

# Relevant excerpts from Dr. Homer Venters's declaration, *Sanchez Martinez v. Donahue*

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## DECLARATION OF HOMER VENTERS, M.D.

I, Homer Venters, declare the following under penalty of perjury pursuant to 28 U.S.C. § 1746 as follows:

### **BACKGROUND**

1. I am a physician, internist and epidemiologist with over a decade of experience in providing, improving and leading health services for incarcerated people. My clinical training includes a residency in internal medicine at Albert Einstein/Montefiore Medical Center (2007) and a fellowship in public health research at the New York University School of Medicine (2009). My experience in correctional health includes two years visiting immigration detention centers and conducting analyses of physical and mental health policies and procedures for persons detained by the U.S. Department of Homeland Security. This work included and resulted in collaboration with ICE on numerous individual cases of medical release, formulation of health-related policies as well as testimony before the U.S. Congress regarding mortality inside ICE detention facilities.
2. After my fellowship training, I became the Deputy Medical Director of the NYC Jail Correctional Health Service. This position included both direct care to persons held in NYC's 12 jails, as well as oversight of medical policies for their care. This role included oversight of chronic care, sick call, specialty referral and emergency care. I subsequently was promoted to the positions of Medical Director, Assistant Commissioner, and Chief Medical Officer. In the latter two roles, I was responsible for all aspects of health services including physical and mental health, addiction, quality improvement, re-entry and morbidity and mortality reviews as well as all training and oversight of physicians, nursing and pharmacy staff. In these roles I was also responsible for evaluating and making recommendations on the health implications of numerous security policies and practices including use of force and restraints. During this time, I managed multiple communicable disease outbreaks including H1N1 in 2009, which impacted almost a third of housing areas inside the adolescent jail, multiple seasonal influenza outbreaks, a recurrent legionella infection and several other smaller outbreaks.
3. In March 2017, I left Correctional Health Services of NYC to become the Director of Programs for Physicians for Human Rights. In this role, I oversaw all programs of Physicians for Human Rights, including training of physicians, judges and law enforcement staff on forensic evaluation and documentation, analysis of mass graves and mass atrocities, documentation of torture and sexual violence, and analysis of attacks against healthcare workers.
4. In December 2018 I became the Senior Health and Justice Fellow for Community Oriented Correctional Health Services (COCHS), a nonprofit organization that promotes

evidence-based improvements to correctional practices across the U.S. In January 2020, I became the president of COCHS. I also work as a medical expert in cases involving correctional health and I wrote a book on the health risks of jail (*Life and Death in Rikers Island*) which was published in early 2019 by Johns Hopkins University Press. A copy of my curriculum vitae, which includes my publications, a listing of cases in which I have been involved and a statement of my compensation, is attached to this report.

#### **TRANSMISSION OF COVID-19**

5. Information and understanding about the transmissibility of the coronavirus disease of 2019 (COVID-19) is rapidly evolving. New information is relevant to the health of ICE detainees and staff.
  - a. In addition to transmission by aerosolized droplets expelled from the mouth by speaking, coughing, sneezing, and breathing, COVID-19 appears to be transmissible through aerosolized fecal contact. This is relevant because the plume of aerosolized fecal material that occurs when a toilet is flushed is not addressable in many detention centers because ICE detainee toilets generally lack lids. This mode of transmission would pose a threat to anyone sharing a cell with a person who has COVID-19 and could occur before a person becomes symptomatic. This mode of transmission could also extend beyond cellmates, especially in circumstances where common bathrooms exist or where open communication between cells exists.<sup>1</sup>
  - b. CDC and state guidance now recommend the use of protective masks for anyone who is in close contact with others, at less than 6 feet distance.<sup>2</sup> This recommendation applies to staff and detainees alike.

#### **COVID-19 IN ICE DETENTION**

6. COVID-19 is a viral pandemic. This is a novel virus for which there is no established curative medical treatment and no vaccine.
7. ICE has not been able to stop the spread of COVID-19 in detention centers. ICE reported that, as of April 7, there were 19 detained people in 11 facilities, 11 ICE employees in 6 facilities, and 60 ICE employees not assigned to a facility who had all tested positive for COVID-19. As of April 20, less than two weeks later, ICE reported a jump to 220 detained people in 28 facilities, 30 ICE employees in 9 facilities, and 86 ICE employees

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<sup>1</sup> <https://www.medpagetoday.com/infectiousdisease/covid19/85315>.

