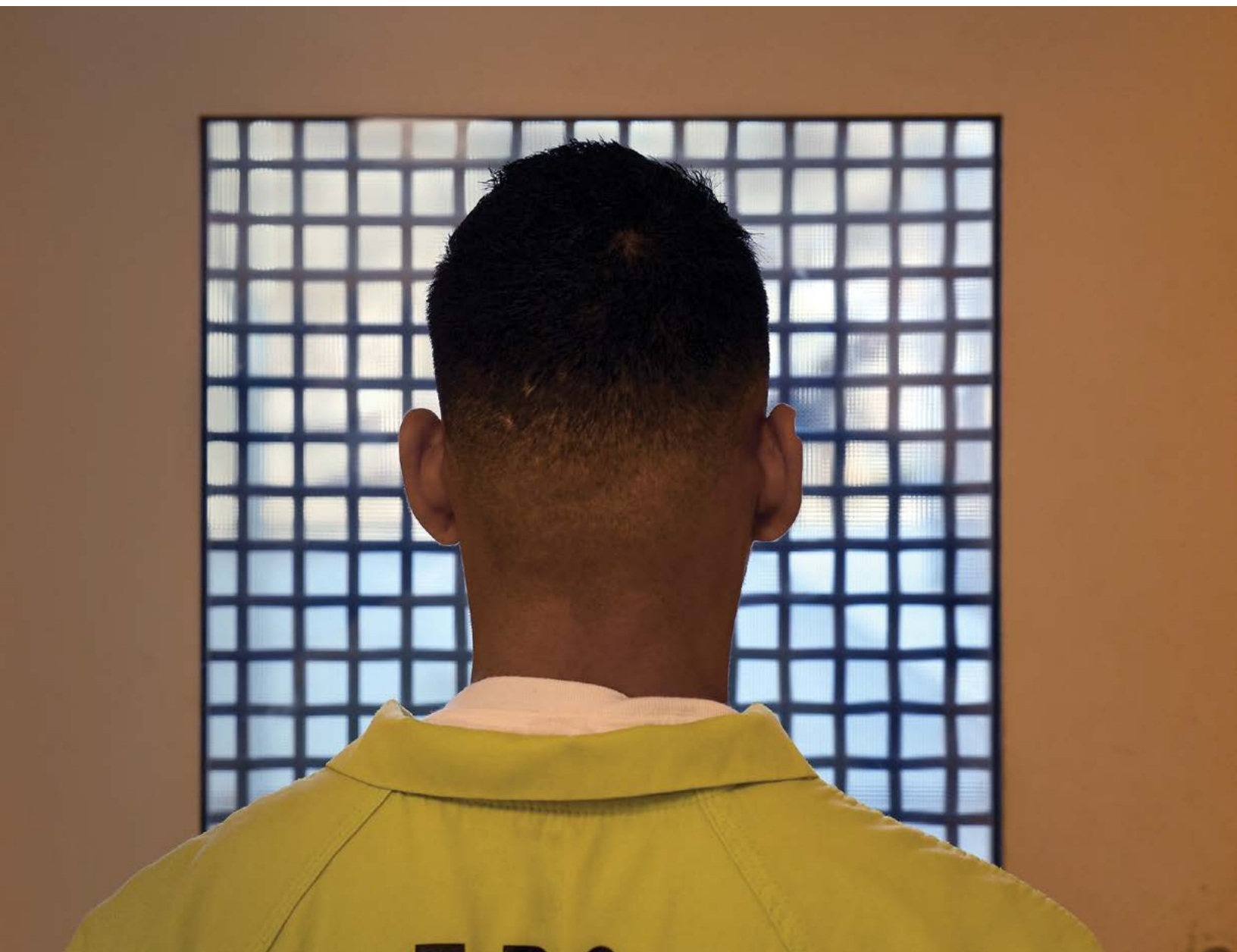


Praying for Hand Soap and Masks

Health and Human Rights Violations in U.S.
Immigration Detention during the COVID-19 Pandemic

Executive Summary

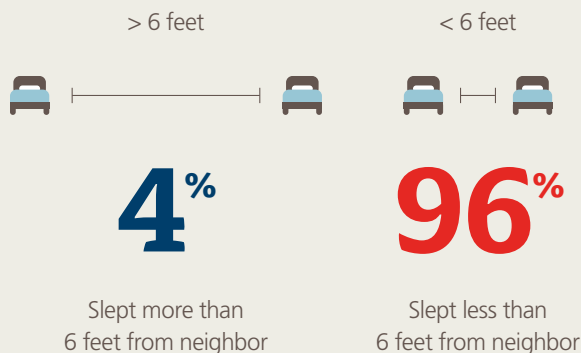
January 2021



The Risks of COVID-19 in U.S. Immigration Detention

Lack of Social Distancing in ICE Detention

Nearly all detainees slept less than six feet from their neighbor.



