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

19 FAOUR ABDALLAH FRAIHAT, *et al.*,
20 Plaintiffs,
21 v.
22 U.S. IMMIGRATION AND CUSTOMS
23 ENFORCEMENT, *et al.*,
24 Defendants.

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

**Supplemental Declaration of
Homer Venters in Support of
Plaintiffs' Reply Brief in Support
of Emergency Motion for
Preliminary Injunction**

Date: April 13, 2020
Time: 9:00 a.m.
Hon. Jesus G. Bernal

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**Pro Hac Vice Application Forthcoming

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

3 **Factual Developments Regarding COVID-19 Since My Prior Declaration**

4 1. In the past two weeks, COVID-19 has entered into correctional
5 facilities, including numerous ICE detention centers, as predicted. ICE reports that,
6 as of April 7, there have been 19 detained people in 11 facilities, 11 ICE
7 employees in 6 facilities, and 60 ICE employees not assigned to a facility who
8 have all tested positive for COVID-19.¹ This is likely just the tip of the iceberg in
9 terms of the number of ICE staff and detainees who are already infected but are
10 unaware due to the lack of testing nationwide, and the fact that people who are
11 infected can be asymptomatic for several days.

12 2. New information about the transmissibility of COVID-19 has also
13 been revealed that is relevant to the health of ICE detainees and staff.

14 a. COVID-19 appears to be transmissible through aerosolized fecal
15 contact. This is relevant because the plume of aerosolized fecal
16 material that occurs when a toilet is flushed is not addressable by
17 closing the lid of ICE detainee toilets, which lack a lid. This mode of
18 transmission would pose a threat to anyone sharing a cell with a
19 person who has COVID-19 and could occur before a person becomes
20 symptomatic. This mode of transmission could also extend beyond
21 cellmates, especially in circumstances where common bathrooms exist
22 or where open communication between cells exists.²

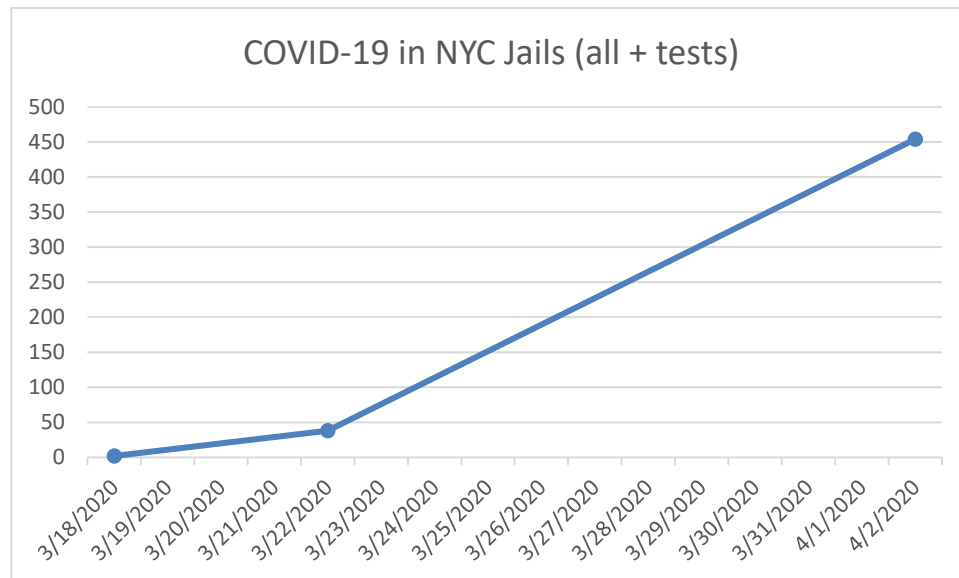
23 b. CDC and state guidelines now recommend the use of protective masks
24 for anyone who is in close contact with others, at less than 6 feet
25

26 ¹ *ICE Guidance on COVID-19*, IMMIGRATION & CUSTOMS ENFORCEMENT (Updated
27 Apr. 3, 2020), <https://www.ice.gov/coronavirus>.

28 ² <https://www.medpagetoday.com/infectiousdisease/covid19/85315>

distance.³ This recommendation would apply to staff and detainees alike.

