Immigrant Detention and COVID-19: How a Pandemic Exploited and Spread through the US Immigrant Detention System

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Introduction

On July 12, 2020, Onoval Perez-Montufa died at the Lakeside Medical Center in Belle Glade, Florida. Perez-Montufa had tested positive for COVID-19 on July 2, after experiencing shortness of breath (ICE 2020h). In its news release, Immigration and Customs Enforcement (ICE) described Perez-Montufa as an “unlawfully present Mexican national subject to mandatory detention,” an “aggravated Felon,” and a convict who had served 12-years for “conspiracy to distribute, and possession with intent to distribute, 5 kilograms or more of cocaine” (ibid.). ICE also took the occasion of his death to tout its “extensive precautions” to limit the spread of COVID-19 and its spending on healthcare services for detainees (ibid.). In addition, it committed to “a comprehensive, agency-wide review of this incident” (ibid). According to ICE, by July 29, 2020, 141 detainees at Glades County Detention Center had contracted COVID-19 (ICE 2020b).

Perez-Montufa’s death followed the May 25th death of Santiago Baten-Oxlag, a 34-year old Guatemalan who died at the Piedmont Columbus Regional Hospital, in Columbus, Georgia, where he had been treated since April 17th (Montoya-Galvez 2020a). Prior to Baten-Oxlag’s hospitalization, ICE held him at the Stewart Detention Center in Lumpkin, Georgia. ICE vowed to undertake “a comprehensive agency-wide review” of Baten-Oxlag’s death (ICE 2020k). CoreCivic, a private prison corporation, administers the Stewart facility. According to ICE, by July 29, 2020, 149 detainees at Stewart Detention Center had contracted COVID-19 (ICE 2020b).2

“ICE does not report on the number of hospitalized or gravely ill persons in its custody, but the deaths of Onoval Perez-Montufa, Santiago Baten-Oxlag, and Carlos Escobar-Mejia will certainly not be the last.”

Baten-Oxlag’s death followed the May 6th death of Carlos Escobar-Mejia, a 57-year old El Salvadoran and 40-year US resident (Rivlin-Nadler 2020). Escobar-Mejia had suffered from hypertension and diabetes, resulting in an amputation.1 He died at Paradise Valley Hospital in National City, California, after being detained at the Otay Mesa Detention Center, which is also administered by CoreCivic. According to ICE, by July 29, 2020, 166 detainees at Otay Mesa had contracted COVID-19 (ICE 2020b).2 ICE does not report on the number of hospitalized or gravely ill persons in its custody, but the deaths of these men from COVID-19 will certainly not be the last.


2 In addition, 66 US Marshals Service detainees at the Otay Mesa facility had tested positive by May 7 (Morrissey 2020).
This report reviews US detention developments from March 1 to August 1, 2020, a period when COVID-19 established itself and spread through the sprawling US detention system and beyond it. The report – which CMS updated regularly during this period – documents ICE’s fatally flawed response to this crisis, paying particular attention to the role of the private corporations that largely operate this system. It explores how the pandemic exploited and exacerbated longstanding problems in this system, such as its privatization, prison-like facilities, correctional standards, lack of transparency, and perverse financial incentives.

“As the pandemic continues to rage and the numbers of infected detainees and facilities with COVID-19 outbreaks continue to climb, the large-scale release of immigrant detainees remains an urgent priority.”

Section I of the report details how the US immigrant detention system became a vector for the spread of the pandemic. Section II describes ICE’s resistance to releasing detainees at a pace and level commensurate with the need. Section III examines the effect of US border closures on asylum seekers, unaccompanied children, and survivors of trafficking. Section IV argues that large-scale release is not just a legal possibility, but a public health imperative. Section V documents how detention and pandemic response standards fail to protect detainees, detention facility staff, or the public. Section VI sets forth expert warnings regarding the spread of COVID-19 in the detention system. It also provides examples of more humane approaches to immigrant detainees in other countries. Section VII describes the desperate response of detainees and their families to this crisis. Section VIII offers a few overarching policy recommendations. As the pandemic continues to rage and the numbers of infected detainees and facilities with COVID-19 outbreaks continue to climb, it argues that the large-scale release of immigrant detainees remains an urgent priority.

I. The Foreseeable and Foreseen Explosion of COVID-19 in the US Immigrant Detention System and Beyond It

In an April 2020 report, entitled “‘We Are Adrift, About to Sink’: The Looming COVID-19 Disaster in United States Immigration Detention Facilities,” Amnesty International criticized ICE for “downplaying the risk of COVID-19 outbreaks in its detention facilities” while also failing “to facilitate adequate sanitation, hygiene, and social distancing between detainees, as is required under CDC guidance and necessary to prevent a devastating outbreak” (AI 2020, 18). A modeling study released in late April projected that infections would increase exponentially in the US detention system over 90-days (Coombs et al. 2020).

By the third week of March, ICE reported that there were no “confirmed” cases of COVID-19 in its detention system, a meaningless claim given its lack of testing, the certainty of “unconfirmed” cases, and the confirmed presence of COVID-19 in facilities holding both immigrant detainees
and prisoners.\(^3\) On March 25, it confirmed its first infected detainee (DHS-OIG 2020, 3). A month later, ICE reported 124 confirmed cases and the number of infected detainees spiraled upwards thereafter to 522 in 34 facilities by May 1; 1,145 in 51 facilities by May 19; 1,327 in 54 facilities by May 27; 2,059 in 61 facilities by June 15; and 2,675 detainees in 67 facilities by June 28 (ICE 2020b). According to ICE, by August 3, 2020, 4,038 detainees in 81 facilities and an additional 45 ICE detention staff (as of June 18) had contracted COVID-19 (ICE 2020b).

![Chart: Center for Migration Studies of New York. Data from Immigration and Customs Enforcement (ICE.)](https://www.documentcloud.org/documents/6818810-Declaration-of-Dr-Homer-Venters.html)

While sobering, ICE’s daily reports on “confirmed” cases revealed only the tip of an iceberg, due in large part to its insufficient testing for COVID-19. Although the agency claims to have begun testing in February 2020 (ICE 2020b), by mid-April it had tested only 300-400 detainees (Misra 2020a). In late April, ICE revealed plans to secure 2,000 tests per month from the US Department of Health and Human Services (HHS) (Hesson and Rosenberg 2020). Yet by May 1, it had tested only 1,073 detainees, by May 19 only 2,194, by May 27 only 2,620, by June 12 only 7,364, by June 28 only 10,513, and by July 24, 2020 only 19,092 (ICE 2020b).

Despite increased testing beginning in June, ICE has tested a very low percentage of detainees. By one estimate, more than 66,000 persons were detained or “newly booked into detention” between ICE’s first confirmed COVID-19 case and late June 2020 (Kuo et al.), a figure that far exceeds its daily detention totals. From March through June, 35,000 detainees “entered or departed” facilities administered by just one of ICE’s private prison contractors, The GEO Group.4

In the crucial early weeks of the pandemic, a high percentage – 51 percent by May 27 – tested positive (ICE 2020b). By July 24, 20.5 percent of those tested were infected (ICE 2020b). These figures constitute a “minimum” since some non-positive tests may be pending or not “confirmed negative” (Kuo et al. 2020). Yet, they far exceed the rates of those tested at public health (7.5 percent), clinical (5.7 percent) and commercial (9.1 percent) laboratories for the week ending July 18 (CDC 2020e).

“If ICE had tested earlier and more extensively, it would have ‘confirmed’ that many times more detainees had contracted COVID-19. In the crucial early weeks of the pandemic, a high percentage - 51 percent by May 27 - tested positive.”