Masking Is Not Universal in ICE Detention

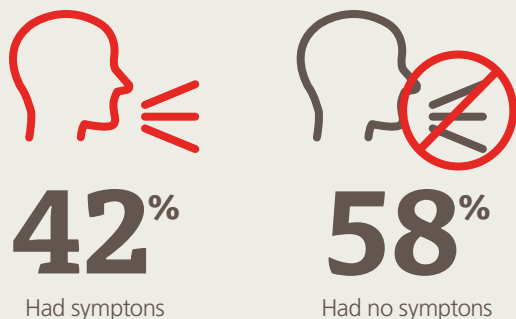
Detainees could not adequately protect themselves against COVID-19.*



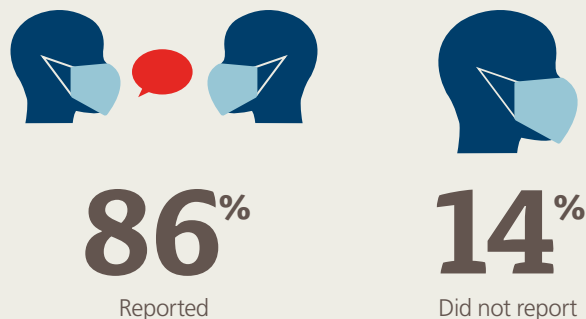
Inadequate Protocols for Symptomatic ICE Detainees

Majority were not tested or isolated after reporting symptoms.

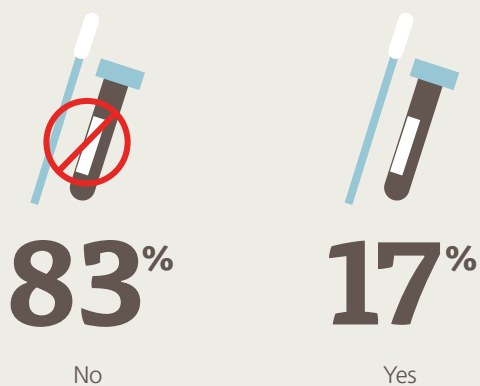
Participant had COVID-19 Symptoms in Detention**



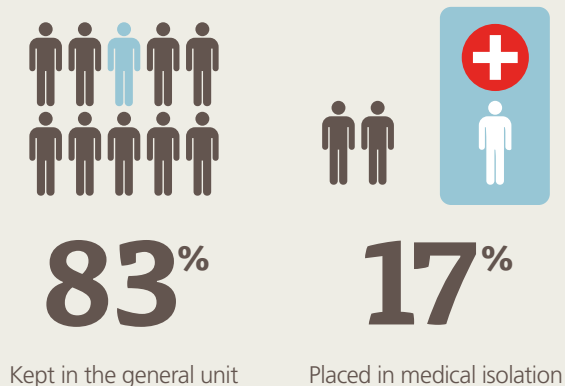
Participant Reported Symptoms to Staff+



Tested for COVID-19 if Reported Symptoms**



Location Placed After Reporting Symptoms**



Source: PHR-Harvard Medical School study of 50 immigrants held in Immigration and Customs Enforcement detention after March 15, 2020.

* Percentages from 41 interviewees detained after ICE established mask recommendation (April 10, 2020).

** Percentages from 50 interviews.

+ Percentages from the 21 interviewees who had symptoms.

++ Percentages from the 18 interviewees who reported symptoms to staff.

Executive Summary



*A security guard patrols outside Otay Mesa Detention Center, CA during a protest following the death there of Carlos Ernesto Escobar Mejia, the first person to die of COVID-19 in ICE detention.
Photo: Sandy Huffaker/AFP/Getty Images*

Physical and psychological abuse and inadequate medical care have long been documented in U.S. Immigration and Customs Enforcement (ICE) facilities, where previous infectious disease outbreaks were poorly contained. In 2020, as the COVID-19 pandemic spread across the United States, it became clear that ICE's continued negligence, coupled with the vast expansion of U.S. immigration detention, would likely lead to a public health disaster.

