standard of care in correctional and community settings is to conduct confirmatory testing, meaning that original samples that run with this test are re-tested with another, more reliable test. ICE should know how many of these Abbott ID Now tests have been conducted, how many still are awaiting confirmatory testing, and what the concordance rate was, especially any instances of apparent false-negative tests.

8
9
10
11
12
28. ICE should also offer testing to anyone newly arrived to a facility as well as anyone before they leave a facility, whether for release to the community, removal to another country, or transfer to another facility. Concerningly, at a recent Senate Judiciary Hearing, ICE recently admitted that it not testing most people prior to removal, which places people at a particularly high risk of severe illness and death.¹⁴ Here, too, the revised PRR is deficient.

13 **Medical Isolation and Quarantine Should Not Result in Solitary Confinement**

14
15
16
17
29. Reports also show that ICE is utilizing the dangerous practice of placing individuals in conditions equivalent to punitive solitary confinement in order to quarantine them or to place them in medical isolation. Such practices are extremely dangerous and increase the likelihood of spread, severe illness and death.

18
19
20
21
22
23
24
25
30. The evidence shows that ICE is imposing conditions equivalent to solitary confinement as part of its COVID-19 response across the country. *See* Zwick Decl. ¶¶ 40-41; Dobbins Decl. ¶ 15; Page Decl. ¶ 15, Rios Decl. ¶ 19; Aguirre Decl. ¶¶ 8-10; Saenz Decl. ¶ 6; Vosburgh Decl. ¶¶ 14-15, 21; Doubossarskaia Decl. ¶ 35. ICE is imposing these conditions on people who are positive for COVID-19 as a means of medical isolation, *see, e.g.*, Page Decl. ¶ 15, as well as a method of quarantining non-positive cases, *see, e.g.*, Saenz Decl. ¶ 6; Dobbins Decl. ¶ 15. Given that it is well known that solitary confinement is dangerous, it is not surprising that these practices have had the dangerous result of causing people's mental and physical deterioration. *See, e.g.*, Saenz Decl. ¶ 6; Doubossarskaia Decl. ¶ 35.

26
27
31. The CDC recommends medical isolation and use of quarantining in certain circumstances, e.g., as a means of isolating positive cases or preventing

28
¹⁴ Monique O Madan, *ICE admits to transferring detainees with COVID-19, says it can't test everybody* MIAMIHERALD (May 28, 2020), <https://www.miamiherald.com/news/local/immigration/article243031176.html>.

1 spread. However, the CDC does not recommend the use of solitary
2 confinement. Solitary confinement is distinct from medical isolation and
3 quarantining in significant ways.¹⁵ Solitary confinement generally involves
4 extended lockdown of a person (22+ hours/day) with severe material
deprivations, lack of contact, and oversight by security personnel.

5 32. By contrast, medical isolation and quarantine do not involve such
6 deprivations. There is nothing about either medical isolation or quarantine
7 that demands that people in those settings be deprived material needs, such
8 as television, reading material, showers/bathroom, and access to telephones
9 or video teleconferencing in order to communicate with loved ones and
10 advocates. Likewise, access to the outdoors should be a part of both medical
11 isolation and quarantine in order to help abate the risk of harm stemming
12 from prolonged isolation in a room. Further, medical isolation and
13 quarantine require oversight by medical and mental health staff—not
security staff. This is especially true of medical isolation of confirmed or
suspected cases of COVID-19 because people can deteriorate extremely
quickly and therefore should be easily observable by medical/mental health
staff.

14 33. The imposition of conditions equivalent to solitary confinement also will
15 deter people from reporting symptoms—which will increase the likelihood
16 of spread and complications from COVID-19. ICE must address the fear
17 among detainees that reporting symptoms of COVID-19 or testing positive
for COVID-19 will result in their punishment.

18 34. Moreover, there is no doubt that placement into a cell designed for solitary
19 confinement for 23 or 24 hours per day represents a psychological stressor
20 and threat to mental health. For example, Mr. Aguirre reports that he was
21 placed into the solitary confinement unit of his facility in Colorado, and that
22 he experienced psychological stress from this setting, without any mental
23 health screening or care. Aguirre Decl. ¶¶ 9-10.