- c. The rate of COVID-19 infection spread in correctional settings is extremely rapid. The data from the NYC jail system reveal that in the space of two weeks, the facility went from zero confirmed infections, to 2, then 38, then 574.⁴



This rapid rate of increase in COVID-19 infections in detention settings has overwhelmed local hospitals and required the deployment of National Guard troops in several states to supplement the lack of staffing and resources.⁵ This rapid spread has also resulted in up to half of all detained people and housing areas in a given facility being placed into quarantine as each new case emerges and the close

³ <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover.html>

⁴ *Board of Correction Daily Covid-19 Update*, NEW YORK BD. OF CORR. (updated Apr. 3, 2020), https://www1.nyc.gov/assets/boc/downloads/pdf/News/covid-19/Public_Reports/Board%20of%20Correction%20Daily%20Public%20Report_4_3_2020_TO%20PUBLISH.pdf.

⁵ <https://www.cantonrep.com/news/20200406/coronavirus-dewine-sending-national-guard-to-elkton-federal-prison-east-of-canton-after-3-deaths> And <https://abc7chicago.com/health/illinois-prisoners-sick-with-covid-19-overwhelm-joliet-hospital/6064085/>

1 contacts for each case enter into quarantine for 14 days. For facilities
2 operating at over 75 percent of capacity, this process will be
3 essentially impossible as newly identified cases require initiating
4 quarantine areas for a prescribed 14-day period and housing areas are
5 not available for these date-based cohorts. The consequence will be
6 either a) mixing of different quarantine cohorts, which will not only
7 extend the effective quarantine period past 14 days but also increase
8 the spread of potentially infected people from different areas of the
9 facility, or b) failure to establish quarantine cohorts all together,
10 meaning that close contacts of cases will remain mixed with other
11 detainees, also increasing the spread of COVID-19 throughout the
12 facility.

13 **ICE Guidelines Contradict or Omit Several Important CDC Guidelines**

14 3. I have reviewed ICE's March 6 and March 27, 2020 documents
15 addressing COVID-19, as well as declarations by ICE Captain Moon and IHSC
16 Physician Rivera and the webpage that ICE has established concerning COVID-19.
17 I have also reviewed the April 4, 2020 guidance from ICE Enforcement and
18 Removal Operations. Collectively, these policies continue to be deficient and at
19 odds with recommendations of the CDC regarding detention settings in a manner
20 that threatens the health and survival of ICE detainees.

- 21 a. ICE protocols and guidance fail to address the key recommendation of
22 the CDC on the need for adequate intake screening of detainees. CDC
23 guidance makes clear that everyone arriving in a detention facility
24 should be screened for signs and symptom of COVID-19, but ICE
25 protocols rely on questions about travel or other known contacts as a
26 precursor to temperature checks and other sign and symptom checks.
27 ICE protocols and guidance also fail to clearly mandate that all
28

1 symptomatic patients be immediately given a mask and placed in
2 medical isolation, and that all staff who have further contact with that
3 patient wear personal protective equipment, as set forth in the CDC
4 guidelines. The ICE protocol also fails to address the now-standard
5 CDC advice that everyone who cannot engage in social distancing
6 wear a face covering.⁶

7 b. ICE protocols and guidance fail to address the key recommendation of
8 the CDC on the need for monitoring and care of symptomatic patients.

9 i. The CDC guidelines make clear that patients who exhibit
10 symptoms of COVID-19 should be immediately placed in
11 medical isolation. ICE guidelines and protocols only invoke this
12 response for newly arrived detainees who also answered yes on
13 screening questions. This approach results in a failure to
14 actively screen the large majority of detainees: people who are
15 already detained.

16 ii. CDC guidelines clearly indicate the need for twice-daily
17 monitoring of patients who are symptomatic or in quarantine,
18 and ICE only mandates a daily check.

19 iii. ICE makes no mention of access to masks for patients in
20 quarantine settings.

21 iv. ICE fails to present a plan for how isolation will be conducted
22 when the number of people exceeds the number of existing
23 isolation rooms or cells. This is almost certain to occur in the
24 coming weeks at multiple facilities.

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27 ⁶ [https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-](https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html)
28 [coverings.html](https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html)

