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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

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THIRD SUPPLEMENTAL DECLARATION OF DR. HOMER VENTERS

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

Background

1. My name is Homer Venters. I am a physician, internist and epidemiologist with over a decade of experience in providing, improving and leading health services for incarcerated people. I have previously submitted three declarations in this case in connection with Plaintiffs' Motion for Preliminary Injunction. *See* ECF 81-11, 113-2, 127-3. My extensive background in correctional medicine is detailed in my first declaration and in my curriculum vitae attached thereto. ECF 81-11.

2. Since the onset of the COVID-19 pandemic, in addition to my work on this case, I have been involved in numerous cases evaluating COVID-19 responses in prisons, jails and immigration detention centers.

3. In connection with my work, I am closely and carefully evaluating best practices and clinical guidance concerning treatment of and detention facility responses to COVID-19, including review of new peer-reviewed publications and local, state and national guidelines and recommendations regarding COVID-19 response in congregate care settings including detention facilities. I am in close and frequent contact with epidemiologists, public health experts, and other medical providers to discuss and assess medically necessary responses to COVID-19. I have been asked to provide input regarding appropriate COVID-19 responses in correctional settings by the National Academy of Sciences, the American Medical Association, The National Association of Counties, Harvard University and other organizations seeking to promote evidence-based COVID-19 care for people with justice involvement.

4. I have carefully monitored ICE's response to COVID-19. I have carefully reviewed ICE's Pandemic Response Requirements (PRR) (including its June 22 revisions), the declarations attached to Plaintiff's motion, ICE's document productions in this case, and have other knowledge of ICE's response to COVID-19 through my independent research and work in other cases across country.

5. Based on my expert opinion, ICE's response to COVID-19 continues to

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

Lack of Special Protections for People with Risk Factors

6. Based on my review of current practices and policies of ICE, including the revised PRR issued on June 22, 2020, it appears that no additional meaningful steps have been taken to create heightened protections for people who are at high-risk of serious illness or death from COVID-19. Detention creates special risks for high-risk detainees that have not been addressed by ICE. To provide but one example, high-risk detainees are often placed into close contact with other detainees when receiving their medications, e.g., while waiting in 'pill-lines.' These lines routinely have detainees with high-risk conditions standing shoulder to shoulder with other detainees. Similarly, many high-risk detainees share very crowded congregate bathroom settings without partitions or share a cell with a common toilet. Both types of settings create repeated exposure to the fecal plum that disperses into the air every time a toilet is flushed, creating a potent vector for transmission of COVID-19 to high-risk patients. The primary vector for COVID-19 infections continues to be staff, who come and go to facilities every day, and I continue to review reports from detainees that staff have stopped wearing masks unless a supervisor is present, especially in housing areas in evenings and over weekends. In addition, basic cleaning and disinfecting efforts appear to be counterproductive in some settings where ICE is utilizing agents that cause irritation of the eyes, nose and mouth of detainees and where the cleaning process is done in close proximity to detainees and where detainees conducting the cleaning or disinfecting may lack basic training or PPE. Although cleaning and disinfecting is a crucial component of infection 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.

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

a. Twice daily screening of symptoms and temperature consistent with CDC recommendations using a structured screening tool;[2]
b. Cohorting of high-risk detainees into specialized housing areas with enhanced infection control measures and training among staff, who are steady on these units;
c. Healthcare evaluations by appropriately trained staff to assess high-risk patients' current conditions, symptoms, medications, and to make a plan for COVID-19 infection;
d. Enhanced medical monitoring of medically vulnerable people when they have COVID-19, as well as treatment protocols;
e. Standards and protocols to ensure that medically vulnerable people are properly evaluated following their recovery from COVID-19;
f. Increased social distancing measures and PPE for high-risk people;
g. Increased medical surveillance of people with Risk Factors, including contact tracing;
h. Expansion of testing to people with Risk Factors and close contacts/staff;
i. Prohibitions on transfer (because transfer risks spread);
j. Clear guidance on how requisite conditions of medical isolation and quarantine to ensure that conditions equivalent to solitary confinement are not imposed;
k. Enhanced cleaning measures for areas occupied by medically 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.