24 35. It is possible to implement medical isolation and quarantine without all of
25 the punitive aspects of solitary confinement, but this requires a commitment
26 of resources and monitoring of the medical isolation and quarantine settings.
27 Several principles must be applied to medical isolation and quarantine
28 settings in order to achieve this goal, however. First, a housing area or unit
being utilized for medical isolation and quarantine cannot simultaneously be
used for solitary confinement, whether termed punishment, punitive or

¹⁵ https://amend.us/wp-content/uploads/2020/04/Medical-Isolation-vs-Solitary_Amend.pdf

1 administrative segregation. Any mixing of these very different sets of
2 priorities and tasks will result in the medical isolation patients and
3 quarantined individuals being treated in a punitive manner. In addition, this
4 approach creates many very difficult infection control issues for the people
detained in these units and the staff who work in them.

5 36. A second principle that must be applied to medical isolation is that every
6 person should have a clinical encounter outside of their cell at least once a
7 day. This encounter should include physical examination in a room designed
8 for clinical care with an examination table, sink, no-touch waste receptacle
9 and computer terminal for systems using electronic medical records. These
10 encounters should have a standard set of elements for each encounter,
11 including what symptoms will be asked about, what objective signs will be
12 measured, and a protocol for nursing staff who conduct these assessments on
13 when these encounters should elicit a higher level assessment by a
physician. Anyone placed into medical isolation should be evaluated by a
physician or mid-level provider within 2 hours, and subsequently at least
once every four days unless daily nursing encounters reveal new or
worsening symptoms of COVID-19 or abnormal vital signs.

14 37. A third principle for medical isolation and quarantine is that patients must be
15 afforded recreation, phone calls, access to tablets and reading material just as
16 they were before. In order to implement these measures, ICE must dedicate
17 resources, both clinical and security staffing. My experiences with medical
18 isolation in a non-punitive manner is that for every five patients in a medical
isolation unit, there is a need for one additional nurse and one additional
security officer to ensure their care.

19 38. The use of solitary confinement as medical isolation or quarantine, or any
20 practice that results in placement of a person into a locked cell for 22 or
21 more hours per day, is likely to increase the risk of serious illness or death
22 from COVID-19. Once people are placed into locked cells, the default
23 becomes that they remain in those cells unless security and health staff take
24 steps to ensure their removal for medical care, recreation and other activities.
25 During an outbreak, staff may become reluctant to do so, or they may simply
26 be unable to keep up with a schedule of out of cell time as the number of
27 people in this type of custody increases. If solitary confinement is utilized as
28 a primary response to COVID-19, the natural tendency to avoid out of cell
time can quickly result in decompensation of patients locked in their cells,
with little or no awareness of staff. This type of decompensation increases
the risk of hospitalization and serious complications from COVID-19. These
dangers are compounded by the fact that people can deteriorate rapidly and
unexpectedly from COVID-19.

1
2 39. In addition, general lockdown, or confinement to cells 22 or more hours a
3 day, for the general population for purposes of quarantining is likewise an
4 inappropriate and dangerous response to COVID-19. Such an approach is
5 dangerous and misguided. First, prolonged isolation causes severe
6 psychiatric stress, and has been known to cause suicidality and mental
7 decompensation. Moreover, in my experience, people forced into isolation
8 quickly become resistant to this practice because of the severe psychological
9 stress that it creates, and the result is an increase in the likelihood of use of
10 force and other security problems that can actually increase physical contact
11 between security staff and detainees, thereby increasing likelihood of
12 transmission.

13 40. Finally, solitary confinement is not a prudent infection control measure. The
14 primary vector for introduction of COVID-19 is staff, not detainees. Staff
15 not only come and go from the facility many more times per day than
16 detainees, they also move throughout every part of the facility, unlike
17 detainees who are generally restricted to a small area. This approach of cell
18 isolation is tantamount to imposing punishment on detainees in the guise of
19 infection control. A preferable approach is to allow for significantly more
20 time out of cells, but to stagger these times, implement social distancing, and
21 use of PPE, all of which requires an adequate commitment of staff.