<sup>2</sup> <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover.html>.

not assigned to a facility who had tested positive for COVID-19.<sup>3</sup> These numbers, which do not include non-ICE staff and contractors at the facilities, are likely just the tip of the iceberg in terms of the number of ICE staff and detainees who are already infected but are unaware due to the lack of testing nationwide, and the fact that people who are infected can be asymptomatic for several days.

8. When COVID-19 impacts a community, it will also impact the detention facilities. In New York, one of the areas of early spread in the U.S., multiple correctional officers and jail and prison inmates have become infected with COVID-19. The medical leadership in the NYC jail system have announced that they will be unable to stop COVID from entering their facilities and have called for release as the primary response to this crisis. Staff are more likely to bring COVID-19 into a facility, based solely on their movement in and out every day.
9. Once COVID-19 is inside a facility, ICE will be unable to stop the spread of the virus throughout the facility given long-existing inadequacies in ICE's medical care and also in light of how these facilities function. ICE has faced longstanding challenges in maintaining adequate health staffing for many years, and the outbreak of this pandemic will dramatically worsen this problem.
10. I have been inside multiple ICE detention facilities, both county jails that house ICE detainees and dedicated facilities. My experience is that the densely packed housing areas, the structure of health services, food services, recreation, bathroom and shower facilities for detained people, as well as the arrangement of entry points, locker rooms, meal areas, and control rooms for staff, all contribute to many people being in small spaces.
11. Detention facilities are designed to force close contact between people and rely on massive amounts of movement every day from one part of the facility to another, e.g., for programming, access to cafeterias, commissary, and medical, just to name a few. This movement is required of detained people as well as staff. My experience managing smaller outbreaks is that it is impossible to apply hospital-level infection control measures on security staff. In a hospital or nursing home, staff may move up and down a single hallway over their shift, and they may interact with one patient at a time. In detention settings, officers move great distances, are asked to shout or yell commands to large numbers of people, routinely apply handcuffs and operate heavy doors/gates, operate large correctional keys and are trained in the use of force. These basic duties cause the personal protective equipment they are given to quickly break and become

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<sup>3</sup> *ICE Guidance on COVID-19*, IMMIGRATION & CUSTOMS ENFORCEMENT (Updated Apr. 20, 2020), <https://www.ice.gov/coronavirus>.

useless, and even when in good working order, may impede their ability to talk and be understood, in the case of masks. For officers working in or around patients at risk or with symptoms, there may be an effort to have them wear protective gowns, as one would in any other setting with similar clinical risks. These gowns cover their radios, cut down their ability to use tools and other equipment located on their belts and in my experience working with correctional staff, are basically impossible to use as a correctional officer.

12. Efforts to lock detained people into cells will worsen, not improve this facility-level contribution to infection control. Units that are comprised of locked cells require additional staff to escort people to and from their cells for showers and other encounters, and medical, pharmacy and nursing staff move on and off these units daily to assess the welfare and health needs of these people, creating the same movement of virus from the community into the facilities as if people were housed in normal units.

### **ICE RESPONSE TO COVID-19 IN DETENTION CENTERS IS DEFICIENT**

13. On the whole, ICE's response to the COVID-19 pandemic is grossly deficient and at odds with recommendations of the CDC regarding detention settings in a manner that threatens the health and survival of ICE detainees. I've reviewed available documents regarding their planning, including the March 6, 2020 interim guidance sheet provided by ICE Health Service Corps,<sup>4</sup> March 27, 2020 Memorandum to ICE wardens ("March 27 memo"),<sup>5</sup> ICE's guidance on its website,<sup>6</sup> the April 4, 2020 Docket Review memo,<sup>7</sup> and the April 10, 2020 ERO COVID-19 Pandemic Response Requirements ("ERO document").

#### **A. The March 6 and March 27 Memoranda**

14. I have reviewed ICE's March 6 and March 27, 2020 documents addressing COVID-19 (together, the "March 2020 ICE Protocols"); although I understand the March 6 interim guidance policies to be superseded by the April 10, 2020 ERO document, it is worth noting that these policies were deficient and at odds with recommendations of the CDC regarding detention settings in a manner that threatens the health and survival of ICE detainees. The April 10 ERO document mandates compliance with the March 27 memo, which also fails to comply with CDC guidance.
15. ICE's March 27 memo takes the dangerous approach of limiting clinical guidelines for COVID-19 response to the detainees being provided direct care by ICE Health Services

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<sup>4</sup> <https://www.aila.org/infonet/ice-interim-reference-sheet-coronavirus>.

