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

FAOUR ABDALLAH FRAIHAT, *et al.*,

Plaintiffs,

v.

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, *et al.*,

Defendants.

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

THIRD SUPPLEMENTAL DECLARATION OF DR. HOMER VENTERS

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THIRD SUPPLEMENTAL DECLARATION OF DR. HOMER VENTERS

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

Background

1. My name is Homer Venters. I am a physician, internist and epidemiologist with over a decade of experience in providing, improving and leading health services for (n)8.3 oS3.6 (r)12Heitte i (e)3ew6c (e)6dl (t)8.5(t.)6.1 Ioraen prw (vi)8.5 (o 2ng,

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

Need for Restriction of Transfers

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

10. Detained individuals continue being transferred daily without universal testing. For example, on June 16, 2020, the Director of Farmville confirmed that 34 people who had been recently transferred to Farmville tested positive for COVID-19 upon arrival. Feldman Decl. ¶ 27. This was not an isolated incident, as transfers are occurring in and out of detention facilities systemwide. *See* Doubossarskaia Decl. ¶ 34 (reports individuals being transferred to and from IAH, Conroe, and South Louisiana); *See* Vosburgh Decl. ¶ 17 (reports 30 individuals transferred to ICE custody at Etowah within the last 2 weeks). One who tested positive for COVID-19 after his

medically vulnerable individuals. Accordingly, the CDC has emphasized that transfers of detained people must be restricted to abate the spread of CO] ls.

13. There are several approaches that ICE should implement in order to mitigate the risk of spreading COVID-

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

19. Declarations of providers and detained individuals show that testing remains inadequate throughout the country. For example, at the Farmville, Virginia

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

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

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

26. I am aware of detained people reporting that swab samples are collected by non-health staff and that the techniques utilized do not appear to be standardized, including nasal swabs of the outside of the nose or very proximal area of the nostril. Health staff should be conducting these tests

27. An additional issue for ICE is whether tests have already been performed using tests with unacceptably high false-

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

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

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

34. Moreover, there is no doubt that placement into a cell designed for solitary confinement for 23 or 24 hours per day represents a psychological stressor and threat to mental health. For example, Mr. Aguirre reports that he was placed into the solitary co (kl)8.5 (s)]TJ0 ooA5 (s)]TJ

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

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

45.

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

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

56. For example, the checklists or surveys utilized by ICE fail to address the identification and care of high-risk detainees. As mentioned above, every high-risk patient should have an encounter with a physician or mid-level provider to assess their specific risks for COVID-19 and create a plan of care. Since the high-risk detainees have largely been identified, a checklist could be utilized to ensure that every person in this cohort has received this type of encounter. More generally, the checkl-(he)3.6 (c)12.4n in this cicri 949 2.637008

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

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

June 22 Revisions to PRR

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

63. As an initial matter, the PRR revisions fail to me12.2 (s)8.4 (t1 ())8.5 (he)3.6(d)8.3 ((to)T