Given the lack of transparent data and the severe health risks in congregate settings caused by the pandemic, Physicians for Human Rights (PHR) staff and Harvard Medical School faculty and students sought to document conditions experienced by people recently released from U.S. immigration detention. From July 13 to October 3, 2020, the research team conducted 50 interviews of immigrants formerly detained by ICE using a standardized questionnaire covering 1) Demographics; 2) COVID-19 education; 3) Hygiene and sanitation measures; 4) COVID-19 testing and medical management; and 5) Protests and retaliation. The 50 participants were detained at 22 different ICE detention facilities – representing nine county facilities and 13 private facilities – in 12 different states. Overall, 52 percent of interviewees reported at least one comorbidity that placed them at an absolute high risk of severe COVID-19 if they contracted the virus. All study participants were 18 years of age or older, in the United States at the time of the interview, and had been held in ICE detention with a release date on or after March 15, 2020.

Information reported by the interviewees uncovered significant shortcomings in ICE's response to the virus. Staff efforts to inform people about COVID-19 were limited and inconsistent. The vast majority of respondents (85 percent) first heard about COVID-19 in detention by watching the news on television, while ICE staff in some facilities attempted to downplay the significance of COVID-19 and actively prevented people from learning about the virus from the news by asking them to change the television channel.

Nearly all immigrants interviewed were unable to maintain social distance throughout the detention center. Eighty percent reported never being able to maintain a six-foot distance from others in their eating area. Some 96 percent reported that they were less than six feet from their nearest neighbor when sleeping. The average distance reported between beds was 2.87 feet. Twenty-seven people reported that when new individuals entered the detention center after March 15, they were not quarantined for two weeks before entering the general unit.

Forty-two percent of participants reported not having access to soap at some point during their detention. When soap or hand sanitizer was not available, some participants reported resorting to using shampoo to wash their hands, and one even used toothpaste. Thirty-six percent of participants reported relying on purchasing soap from the commissary. Several people relied on donations from outside organizations, while others had to forgo other basic

“People had to choose between buying food from the commissary or bar soap, they couldn’t afford both.”

25-year-old man, Port Isabel Detention Center

necessities to purchase soap. Eighteen percent of participants reported most commonly using water alone to wash their hands. Eighty-two percent of people reported not having access to hand sanitizer anywhere in the detention facility. Twenty-six percent of participants reported never observing disinfection of frequently touched surfaces in common areas (e.g. doorknobs, light switches, countertops, recreation equipment). The overwhelming majority (83 percent) reported that detainees disinfected the common areas themselves.

Twenty-one out of 50 people interviewed (42 percent) experienced symptoms of COVID-19 during the pandemic, such as fever, cough, muscle aches, and loss of smell. Three out of these 21 (14 percent) never officially reported their symptoms due to fear of being sent to solitary confinement or other punishment, or anticipation of denial of medical care. Out of all respondents who reported symptoms, only 17 percent (three people) were appropriately isolated from the general population and tested for COVID-19, one of whom tested positive. The remaining 83 percent (15 people) reported their symptoms to facility staff members but did not get tested for COVID-19 and were not isolated.

Interviewees reported facing prolonged wait times before being able to see a medical professional, with an average wait time of 100 hours (approximately four days). One person reported having had to wait a total of 25 days for an appointment. Importantly, two people were never seen by a medical professional at all, even after reporting their symptoms to staff members.

While 88 percent of all participants (44 people) had at least one comorbidity placing them at possible increased risk of severe COVID-19, 56 percent (28 people) reported these risk factors to detention staff, but only four of them were told that they were at high risk of having a serious illness with COVID-19. None of those four were given the option to have an individual room.

Forty-three study participants (86 percent) stated that they reported and/or protested about issues related to COVID-19, including verbally complaining to staff about unsanitary conditions or lack of personal protective equipment, filing formal grievances, going on hunger strikes, reporting conditions to lawyers, reporting conditions to the media, and sending messages to family members with the hope they would be publicized. Of these 43 who protested, 56 percent (24 people) reported experiencing acts of intimidation and retaliation after their complaints, including verbal abuse by detention facility staff, being pepper sprayed, being placed in solitary confinement, and experiencing threats or actions of limiting food, communication, or commissary access.

As civil detainees, people in immigration detention are entitled to due process under the Fifth Amendment of the U.S. Constitution and cannot be held in punitive conditions. The government cannot put people in danger or act with deliberate indifference to a foreseeable or obvious threat, and is required to provide for the reasonable health and safety of people in detention. The UN Standard Minimum Rules for the Treatment of Prisoners, which apply in all detention settings, confirm that health care for people who are detained is the responsibility of the state, and that health care also must follow public health principles in regard to management of infectious disease, including treatment and clinical isolation.