A simulation by the Vera Institute for Justice – which accounted for new “book ins” and transfers between facilities – estimated that 19 percent of all detainees over a 60-day period between mid-March and mid-May 2020 would have contracted COVID-19, a figure 15 times higher than the number of confirmed cases by ICE in mid-May (Kuo et al.). If ICE had tested earlier and more extensively, it would have “confirmed” that many times more detainees had contracted COVID-19.

**The Spread of COVID-19 through Deportations**

Untested deportees spread the coronavirus during the early months of the crisis (Dickerson and Semple 2020). According to a study by the Center for Economic and Policy Research (CEPR), ICE Air made 232 flights with deportees to Latin American and Caribbean countries between February 3 and April 24, 2020 (Johnston 2020). As a result, it is likely that “many” countries received infected deportees (ibid.). The large number (by July 29) of infected detainees (101) and ICE staff (15) at one of its pre-deportation facilities, the Alexandria Staging Facility in Louisiana, supports this conclusion (ICE 2020b). Moreover, deported and expelled migrants, who arrived at their destinations without any notice or treatment plan, almost certainly infected members of their families, community members, and other guests at migrant shelters.

In late May, Guatemalan President Alejandro Giammattei criticized the United States for not acting as “Guatemala’s ally” due to the large number of infected deportees it sent to Guatemala (Pérez 2020). As a result, Guatemala repeatedly suspended US deportation flights (Carcamo and O’Toole 2020). Overall, at least 186 deportees tested positive following their arrival in Guatemala, including “nearly all” of the 65 deportees on a May 13 flight (Associated Press, 2020).

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The United States ultimately agreed to test every potential deportee to Guatemala, as a condition of resuming deportation flights to Guatemala (Carcamo and O’Toole 2020).

US deportees have also tested positive upon arrival in Haiti, a country whose four medical centers have only 200 beds available for COVID-19 patients (Sieff 2020a). In early May, a Haitian presidential panel recommended that Haiti suspend the admission of US deportees (Madan and Charles 2020a). ICE informed Haitian officials in May that it would test potential deportees prior to their flights (ibid.). Ecuador, El Salvador, Honduras, Jamaica, and Mexico have also requested that the United States test potential deportees (Hesson and Rosenberg 2020).

Many deportees have also tested positive after reaching Mexico (Sieff and Miroff 2020), prompting the mayor of Reynosa, Tamaulipas to query, “Why are they continuing these deportations in the middle of a deadly pandemic, including people who are already sick and who knows how many asymptomatic people” (Sieff 2020b). ⁵

In March and early April, ICE released several news bulletins on its use of ICE Air – following deportation flights – to transport stranded US citizens and lawful permanent residents to the

⁵ Compounding the concerns of these countries, when ICE has tested deportees, it has used a test with a history of producing false negatives (Madan and Charles 2020b).
United States (ICE 2020e). While a laudable goal, the US government has not reported on whether any of these returnees contracted COVID-19 on the flights.

**Infected Staff of Private Prisons and Other Contractors**

In mid-April, an ICE official declared that the agency did not “track” but had “learned that a number of non-ICE employees (contractors) in facilities that hold ICE detainees have contracted COVID-19, and some of them died from COVID-19.” 6 He also reported that ICE was “unable to determine how many non-ICE personnel in state and local jails” that held immigrant detainees had “contracted COVID-19 or died from COVID-19.” 7 The official also confirmed that ICE had “learned that some non-ICE detainees in non-ICE facilities, shared with ICE detainees, also contracted COVID-19, and some of them died from COVID-19.” 8 An April 8-20, 2020 survey by DHS’s Office of Inspector General (OIG) found that staff in 23 percent of the 188 detention facility respondents had tested positive for COVID-19 and that “almost 850 employees were unavailable because of the pandemic” (DHS-OIG 2020, 11). In the July 13 testimony before the

> “By not reporting on infections of private prison staff, ICE has neglected to present a full picture of the risks faced by the immigrants in its custody.”

House Subcommittee for Border Security, Facility and Operations, the Chief Executive Officers of four private prison contractors indicated that roughly 900 of their detention employees had tested positive for COVID-19 (Misra 2020b).

The failure to track and report on the staff of infected contractors represents a glaring omission given the degree to which private prison corporations administer the US detention system. As of November 2019, two corporations – The GEO Group and CoreCivic – managed facilities that held more than one-half of all ICE detainees. Five private contractors – The GEO Group, CoreCivic, LaSalle Corrections, Management & Training Corp., and Immigration Centers of America – administered facilities with more than three-quarters of ICE detainees (Gomez et al. 2019). As of early May, private prisons owned nine of the 10 facilities in Texas with confirmed COVID-19 outbreaks (Trevizo 2020). By not reporting on infections of private prison staff, ICE has neglected to present a full picture of the risks faced by the immigrants in its custody.

CoreCivic administers the massive Stewart Detention Center. On April 2, ICE reported no confirmed cases of infected detainees at Stewart, but one suspected case. 9 By April 10, it “knew

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7 Id.

8 Id.

By April 28, 42 CoreCivic employees and one ICE employee at this facility had tested positive (Stokes 2020). By June 16, 31 detainees had tested positive (ICE 2020b). According to ICE, by July 29, 2020, 149 detainees at Stewart had contracted COVID-19 (ICE 2020b).

The pandemic also places detention guards, staff and contractors at grave risk. CoreCivic has touted the $500 “Hero Bonus” it provides to its detention employees. Yet guards at the Otay Mesa Detention Center have sued CoreCivic for allegedly failing to meet its legal obligation to provide a safe working environment.12

By late April, two guards at the Richwood Correctional Center in Monroe, Louisiana had died from COVID-19 (Merchant 2020).13 Prison officials had advised the guards not to wear masks or gloves “to avoid spreading panic among detainees” (ibid). Subsequently, officials informed detention staff that “they would be required to work 12-hour shifts, seven days a week” due to staffing shortages caused by the COVID-19 crisis (ibid.). The widow of one of the guards also reportedly contracted the virus (ibid.).

On June 14, an officer at the Eloy Detention Center in Arizona, run by CoreCivic, died of COVID-19 complications during an “explosion” of cases at the facility (Gonzalez 2020). According to ICE, by July 29, 2020, 252 detainees at the Eloy facility had contracted COVID-19 (ICE 2020b).

ICE also fails to provide information on members of surrounding communities that may have contracted COVID-19 due to exposure to detainees and detention staff. The surge in infections in detention centers has raised concerns in host communities, many in “rural areas with little medical infrastructure.”14 Frio County commissioners and city officials, for example, have asked The GEO Group – which manages the South Texas ICE Processing Center in Pearsall, Texas – to explain its plans to safeguard the community from the outbreak at its facility (Treviso 2020).15 According to ICE, by July 29, 2020, 132 detainees at this facility had contracted COVID-19 (ICE 2020b).

10 Id.


13 This facility is run by LaSalle Corrections.


15 The county financed the construction of this facility.
Transfers of Infected Detainees and Inmates

The transfer of infected immigrant detainees and inmates held in “non-dedicated” facilities with ICE detainees has contributed to the spread of the virus throughout the detention system. Between March 1 and April 25, for example, 174 persons were transferred to the South Texas ICE Processing Center, from Bexar County jail where (by May 7) 303 inmates and 55 staff had contracted COVID-19 (Trevizo 2020).