<sup>5</sup> <https://www.ice.gov/doclib/coronavirus/attf.pdf>.

<sup>6</sup> <https://www.ice.gov/covid19>.

<sup>7</sup> <https://www.ice.gov/doclib/coronavirus/attk.pdf>.

Corps (IHSC) staff, which represents approximately 13,000 detainees.<sup>8</sup> As a result, detention centers operated by public and private contractors are not provided with this guidance. This approach to management of the COVID-19 outbreak ensures that vital information would remain in these facilities, instead of being acted upon by ICE. As a result, ICE could not have known when its own policies or even basic standards of infection control were being followed.

16. The March 2020 ICE Protocols failed to address the key recommendation of the CDC on the need for adequate staffing and training of staff. ICE's March 27 memo simply states that "facilities are expected to be appropriately staffed," but provides no guidance whatsoever on how that could be accomplished in the context of existing staffing gaps, a decreased workforce, and increased needs resulting from steps required to screen, monitor and treat detainees for COVID-19. CDC Detention Guidelines make clear the need for a concrete plan for ensuring adequate staffing as part of the COVID-19 response.<sup>9</sup> These guidelines also make clear the need to orient staff to the critical need to stay home if and when they experience symptoms of COVID-19 infection. The March 27 guidance mentions only the "expectation" of appropriate staffing levels rather than implementing any meaningful oversight system to ensure that staffing levels are appropriate. Critically, appropriate staffing levels refers not only to a sufficient number of staff but also to a sufficient number of qualified staff. In my experience, many facilities rely heavily on guards and LPNs to do medical work that they are not qualified to do; likewise, many facilities rely on RNs to do medical work that only doctors or physician-assistants are qualified to do. There is no indication whatsoever that ICE is implementing procedures to ensure not only sufficient numbers of staff but also sufficient numbers of qualified staff. This is a very serious defect because access to qualified medical professionals is crucial during this rapidly evolving pandemic.
17. The March 2020 ICE Protocols failed to address the key recommendation of the CDC on the need for adequate intake screening of detainees. CDC Detention Guidelines make clear that everyone arriving in a detention facility should be screened for signs and symptoms of COVID-19, but the March 2020 ICE Protocols relied on questions about travel or other known contacts as a precursor to temperature checks and other sign and symptom checks. It is likely that almost everyone in the general public who is not practicing social distancing is in contact with the COVID-19 virus, and these questions give a false impression that they will somehow help identify those most likely to have this type of contact. According to the CDC, the appropriate focus should be on checking for active symptoms including fever and known sick contacts of any type every time a

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<sup>8</sup> <https://www.ice.gov/ice-health-service-corps>.

<sup>9</sup> Guidance for Correctional & Detention Facilities ("CDC Detention Guidelines")  
<https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>.

person, whether a staff member or detained person, enters an ICE facility. The March 2020 ICE Protocols also failed to clearly mandate that all symptomatic patients be immediately given a mask and placed in medical isolation, and that all staff who have further contact with that patient wear personal protective equipment, as set forth in the CDC Detention Guidelines. These protocols also failed to address the now-standard CDC advice that everyone who cannot engage in social distancing wear a face covering.<sup>10</sup>

18. The March 2020 ICE Protocols provided no guidance about identification of high-risk patients at the time of entry or any special precautions that would be enacted to protect them. The protocol also failed to address the identification of high-risk patients who have already been admitted.
19. The March 2020 ICE Protocols stated that people with suspected COVID-19 contact would be monitored for 14 days with symptom checks. The protocols were written as if this would be a rare occurrence, reflecting smaller outbreak management, but the prevalence of COVID-19 has grown to such an extent that a large share of newly arrived people will have recent contact with someone who is infected. ICE would need to use this level of monitoring for every person arriving in detention. Accordingly, ICE would need to dramatically expand its medical facilities and staffing to conduct this daily monitoring of every newly arrived person for 14 days. The protocols failed to contemplate these necessary changes.
20. The March 2020 ICE Protocols failed to address the key recommendation of the CDC on the need for monitoring and care of symptomatic patients.
  - a. The CDC Detention Guidelines make clear that patients who exhibit symptoms of COVID-19 should be immediately placed in medical isolation. The March 2020 ICE Protocols only invoked this response for newly arrived detainees who also answered yes to screening questions. This approach results in a failure to actively screen the large majority of detainees: people who are already detained.
  - b. CDC Detention Guidelines clearly indicate the need for twice-daily monitoring of patients who are symptomatic or in quarantine, and ICE only mandated a daily check.
  - c. ICE made no mention of access to masks for patients in quarantine settings.
  - d. ICE failed to present a plan for how isolation would be conducted when the number of people exceeded the number of existing isolation rooms or cells, a near certainty.