22 41. Defendants could remedy many of these defects simply by providing clear
23 guidance and mandates to facilities in their PRR. For example, the PRR
24 acknowledges the need for isolation beds and even notes that transfer,
25 hospitalization, or release may be necessary where a facility does not have
26 sufficient isolation beds. The revised PRR, however, fails to provide
27 facilities with adequate guidance as to what isolation appropriately means.
28 The PRR should make clear that medical isolation and quarantines should
not be solitary confinement conditions. And to the extent proper medical
isolation beds are not available in a facility, then the PRR should further
clarify that release/hospitalization is necessary—and that finding beds in
conditions equivalent to solitary confinement is not proper. The revised
PRR's failure to include such guidance and safeguards means that medically
vulnerable people remain at significant risk of being inappropriately placed
into solitary confinement conditions that threaten their physical and mental
health.

ICE's Definition of Severe Psychiatric Illness

42. The ICE directive regarding which detainees should be considered for

1 release based on the presence of “Severe Psychiatric Illness” is
2 inappropriate. Traditional definitions of serious mental illness in detention
3 settings include many more psychiatric diagnoses, including major
4 depression and personality disorders that are well known to be associated
5 with impairments of insight and judgement.¹⁶ There are several key
6 omissions and errors in the approach taken by ICE.

7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
43. First, the list utilized by ICE omits many of the major psychiatric diagnoses that would impair the ability to engage in COVID-19 prevention, diagnosis and treatment efforts. ICE has listed several diagnoses associated with psychosis and intellectual or neurocognitive deficits, but has omitted significant diagnoses including major depressive disorder. In addition, there are numerous other diagnoses that may result in profound functional impairments that render patients unable to appreciate or engage with health services and COVID-19 prevention, diagnosis and treatment efforts, including but not limited to post-traumatic stress disorder and anxiety disorders. The primary reason that these diagnoses should be added, along with any person who is experiencing functional impairments that impede insight or judgment, is that people with serious mental illness may face challenges in identifying or reporting symptoms of COVID-19. These challenges may not be clearly identifiable by staff, and it is very possible that people with severe depression, anxiety, PTSD and other psychiatric problems may simply avoid health staff. As a result, it is important to affirmatively include them as part of the high-risk cohort and implement active surveillance for COVID-19, meaning that twice per day, they should be assessed by a health professional for symptoms of COVID-19 along with signs of mental health deterioration.

44. Second, there are people who are prescribed psychotropic medications that render them heat sensitive, meaning that the medication they take impairs the ability of their body to regulate heat. This issue is relevant in high heat settings, but it is also relevant to COVID-19, because of the role of fever and dehydration in both conditions. Many of the chronic health problems that already qualify as COVID-19 risk factors, including heart and lung disease, and diabetes, are markers of heat sensitivity. As a result, any person who is heat sensitive because of medications or because of a health problem should be considered as high-risk for serious illness or death from COVID-19.¹⁷

¹⁶ <https://www.mass.gov/files/documents/2016/09/ov/622.pdf> and <https://www.gao.gov/assets/700/690090.pdf>

¹⁷ https://dbh.dc.gov/sites/default/files/dc/sites/dmh/release_content/attachments/877

1
2 45. Third, identification of people who meet these criteria should also result in
3 increased surveillance and engagement while detained. This includes at least
4 daily (but preferably at least twice daily) monitoring of signs and symptoms
5 of COVID-19 by health staff, implementation of social distancing in housing
6 areas and common spaces, including pill lines, and access to hand washing
7 and hand sanitizer. People who have serious mental illness should also be
8 considered for cohorting into specialized housing areas, where they can
9 receive group and individual therapy and other activities designed to reduce
10 or mitigate the risks of harm conferred by detention. If people with severe
11 mental illness become infected and are placed in medical isolation, then they
12 should be provided regular screenings by mental health staff to ensure they
13 are not deteriorating.

14 46. The revised PRR altogether fail to include these necessary precautions, thus
15 heightening the risk of harm to people with severe psychiatric illnesses.

