In late March, I argued in an earlier version of this paper that the US Department of Homeland Security (DHS) should immediately embark on an aggressive program of release, supervised release and alternative-to-detention (ATD) programs for immigrant detainees in response to the Coronavirus Disease 2019 (COVID-19) pandemic. [1] Since that time, the number of immigrants in Immigration and Customs Enforcement (ICE) detention has fallen by nearly 8,400, but not nearly as fast or dramatically as necessary, given the perilous conditions in which nearly 30,000 immigrant detainees remain and how rapidly the virus has swept through immigrant detention facilities throughout the country and beyond.
On March 17, Immigration and Customs Enforcement (ICE) reported that there were no “confirmed” cases of COVID-19 in its detention centers, a meaningless claim given the paucity of testing and the certainty of “unconfirmed” cases, as affirmed by ensuing lawsuits.[2]

A month later, ICE reported 124 confirmed cases. Six weeks later, as of May 1, this number had more than quadrupled to 522 cases in 34 facilities, as well as 39 confirmed cases among ICE employees in those facilities (ICE 2020b).[3]

Yet ICE’s figures point to only the tip of the iceberg. By mid-April, ICE had tested only 300-400 detainees for COVID-19 infection (Misra 2020). By May 1, it had tested 1,073 detainees, a very low percentage of those in its custody during the course of the pandemic (ICE 2020b). Moreover, ICE figures do not count former detainees who contracted COVID-19 in its custody,[4] a large number of whom were deported prior to being tested (Dickerson and Semple 2020). Nor do they count the infected staff of ICE contractors, including employees of the private corporations that own and operate its largest detention centers and that administer many state and local ICE contract facilities.[5] On April 2, for example, ICE reported no confirmed cases of infected detainees, but one suspected case, at the massive Stewart Detention Center in Lumpkin, Georgia (Stewart). CoreCivic, one of
ICE’s largest private detention contractors, operates Stewart.\footnote{By April 10, ICE “knew of” 30 suspected and five confirmed cases at Stewart.\footnote{As of April 28, 42 CoreCivic employees and one ICE employee at Stewart had tested positive for COVID-19 (Stokes 2020). In an April 21 email to Mark Dow, Amanda Gilchrist, the Director of Public Affairs at CoreCivic said there had been 98 positive cases among CoreCivic staff since the onset of the pandemic, a number that did not count staff who had “recovered from COVID-19” and received “a doctor’s clearance to return to work” (on file with author).}} By April 10, ICE “knew of” 30 suspected and five confirmed cases at Stewart.\footnote{As of April 28, 42 CoreCivic employees and one ICE employee at Stewart had tested positive for COVID-19 (Stokes 2020). In an April 21 email to Mark Dow, Amanda Gilchrist, the Director of Public Affairs at CoreCivic said there had been 98 positive cases among CoreCivic staff since the onset of the pandemic, a number that did not count staff who had “recovered from COVID-19” and received “a doctor’s clearance to return to work” (on file with author).} As of April 28, 42 CoreCivic employees and one ICE employee at Stewart had tested positive for COVID-19 (Stokes 2020). In an April 21 email to Mark Dow, Amanda Gilchrist, the Director of Public Affairs at CoreCivic said there had been 98 positive cases among CoreCivic staff since the onset of the pandemic, a number that did not count staff who had “recovered from COVID-19” and received “a doctor’s clearance to return to work” (on file with author).

ICE has confirmed 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” (Tanvi 2020). However, it has been “unable to determine how many non-ICE personnel in state and local jails have contracted COVID-19 or died from COVID-19” (ibid.). Finally, it reports 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” (ibid.).

As of March 21, 38,058 immigrants were in ICE custody. By April 25, this number had dropped to 29,675 including 15,855 persons apprehended by ICE and Homeland Security Investigations, and 13,820 referred by Customs
and Border Protection (CBP) (ICE 2020a). 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).

As of April 25, ICE still unconscionably held 5,261 persons who had established “persecution” and “torture” claims, and who should not be detained in any circumstances, much less the present. It also continues to detain persons approved for release. In a particularly disturbing report, detainees in New York cannot post bond because of the closure of ICE’s New York City office (Katz 2020). Finally, it continues to detain families and minors. On April 13, the Washington Post reported that the population at ICE’s three family detention centers had fallen from 1,350 to 826 persons (Hsu 2020). By April 21, the number had fallen to 698 persons, including 342 minors.[8]

On March 28, a federal district judge issued a temporary restraining order that required the administration to “make and record continuous efforts” to release the more than 5,000 minors in ICE family detention facilities and Office of Refugee Resettlement (ORR) shelter-like facilities for unaccompanied minors.[9] Her 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, the judge ordered ORR and ICE to continue “to make every effort to promptly and safely release” children with “suitable custodians.”[10]

**ICE Policies and Procedures**

ICE can decrease its detention population in two main ways, by admitting fewer immigrants into its system and by more generous and, in the circumstances, appropriate release standards. It has failed to move decisively enough in either direction.