ICE also transferred 72 detainees in April from facilities with confirmed cases in New York and Pennsylvania, to the detention facility in Prarieland, Texas, which had no confirmed cases at the time. According to ICE, by July 29, 70 detainees at the Prarieland Detention Facility had contracted COVID-19 (ICE 2020b), including at least 21 of the Bexar transferees.16

New arrivals at the Rolling Plains Detention Center in Haskell, Texas, administered by LaSalle Corrections, tested positive in late April, leading to a COVID-19 outbreak at that facility (Seville and Rappleye 2020). According to ICE, by July 29, 55 detainees at Rolling Plains had contracted COVID-19 (ICE 2020b).

On May 14th, ICE moved 40 detainees from Irwin County Detention Center in Ocilla, Georgia – where COVID-19 had become established – to the Stewart Detention Center, another facility experiencing an outbreak, explaining nonsensically that it sought to “stem the potential spread of COVID-19 by reducing populations in facilities where people are infected” (Wessler 2020).

In a court hearing in late May, a DOJ attorney representing ICE said that not every transferred detainee was tested, 17 which led to transfers of infected, but asymptomatic detainees (Madan and Charles 2020b). As of mid-July, facilities operated by private prison corporations continued to accept transferred detainees and their “screening procedures” failed to identify infected, asymptomatic detainees (Misra 2020b).

Public officials have criticized the transfer of immigrants held in jails and prisons to the Aurora (Colorado) Contract Detention Facility, which The GEO Group operates. They maintain that transfers increase the risk of infection to detainees, staff, and members of the broader community (Herrick 2020). According to ICE, as of July 29, 2020, 20 detainees had tested positive in the Aurora facility (ICE 2020b).

In a letter to DHS Acting Secretary Chad F. Wolf, Senate Democrats charged that ICE had responded to court directives to reduce crowding by transferring detainees, including a group of

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17 As of early May, detainees in a packed dormitory in the Irwin facility with “acutely sick” persons had still not been tested (Wessler 2020).
“at least 200” from Florida. The letter also attributed the high rate of infection in Adams County, Mississippi to the transfer of 200 persons to the Adams County Correctional Center. According to ICE, as of July 29, 2020, 40 detainees had tested positive in the Adams facility (ICE 2020b)

“The coronavirus spread through the transfer of persons between detention facilities and from prisons to detention centers. It spread through the movement of guards within and between facilities, and through private contractors who provide food, medical, mental health, janitorial, video and phone services in detention facilities.”

In short, the coronavirus spread through the transfer of persons between detention facilities (Merchant 2020) and from prisons to detention centers (Seville and Rappleye 2020). It spread through the movement of guards within and between facilities, and through private contractors who provide food, medical, mental health, janitorial, video and phone services in detention facilities (Gomez 2019).

II. The Slow Decline in Detainee Numbers

Between March 21 and July 25, the number of ICE detainees fell significantly – from 38,058, to 21,884 (ICE 2020a) – but not as steeply as necessary in the circumstances. Over the same period, the spread of the virus accelerated through the detention system, into local communities, and to the nations of infected US deportees. The July 25 figure includes 13,501 persons apprehended by ICE and Homeland Security Investigations, and 8,383 referred by Customs and Border Protection (CBP) (ibid.).

By way of comparison, Canada – which detains many times fewer immigrants than the United States – released more than one-half of those in its custody between March 17 and April 19 (Global News 2020). Mexico released nearly all of the migrants in its custody, although relegating many to dangerous situations (Averbuch 2020).

“As of July 25, ICE still held 3,306 persons who had established a ‘credible fear of persecution’ or a ‘reasonable fear of persecution or torture.’”

As of July 25, ICE still held a large number of persons (3,306) who had established a “credible fear of persecution” or a “reasonable fear of persecution or torture” (ICE 2020a). Persons in these categories – bona fide asylum-seekers and persons seeking “withholding of removal” under the Convention Against Torture – should not be detained. In mid-May, ICE also held

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19 Id.
nearly 11,000 non-violent persons.\textsuperscript{20}

ICE also continues to detain families and minors. On March 28, Judge Dolly Gee, a federal district judge, issued a temporary restraining order, requiring ICE and HHS’s Office of Refugee Resettlement (ORR) to “make and record continuous efforts” to release the more than 5,000 minors held in ICE family residential centers (FRCs) and in ORR shelter-like facilities for unaccompanied minors.\textsuperscript{21} Gee’s decision recognized the “severity of the harm” to which children in these facilities, particularly ICE facilities, “are exposed and the public’s interest in preventing outbreaks of COVID-19 … that will infect ICE and ORR staff, spread to others in geographic proximity, and likely overwhelm local healthcare systems.” On April 24, Gee ordered ORR and ICE “to make every effort to promptly and safely release” children with “suitable custodians.”\textsuperscript{22}

By July 9, 35 persons had been diagnosed with COVID-19 at the Karnes County Residential Center in Texas (Aleaziz and Flores 2020).

On May 21, a group of House Democrats wrote DHS/ICE for information regarding reports that ICE had tried to pressure parents to relinquish control of their children to ORR or to a non-parent “custodian” by insisting that the children would otherwise remain indefinitely detained.\textsuperscript{23} ICE has denied offering parents the so-called “binary choice” between family separation and long-term detention.

On June 26, Judge Gee ordered the transfer of class members held for more than 20 days at ICE’s three FRCs, to non-congregate settings. The options included release to “suitable sponsors” or other “COVID-free non-congregate settings with the consent of their adult guardians/parents”, or release “with their guardians/parents if ICE exercises its discretion” to release the parents.\textsuperscript{24} Yet ICE refused to release their parents, forcing the families either to remain together in detention or to separate.

In a separate suit, a federal district judge rejected the request of more than 200 detainees held in FRCs for a preliminary injunction, ordering their release based on detention conditions that


violate their due process rights. In effect, this relief would have allowed parents to be released with their children from FRCs. The court, however, found that the plaintiffs failed to meet their burden that “no other court-ordered remedy,” short of release, would address the alleged due process violations. At this writing, ICE has detained some of the children in its FRCs for almost a year (Murdza 2020). In the circumstances, the burden should instead rest with the government to justify continued detention.

“In the circumstances, the burden should rest with the government to justify continued detention.”

As of May 11, 2020, there were 1,500 unaccompanied children in the 195 shelter-like facilities funded by ORR, awaiting placement with a sponsor, typically a close family member (HHS 2020). By June 8, there were 1,077 children in ORR care and 124 in ICE custody. ORR does not report on the numbers of infected children in its care. However, the coronavirus has raced through many of its facilities as well. In one Chicago facility, 42 immigrant children had tested positive for COVID-19 as of April 21 (Sanchez 2020). In early April, seven staff members tested positive at a Houston area facility (Trovall 2020).

On April 13, the Washington Post reported that the population at ICE’s family centers had fallen from 1,350 to 826 persons (Hsu 2020). By April 21, the number had declined to 698 persons, including 342 minors. As of July 9, ICE held 319 immigrants, including 157 children in FRCs (Aleaziz and Flores 2020).

III. The Effect of DHS Policies and Practices on Asylum-Seekers, Children, and Survivors of Trafficking

The decline in the US detention population during the pandemic can be largely attributed to diminished arrivals into this system (Wessler 2020), particularly persons referred by Customs and Border Protection. However, US border policies – which the administration has cast as a public health imperative – have endangered asylum seekers, unaccompanied children, and survivors of trafficking. They have also violated US law.

On March 20, the Center for Disease Control and Prevention (CDC) issued a document titled “Order Suspending Introduction of Certain Persons from Countries Where a Communicable Disease Exists,” which closed US land borders to non-essential travelers (CDC 2020a). CDC subsequently extended the order through May 20 (CDC 2020b). On May 26, it expanded the order to coastal ports-of-entry (POEs) and extended it indefinitely – until “the danger of further introduction of COVID-19 into the United States has ceased to be a serious danger to the public health, and the continuation of the Order is no longer necessary to protect the public health” (CDC 2020c).