“I put in a medical request five times, the fifth time they finally saw me.... They didn’t listen to my lungs or ask me questions, they didn’t even let me sit down.”

41-year-old man from Ghana, held at Stewart Detention Center, GA

Underlying Risk Factors for Severe COVID-19: Asthma, Hypertension, Overweight

Symptoms Reported



Shortness of breath, fatigue

Waiting Time to See a Clinician



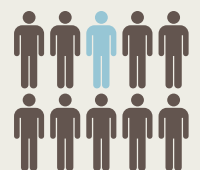
Hours

Tested for COVID-19



No

Location after Reported Symptoms



Kept in the general unit

Source: PHR-Harvard Medical School study of 50 immigrants held in Immigration and Customs Enforcement detention after March 15, 2020.

Recommendations

In fact, international law limits the use of immigration detention and prohibits criminalizing border crossing for asylum seekers. Article 31(2) of the UN Refugee Convention permits states to restrict refugee freedom of movement only when necessary, otherwise it may amount to a “penalty,” which is prohibited under the Convention. The UN High Commissioner for Refugees’ (UNHCR) Executive Committee considers detention of asylum seekers as meeting the necessity test only when the government detains people to verify their identity or issue documents, to make a preliminary assessment of their asylum claim, or based on an individualized security assessment. International standards consider immigration detention as a last resort and require periodic hearings for all types of detention in order to prevent arbitrary detention.

International bodies and U.S. federal courts have applied these standards to the context of the pandemic. The World Health Organization, the UN High Commissioner for Human Rights, and UNHCR stated in March 2020 that, given the risk of severe illness and death from COVID-19, people in immigration detention should be released “without delay.” U.S. federal courts have variously ordered ICE to locate and release people at high risk of severe illness or death due to the coronavirus, to give masks and sanitizer to detainees, to ensure availability of testing, and to take a range of precautionary measures, such as isolating people who test positive, temporarily halting intake, enforcing social distancing and mask wearing, and providing appropriate sanitary and hygiene supplies.

The harsh and punitive conditions reported in this study show that ICE practices did not comply with Centers for Disease Control and Prevention guidance or with ICE’s own Pandemic Response Requirements, creating unacceptable health risks which violated the constitutional and human rights of detainees. International law requires governments to use immigration detention only as a last resort, and the U.S. constitution prohibits punitive conditions in civil detention, requiring the government to ensure safe and healthy conditions. As an urgent matter, the U.S. government should release all people from immigration detention to allow them to safely shelter in the community, absent a substantiated individual determination that the person represents a public security risk. Safely releasing people from immigration detention is in accordance with international human rights and U.S. constitutional standards and represents the best way to prevent further outbreaks of COVID-19.

ICE neglected to practice even the most basic measures necessary for identifying, treating, and mitigating the spread of COVID-19 within its detention centers.

To the U.S. Department of Homeland Security:

- Immigration and Customs Enforcement (ICE) should use its discretionary authority to release all people from immigration detention and allow them to safely shelter in place in non-custodial settings, unless there is a substantiated individualized determination that the person represents a public security risk. Release should start with those who are over the age of 65 or have underlying conditions which may increase their vulnerability to severe illness and death from COVID-19; safe medical release should be coordinated with community groups;
- End detention of children and families. Families and children held in ICE detention centers must be immediately released together, in the best interest of the child;
- Scale up community-based alternatives to detention which are contracted to non-profit organizations;
- Fully implement recommendations of medical expert consultants to the Department of Homeland Security (DHS), DHS Office of the Inspector General (OIG), and DHS Office for Civil Rights and Civil Liberties, and ensure sanctions for non-compliance, including facility closure. Make inspection reports available to the U.S. Congress and to the public within 60 days of inspection;
- Fully comply with the 2009 Parole Directive by fully considering and granting parole and bond requests, absent an individualized assessment that the person presents a threat to public safety or a flight risk;
- Establish an Ombudsman for Immigration Detention to investigate misconduct and inspect DHS facilities and to ensure that people in detention can file grievances without fear of retaliation, as required and funded by Congress;
- Establish a mechanism for independent medical oversight through regular inspections by respected public health professionals in the context of a robust certification process;
- Mandate ICE Health Service Corps to take responsibility for health care in all ICE detention facilities in order to end fragmentation of medical care;
- Ensure a robust system to respond to internal complaints, whether by whistleblowers, including health professionals, or people in detention, without fear of retaliation; and
- Absent preferred release, adopt measures specifically related to the coronavirus in order to mitigate spread:
 - Provide regular and transparent reporting regarding the total number of tests, infections, and deaths, including people in detention, ICE staff, and contracted staff, as well as numbers of deportations and transfers of people testing positive for COVID-19;
 - Increase COVID-19 screening and mass testing, including for those who are asymptomatic;
 - Ensure immediate and free access to personal protective equipment and to hygiene and sanitary supplies in all facilities;
 - Fully implement social distancing recommendations, including public health-appropriate eating and sleeping arrangements;
 - Ensure humane measures for medical isolation and quarantine that do not amount to solitary confinement, but rather ensure contact with family and legal counsel, access to library, recreation, and all other amenities;
 - Ensure rapid access to medical care outside of ICE facilities for COVID-19-positive detainees;