**CBP Referrals and the Effect of Closing the Border**

On March 20, the Center for Disease Control and Prevention (CDC) issued an “Order Suspending Introduction of Certain Persons from Countries Where a Communicable Disease Exists,” which closes US land borders to non-essential travelers (CDC 2020a). On April 19, it extended this order through May 20 (CDC 2020b). The order has resulted in the expulsion, with only cursory screening, of non-citizens apprehended by CBP near its land borders and at Ports-of-Entry. Although
CBP border facilities have emptied as a result (O’Toole 2020), high numbers of CBP-referred immigrants remain in ICE custody.

The CDC order seeks to prevent the “serious danger” of the introduction and spread of COVID-19 at POEs and Border Patrol stations – which it accurately characterizes as “congregate settings” – and into the US “interior.” In fact, social distancing and minimizing movement in public space have been central tools in the nation’s response to COVID-19. 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 order also overreaches in ways that endanger migrants and spread the virus. In particular, it has temporarily eviscerated US asylum laws and anti-trafficking protections for minors, and returned unknown numbers of persons to life-threatening conditions (CMS 2020). The US can achieve its legitimate public safety concerns related to stemming the spread of COVID-19, while ensuring the safety of asylum-seekers and potential trafficking victims.
The expulsion process occurs in an average of 96 minutes, without medical examination, except for migrants “in distress” (Miroff 2020). Removal via “ICE Air” for “detainees who are not ‘new apprehensions’” entails “medical clearance,” not just the “visual screening” provided to “new apprehensions” (ICE 2020a). Persons deported by plane also receive “temperature screening” at the “flight line” (ibid.). Despite these precautions, DHS has deported significant numbers of infected persons, whether in visible distress or not. Deported or expelled migrants arrive at their destinations without any treatment plan or notice of their condition to health officials or to the shelter providers that will temporarily house them. The Guatemalan government has repeatedly suspended US deportation flights due to high rates of infection among US deportees <https://www.aljazeera.com/news/2020/04/guatemala-migrants-deportation-flight-coronavirus-200418064902038.html>. Fifty to 75 percent of deportees in one flight – tested positive for coronavirus after being quarantined in Guatemala (The Guardian 2020). US deportees constitute 17 percent of Guatemala’s confirmed coronavirus cases (Sieff and Miroff 2020). US deportees to Mexico and to Haiti have also tested positive for the virus (ibid.). However, DHS has rejected Mexico’s request to test deportees for the virus (ibid.).

*Detainees Apprehended by ICE*
ICE’s detention and enforcement priorities are also overly broad. 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, reportedly infuriated White House and other administration ideologues (Lipman and Kumar 2020). In fact, the policy does not go nearly far enough.

ICE need not and should not detain all persons subject to mandatory detention on criminal grounds. As of April 25, 37 percent of ICE detainees had been convicted of a crime (ICE 2020a). However, most ICE detainees with criminal records are non-violent offenders; high percentages have been convicted of immigration and traffic offenses, and misdemeanors (USCCB-MRS and CMS 2015). Moreover, ICE detainees have served whatever criminal sentences, if any, were imposed on them (ibid.).

ICE maintains that it has no choice but to detain immigrants subject to mandatory detention. Yet US immigration laws cannot abridge Constitutional rights,
including the Fifth Amendment’s prohibition against deprivation of “life, liberty, or property, without due process of law.” In addition, the law offers exceptions to “arriving aliens” subject to “mandatory” detention, who can be paroled (released) for “urgent humanitarian reasons” or a “significant public benefit.”[11] Saving lives and slowing the spread of a catastrophic pandemic certainly meet these standards. The administration could also recognize ATD programs as a form of detention, opening them to mandatory detainees, or it could work with Congress to suspend mandatory detention for select populations, given the “serious danger” detention poses to public health and to the spread of COVID-19.[12]

ICE has reviewed for possible release detainees 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). As of April 15, this process had led to the release of 700 detainees. This is a substantial number, but not nearly enough.

Federal courts increasingly agree. On April 20, for example, a federal district judge in California ordered ICE to identify, track and make timely custody determinations for all detainees with risk factors that put them at “heightened” risk of serious illness and death if infected with COVID-19.[13] The judge recited a litany of
unhygienic and dangerous conditions in ICE facilities, concluding that ICE had “likely exhibited callous indifference” to detainees with particular vulnerabilities.[14] On April 30, a magistrate judge recommended the immediate release of 13 of 16 detainees with risk factors in Louisiana facilities.[15] Another magistrate recommended that ICE “prove that it is accelerating the release process for non-criminal detainees” in three South Florida detention facilities (Madan 2020).