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<sup>10</sup> <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html>.

21. The March 2020 ICE Protocols failed to address the key recommendation of the CDC Detention Guidelines on the need for social distancing. ICE's March 27 memo mentions social distancing briefly, but fails to address how ICE facilities will enact modified meal or recreation times and also fails to address the most common scenarios in which high risk detainees find themselves in close quarters, including shared cells, medication lines, bathroom facilities, common walkways and day rooms, sally ports and transportation. Again, because there is no cure for COVID-19, social distancing remains the most effective means of prevention, and ICE failed to meaningfully implement this precaution in its March 2020 guidance.
22. The March 2020 ICE Protocols failed to address the recommendation of the CDC Detention Guidelines on the need to limit transportation of detainees as a means to limit the spread of COVID-19. CDC Detention Guidelines state that transfers should be limited to those that are absolutely necessary and that receiving facilities must have capacity to isolate symptomatic patients upon arrival. ICE protocols failed to address these issues. CDC Detention Guidelines make clear the need for a clear plan for all aspects of transport of suspected COVID-19 infected people, and ICE does not have or did not report such a plan. The CDC Detention Guidelines recommend a level of infection control measures in transportation of symptomatic or potentially COVID-19 positive patients that would require far more staffing and training than ICE has the capacity to provide for large scale transfers: "If a transfer is absolutely necessary, perform verbal screening and a temperature check as outlined in the Screening section below, before the individual leaves the facility. If an individual does not clear the screening process, delay the transfer and follow the protocol for a suspected COVID-19 case – including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing. If the transfer must still occur, ensure that the receiving facility has capacity to properly isolate the individual upon arrival. Ensure that staff transporting the individual wear recommended PPE . . . and that the transport vehicle is cleaned thoroughly after transport." In other words, transferring people between facilities, as ICE routinely does and as I understand is still going on, requires far more measures than ICE implements and should be ceased.
23. The March 2020 ICE Protocols failed to address the recommendation of the CDC Detention Guidelines on the need for environmental cleaning of both housing areas and other common spaces within facilities. CDC Detention Guidelines provide clear details about the types of cleaning agents and cleaning processes that should be employed, while ICE provided no guidance to facilities on this critical issue. Reliance on detainees for conducting critical environmental cleaning, without proper training, protection or supervision, represents a gross deviation from correctional practices, and will likely contribute to the spread of COVID-19 throughout the ICE detention system.

**B. The April 4, 2020 Docket Review Guidance**

24. None of the ICE COVID-19 protocols set forth sufficient policies or protocols addressing release of medically vulnerable detained people in light of the significant risks to those people posed by COVID-19. This must be done immediately and is in contrast to the efforts made in many prison and jail systems across the country.
25. The April 4 list of risk factors for serious illness and death from COVID-19 infection developed by ICE is inconsistent with CDC guidelines and fails to adequately advise facilities on which detainees are at elevated risk. This list is included in a memo to Field Office Directors regarding Docket Review, and fails to include very basic risk factors identified by the CDC, including body mass index over 40 and being a current or former smoker.<sup>11</sup> By apparently assigning this process to field directors and their staff, who are not medical professionals, advising security staff to check with medical professionals after the fact, and failing to include CDC-identified risk factors, this docket review process will likely leave many people with true risk factors in detention. This is particularly the case if they're detained under certain immigration law provisions, where the guidance recommends officers not release them despite risks. Thus, the guidance appears to be just that – guidance, and the risk factors are not determinative. In fact, the guidance appears to not make these risk factors determinative for release—even for people who are not subject to mandatory detention. ICE also identifies people under the age of 60 in this cohort but the age of 55 is appropriate. Because detained people have consistently been identified as having higher levels of health problems that reflect that they are 10-15 years more progressed than chronological age, numerous organizations and research studies have used the age of 55 to define the lower limit of older detainees.<sup>12</sup> ICE also limits the high risk period for women to 2 weeks after child birth, yet one of the most serious increased risk during pregnancy is hypercoagulable state, which increases the risk of blood clots in the large veins of the lower extremities, and sometimes in the lung which can prove fatal. This risk extends to 6 weeks post-partum and also occurs independently with COVID-19 infection.<sup>13</sup> Accordingly, ICE should include these definitions in its list of risk factors. ICE should also put in place a mechanism to ensure that risk factors reflect the evolving science and data concerning COVID-19, since it is likely that additional risk factors will emerge as more data is collected.
26. The April 4 promulgation of an incomplete list of risk factors in a memo relating to discretion for release occurs in a complete vacuum of guidance on special protection and