- 1 c. ICE protocols and guidance fail to address the key recommendation of
2 the CDC on the need for social distancing. ICE's March 27 memo
3 mentions social distancing briefly, but fails to address how ICE
4 facilities will enact modified meal or recreation times and also fails to
5 address the most common scenarios in which high risk detainees find
6 themselves in close quarters, including shared cells, medication lines,
7 bathroom facilities, common walkways and day rooms, sally ports and
8 transportation. This critical issue is also ignored in the declarations of
9 Captain Moon. Again, because there is no cure for COVID-19, social
10 distancing remains the most effective means of prevention, and ICE
11 has failed to meaningfully implement this precaution into its guidance.
- 12 d. ICE protocols and guidance fail to address the key recommendation of
13 the CDC on the need to limit transportation of detainees as a means to
14 limit the spread of COVID-19. CDC guidelines state that transfers
15 should be limited to those that are absolutely necessary and that
16 receiving facilities must have capacity to isolate symptomatic patients
17 upon arrival. ICE protocols and guidance fails to address these issues.
18 CDC guidelines make clear the need for a clear plan for all aspects of
19 transport of suspected COVID-19 infected people, and ICE does not
20 have or report such a plan. This critical issue is also ignored in the
21 declarations of Captain Moon.
- 22 e. ICE protocols and guidance fail to address the key recommendation of
23 the CDC on the need for environmental cleaning of both housing
24 areas and other common spaces within facilities. CDC guidelines
25 provide clear details about the types of cleaning agents and cleaning
26 processes that should be employed, while ICE provide no guidance to
27 facilities on this critical issue. The declarations of Captain Moon that
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1 state generally that ICE is providing adequate environmental cleaning
2 stand in stark contrast to the declarations of detainees to the contrary,
3 cited in my previous report. The reliance on detainees for conducting
4 critical environmental cleaning, without proper training, protection or
5 supervision, represents a gross deviation from correctional practices,
6 and will likely contribute to the spread of COVID-19 throughout the
7 ICE detention system.

- 8 f. ICE protocols and guidance fail to address the key recommendation of
9 the CDC on the need for adequate staffing and training of staff. ICE's
10 March 27 memo simply states that "facilities are expected to be
11 appropriately staffed," but provides no guidance whatsoever on how
12 that can be accomplished in the context of existing staffing gaps, a
13 decreased workforce, and increased needs resulting from steps
14 required to screen, monitor and treat detainees for COVID-19. CDC
15 guidelines make clear the need for a concrete plan for ensuring
16 adequate staffing as part of the COVID-19 response. These guidelines
17 also make clear the need to orient staff to the critical need to stay
18 home if and when they experience symptoms of COVID-19 infection.
19 In sum, aside from its March 27 "expectation" of appropriate staffing
20 levels, ICE has not implemented any meaningful oversight system to
21 ensure that staffing levels are appropriate. Critically, appropriate
22 staffing levels refers not only to a sufficient number of staff but also
23 to a sufficient number of qualified staff. In my experience, many
24 facilities rely heavily on guards and LPNs to do medical work that
25 they are not qualified to do; likewise, many facilities rely on RNs to
26 do medical work that only doctors or physician-assistants are qualified
27 to do. There is no indication whatsoever that ICE is implementing
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1 procedures to ensure not only sufficient numbers of staff but also
2 sufficient numbers of qualified staff. The declaration of Dr. Rivera
3 confirms that ICE is relying on an emergency staffing plan from 2014,
4 updated in 2017, but the current shortages in staffing for health staff
5 in particular, stretch across all communities, and staffing shortages
6 represent a real emergency in many settings already. This is
7 particularly concerning given that many ICE facilities are located in
8 rural areas far from qualified medical professionals. This is a very
9 serious defect that must be immediately remediated because access to
10 qualified medical professionals is crucial during this rapidly evolving
11 pandemic.

- 12 g. Several CDC guidelines address people with factors that put them at
13 an increased risk of significant injury or death, but the ICE protocols
14 do not even identify what precautions should be taken to protect
15 people with those risk factors in ICE custody. In addition, the Apr. 4
16 list of risk factors for serious illness and death from COVID-19
17 infection developed by ICE is inconsistent with CDC guidelines and
18 fails to adequately advise facilities on which detainees are at elevated
19 risk. This list is included in a memo to Field Office Directors
20 regarding Docket Review, and fails to include very basic risk factors
21 identified by the CDC, including body mass index over 40 and being a
22 current or former smoker.⁷ By apparently assigning this process to
23 field directors and their staff, who are not medical professionals,
24 advising security staff to check with medical professionals after the
25 fact, and failing to include CDC-identified risk factors, this docket
26

27 ⁷ [https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-](https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html)
28 [higher-risk.html](https://www.cdc.gov/mmwr/volumes/69/wr/mm6913e2.htm) And <https://www.cdc.gov/mmwr/volumes/69/wr/mm6913e2.htm>.