Several courts have ordered the release of high-risk detainees. On April 30, for example, a US district court judge in Maryland ordered the release of a detainee, following the confirmed COVID-19 infection of a nurse in the facility. The court criticized “the deficiencies” in the facility’s “mitigation measures,” and pointed out that it had no apparent plans to test or quarantine the detainees with whom the nurse had come in contact. [16]

ICE seems to recognize the need to expand and expedite the release of those in its custody. It tacitly acknowledges that it cannot adequately protect its detainees and that its policies work at cross-purposes to its goal of prevention of COVID-19. An ICE document from April 10, 2020 entitled “COVID-19 Pandemic Response Requirements” provides instruction and guidance to its detention facilities and sets forth its expectations for mitigating the risk of
infection to detainees and detention stakeholders (ICE 2020d). The document requires “pre-intake” screening for “new entrants,” both “temperature screening” and “a verbal symptoms check” (ibid.) However, screening does not cover existing detainees, will not identify asymptomatic infected “new entrants,” and falls well short of actual testing.

The policies concede 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.” Yet facilities may have a financial incentive to remain at or near capacity, and reductions by 75 percent may well be insufficient to stem the spread of the virus. ICE’s guidance also advises facilities, “to the extent possible,” to house detainees in individual cells. Yet in dormitory-style detention facilities, this will be impossible. Thus, the guidance offers what seems to be a hopeless solution; i.e., that those “sharing sleeping quarters” – where the space between beds or cots typically is far less than six feet – should sleep “head to foot” and pursue other unspecified “social distancing strategies.”
The document also calls for consideration of the release of those “who may be at higher risk for serious illness” from exposure. Yet the virus has killed thousands of low-risk persons as well. ICE also urges detention facilities to consider “cohorting” (housing together) “all new entrants” for 14 days. According to one medical doctor, this strategy will only work if new entrants are not exposed to detainees, guards, or others from outside their cohort, which is very unlikely in detention settings. The guidance concedes that “cohorting options and capabilities” vary by facility. According to this doctor, the “safer solution would be simply to allow detainees to live with their families.”

For suspected or confirmed infected persons, it advises that facilities make “every possible effort” to isolate the detainee, but it acknowledges that the number of confirmed cases may exceed the number of “individual isolation spaces.” It sensibly directs that “ill detainees’ should not be “cohorited with other infected individuals,” but “if unavoidable” it advises that “all possible accommodations” should be made until the transfer of infected detainees, presumably to other detention facilities. These safeguards hardly inspire confidence. In fact, they acknowledge the obvious: ICE detention system cannot safeguard those in its custody.
Indeed, ICE has limited ability to enforce or even assess compliance with these guidelines, and ICE staff have conceded that they lack effective control over the operation of contract facilities.\[17\] This situation points to systemic, well-documented problems in the US immigrant detention system that COVID-19 now exploits and throws into sharp relief. One expert concludes that: (1) ICE’s guidance is inconsistent with CDC guidelines in critical ways; (2) ICE’s longstanding oversight deficiencies makes it “unlikely” that it will “ensure compliance” with its guidance, and (3) as a result “ICE detainees will experience higher risks of serious illness and death.”\[18\] In fact, this is exactly what has occurred and it will continue to occur without expedited, large-scale testing and release of detainees.

**Expert Opinion**

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).[19] 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.” Attorney General William Barr has ordered the early release of at-risk inmates in federal prisons (Gerstein 2020), but has remained silent on immigrant detainees who endure the same conditions and risks.

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.[20]
The letter continued that social distancing was “nearly impossible in immigration detention.” As a result, it “strongly recommend that ICE implement community-based alternatives to detention to alleviate the mass overcrowding in detention facilities.”

A medical expert and a consultant to both DHS and the US Department of Justice, reports 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. [21] 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.” Detainees share “toilets, sinks, and showers” and their “[f]ood preparation and food service is communal.” Because detention staff “arrive and leave on a shift basis,” there is “little to no ability to adequately screen staff for new, asymptomatic infection.”

In a March 19 letter, two medical doctors, who have investigated immigrant detention facilities and worked as subject matter experts for DHS, 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.”[22] 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 members of surrounding communities (Sholchet 2020).

The World Health Organization (WHO) has warned that prisoners and detainees “are likely to be more vulnerable” to COVID-19 and 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). It explains that for this reason “[p]rison health is ... widely considered as public health” (ibid.) On March 31, WHO, UNHCR, the International Organization for Migration, and the Office of the United Nations High Commissioner for Human Rights (OCHR) expressed similar concerns over the “situation for 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.)