16 **Need for Care of COVID-19 Patients**

17 47. It is imperative that ICE create a COVID-19 plan for the care of anyone who
18 is at increased risk of serious illness or death from COVID-19. As it stands,
19 the PRR lacks such a plan. Such a plan would involve, at a minimum,
20 reviewing a patient's high-risk status, assessing the degree to which their
21 health problems are under control, and evaluating the impact of their
22 medications for their conditions on COVID (e.g., some essential medications
23 impact the body's immune response or may otherwise create special
24 vulnerabilities during COVID-19 infection). That level-of-control
25 assessment would detail the patient's baseline symptoms, including the
26 frequency of symptoms and circumstances under which the symptoms
27 improve or worsen and the efficacy of any current medication. A care plan
28 for an individual at a high-risk for COVID-19 would also provide enhanced
education about COVID-19 symptoms and planning tailored to the
possibility of COVID-19 infection, which would generally involve daily
screening for COVID-19 symptoms. This approach is especially critical for
detainees with any heart or lung problems, or other conditions that include
symptoms that can appear very similar to those for COVID-19. These
measures are not mere best practices — they are all standard elements of
care planning that I have implemented time and time again to protect high-

[7/heatadvice.pdf](#) and <https://www.health.harvard.edu/skin-and-hair/10-types-of-medications> and <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm4921a3.htm>

1 risk patients during outbreaks in prisons and jails. They are necessary
2 components of care-planning for patients at a high risk of COVID-19
3 infection, because the CDC explicitly states that poorly controlled health
4 problems represent additional risk for people infected by COVID-19, over
and above the risk created simply by having a particular health problem.

5 48. Care for COVID-19 patients extends beyond simply clearing them to return
6 to general population housing areas because they have reached a 14-day
7 mark after their diagnosis. The World Health Organization has reported that
8 physical recovery from COVID-19 can extend well beyond the period of
9 active infection, taking six weeks or longer.¹⁸ Many of the people I have
10 spoken with in detention settings report ongoing symptoms post-COVID-19
11 infection including shortness of breath, chest pain, tinnitus and daily
12 headaches. These symptoms last weeks or longer and ICE must create a plan
of care that assesses, documents and treats these problems among detained
people. At times, patients may appear to be improving and their condition
may worsen unexpectedly and rapidly; ICE's PRR must contemplate these
foreseeable circumstances.

13 49. Once a person leaves medical isolation, they should be transferred into a
14 housing area for people recovering from COVID-19. Here, detainees should
15 continue to be exempt from work requirements and every person in these
16 units should have a clinical encounter for every person who is known or
17 suspected to have experienced COVID-19 with a physician to assess any
18 new symptoms or disabilities that exist and create a plan for recovery that
19 addresses their symptoms and disability. For example, Mr. Aguirre reports in
20 his declaration that weeks after being diagnosed with COVID-19, he is
21 experiencing shortness of breath, but he has not been evaluated by a
22 physician for this ongoing issue. Aguirre Decl. ¶13. This is especially
dangerous given that COVID-19 can cause serious complications to a
person's health that last after infection. These units must also be adequately
staffed by qualified medical personnel who are qualified to take patients'
vitals and check symptoms.

23 50. Basic elements of a post COVID-19 assessment include asking patients
24 whether they experienced any of the CDC listed symptoms during their
25 COVID-19 infection, and whether they continue to experience any of those,
26 or any other symptoms. This COVID-19 recovery encounter should occur
27 with every patient who was confirmed or is suspected of having COVID-19.
These efforts will likely include pulmonary rehabilitation and physical

28 ¹⁸ <https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf>

1 therapy or exercise as part of what patients need to recover from COVID-
2 19.¹⁹ At a baseline, any patient who experienced shortness of breath or other
3 pulmonary symptoms should have their respiratory status and symptoms
4 documented and be considered for incentive spirometry.²⁰ Patients with
5 chest pain should be evaluated for cardiac complications of COVID-19, have
6 an EKG conducted and referred for cardiology consultation. Because
7 COVID-19 is associated with high rates of blood clots as well as kidney and
8 liver damage, these recovery encounters should also contain structured
9 questions to elicit, and when indicated, conduct laboratory testing for these
10 concerns.

11 51. Implementing these basic and required elements of COVID-19 care will
12 require adequate staff as well as training. Many of the declarations I have
13 reviewed indicate that even basic health encounters that occur presently do
14 not result in competent documentation of findings or communication with
15 patients. Mr. Aguirre reported that even when he was ill with COVID-19,
16 health staff who took his vital signs would not always write them down into
17 his records. Aguirre Decl. ¶¶ 5, 9. He also reported that he was not given his
18 COVID-19 test results in writing by health staff. *Id.* ¶ 10.