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<sup>11</sup> <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html> and <https://www.cdc.gov/mmwr/volumes/69/wr/mm6913e2.htm>.

<sup>12</sup> <https://nicic.gov/aging-prison> and <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3464842/>.

<sup>13</sup> <https://www.acog.org/patient-resources/faqs/womens-health/preventing-deep-vein-thrombosis> and <https://www.medpagetoday.com/infectiousdisease/covid19/85865>.



clinical management of people with those risk factors while in detention. This Memo describes an overly discretionary decision-making process for release that does not sufficiently favor depopulation as public health requires and that has no urgency to it. Reviews and releases must be undertaken immediately.

27. The April 4 ICE memo to Field Directors on identification and release of detained people with risk factors for serious illness and death from COVID-19 infection is both incomplete and revelatory. ICE has omitted multiple important risk factors identified by the CDC in its own list but has also failed to create any surveillance of the outbreak across facilities that includes the number of patients experiencing symptoms, confirmed COVID-19 infection or hospitalization by presence or absence of CDC risk factors.

### **C. The April 10, 2020 ERO Document**

28. The ERO document identifies multiple areas of COVID-19 response that all facilities holding ICE detainees must supposedly adhere to. Multiple sections of this document reflect inconsistencies or critical omissions from CDC Detention Guidelines for response to COVID-19. In addition, ICE is unlikely to ensure compliance with the policies laid out in this document due to longstanding lack of information systems, quality assurance and oversight mechanisms that are standard in other carceral or detention settings. These inconsistencies and omissions increase the risk that facilities holding ICE detainees will not follow evidence-based practices in infection control and that ICE detainees will experience higher risks of serious illness and death because of these deficiencies.
29. The ERO document omits key aspects of CDC guidelines for self-monitoring and quarantine for staff and detainees who have had contact with suspected or known cases of COVID-19.
  - a. Staff who have contact with a known or suspected case of COVID-19 are only mentioned in one section of this document “Exposed employees must then self-monitor for symptoms (i.e., fever, cough, or shortness of breath).” This omits several critical aspects of CDC guidelines that bear on this very scenario, contacts between critical staff and COVID-19 suspected or known cases. The CDC guidelines include the following directives:<sup>14</sup>
    - i. Pre-Screen: Employers should measure the employee’s temperature and assess symptoms prior to them starting work. Ideally, temperature checks should happen before the individual enters the facility.

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<sup>14</sup> <https://www.cdc.gov/coronavirus/2019-ncov/community/criticalworkers/implementing-safety-practices.html>.

- ii. Regular Monitoring: As long as the employee doesn't have a temperature or symptoms, they should self-monitor under the supervision of their employer's occupational health program.
  - iii. Wear a Mask: The employee should wear a face mask at all times while in the workplace for 14 days after last exposure. Employers can issue face masks or can approve employees' supplied cloth face coverings in the event of shortages.
  - iv. Social Distance: The employee should maintain 6 feet and practice social distancing as work duties permit in the workplace.
  - v. Disinfect and Clean work spaces: Clean and disinfect all areas such as offices, bathrooms, common areas, shared electronic equipment routinely.
- b. In addition, the ERO document provides no guidance on how facilities should act if one of these staff members with a known/suspected contact becomes ill at work. The CDC provides clear guidance however:
- i. "If the employee becomes sick during the day, they should be sent home immediately. Surfaces in their workspace should be cleaned and disinfected. Information on persons who had contact with the ill employee during the time the employee had symptoms and 2 days prior to symptoms should be compiled. Others at the facility with close contact within 6 feet of the employee during this time would be considered exposed."
- c. Key CDC recommendations for detainees who have contact with a known or suspected case of COVID-19 are similarly left out of the ERO document. The ERO document addresses this aspect of facility management with the following: "If an individual is a close contact of a known COVID-19 case or has traveled to an affected area (but has no COVID-19 symptoms), quarantine the individual and monitor for symptoms two times per day for 14 days." This omits several critical aspects of CDC guidelines that bear on this very scenario, the quarantine of detainees who have contacts with suspected or known cases. In the section on "Management," the CDC Detention Guidelines include specific protocols applicable to quarantine. Examples of these protocols include:<sup>15</sup>