Michael Flynn is the Executive Director of the Global Detention Project in Geneva, which tracks diverse national detention policies related to the COVID-19 pandemic “within the context of their migration control
policies.” (GDP 2020). Flynn told me by email that the United States could benefit from the experience of other countries:

In Spain, one of the hardest hit countries in Europe, authorities have begun releasing immigration detainees because of the inability to remove them from the country. To keep someone in detention there must be a viable procedure in place to deport them. The country is now considering the mass release of all detainees in deportation procedures. In the UK, the Home Office has released nearly a third of its immigration detainees because of the failure of authorities to protect them from contracting covid-19. Similarly, in Switzerland, entire detention facilities are being shuttered precisely because of the inability in these facilities to keep detainees and staff from being exposed to the virus.

Detention, he concludes, “exposes an already vulnerable population to the increased possibility of getting gravely ill in an environment that is patently unfit for providing adequate healthcare.”

As stated, ICE seems to understand these grim realities, but its policies do not reflect them. Detainees and their families understand in a more intimate way the deadly risk that these conditions pose. In recent weeks, they have responded with hunger strikes and desperate appeals for release (Lang 2020).
On April 7, Amnesty International reported the case of a pregnant Honduran asylum-seeker, who believes that she cannot protect herself or her 4-year-old daughter from contracting the virus in a family detention center. It reported that:

ICE and its detention facilities have failed to adequately provide soap and sanitizer or introduce social distancing. Nor has it halted the unnecessary transfers of people between facilities in the interest of public health, routinely transporting thousands in and out of facilities ... ICE has the obligation to grant humanitarian parole to immigration detainees before any more people in its custody contract COVID-19. Thus far, ICE has failed to adopt even the most minimum necessary measures to protect public health both in and around its large network of facilities.

While downplaying the risk of COVID-19 outbreaks in its detention facilities, ICE has concealed and understated the number of detainees who may have been exposed to or contracted COVID-19, hiding vital information about potential outbreaks from the people detained, their lawyers and loved ones, and the public (AI 2020).

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).

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).

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 shares a small cell at the McHenry County Jail in Illinois with a man “who coughs all night” (Zamudio 2020).

**Conclusion**

As previously argued in this regularly updated paper, immigrant detention is intended to serve two main purposes, to ensure that non-citizens appear for their removal proceedings and to protect the public. Yet in the current circumstances, detention imperils detainees, the staff and contractors at detention facilities, court officials, health care providers, the public, communities that host detention centers, and those to which detainees
eventually return. ICE has adopted unenforceable policies and practices that do not reflect the severity of this crisis. It cannot safeguard those in its custody and should move with alacrity to release far more immigrants. Detention should not be a death sentence.

References


Hsu, Spencer S. “Number of migrants held at ICE family centers plummets.” Washington Post, Apr. 13.
(last visited Apr. 27, 2020).


https://www.ice.gov/doclib/coronavirus/eroCOVID19res
ponseReqsCleanFacilities.pdf

(last visited May 1, 2020).


https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30769-3/fulltext


custody-at-the-border/ar-BB12oCra


O'Toole, Molly. “Trump administration, citing coronavirus, expels 10,000 migrants in less than 3 weeks.” Los Angeles Times, Apr. 9.


https://www.wabe.org/more-than-40-employees-at-ga-immigrant-detention-center-test-positive-for-covid-19/?fbclid=IwAR35iPa-qU3WE0E2TREbx9zU48xIRaKn0CpqLZFoziH1DPto-


Zamudio, Maria Ines. “Detained Immigrants Turn To The Courts To Protect Themselves From COVID-19.” NPR, Apr. 23. 
https://www.wbez.org/stories/detained-immigrants-turn-to-the-courts-to-protect-themselves-from-covid-19/e66b4471-9daa-4ad0-8a2d-eedf3e2ddc41

[1] ICE has abundant experience in overseeing ATD program. As of April 25, 89,283 persons were enrolled in ATD programs, with various levels of supervision (ICE 2020a). Well-structured ATD programs <https://journals.sagepub.com/doi/pdf/10.1177/233150241500300203> have consistently ensured high appearance rates at immigration hearings.

https://www.politico.com/f/?id=00000171-1a1a-da0d-a17b-fe5bec870000

[3] Recent reports have documented the infection of unaccompanied children in ORR-funded facilities <https://abcnews.go.com/Politics/immigrant-detention-numbers-decline-covid-19-

[4] ICE reports that some infected detainees “may no longer be in custody.” It does not report on formerly detained deportees with COVID-19.


[7] Id.


https://files.constantcontact.com/baccf499301/cd171d0c-09c7-4050-a8b0-4b640ca093c8.pdf


[12] By way of contrast, the administration has shown no compunction about suspending US legal immigration laws during the pandemic.

Preliminary Injunction).

https://www.splcenter.org/sites/default/files/fraihat_pi_grant.pdf

[14] Id.


ICE’s history in containing infectious diseases in its detention facilities has been problematic.