27 Id.
The CDC order has resulted in the expulsion, with only cursory screening, of non-citizens apprehended by Customs and Border Protection near its land borders and at ports-of-entry. CBP expelled 69,307 encountered by the Border Patrol from March through June 2020, and an additional 2,892 persons apprehended by its Office of Field Operations at POEs (CBP 2020). CBP border facilities initially emptied as a result (O’Toole 2020; Miroff 2020a; Miroff 2020b), and referrals from CBP to ICE have diminished.

The CDC order purportedly seeks to prevent the “serious danger” of the “introduction” of COVID-19 by “persons from the foreign countries” at land and coastal POEs and Border Patrol stations, which it accurately characterizes as “congregate settings,” and into the US “interior” (CDC 2020a). Social distancing and minimizing movement in public space have become central tools in the nation’s response to the pandemic. Yet the administration has not acted with similar urgency to slash detention populations at ICE facilities, which are likewise congregate settings “not designed for, and … not equipped to, quarantine, isolate, or enable social distancing by persons who are or may be infected with COVID-19” (CDC 2020a).

The “major concern” of the 188 detention facilities responding to a survey by the DHS Office of Inspector General (OIG) from April 8-20, 2020 “was their inability to practice social distancing among detainees, and to isolate or quarantine individuals who may be infected by COVID-19,” (DHS-OIG 2020, 7). OIG concluded that “the nature of detention facilities makes social distancing impractical, as detainees are housed together in dorm-like pods, some with as many as 50 to 75 detainees in each pod” and “most detention centers have few means to isolate large numbers of detainees” (DHS-OIG 2020, 9).

Respondents also expressed concern over the availability of sufficient staff and protective equipment in the event of an outbreak in their facilities (ibid., 6). In addition, 73 of the 157 non-dedicated respondents – those facilities that house both immigrant detainees and inmates – reported that they lacked COVID-19 testing capacity on site (ibid., 7).

The CDC order also overreaches in ways that endanger migrants and compromise the nation’s “health protection agency.” In particular, the order has eviscerated US asylum laws and anti-trafficking protections for minors, and has returned thousands of persons to potentially life-threatening conditions (CMS 2020). The United Nations High Commissioner for Refugees (UNHCR) has recognized that states may need “to implement exceptional measures to curb the spread of COVID-19” (UNHCR 2020).
the virus and to protect public health” (UNHCR 2020). However, it has urged that alternative measures be adopted “to protect public health while ensuring access to territory for persons seeking international protection and protecting them against the risk of refoulement” (ibid.).

“The CDC order also overreaches in ways that endanger migrants. In particular, the order has eviscerated US asylum laws and anti-trafficking protections for minors, and has returned thousands of persons to potentially life-threatening conditions.”

Under US law, asylum seekers without proper documents must express a fear of persecution or request asylum in order to avoid “expedited removal.” If they communicate fear, border officials must refer them to US Citizenship and Immigration Service (USCIS) asylum officers for an interview. The president and administration officials have characterized this statutory requirement – which CBP officers often observed in the breach—as an immigration enforcement “loop-hole” (Kerwin 2018). If determined by an asylum officer to possess a credible fear, USCIS is obliged to refer asylum-seekers to removal proceedings, where they can request asylum. At this point, they can be “paroled” (released) by DHS or released on bond by an immigration judge (Hillel 2019).

The CDC order denies asylum-seekers these protections. It states that border officials can admit certain individuals based on “the totality of the circumstances, including consideration of significant law enforcement, officer and public safety, humanitarian, and public health interests” (CDC 2020a). In practice, however, border officials consider exceptions only for those expressing a fear of torture if returned home (Lind 2020). Between March 21 and mid-May 13, USCIS screened only 59 cases under the Torture Convention, rejected 54 of them, and allowed just two persons to remain in the United States (Miroff 2020b).

The administration has similarly attacked the Trafficking Victims Protection Reauthorization Act (TVPRA), which requires that unaccompanied minors from non-contiguous countries be expeditiously transferred to HHS and be permitted to seek asylum and other relief. The CDC order violates these requirements. The United States can achieve its public health and safety objectives in stemming COVID-19, while ensuring the safety of asylum-seekers, children, and potential trafficking victims. Yet by June 25, it had expelled more than 2,000 unaccompanied children with no process or protections, and in April, May, and June had transferred only 162 children to ORR (Montoya-Galvez 2020c).

In a May 18 letter, a group of public health experts sharply criticized the Trump administration for “using the imprimatur” of CDC “to circumvent laws and treaty protections designed to

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29 Immigration and Nationality Act (INA) § 235(b)(1)(A)(i). The geographical reach of the “expedited removal” process has expanded significantly over the years.

30 The Trump administration has perversely begun to use Border Patrol agents as asylum officers (Heyman, Slack and Martinez 2019).

save lives.” 32 The letter accused the administration of disregarding “alternative measures that can protect public health while preserving access to asylum and other protection.” 33 It pointed out that the order did not apply to airline or ship travel, which pose “a higher risk of disease transmission than land travel.” 34 It also outlined ways to safeguard asylum seekers, unaccompanied children, and relevant public officials, consistent with the “best available public health guidance,” 35 and it recommended that the United States follow the example of the European Union, which exempts those seeking international protection from travel restrictions.

The CDC order treats asylum-seekers, children, and other migrants as a potential source of contagion to the United States, but the opposite has been closer to true. The detention and deportation policies of the United States – a nation with 4 percent of the world’s population, but which has experienced 29 percent of the world’s COVID-19 deaths (Chamie 2020) – has contributed to the spread of the pandemic to nations with far lower infection rates. 36

The expulsion process occurs in an average of 96 minutes, without medical examination, except for migrants “in distress” (Miroff 2020a). Removal via ICE Air of “detainees who are not ‘new apprehensions’” entails “medical clearance;” “new apprehensions” receive only visual screening (ICE 2020a). Persons deported by plane also receive a “temperature screening” at the “flight line” (ibid.). Yet these precautions do not test for the virus and, thus, have not prevented the deportation of significant numbers of infected persons. In a May 1st letter to US Secretary of State Mike Pompeo and Acting DHS Secretary Chad Wolf, 15 Senate Democrats decried the apparent lack of regard for effective pre-deportation “screening, and testing, quarantining and treating symptomatic migrants in accordance with medical guidelines.” 37 They characterized this practice not only as a “breach” of public health and humanitarian standards, but as a threat to the “United States’ ability to defend against re-introduction of the virus once the epidemic is brought under control in the United States.” 38 According to ICE, by July 29, 101 detainees at ICE’s pre-deportation Alexandria Staging Facility in Louisiana and an additional 15 ICE employees (as of June 18) had contracted COVID-19 (ICE 2020b).


33 Id.

34 Id.

35 Id.

36 A Cato Institute analysis concluded that as of April 7, 2020, 10.7 million travelers – most of them not US citizens – had entered the United States from “countries with confirmed COVID-19 cases.” (Bier 2020). By then, COVID-19 had established itself and begun to spread in the United States.


38 Id.
IV. Release Is a Legal Option and a Public Health Imperative

ICE has continued to arrest and detain immigrants during the pandemic. On March 18, the agency announced that it would prioritize immigration enforcement against “public safety risks and individuals subject to mandatory detention based on criminal grounds” (ICE 2020c). For others, it vowed to exercise prosecutorial discretion to delay enforcement and to expand its use of ATDs. ICE’s announcement of this potentially life-saving policy, which tracked Obama-era enforcement priorities, infuriated White House and other administration ideologues (Lipman and Kumar 2020). Although ICE arrests have fallen significantly over the course of 2020 (Stock et al. 2020), the new policy does not go far enough.