1 review process will likely leave many people with true risk factors in
2 detention. This is particularly the case if they're detained under
3 certain immigration law provisions, where the guidance recommends
4 officers not release them despite risks. Thus, the guidance appears to
5 be just that – guidance, and the risk factors are not determinative. In
6 fact, the guidance appears to not make these risk factors determinative
7 for release—even for people who are not subject to mandatory
8 detention. ICE also identifies people under that age of 60 in this
9 cohort but the age of 55 is appropriate. Because detained people have
10 consistently been identified as having higher levels of health problems
11 that reflect 10-15 years more progressed than chronological age,
12 numerous organizations and research studies have used the age of 55
13 to define the lower limit of older detainees.⁸ ICE also limits the high
14 risk period for women to 2 weeks after child birth, yet one of the most
15 serious increased risk during pregnancy is hypercoagulable state,
16 which increases the risk of blood clots in the large veins of the lower
17 extremities, and sometimes in the lung which can prove fatal. This
18 risk extends to 6 weeks post-partum and also occurs independently
19 with COVID-19 infection.⁹ Accordingly, ICE should include these
20 definitions in its list of risk factors. ICE should also put in place a
21 mechanism to ensure that risk factors reflect the evolving science and
22 data concerning COVID-19, since it is likely that additional risk
23 factors will emerge as more data is collected. The declaration of Dr.

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25 ⁸ <https://nicic.gov/aging-prison> and
26 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3464842/>

27 ⁹ <https://www.acog.org/patient-resources/faqs/womens-health/preventing-deep-vein-thrombosis> And
28 <https://www.medpagetoday.com/infectiousdisease/covid19/85865>.

Rivera not only fails to identify what risk factors are being considered by ICE medical staff, but also fails to mention any plan to determine which currently detained people have these risk factors, and what special protections, if any, will be created for this high-risk cohort.

ICE's Inadequate Response to COVID-19 in Areas Where There is no Direct CDC Guidance

4. Numerous and significant failures of the ICE response to COVID-19 also exist in areas in which the CDC does not provide direct guidance, but that detention facilities must implement. These failures threaten the health and survival of ICE detainees.

a. Neither the ICE COVID-19 protocols nor the declarations set forth any policies or protocols addressing release of medically vulnerable detained people in light of the significant risks to those people posed by COVID-19. This must be done immediately and is in contrast to the efforts made in many prison and jail systems across the country. The Apr. 4 promulgation of an incomplete list of risk factors in a memo relating to discretion for release occurs in a complete vacuum of guidance on special protection and clinical management of people with those risk factors while in detention. This Memo describes an overly discretionary decisionmaking process for release that does not sufficiently favor depopulation as public health requires and that has no urgency to it. Reviews and releases must be undertaken immediately.

b. ICE does not have any mechanisms to monitor or promote the health of all people in its charge. This failure is documented in many reports about ICE's inadequate healthcare system, but now poses a grave risk to their survival as ICE struggles to mount a competent response to

COVID-19 across more than 150 facilities, on behalf of roughly 40,000 detainees and almost as many direct and contract staff. The declaration of Dr. Rivera reflects that no incident command system is in place to manage this response, and reporting and communication among direct and contract health and security leadership of the ICE detention system occurs in a fragmented, one-way, or as-needed basis.

- i. ICE's March 27 memo takes the dangerous approach of limiting clinical guidelines for COVID-19 response to the detainees being provided direct care by ICE health services corps (IHSC) staff, which represents approximately 13,000 detainees.¹⁰ As a result, detention centers operated by public and private contractors are not provided with this guidance. This approach to management of the COVID-19 outbreak ensures that vital information will remain in these facilities, instead of being acted upon by ICE. As a result, ICE will not know when its own policies or even basic standard of infection control are being followed. ICE's failure to properly monitor and oversee medical care at its detention centers has been a chronic concern in the health services provided to ICE detainees prior to this outbreak and has been cited as a core failure of ICE in its obligations to establish quality assurance throughout its detention network.¹¹ There is no indication that ICE can adequately monitor the response across its system to COVID-19. Absent robust and centralized oversight, ICE will

¹⁰ <https://www.ice.gov/ice-health-service-corps> and

¹¹ <https://www.oig.dhs.gov/sites/default/files/assets/2019-02/OIG-19-18-Jan19.pdf>
And <https://www.oig.dhs.gov/sites/default/files/assets/2019-06/OIG-19-47-Jun19.pdf>

1 not be able to provide a coordinated response informed by on-
2 the-ground data from detention centers. This is in stark contrast
3 to many prison systems across the country that are coordinating
4 their efforts, including with health departments.