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<sup>15</sup> <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#management>.

- i. Provide PPE to staff working in quarantine settings, and masks to detainees in these settings.
  - ii. **Quarantined individuals should be monitored for COVID-19 symptoms twice per day, including temperature checks.**
  - iii. **Meals should be provided to quarantined individuals in their quarantine spaces.** Individuals under quarantine should throw disposable food service items in the trash. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands after removing gloves.
30. The ERO document mandates that every facility holding ICE detainees have a COVID-19 mitigation plan in place. The ERO document specifies the following: “Consistent with ICE detention standards, all facilities housing ICE detainees are required to have a COVID-19 mitigation plan that meets the following four objectives:
  - a. To protect employees, contractors, detainees, visitors to the facility, and stakeholders from exposure to the virus;
  - b. To maintain essential functions and services at the facility throughout the pendency of the pandemic;
  - c. To reduce movement and limit interaction of detainees with others outside their assigned housing units, as well as staff and others, and to promote social distancing within housing units; and
  - d. To establish means to monitor, cohort, quarantine, and isolate the sick from the well.
31. My experience in reviewing policies and procedures in detention settings around the nation is that many facilities holding ICE detainees do not have such a plan and that since a critical part of the CDC recommendations include preparation for COVID-19, many facilities have already failed to meet many basic elements of the COVID-19 responses recommended by the CDC. Even if ICE is able to ensure and report that every facility has created such a plan, it is likely that the lack of COVID-19 response plan to prepare many facilities and respond to the early stages of the outbreak will increase the risk of serious illness or death. Many ICE facilities are in the throes of COVID-19 infection, and waiting until this pandemic is at its peak to require a mitigation plan represents a gross deviation from both CDC guidelines and basic correctional practice. Key areas of work that must be conducted before COVID-19 arrives include training of staff, ordering of supplies,

planning for quarantine housing and monitoring, and identification of surge staffing. Starting these basic tasks immediately makes it much less likely that facilities will succeed in their efforts to slow spread of the virus.

32. The ERO document identifies a list of high-risk conditions that is inconsistent with the guidance given by ERO just days earlier and fails to adhere to CDC guidelines.
  - a. The new ERO document fails to identify pregnant or post-partum women. The ERO docket review guidelines dated April 4, 2020, failed to identify smoking history or body mass index over 40 as risk factors, both of which are included by the CDC.
  - b. The age for older detainees was indicated as 65 in the new ERO document and 60 in the prior document. The correct age, based on correctional standards, should be 55.
33. The purpose of the ERO document's identification of high-risk patients is unclear beyond custody review, but it fails to establish any higher level of protection from COVID-19 infection.
  - a. The prescribed actions in the ERO document regarding high-risk detainees include identifying who they are, emailing their name, location, medical issues and medications, and facility point of contact information to ICE headquarters apparently for review for release.
  - b. No guidance is given about how these high-risk patients can be protected from being infected with COVID-19, unless and until they are in a quarantine area or have been identified as symptomatic.
  - c. Having identified the detainees who are at increased risk of serious illness and death, and initiated a process to effectuate their release based on that risk, ICE must also create increased surveillance of these detainees, including twice daily symptom checks with temperature checks.
34. The ERO document creates an unwieldy and unrealistic process for facilities to notify ICE headquarters regarding high risk detainees.
  - a. The process of requiring every facility to send emails about every individual detainee with risk factors is unwieldy and unlikely to be effective. I have created

surveillance tools for high risk patients in multiple detention scenarios and several key elements of this process are problematic:<sup>16</sup>