ICE has argued that it has no choice but to detain immigrants who are subject to mandatory detention. The US Supreme Court has held that mandatory detention during the pendency of removal proceedings is “constitutionally permissible.”39 This holding, however, does not preclude DHS/ICE from releasing imperiled detainees or opting not to detain them in the first place.

The Immigration and Nationality Act (INA) creates a series of carve-outs and exceptions to mandatory detention. It mandates, for example, the detention of persons who are in removal proceedings on various criminal and terrorist-related grounds.40 However, it also allows ICE to release persons in these categories if necessary to protect a witness, potential witness, person cooperating in a criminal investigation, or an immediate family member of such a person.41

It provides that ICE “shall take into custody” persons subject to mandatory detention “when the alien is released.”42 The Supreme Court has interpreted this language to require detention, even if the non-citizen has never been in criminal custody or if ICE has failed to assume custody of them for a long period after their release from prison.43 However, the decision did not speak to the constitutionality of this provision, and it remains an open question whether “mandatory detention of aliens long after their release from criminal custody is constitutionally permissible” (Hillel 2019).

The INA mandates the detention of “applicants for admission,” whether those arriving at POEs or apprehended after an unauthorized entry.44 However, it also allows DHS to parole (release) applicants for admission for “urgent humanitarian reasons or significant public benefit.”45 Saving lives and slowing the spread of a catastrophic pandemic should meet these standards. Moreover, one category of “arriving alien” – asylum-seekers subject to expedited removal who harbor a

40 INA §236(c) (1).
41 INA §236(c) (2).
42 INA §236(c) (1).
44 INA §235(b).
45 INA § 212(d)(5)(A).
“credible fear” of persecution – can be released.

The INA also mandates the detention of persons ordered removed within a 90-day “removal period.” To avoid finding this provision unconstitutional, the Supreme Court interpreted it to require detention only “for a period reasonably necessary to secure removal,” generally for six-months following the removal order. ICE should be able to track and identify non-mandatory detainees, as well as persons who fit into mandatory detention categories, but who it can release under the law.

Beyond the statutory exceptions to mandatory detention, constitutional claims have loomed large in legal challenges to detention during the pandemic. Most of the lawsuits have been habeas corpus actions, challenging the custody of persons “in violation of the Constitutions or laws or treaties of the United States.” ICE and immigration courts have a fundamental duty to protect the rights of detainees, including through release.

The immense number of non-detainees in the removal adjudication system undermines the claim that detention is necessary to safeguard the public. In April 2020, the US immigration courts had a growing backlog of more than 1.2 million cases (TRAC 2020), not counting 360,000 closed cases due to Attorney General Sessions’ decision that immigration judges and the Board of Immigration Appeals cannot administratively close cases, except in narrow circumstances. In June 2019, ICE’s non-detained docket included roughly three million persons in various stages of the removal adjudication process (Singer 2019, 5).

“The great majority of detainees do not present a public safety threat. All ICE detainees with criminal records have served any sentence they received.”

The great majority of detainees do not present a public safety threat. By the end of March 2020, 61.2 percent of ICE detainees had never been convicted of a crime and just 10.7 percent had committed a “Level 1” crime, which are “thought to pose a threat to public safety” (TRAC 2020). These statistics are consistent with earlier findings that most detainees with criminal records are non-violent offenders, as classified by the Federal Bureau of Investigations (FBI) National Crime Information Center (NCIC), and that high percentages have been convicted of misdemeanors, or immigration traffic, and drug possession offenses (USCCB-MRS and CMS 2015). Santiago

46 INA §241(a)(1).
48 28 USC §2241(c)(3).
49 Matter of Castro Tum, 27 I & N Dec. 271 (A.G. 2018). These cases could be re-calendared and added to the backlog.
50 These cases include persons released by the government, never detained, in the custody of state or other federal law enforcement agencies, and persons with final removal orders who have absconded or who cannot be removed because no other nation will accept them.
Baten-Oxlag, for example, had been convicted of driving under the influence. Most importantly, all ICE detainees with criminal records have served any sentence they received. Forty-seven percent of those in ICE custody on July 25 – down from 60 percent on May 23rd – had not been convicted of a crime (ICE 2020a).

ICE’s website lists select “charges or convictions” for 401 of the 510 persons released (ibid.). Yet this list does not distinguish charges from convictions or indicate the numbers convicted by category of crime. It also seems to be incomplete and weighted more heavily to violent offenses. In any event, federal judges have reviewed the records of all those ordered released.

The more than 100 lawsuits filed in federal court, seeking the release of individuals or groups of detainees have opened a window on ICE’s detention system and its network of private prison corporations (Shah 2020). One commentator has pointed out that some courts have appropriately shifted their analysis of the “public interest” at issue in detention from the prevention of flight risk and potential danger to the community, to a broader view of the public health and safety risks posed by the failure to release persons confined in patently unsafe conditions (ibid.).

On April 20, for example, Judge Jesus G. Bernal of the Central District of California in a nationwide class action lawsuit ordered ICE to identify, track and make timely custody determinations for all detainees with factors that put them at risk of serious illness and death if infected. The court certified two subclasses: (1) all ICE detainees with at least one risk factor that places them “at heightened risk of severe illness and death upon contracting the COVID-19 virus;” and (2) all ICE detainees “whose disabilities place them at heightened risk of severe illness and death” if they contract COVID-19. The judge recited a litany of unhygienic and dangerous conditions in ICE facilities, concluding that ICE had “likely exhibited callous indifference” to detainees with


54 These risk factors were; (1) age (55 or over); (2) pregnancy; and (3) chronic health conditions, including cardiovascular disease, high blood pressure, chronic respiratory disease, diabetes, cancer, liver disease, kidney disease, autoimmune diseases, severe psychiatric illness, a history of transplantation, and HIV/AIDS.

55 Similarly, a US district court judge for the Southern District of California certified as a vulnerable subclass of detainees at Otay Mesa Detention Center those aged 60 and over whose medical conditions put them “at heightened risk of severe illness or death from COVID-19.” It ordered ICE to identify and release subclass members “in a manner that comports with public health guidelines for self-quarantine …, social distancing, and other recommendations of public health departments in their destination cities or counties.” Alcantara, et al., v. Archambeault et al., No: 20cv0756 DMS (AHG) (S.D. CA., April 30, 2020) (Order Granting Plaintiff-Petitioners’ Emergency Ex Parte Motion For Subclass-Wide Temporary Restraining Order).
particular vulnerabilities.\textsuperscript{56} He ordered ICE, \textit{inter alia}, “to identify and track” all detainees with risk factors and “to make timely custody determinations” in their cases.

On May 5, ICE reported that it had identified 4,409 detainees in its long-term facilities “who belong to one or both” subclasses and that it had been “conducting new custody reviews as soon as possible following the identification of subclass members.”\textsuperscript{57} Yet by July 27, ICE had released only 510 detainees “after court order” (ICE 2020b), and had reportedly refused to identify vulnerable detainees with the same characteristics as those determined by federal district courts to need special protections. By mid-May, ICE reported that it had released 900 detainees (Montoya-Galvez 2020b), based on its review of who “might be at higher risk for severe illness as a result of COVID-19,” including pregnant women and persons over age 60 (ICE 2020b).

V. Detention and Pandemic Response Standards Fail to Protect Detainees, Detention Facility Staff, or the Public

Over the years, the US Department of Justice (DOJ) and DHS have developed extensive immigrant detention standards and guidelines, which constitute a significant improvement over the barebones standards that preceded them. However, none of these standards has been codified by regulation. Moreover, the standards are based on a correctional incarceration model, which is not appropriate for civil detainees in ICE custody (Schriro 2017; USCCB-MRS and CMS 2015).