19 52. Unfortunately, ICE's revised PRR fails to prescribe any of these medically
20 necessary protocols for the care and treatment of COVID-19 patients,
21 particularly those who are medically vulnerable. In my expert opinion, it is
22 crucial that ICE specifically prescribe such precautionary measures to
23 protect medically vulnerable from infection, during their illness, and as they
24 are recovering.

25 **ICE's Oversight of COVID-19 is Deficient**

26 53. The ICE checklists I have reviewed reveal multiple deficiencies in how ICE
27 is overseeing facilities' COVID-19 response generally and protecting
28 medically vulnerable people specifically.

54. Checklists can be important features of ensuring adequate provision of
health and other services, but when utilized to measure tasks that are not
well-suited to a simple checkoff process, there is ample research to show
that they can be ineffective and even counterproductive.²¹ In order to

¹⁹ https://rehabmed.weill.cornell.edu/sites/default/files/post_covid_rehab_-_patient_guide_0.pdf and <https://www.healthline.com/health-news/what-to-do-after-recovering-from-covid-19#Walking>

²⁰ <https://lunginstitute.com/blog/incentive-spirometry-benefits/>

²¹ <https://psnet.ahrq.gov/primer/checklists>

1 actually improve the outcomes of an important process, a checklist must
2 measure tasks or outcomes that are amenable to a yes or no measurement,
3 and the use of a checklist must be monitored to ensure that the elements
4 being recorded actually reflect the truth. Without these elements, a checklist
5 quickly becomes a rote administrative exercise, divorced from the realities
6 of whatever process was originally being monitored.

7 55. I have reviewed checklist surveys from approximately 132 facilities, of
8 which approximately 97 use the same questionnaire. These checklists
9 contain many errors in scope and content.

10 56. For example, the checklists or surveys utilized by ICE fail to address the
11 identification and care of high-risk detainees. As mentioned above, every
12 high-risk patient should have an encounter with a physician or mid-level
13 provider to assess their specific risks for COVID-19 and create a plan of
14 care. Since the high-risk detainees have largely been identified, a checklist
15 could be utilized to ensure that every person in this cohort has received this
16 type of encounter. More generally, the checklists or survey should have
17 several questions about what special protections are being implemented for
18 high-risk detainees.

19 57. In addition, many of the processes included in the ICE checklists require
20 ongoing monitoring, not a checklist question. For example, social distancing
21 and infection control are complex areas of work that require development
22 and implementation of quality assurance tools to ensure that these policies
23 are followed. The presence of a policy may be worth noting in a checklist,
24 but the standard in infection control and detention management is to have
25 monthly monitoring of how and whether that policy is implemented. The
26 checklists also often do not address the adequacy or underlying elements of
27 an adequate policy—only the existence of a policy. In any event, many of
28 the declarations I have reviewed indicate that facility policies are not being
29 followed. For example, Mr. Aguirre reported in his declaration that multiple
30 people would use the same phone in the new admission area without any
31 cleaning or disinfecting in between uses. Aguirre Decl. ¶4.

32 58. The lack of any meaningful monitoring of implementation is reflected
33 throughout the checklist and thus, the mention of these critical areas of work
34 in the checklists is not likely to make a meaningful contribution to the health
35 of detainees. Critical areas that require quality assurance assessments with
36 monthly monitoring and central review include screening of detainees and
37 staff (daily screening for symptoms and signs of COVID-19), the training of
38 staff for, and implementation of, contact tracing, the clinical care of people

1 in medical isolation and in recovery for COVID-19, amongst other issues.
2 Meaningful assessments of these benchmarks are lacking from the
3 checklists.

4 59. Related to the lack of quality assurance in this approach by ICE, there does
5 not appear to be any clear method to how these checklists will be reviewed,
6 or how reviews would result in any action that finds or addresses
7 deficiencies. Many of the checklists or surveys that I reviewed included
8 deficiencies but no plan for how those deficiencies would be addressed.
9 Rather, they are simply reports by facility staff, such as wardens and facility
10 administrators, who already have a bias not to report deficiencies. Although
11 I understand that Detention Service Managers (“DSMs”) and Detention
12 Standards Compliance Officers (“DSCOs”) are charged with reviewing and
13 following up on these checklists, it is unlikely that they have the medical
14 training necessary to perform these tasks, such as an assessment of the
15 adequacy of any policies concerning medical care or audits of medical
16 staffing ratios. DSMs and DSCOs also do not have adequate training for
17 oversight checklists. Further, as discussed below, I have reviewed several
18 survey responses that indicate the need for follow-up, but there is no
19 indication that that follow-up was actually conducted.