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

Need for Restriction of Transfers

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

10. Detained individuals continue being transferred daily without universal testing. For example, on June 16, 2020, the Director of Farmville confirmed that 34 people who had been recently transferred to Farmville tested positive for COVID-19 upon arrival. Feldman Decl. ¶ 27. This was not an isolated incident, as transfers are occurring in and out of detention facilities systemwide. *See* Doubossarskaia Decl. ¶ 34 (reports individuals being transferred to and from IAH, Conroe, and South Louisiana); *See* Vosburgh Decl. ¶ 17 (reports 30 individuals transferred to ICE custody at Etowah within the last 2 weeks). One who tested positive for COVID-19 after his transfer to Pulaski, a detention center in Chicago, describes being transferred in a small, enclosed van without PEE and with multiple detained noncitizens who were coughing and exhibiting other symptoms of COVID-19. *See* Zwick Decl. ¶ 32. On June 10, 2020, 50 people were reportedly transferred from Broward Transitional Center to Georgia, only to be brought back to Miami, and then finally flown to Louisiana. In fact, a few of those 50 individuals were eventually brought back to BTC two days later. *See* King Decl. ¶ 16. One detained individual has been transferred a shocking total of 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.

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

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]

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[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.

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

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

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

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

Need for Expanded Testing

18. To date, ICE has conducted only 8,858 tests for a total population of 24,041. This represents only about one third of the detained population. The overall lack of testing by ICE, combined with the fact that many people show no or few symptoms, means that the current number of infected detainees are 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

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

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

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

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[7] *See, e.g., See* D. Sutton, K. Fuchs, M. D'Alton, D. Goffman, Universal screening for SARS-CoV-2 in women admitted for delivery N ENGL J MED, (May 28, 2020), 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.

[8] *A Systematic Approach To Mitigate The Spread Of COVID-19 In Immigration Detention Facilities* HEALTHAFFAIRS (June 17, 2020) https://www.healthaffairs.org/do/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).

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

21. CDC guidance on the need for expanded COVID-19 testing in congregate settings, including prisons, makes clear that the approach to testing should be linked to the overall infection control plan. In the case of ICE, the repeated and ongoing practice of transferring detainees around their network of facilities represents a departure from CDC and basic infection control guidance. As a result, the ICE approach to testing must necessarily be as broad and inclusive as possible, involving an initial offer of testing for each detained person, together with subsequent testing based on specific criteria.

22. In addition, there are multiple other circumstances under which testing should be implemented.

23. Updated guidelines from the CDC make it clear that ICE must expand ongoing testing for COVID-19 among detained people to prevent new outbreaks in individual facilities. CDC guidance lists people who are at high priority for testing, including "[r]esidents in long-term care facilities or other congregate living settings, including prisons and shelters, **with** symptoms."[11] This includes all ICE detainees and thus, ICE must establish a mechanism to screen every detainee on a daily basis for symptoms of COVID-19, as well 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.

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[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

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

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

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

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

[12] https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html

[13] https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/principles-contact-tracing-booklet.pdf

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.

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.

Medical Isolation and Quarantine Should Not Result in Solitary Confinement

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.

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.

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

[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.

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

32. By contrast, medical isolation and quarantine do not involve such deprivations. There is nothing about either medical isolation or quarantine that demands that people in those settings be deprived material needs, such as television, reading material, showers/bathroom, and access to telephones or video teleconferencing in order to communicate with loved ones and advocates. Likewise, access to the outdoors should be a part of both medical isolation and quarantine in order to help abate the risk of harm stemming from prolonged isolation in a room. Further, medical isolation and 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.