ICE administers a national detention system that should be subject to uniform, national standards. However, different standards govern different types of detention facilities. ICE’s Performance Based National Detention Standards (PBNDS), revised most recently in 2016, cover facilities dedicated entirely to immigration detention (ICE 2020f). A separate set of National Detention Standards (NDS) for Non-Dedicated Facilities – released in 2019 – govern facilities that hold immigrant detainees and other populations, such as those in the US Marshals Service custody or prisoners in state or municipal prisons and jails (ICE 2020g). These streamlined standards address medical, health, security, administration, and other issues relevant to the COVID-19 crisis. They eliminate or reduce “a number of prior standards” on the


ground that local law enforcement “appropriately covers these requirements” (ibid., Foreword).

On March 23, the CDC released its “Interim Guidance on Management of Coronavirus Diseases (COVID-19) in Correctional and Detention Facilities,” which “seeks to reduce the risk of transmission and severe disease from COVID-19,” but with the recognition that these standards “may need to be adapted based on individual facilities’ physical space, staffing, population, operations, and other resources and conditions.” (CDC 2020d).

An April 10, 2020 document entitled “COVID-19 Pandemic Response Requirements,” which ICE developed in consultation with CDC, provides instruction and guidance to detention facilities and sets forth ICE’s expectations for mitigating the risk of infection to detainees and detention stakeholders (ICE 2020d). The document requires both dedicated detention facilities and non-dedicated facilities to comply with the March 23rd CDC guidelines.

In a June 2nd statement to the US Senate Judiciary Committee, Dr. Scott A. Allen, M.D., a physician for the Rhode Island Department of Corrections and a subject matter expert for DHS’s Office of Civil Rights and Civil Liberties, criticized the “gaping holes” in the CDC’s March 23rd guidelines. Allen singled out their “failure to contemplate population reduction and failure to provide adequate guidelines for testing.” He stated: “The fact is, in the real world, the guidelines—and accordingly their implementation by BOP [Bureau of Prisons] and ICE—are failing to stop the spread. The number of cases and deaths continues to grow.

Infectious disease experts emphasize the overarching importance of testing, tracing the contacts of those who have tested positive, and isolating the infected (Quammen 2020). The ICE detention system has failed in all three regards. As the guidelines tacitly acknowledge, ICE cannot adequately protect detainees or stem the spread of the virus.

ICE’s April 10 pandemic response requirements include “pre-intake” screening for “new entrants,” both “temperature screening” and “a verbal symptoms check” (ICE 2020d, 12). However, this screening does not cover existing detainees, cannot identify infected but asymptomatic “new entrants,” and falls short of actual testing. On June 9, ICE announced a pilot program, which it hoped to expand, that provided voluntary testing at the Northwest ICE Processing Center in Tacoma and the Aurora Contract Detention Facility (ICE 2020i).

The April 10 document concedes that “strict social distancing may not be possible in congregate settings, such as detention facilities,” and thus advises detention centers, “to the extent possible,” to reduce their populations to “75 percent of capacity” (ICE 2020d, 13). Yet even a far greater reduction would be insufficient to stem the spread of the virus in dormitory-style detention


59 Id.
facilities, such as the Mesa Verde Detention facility where “100 men … sleep in double bunks that are two to three feet apart” (Stock et al. 2020). In these conditions, the guidance offers a hopeless course of action; i.e., that those “sharing sleeping quarters” should sleep “head to foot” and pursue other unspecified “social distancing strategies” (ICE 2020d, 20). ICE’s guidance also advises facilities, “to the extent possible,” to house detainees in individual “rooms,” but this option is not, in fact, possible (ibid).

Moreover, ICE has a financial incentive to meet the facility occupancy requirements set forth in its detention contracts (Herrick 2020), and it “routinely moves detained individuals to ensure, among other things, that minimum bed space numbers in contracts with private prisons and state and local jails are met.”60 In addition, ICE does not want to establish a “precedent” in releasing detainees, which could “survive the Covid-19 pandemic” (Wessler 2020).

The guidelines also call for consideration of the release of those “who may be at higher risk for serious illness” from exposure (ICE 2020d, 14). Yet the virus kills low-risk persons as well. ICE also urges detention facilities to consider “cohorting” (housing together) “all new entrants” for 14 days (ibid.). However, the guidance concedes that “cohorting options and capabilities” vary by facility (ibid.). Moreover, as one physician who has treated COVID-19 patients told the author, this strategy would work only if new entrants were not exposed to detainees, guards, or others from outside their cohort, which is unlikely in a detention setting. The “safer solution,” he said,

“would be simply to allow detainees to live with their families.”

The guidance advises that facilities make “every possible effort” to isolate infected detainees (suspected and confirmed), but acknowledges that the number of confirmed cases may exceed the number of individual spaces available (ICE 2020d, 21-22). It directs that “ill detainees” should not be “coholed with other infected individuals” (ibid.). However, if this is “unavoidable” it advises that “all possible accommodations” be made until the transfer of infected detainees (ibid.). Yet, as discussed, transfers, new entrants, and the movement of staff and contractors in and out of facilities, have been the engine for COVID-19’s spread. In short, these safeguards acknowledge the obvious: that ICE can take modest steps that may make a bad situation better, but it cannot ultimately safeguard those in its custody.

“ICE can take modest steps that may make a bad situation better, but it cannot ultimately safeguard those in its custody.”

The Chief Executive Officer of LaSalle Corrections, a private prison corporation that operates detention facilities, testified on the possibility of cohorting infected detainees, those suspected of being infected, and their contacts “when individual space is limited.” 61 Yet, such a strategy would invariably infect the uninfected.

A May 14 letter to DHS and ICE by the Chairwoman of the House Committee on Oversight and Reform and the Chairman of the Subcommittee on Civil Rights and Civil Liberties, questioned ICE’s claimed compliance with CDC guidelines. 62 The letter pointed out that, contrary to ICE policy and practice, CDC recommended against cohorting detainees who had been exposed to coronavirus, except if there were no other “available options.” It is easy to see why. Cohorting detainees who have been exposed to, but who have not contracted COVID-19, with those who have contracted COVID-19 (but may be asymptomatic), makes it likely that the former will become infected. Yet, ICE co-opts as a matter of course, and “at some facilities” it is “making little effort to isolate exposed detainees.” 63 The CEO of CoreCivic testified that his agency quarantines detainees “exposed to a positive case … with other detainees who have also been exposed.” 64 It would be far safer to release such detainees, with a plan to test, isolate, and treat them for a period of time.


63 Id.

Inconsistencies between ICE and CDC Guidelines

Homer Venters, the former Director of Programs for Physicians for Human Rights and the Chief Medical Officer for the NYC Jail system, concludes that ICE’s guidance is inconsistent with CDC guidelines in three critical ways. First, ICE cannot adhere to social distancing standards “in virtually every facility it operates.” Even in facilities at roughly a third of capacity, such as those managed by the private prison corporation Management and Training Corporation (MTC), effective social distancing may be impossible. MTC’s five facilities have a combined capacity of nearly 5,000, but consist of “open-bay housing units with dorms that can accommodate up to 100 individuals.”

Second, ICE’s longstanding oversight deficiencies make it “unlikely” that it can “ensure compliance” with its guidance. A 2018 report by DHS’s Office of Inspector General (OIG) agreed with this assessment. It concluded that neither ICE’s inspections program – which is administered by the private Nakamoto Group, Inc. and ICE’s Office of Professional Responsibility, Inspections and Detention Oversight Division (ODO) – nor ICE’s on-site monitoring system by


its Enforcement and Removal Operations (ERO) division, promote “consistent compliance with detention standards or comprehensive correction of identified deficiencies” (DHS-OIG 2018, 4).