- i. The process of emailing thousands of names with relevant information, or even spreadsheets, tables and other documents from over 150 facilities creates an unreliable and error prone system for finding the most vulnerable detainees inside ICE facilities.
- ii. The process identified by ICE is static, meaning that as detained people move from one facility to another, there will be no way for their location to be automatically updated with their high-risk status, requiring labor intensive and error-prone records reviews.
- iii. This approach will not allow for day to day management of the high-risk population by ICE leadership, since there will not be any way to be automatically notified when people are released, become ill for non-COVID-19 reasons, or even to automatically cross check the new COVID-19 cases against this initial batch of hundreds or thousands of emails.
- iv. ICE should create single portal into which every facility can enter data on the detainees who meet CDC criteria for being high-risk. I employed such a portal as Chief Medical Officer of the NYC jail system, and we relied on this before and after the implementation of an electronic medical record as a way to identify high-risk patients and then track them from one facility to another. This type of approach is also essential for ICE to meet its stated obligations regarding re-entry planning for people who are leaving amid the COVID-19 crisis and coordination with local and state public health partners.
- v. The net effect to this cumbersome and inefficient process will be that it will move unacceptably slowly in a fast-changing situation, far fewer detainees with risk factors will actually be released than could have occurred based on policies, and more high-risk patients will be at risk of serious illness and death in ICE detention.

35. The ERO document fails to include vital elements of CDC guidelines on preventing the spread of COVID-19 inside detention settings:

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<sup>16</sup> <https://cochs.org/files/health-it-hie/nyc-meaningful-use.pdf>;  
[https://www.researchgate.net/publication/264512394\\_Data-Driven\\_Human\\_Rights\\_Using\\_the\\_Electronic\\_Health\\_Record\\_to\\_Promote\\_Human\\_Rights\\_in\\_Jail](https://www.researchgate.net/publication/264512394_Data-Driven_Human_Rights_Using_the_Electronic_Health_Record_to_Promote_Human_Rights_in_Jail).

- a. The ERO document fails to mention or provide guidance on key aspects of social distancing including:
  - i. Intake pens
  - ii. Clinical and medication lines
  - iii. Bathroom and shower areas
  - iv. Sally ports
  - v. Staff entry, symptom checking, meal and locker room areas
- b. The ERO document fails to include guidance on the importance of communication with detainees about changes to their daily routine and how they can contribute to risk reduction, both of which are explicitly identified by the CDC guidelines. This is particularly important in a cross-cultural, multi-lingual setting like ICE detention. Simply posting signs is insufficient to communicate with detained people or staff, particularly during a stressful and chaotic situation like an outbreak. My personal experience leading both small and large scale outbreak responses behind bars is that frequent communication, in housing areas and other parts of detention settings where detained people are held, and where staff work, is critical to delivering important messages about infection control and also hearing about what is working and what isn't.
- c. The ERO document fails to include many critical aspects of cleaning and disinfection outlined in CDC guidelines including:
  - i. CDC guidelines identify a higher level of cleaning and disinfection after a person has been identified as a suspected COVID-19 case. This common sense approach is critical to ensuring that the most high-risk scenarios encountered by detainees and staff alike are responded to appropriately.
  - ii. The ERO document only mentions cleaning of vehicles after transport of a known/suspected case but fails to mention anything about the housing area, cell, bunk or personal effects of detainees, or the computer, equipment or other belongings of staff.
  - iii. CDC guidelines indicate that in settings where people are held overnight, response to a known or suspected COVID-19 case should include closing off areas used by the person who is sick, opening outside doors and windows to increase air circulation in the area and

waiting 24 hours (or as long as possible) before cleaning/disinfecting.

- iv. The ERO document fails to establish what PPE should be utilized by staff or detainees cleaning areas occupied by a known or suspected COVID-19 case.
- d. CDC guidelines clearly recommend against transfer of detainees between facilities, as a means to prevent the regional spread of COVID-19. This approach is only mandated with regard to non-ICE detainees by the April 10 ERO document, leaving transfers of people in custody of ICE unrestricted.
- e. The ERO document requires that everyone in facilities engage in hand washing for 20 seconds with soap and water but fails to address how this can be accomplished in facilities that utilize metered faucets that make this process essentially impossible.
- f. The ERO document fails to establish or mandate a respiratory protection program, a critical guideline of the CDC: **“If not already in place, employers operating within the facility should establish a respiratory protection program as appropriate, to ensure that staff and incarcerated/detained persons are fit tested for any respiratory protection they will need within the scope of their responsibilities.”** Simply giving out N95 or other masks to staff and detainees and failing to train them and identify the high-risk tasks or scenarios they will encounter serves only to decrease the overall effectiveness of infection control and increase the risk of serious illness and death in ICE facilities. The ERO document gives some details about cloth masks, but there is no mention of any plan to train, record or supervise members of the respiratory protection team, despite the CDC clearly including security personnel in this team.<sup>17</sup>