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

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

35. It is possible to implement medical isolation and quarantine without all of the punitive aspects of solitary confinement, but this requires a commitment of resources and monitoring of the medical isolation and quarantine settings. Several principles must be applied to medical isolation and quarantine 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

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

36. A second principle that must be applied to medical isolation is that every person should have a clinical encounter outside of their cell at least once a day. This encounter should include physical examination in a room designed for clinical care with an examination table, sink, no-touch waste receptacle and computer terminal for systems using electronic medical records. These encounters should have a standard set of elements for each encounter, including what symptoms will be asked about, what objective signs will be measured, and a protocol for nursing staff who conduct these assessments on 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.

37. A third principle for medical isolation and quarantine is that patients must be afforded recreation, phone calls, access to tablets and reading material just as they were before. In order to implement these measures, ICE must dedicate resources, both clinical and security staffing. My experiences with medical 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.

38. The use of solitary confinement as medical isolation or quarantine, or any practice that results in placement of a person into a locked cell for 22 or more hours per day, is likely to increase the risk of serious illness or death from COVID-19. Once people are placed into locked cells, the default becomes that they remain in those cells unless security and health staff take steps to ensure their removal for medical care, recreation and other activities. During an outbreak, staff may become reluctant to do so, or they may simply be unable to keep up with a schedule of out of cell time as the number of people in this type of custody increases. If solitary confinement is utilized as 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.

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

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

41. Defendants could remedy many of these defects simply by providing clear guidance and mandates to facilities in their PRR. For example, the PRR acknowledges the need for isolation beds and even notes that transfer, hospitalization, or release may be necessary where a facility does not have sufficient isolation beds. The revised PRR, however, fails to provide facilities with adequate guidance as to what isolation appropriately means. 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

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

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

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

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

Need for Care of COVID-19 Patients

47. It is imperative that ICE create a COVID-19 plan for the care of anyone who is at increased risk of serious illness or death from COVID-19. As it stands, the PRR lacks such a plan. Such a plan would involve, at a minimum, reviewing a patient's high-risk status, assessing the degree to which their health problems are under control, and evaluating the impact of their medications for their conditions on COVID (e.g., some essential medications impact the body's immune response or may otherwise create special vulnerabilities during COVID-19 infection). That level-of-control assessment would detail the patient's baseline symptoms, including the frequency of symptoms and circumstances under which the symptoms improve or worsen and the efficacy of any current medication. A care plan 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

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

48. Care for COVID-19 patients extends beyond simply clearing them to return to general population housing areas because they have reached a 14-day mark after their diagnosis. The World Health Organization has reported that physical recovery from COVID-19 can extend well beyond the period of active infection, taking six weeks or longer.[18] Many of the people I have spoken with in detention settings report ongoing symptoms post-COVID-19 infection including shortness of breath, chest pain, tinnitus and daily 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.

49. Once a person leaves medical isolation, they should be transferred into a housing area for people recovering from COVID-19. Here, detainees should continue to be exempt from work requirements and every person in these units should have a clinical encounter for every person who is known or suspected to have experienced COVID-19 with a physician to assess any new symptoms or disabilities that exist and create a plan for recovery that addresses their symptoms and disability. For example, Mr. Aguirre reports in his declaration that weeks after being diagnosed with COVID-19, he is experiencing shortness of breath, but he has not been evaluated by a 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.

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

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

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

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

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

ICE's Oversight of COVID-19 is Deficient

53. The ICE checklists I have reviewed reveal multiple deficiencies in how ICE is overseeing facilities' COVID-19 response generally and protecting 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

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

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

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

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

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

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

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

60. For example:

- The survey response for Chase County Detention Facility (beginning at ICE00001512) indicates that the facility is not adequately supplied with cleaning products to maintain a sterile work environment for 30 days, that the facility does not have disinfecting or sanitizing protocols for transportation assets, that the facility does not have staff training plans, and that there are no policies or procedures in place to disinfect detainee funds and personal property;
- 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

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

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

June 22 Revisions to PRR

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

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

64. Even in those instances where the PRR revisions add some precautions, those precautions remain deficient. For example, the PRR requires that detention facility staff wear PPE when they are within 6 feet of detained people. However, the PRR does not mandate that staff wear PPE when they 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

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

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

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

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

Dr. Homer Venters