Third, and due to these deficiencies, Venters said that ICE detainees would “experience higher risks of serious illness and death.”68 In fact, this is exactly what has come to pass and will continue without large-scale screening, testing, and release of detainees.

Exacerbating matters, ICE has limited ability to enforce or even assess compliance with these guidelines. ICE staff have conceded that they lack effective control over the operation of contract facilities.69 Moreover, ICE contractors like CoreCivic insist that they have complied with CDC guidelines, notwithstanding high rates of infection in their facilities. Yet, CoreCivic allegedly threatened to deny protective masks to detainees unless they agreed to hold it “harmless” for any legal claims related to wearing them (Morrissey 2020a).

In December 2019, an investigative team from USA Today reported extensively on the role of private corporations in the US detention system in the Trump era. It found “more than 400 allegations of sexual assault or abuse, inadequate medical care, regular hunger strikes, frequent use of solitary confinement, more than 800 instances of physical force against detainees, nearly 20,000 grievances filed by detainees and at least 29 fatalities, including seven suicides” (Gomez et al. 2020). COVID-19 has exploited many of these systemic problems.

VI. Expert Warnings That Have Come to Pass

Public health experts have long recognized prisons as “risk environments,” which can lead to the concentration and transmission to inmates and to the broader community of HIV, hepatitis B, hepatitis C, tuberculosis, and other infectious diseases (Kamarulzaman et al. 2016). According to Dr. Scott A. Allen, MD:

Jails, prisons, and detention facilities are not islands – in fact, they are more like bus terminals with people coming and going. New arrestees and detainees arrive every day, in fits and spurts, sometimes arriving in large groups. Immigrants are transferred regularly throughout the detention system, with staff accompanying them as escorts. They are released without warning at court and immigrants are dropped at bus stations and airports. Officers and staff come and go, three shifts a day. And the virus can easily move back and forth by means of the asymptomatic “silent spreaders” who carry the virus but do not have symptoms.70

ICE has a particularly bad track record at preventing and responding to infectious disease outbreaks

68 Id.


(Ghandehari and Viera 2020, 3; Dow 2020; Hall and Smith 2020), including a 2018 outbreak of the mumps in two Texas detention centers that spread to 57 facilities (Stock et al. 2020).

“Attorney General William Barr has ordered the early release of at-risk inmates in federal prisons. However, he has remained silent regarding the need to release immigrant detainees who endure the same conditions and risks, often in the same facilities.”

On March 20, the American Jail Association posted a set of “Recommended Strategies for Sheriffs and Jails to Respond to the COVID-19 Crisis,” which emphasize the need to “reduce the jail population as quickly as possible” (Deitch 2020). This document explains that “immediate reductions ... are critical because of the need to allow for social distancing, because the virus could be a death sentence to many incarcerated people, and because this will reduce the strain on the health care delivery system in the jail” (ibid.). Attorney General William Barr has ordered the early release of at-risk inmates in federal prisons (Gerstein 2020). However, he has remained silent regarding the need to release immigrant detainees who endure the same conditions and risks, often in the same facilities. In fact, the immigrant detention crisis might be viewed as part of the larger crisis in US prisons and jails. As of July 31, 2020, 86,472 residents and 20,561 staff of US prisons and jails were “confirmed” to have contracted COVID-19, and 754 residents and 57 staff had died (UCLA Law 2020).

In an open letter to ICE Acting Director Matthew T. Albence, several hundred medical professionals detailed the problem:

Detention facilities, like the jails and prisons in which they are housed, are designed to maximize control of the incarcerated population, not to minimize disease transmission or to efficiently deliver health care. This fact is compounded by often crowded and unsanitary conditions, poor ventilation, lack of adequate access to hygienic materials such as soap and water or hand sanitizers, poor nutrition, and failure to adhere to recognized standards for prevention, screening, and containment. The frequent transfer of individuals from one detention facility to another, and intake of newly detained individuals from the community further complicates the prevention and detection of infectious disease outbreaks. A timely response to reported and observed symptoms is needed to interrupt viral transmission yet delays in testing, diagnosis and access to care are systemic in ICE custody.

The letter argued that social distancing was “nearly impossible in immigration detention.” It recommended that “ICE implement community-based alternatives to detention to alleviate the

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71 In this way, the Attorney General’s approach resembles that of states such as Tunisia, which has announced the release of prisoners, but not immigrant detainees (Welsford and Flynn 2020).


73 Id.
mass overcrowding in detention facilities.”74

A medical consultant to DHS and the US Department of Justice reported that immigrant detention centers present “a greater risk” of “the spread of COVID-19” than USCIS field offices, which DHS has closed in response to the crisis.75 They are also more dangerous than cruise ships because of “conditions of crowding, the proportion of vulnerable people detained, and often scant medical care resources.”76 Detainees share “toilets, sinks, and showers” and their “[f]ood preparation and food service is communal.”77 Because detention staff “arrive and leave on a shift basis,” there is “little to no ability to adequately screen staff for new, asymptomatic infection.”78

In a March 19 letter, two medical doctors, who have investigated immigrant detention facilities and worked as DHS subject matter experts, warned Congress of “the imminent risk to the health and safety of immigrant detainees, as well as to the public at large, that is a direct consequence of detaining populations in congregate settings.”79 They urged the release of detainees from these “high-risk” settings in order to avoid a “tinderbox scenario,” in which a “rapid outbreak” of COVID-19 overwhelmed local hospitals, monopolized health care resources, and infected

74 Id.
76 Id.
77 Id.
78 Id.
members of surrounding communities.\textsuperscript{80}

The World Health Organization (WHO) warns that “prisons, jails and similar settings where people are gathering in close proximity may act as a source of infection, amplification and spread of infectious diseases within and beyond prisons” (WHO 2020). For this reason, prison health is “widely considered as public health” (ibid.) On March 31, the WHO, United Nations High Commissioner for Refugees, International Organization for Migration, and the Office of the United Nations High Commissioner for Human Rights voiced similar concerns regarding “refugees and migrants held in formal and informal places of detention, in cramped and unsanitary conditions” (OCHR, IOM, UNHCR, and WHO). It urged that they be released “without delay” (ibid.)

**Practices in Other Countries**

The Global Detention Project (GDP) in Geneva tracks national detention policies related to the COVID-19 pandemic “within the context of their migration control policies” (GDP 2020). GDP reports that Spain had emptied its seven immigrant detention centers by early May, for the first time in three decades, due to the impossibility of removing detainees (Martín 2020). In the United Kingdom, the number of immigrant detainees fell from 1,225 people on January 1, 2020, to 368 in early May (GDP 2020). In Italy, three of nine pre-removal detention centers had closed, and the number of immigrant detainees had fallen from 600 to 178 by May 29 (Roman 2020). In Switzerland, some cantonal authorities have released all of their “immigration detainees … because returns are no longer possible,” although there has not been a national moratorium of detention orders (GDP 2000). Zambia has released all of its detainees (Flynn and Welsford 2020). However, the broader trend has been to decrease prison populations, but resist “taking concerted action to empty detention centres” (ibid).