36. The ERO document fails to address the re-entry needs of people leaving ICE custody. This is a critical failure given their ongoing docket review. The CDC makes clear recommendations on this process:

- a. If an individual does not clear the screening process, follow the protocol for a suspected COVID-19 case<sup>18</sup> – including putting a face mask on the individual,

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<sup>17</sup> <https://www.cdc.gov/niosh/npptl/hospresptoolkit/programeval.html>. CDC definition of healthcare personnel includes “paid and unpaid persons who provide patient care in a healthcare setting or support the delivery of healthcare by providing clerical, dietary, housekeeping, engineering, security, or maintenance services.”

<sup>18</sup> <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#Medicalisolation>.

immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing.

- b. If the individual is released before the recommended medical isolation period is complete, discuss release of the individual with state, local, tribal, and/or territorial health departments to ensure safe medical transport and continued shelter and medical care, as part of release planning. Make direct linkages to community resources to ensure proper medical isolation and access to medical care.
- c. Before releasing an incarcerated/detained individual with COVID-19 symptoms to a community-based facility, such as a homeless shelter, contact the facility's staff to ensure adequate time for them to prepare to continue medical isolation, or contact local public health to explore alternate housing options.

#### **D. Critical Issues the ICE Has Failed to Address Absent Direct CDC Guidance**

37. ICE does not have any mechanisms to monitor or promote the health of all people in its charge. This failure is documented in many reports about ICE's inadequate healthcare system, but now poses a grave risk to their survival as ICE struggles to mount a competent response to COVID-19 across more than 150 facilities, on behalf of roughly 40,000 detainees and almost as many direct and contract staff. ICE's failure to properly monitor and oversee medical care at its detention centers has been a chronic concern in the health services provided to ICE detainees prior to this outbreak and has been cited as a core failure of ICE in its obligations to establish quality assurance throughout its detention network.<sup>19</sup> There is no indication that ICE can adequately monitor the response across its system to COVID-19. Absent robust and centralized oversight, ICE will not be able to provide a coordinated response informed by on-the-ground data from detention centers. This is in stark contrast to many prison systems across the country that are coordinating their efforts, including with health departments.

38. ICE has no plan or even capacity to provide daily clinical guidance to all of the clinical staff it relies on to care for ICE detainees, whether at ICE-operated facilities or contract facilities. The differing levels of oversight and clinical involvement across the various types of ICE facilities means that ICE is unable to promulgate and support a consistent set of clinical practices for all ICE detainees. This is a core failure because of the new nature of COVID-19 and constantly changing clinical guidance on how to treat patients. Daily briefings with health administrators and medical and nursing leadership should be

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<sup>19</sup> <https://www.oig.dhs.gov/sites/default/files/assets/2019-02/OIG-19-18-Jan19.pdf>;  
<https://www.oig.dhs.gov/sites/default/files/assets/2019-06/OIG-19-47-Jun19.pdf>.



held; both are a core aspect of outbreak management and provide a critical avenue for receiving feedback on real-time conditions inside facilities. ICE has not articulated any plan to ensure that this type of basic communication is in place across its network of detention settings. This guidance should also include uniform recommendations on when and how to transport patients to the hospital. Failure to implement this kind of procedure—particularly in light of the other defects described herein—poses a significant risk to the health and lives of ICE detainees.

39. As ICE determines to release people from detention, they should be afforded symptom screening akin to what is done with staff, but the release of detainees to the community will lower their own risks of infection and will also serve to flatten the overall epidemic curve by decreasing the rate of new infections and the demands on local hospital systems. From a medical and epidemiologic standpoint, people are safer from COVID-19 infection when not detained, and the epidemic curve of COVID-19 on the general community is flattened by having fewer people detained.

I declare under penalty of perjury that the statements above are true and correct to the best of my knowledge.

Signed this 28th day of April, 2020 in Port Washington, NY.

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Homer Venters