5 ii. ICE has no plan or even capacity to provide daily clinical
6 guidance to all of the clinical staff it relies on to care for ICE
7 detainees, whether at ICE-operated facilities or contract
8 facilities. This is a core failure because of the new nature of
9 COVID-19 and constantly changing clinical guidance on how
10 to treat patients. Daily briefings with health administrators and
11 medical and nursing leadership should be held, which are both a
12 core aspect of outbreak management and provide a critical
13 avenue for receiving feedback on real-time conditions inside
14 facilities. ICE has not articulated any plan to ensure that this
15 type of basic communication is in place across its network of
16 detention settings. This guidance should also include uniform
17 recommendations on when and how to transport patients to the
18 hospital. Failure to implement this kind of procedure—
19 particularly in light of the other defects described herein—poses
20 a significant risk to the health and lives ICE detainees.

21 iii. ICE has failed to establish the type of COVID-19 surveillance
22 that is required to manage their COVID-19 response. Because
23 ICE is responsible for approximately 40,000 lives inside over
24 150 facilities, with a wide variety of contract and administration
25 types, ICE leadership, namely the IHSC, must establish a
26 competent surveillance system for COVID-19 that includes, at a
27 minimum, a dashboard reflecting critical and real-time
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information for clinical cases and facility resources. A dashboard is a collection of real time data used to manage healthcare and other operations, and COVID-19 dashboards are now used by every state and the federal government to manage their day to day resource and clinical responses to this pandemic.¹² My experience during H1N1 when my team and I needed to create an outbreak dashboard for 13 jails holding 15,000 patients was that we were able to design and implement this approach in a 3-4 week timeline, but that we established data streams from hotspots and most impacted facilities within a week. This approach for ICE would include, but not be limited to the following variables and would be utilized by IHSC leadership to track each individual facility and then roll up to State, regional and national dashboards;

Clinical Surveillance (number of detainees)					
Number of symptomatic (w and w/o CDC risk factors)	Number awaiting/received tests (w and w/o CDC risk factors)	Number positive tests (w and w/o CDC risk factors)	Number of detainees in quarantine (w and w/o CDC risk factors) quarantine* ¹³	Number of patients awaiting/in/returned from hospital for COVID-19 (w and w/o CDC risk factors)	Number of patients awaiting/in/returned from hospital for COVID-19(w and w/o CDC risk factors)
Resource allocation					
Deficit in security FTE	Deficit in nursing/mid-level/MD FTE	PPE deficits by masks/gowns/gloves etc.	Cleaning, soap, hand sanitizer	Sinks and other plumbing not operational	Restrictions in local hospital beds ¹⁴

¹² Example of FL State COVID-19 dashboard
<https://experience.arcgis.com/experience/96dd742462124fa0b38ddedb9b25e429>.

¹³ An additional data mandate for every facility is to create a histograms that shows the number of people in quarantine for each of the 14 days. so that the facility. State, regional and national data can show the trends in quarantine and new cases.

¹⁴ Many correctional facilities are already experiencing restrictions from local hospitals. Some local hospitals have informed detention centers that they will only accept COVID-19 patients, while others have restricted all access.

			supply deficits		
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This centralized surveillance is absolutely necessary in COVID-response. On the clinical side, some local hospitals have already closed their doors to incarcerated patients and the lack of access of ICE patients to hospital-level care (such as intensive care beds and respiratory rehabilitation) should be a core concern for ICE--not one that can be resolved by local facilities alone. On the resource side, the staffing requirements are extremely acute in detention settings and the deployment of the Ohio National Guard in a prison in Ohio should trigger immediate high-level review of staffing, PPE and other resources issues across the ICE network. ICE's surveillance system must also account for the availability of hospital beds and intensive care unit beds (as well as other hospital-level equipment, such as ventilators, that are lacking in facilities but crucial for COVID-19 treatment). Currently ICE appears not to provide this kind of crucial surveillance and coordination. In addition, many patients will require nursing home placement in subacute care settings, a resource traditionally inaccessible to most ICE detainees because of their lack of insurance status. Absent tracking of this kind of crucial data, ICE will not be able to ensure that individuals in its custody have access to life-saving medical care. One critical measure in assessing staffing is to measure the staffing *deficit* (unmet need) to perform the work of the facility, not use the baseline staffing matrix. If a facility has 1,000 detainees and regularly employs 150 security staff, 5

1 physicians and 25 nurses across three shifts, by example, the
2 arrival of COVID-19 in the facility will require significantly
3 more work to be done, with additional security and nursing staff
4 working in quarantine units and medical clinics particularly,
5 and additional security staff needed to enable social distancing,
6 which is a labor intensive process.

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

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

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

26
27 Signature:

28 

Homer Venters MD, MS

Date: 4/9/2020

Location: Port Washington, NY