**VII. The Response of Detainees and Their Families**

ICE policies and CDC guidance recognize the impossibility of social distancing in most facilities. Detainees and their families understand in a more personal way the deadly risk that these conditions pose. According to the US-based Detention Watch Network, detainees have responded with more than 29 confirmed hunger strikes since March, and countless desperate appeals for release (Lang 2020).

\begin{quote}
“ICE policies and CDC guidance recognize the impossibility of social distancing in most facilities. Detainees and their families understand in a more personal way the deadly risk that these conditions pose.”
\end{quote}

On April 7, USA Today reported on a Cuban asylum-seeker, detained for eight months at the South Louisiana ICE Processing Center, who spoke of the impossibility of social distancing in her dormitory, where more than 70 women “share five bars of soap” and “guards come in and out … without wearing masks or gloves.” (Gomez, Clark and Plevin 2020). According to ICE, by July

\textsuperscript{80} Id.
29, 2020, three detainees at the South Louisiana Correctional Center had contracted COVID-19 (ICE 2020b).

On April 12, the Washington Post reported on an El Salvadoran detainee, desperate to leave the Farmville Detention Center in Prince Edward County, Virginia, where lawyers reported that an “entire dorm — where more than 60 people sleep — has been quarantined” (Lang 2020). According to ICE, by July 29, 2020, 290 detainees at the Farmville Detention Center had contracted COVID-19 (ICE 2020b).

On April 23, National Public Radio reported on a 65-year-old Pakistani immigrant who has lived in the United States for 22 years, and now shares a small cell at the McHenry County Jail in Illinois with a man “‘who coughs all night’” (Zamudio 2020). According to ICE, by July 29, 2020, one detainee at the McHenry County Adult Correctional Facility had contracted COVID-19 (ICE 2020b).

On April 28, The Intercept reported on reprisals against detainees who had been communicating their fears to family members, reporters, and the broader public through tele-conferencing apps and other means (Nathan 2020). At Irwin County Detention Center in Georgia, one woman recounted that an ICE official told her and fellow protestors that “‘the hospitals are filled and there’s no place to send us … that ICE’s only job is to deport us, and they make their money doing that … that we were like roaches that ICE keeps in boxes. To make money.’” (ibid.). Subsequently, detention officials placed several of these women in solitary confinement, held them incommunicado, and pressured them to sign papers saying they had “acted improperly” in making a video regarding their situation. According to ICE, by July 29, 2020, 23 detainees at the Irwin County Detention Center had contracted COVID-19 (ICE 2020b).

On May 8, Nicholas Morales, who participated in a hunger strike at Elizabeth Detention Center in New Jersey, described the detainees’ feelings of “being left to die” after a guard contracted COVID-19 (Morales 2020). Detainees lived in dormitories of 40 persons, with only two to three feet between beds. They “shared toilets, showers, sinks, communal surfaces and breathing air,” were denied hand sanitizers and masks, and could not disinfect “shared surfaces” (ibid.). It ultimately took a federal court order for Morales – the spouse and parent of US citizens who himself had arrived in the United States as a child – to be released. According to ICE, by July 29, 2020, 18 detainees at the Elizabeth Detention Center had contracted COVID-19 (ICE 2020b).

On May 17, Choung Woong Ahn, a 74-year-old South Korean committed suicide at the Mesa Verde ICE Processing Center in Bakersfield, California (ICE 2020j). Ahn had “diabetes, hypertension and several heart-related issues,” putting him at risk of death if he contracted COVID-19. Since March, a group of attorneys had been requesting his release. Ahn’s brother said: “‘He did not deserve to be treated this way. He’s a human being, but to them, he’s just a

81 Detainees reported on overcrowding, lack of protective equipment, fellow detainees with COVID-19 symptoms, and unsanitary conditions.

number. There are other people in the same situation. It shouldn’t be happening again.’” In response to Ahn’s death, ICE announced that it was “undertaking a comprehensive agency-wide review of this incident” (ibid.). According to ICE, by July 29, 2020, one detainee at the Mesa Verde ICE Processing Center had contracted COVID-19 (ICE 2020b).

In a June 15 report, Shakira Najera Chilel, an asylum-seeker from Guatemala, expressed fear of contracting COVID-19. “‘I feel completely dead,’” she said. Chilel is detained at the Eloy Federal Contract Facility in Arizona, administered by CoreCivic, where the number of infected detainees increased six-fold over a single week-end (Reznick 2020), and stood at 132 on June 16 (ICE 2020b). According to ICE, by July 29, 2020, 252 detainees at Eloy had contracted COVID-19 (ibid.).

In a June 29 article, BuzzFeed News reported on an asylum-seeker from Ecuador who had been kidnapped and held with her 4-year-old-daughter for six-weeks in Mexico, before the two were forcibly separated (Flores 2020). Her unit at the El Paso Service Processing Center had recently been quarantined for the third time, after a new detainee tested positive for COVID-19. The woman has severe health problems and fears she will contract COVID-19 before she can be reunited with her daughter. According to ICE, by July 29, 2020, 162 detainees at the El Paso Service Processing Center had been infected with COVID-19 (ICE 2020b).

On July 23, CNN reported that 74 percent of detainees (268 in total) at the ICE detention center in Farmville, Virginia had contracted COVID-19, up from 49 cases in just one month (Alvarez 2020). Of 74 detainees transferred to the facility, 51 tested positive for COVID-19. Detainees reported that staff continued to intermingle with infected detainees and the general population. “We’re just stuck in here,” said one detainee. “We can’t do anything about it” (ibid.).

**VIII. Conclusion and Policy Recommendations**

Immigrant detention is intended to serve two main purposes, to ensure that non-citizens appear for their removal proceedings, and, in rare cases, to protect the public. As an overarching rule, DHS/ICE should select the “least restrictive” means at its disposal to safeguard the persons in its custody, to ensure they appear for their hearings, and protect the public. It should use detention as a last resort, not as its default option.

“As an overarching rule, DHS/ICE should use detention as a last resort, not as its default option.”

In the current circumstances, detention imperils detainees, detention staff, contractors, court officials, health care providers, and the members of communities near facilities to which detainees ultimately return. ICE has adopted – abetted by CDC – unenforceable policies and practices that fail to reflect the severity of this crisis. It cannot safeguard those in its custody and should move with greater dispatch to release far more detainees.

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83 Id.

84 ICE is already obligated to “consider placement in the least restrictive setting available” for 18-year-old detainees after they “age out” of ORR custody at age 18. 8 USC §1232(c)(2)(B).
The Heroes Act, which the House of Representatives passed on May 15, 2020, would require DHS to review the files of detainees during the current public health emergency in order to assess the “need for continued detention.”

85 The Act would also require ICE to prioritize non-mandatory detainees for release on recognizance or to an alternative to detention program.

“ICE has adopted - abetted by CDC - unenforceable policies and practices that fail to reflect the severity of this crisis. It cannot safeguard those in its custody and should move with greater dispatch to release far more detainees.”

ICE should also thoroughly review and assess the possibility of release for mandatory detainees. In addition, the administration should work with Congress to eliminate mandatory detention. In the meantime, ICE should make its alternative to detention programs available to “mandatory detainees” by formally acknowledging that these programs – many of which have strict tracking and reporting requirements – constitute a form of detention.

ICE has abundant experience in administering ATD programs, and both private corporations and non-profit organizations have extensive experience in running them. 86 Well-structured ATD programs have consistently ensured high court appearance rates (USCCB-MRS and CMS 2015). DHS/ICE should particularly support the establishment of “community- and case management-based” programs (Women’s Refugee Commission 2019), that can isolate, treat, and care for infected or exposed former detainees. The overarching need remains to expedite and expand releases, and to overcome the countervailing financial, bureaucratic, and ideological incentives to sustain the troubled US detention system in its current form.


86 As of July 25, 86,847 persons were enrolled in ATD programs, which provide various levels of supervision (ICE 2020a). However, participation in these programs has remained relatively flat over the course of the pandemic.
References