20 60. For example:

- 21 • The survey response for Chase County Detention Facility (beginning at
22 ICE00001512) indicates that the facility is not adequately supplied with
23 cleaning products to maintain a sterile work environment for 30 days, that
24 the facility does not have disinfecting or sanitizing protocols for
25 transportation assets, that the facility does not have staff training plans, and
26 that there are no policies or procedures in place to disinfect detainee funds
27 and personal property;
- 28 • The survey response for the Adams County Detention Center (beginning at
ICE1264) states that detainees have not received training on how to correctly
don PPE, and that over 100 detained individuals were transferred to the
facility in mid-May;
- The survey response for the Glades County facility (beginning at ICE975)
indicates that detainees are not wearing a mask during the custody
classification process, that alternate work arrangements have not been
implemented, and that transfers of detainees have not been appropriately
restricted.
- It also appears that many facilities leave checklist or survey responses blank
or with generic responses. Many of the responses by ICE vendor GEO
include nonspecific responses such as “GEO is following applicable

1 sanitation policies, standards, CDC, and ICE guidance to determine the
2 facility's sanitation schedule." This type of response is present for multiple
3 areas of questions and reflects a lack of training or oversight in this process.

4 61. In addition, it appears that some facilities have not responded to these
5 surveys at all.

6 **June 22 Revisions to PRR**

7 62. I have reviewed ICE's recent revisions to the PRR. As I note in various
8 sections above, ICE's revisions are minimal, inadequate, and fail to address
9 and mandate crucially needed precautions. As a result, the PRR continues to
10 fail to ensure that people with Risk Factors are protected from COVID-19.

11 63. As an initial matter, the PRR revisions fail to meaningfully address and
12 remediate the deficiencies outlined above concerning ongoing transfers,
13 inadequate testing, overuse of solitary confinement, improper use of harsh
14 disinfectants, and lack of increased medical surveillance and care planning
15 for people with Risk Factors. The PRR likewise continues to fail to prescribe
16 necessary medical staffing ratios and does not provide meaningful clinical
17 guidance regarding the treatment and monitoring of COVID-19 generally or
18 people with Risk Factors specifically. In fact, although the PRR discusses
19 precautionary measures in general terms, the PRR is almost altogether
20 lacking in terms of providing specific guidance on how to actually treat
21 COVID-19 and what increased treatment and monitoring precautions are
22 crucial for people with Risk Factors. In fact, aside from outlining the
23 custody redetermination process for people with Risk Factors, the PRR
24 revisions add almost no precautions specifically aimed at creating safer
25 detention conditions for people with Risk Factors. This is dangerous. A
26 proper set of guidelines to facilities would outline not only how to prevent
27 the spread of COVID-19 but also prescribe protocols for pre-infection
28 planning of medically vulnerable people, treatment of medically vulnerable
people, enhanced surveillance, and post-recovery evaluations and
assessments.

24 64. Even in those instances where the PRR revisions add some precautions,
25 those precautions remain deficient. For example, the PRR requires that
26 detention facility staff wear PPE when they are within 6 feet of detained
27 people. However, the PRR does not mandate that staff wear PPE when they
28 are in close proximity to facility staff or other visitors—notwithstanding the
fact that staff and visitors are more likely to infect people.

65. As another example, the revised PRR fails to mandate that newly admitted

1 detainees be cohorted for 14 days, which is a correctional standard and
2 recommendation of the CDC. To simply indicate that facilities should utilize
3 “considerable effort” to achieve such a basic infection control standard
4 indicates that ICE is not ready to measure or hold accountable its facilities.

5 ***

6 66. I have knowledge of the following information relating to the conditions
7 facing migrants in immigration detention centers, and I can testify to it if
8 needed.

9 I declare under penalty of perjury and under the laws of the United States, pursuant
10 to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my
11 knowledge, memory, and belief.

12 Executed on the 24th of June, in the year 2020, in the city of Port Washington, NY.

13
14
15 

16
17
18 Dr. Homer Venters