Recommendations

continued

To the U.S. Department of Homeland Security, continued:

- Cease the use of solitary confinement as a form of medical isolation;
- Ensure easy access to public health information about COVID-19 in the languages understood by people in detention; and
- Cease arrests, transfers, including through use of detainees, and deportations, which accelerate spread of the coronavirus among immigrants, ICE staff and contractors, and local communities, and within the country of deportation.

To the U.S. Congress:

- Reduce the number of people in immigration detention without delay by eliminating local bed count quotas (number of detention beds available for interior enforcement), rejecting funding requests to expand detention capacity, eliminating funding for private prison contracts, and increasing funding for community-based alternatives to detention which are contracted to non-profit organizations;
- Adopt binding legislation codifying detention standards, including standards of medical care, so that DHS provision of medical care is not regulated by haphazard and inconsistent internal guidelines;
- Exercise oversight (including funding penalties) regarding DHS's establishment of the Ombudsman for Immigration Detention as a nonpartisan, impartial expert body to investigate misconduct, inspect facilities, and make recommendations;
- Support legislative efforts, such as those which provide for release from immigration detention during a communicable disease-related national emergency, and halt most arrests and apprehensions, as these only increase the detention population during the pandemic;
- Repeal the Anti-terrorism and Effective Death Penalty Act and the Illegal Immigration Reform and Immigrant Responsibility Act, which violate international legal standards limiting use of immigration detention; decriminalize unauthorized entry of asylum seekers, which is in violation of the Refugee Convention; and
- Continue to uphold whistleblower protections and safeguard the ability of health professionals working in detention facilities to report concerns about conditions.

To State Governors and Local Public Health Authorities:

- Require immigration detention facilities, including county and local jails under inter-governmental service agreements, to reduce their detention populations in order to comply with state and local public health and licensing laws and regulations;
- Direct local and state law enforcement to cease compliance with detainees that facilitate spread of the virus between closed facilities; and
- Coordinate with U.S. Congress representatives, as well as DHS internal oversight bodies OIG and Office for Civil Rights and Civil Liberties, regarding facility oversight and monitoring, including unannounced inspections by independent, outside experts.

To the Centers for Disease Control and Prevention (CDC):

- Issue clear guidance to local, state, and federal detention officials, judges, and law enforcement agencies on reducing immigration detention intake and population size to reduce the spread of COVID-19;
- CDC guidance on safe conditions in detention settings should require a high standard of precaution and eliminate caveats based on purely operational considerations;
- Issue public health guidelines distinguishing “solitary confinement” from “quarantine” and “medical isolation” to prevent punitive conditions for those who are exposed to COVID-19;
- Review and adopt recommendations by expert organizations such as the National Academies; and
- Assemble a formal CDC working group on COVID-19 and detention settings.

To the UN Human Rights Committee:

- Continue to issue guidance for states regarding their obligations to prevent arbitrary detention through procedural guarantees and to prevent cruel, inhuman, and degrading treatment through adequate conditions of confinement and medical care, and underscore human rights law limitations on state use of immigration detention.

Cover: A Honduran detainee at an unnamed ICE detention facility in December 2019.

Photo: Michael S. Williamson/Washington Post/Getty Images



Physicians for
Human Rights

For more than 30 years, Physicians for Human Rights (PHR) has used science and the uniquely credible voices of medical professionals to document and call attention to severe human rights violations around the world. PHR, which shared in the Nobel Peace Prize for its work to end the scourge of landmines, uses its investigations and expertise to advocate for persecuted health workers and facilities under attack, prevent torture, document mass atrocities, and hold those who violate human rights accountable.



Shared in the 1997
Nobel Peace Prize