

Examining Best Practices for Incarceration and Detention During COVID-19

U.S. Senate Committee on the Judiciary

Written Statement of Dr. Scott A. Allen, MD

June 2, 2020

Chairman Graham, Ranking Member Feinstein, and the distinguished Members of the Committee, thank you for giving me the opportunity to discuss the best practices for containing COVID-19 in incarceration and detention settings.

I am a medical doctor with over two decades of experience in correctional health. I am a Professor Emeritus of Medicine, former Associate Dean of Academic Affairs, and former Chair of the Department of Medicine at the University of California Riverside School of Medicine. In the past, I have served for seven years as a full-time physician for the Rhode Island Department of Corrections; and, for the final three of those years, I served as the State Medical Program Director. I have published over 25 peer-reviewed papers in academic journals related to prison health care and am a former Associate Editor of the International Journal of Prisoner Health Care. I have consulted on detention health issues both domestically and internationally for the Open Society Institute and the International Committee of the Red Cross, among others. I have worked with the Institute of Medicine on several workshops related to detainee healthcare and serve as a medical advisor to Physicians for Human Rights. I am the co-founder and co-director of the Center for Prisoner Health and Human Rights at Brown University, and a former Co-Investigator of the University of California Criminal Justice and Health Consortium. Currently, I serve as the court appointed monitor for Riverside County Jails, my home county, and as a medical subject matter expert for the Office of Civil Rights and Civil Liberties in the Department of Homeland Security, where I have inspected multiple immigration facilities across the country over the past 6 years. In the course of that work, I have made protected disclosures to Congress, including a letter regarding the COVID-19 threat in immigration detention submitted in March of this year.¹ I am speaking today as an individual in my personal capacity and do not speak for the Department of Homeland Security.

Correctional health *is* public health, and failure to control outbreaks in detention, jails, and prisons will critically handicap our efforts to contain the spread of the virus in our communities. While weaknesses in data collection and transparency means data are imprecise, the silent spreading of this virus from these facilities to their surrounding communities likely resulted in

¹ Scott A. Allen, MD, FACP and Josiah Rich, MD, MPH, Letter to Congress (March 19, 2020), available at <https://whistleblower.org/wp-content/uploads/2020/03/Drs.-Allen-and-Rich-3.20.2020-Letter-to-Congress.pdf>.

many community infections and deaths. It is no mere coincidence that several of the hotspots for coronavirus in the community are in settings where jail and prison outbreaks have occurred.

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.²

If you are not careful, detention and correctional facilities can be a hub of spread of the virus throughout the community. In our March 18, 2020 letter to Congress, Dr. Jody Rich and I warned of a so-called “tinderbox scenario” where rapid spread of the virus through a detention facility could rapidly overwhelm local hospital capacity and result in community spread of the virus.³ Now the flames are growing. Indeed, recent data from the COVID Prison Project shows that prison populations test substantially higher than the general population in many states.⁴ Similarly, a new study in the *Journal of Urban Health* shows that optimistically, 72% of individuals in ICE detention are expected to be infected by day 90, with nearly 100% infected under more pessimistic conditions; the study further shows that COVID-19 outbreaks among a minimum of 58 ICE facilities (52%) would overwhelm ICU beds within a 10-mile radius.⁵ This means many hospitals are precipitously close to being overwhelmed if and when outbreaks occur at these facilities, presenting a massive threat to the surrounding communities’ public health. Again, these facilities are not islands.

Correctional health is often left out of public health discussions, yet it is at the tip of the spear in public health. Correctional and detention institutions are at the front lines in addressing mental health, addiction, and infectious diseases. The coronavirus challenge confronts a profession well

² There have been multiple examples of ICE’s active transfer of detainees being a source of spread of the virus, causing outbreaks in detention facilities. See, e.g., Lisa Riordan Seville and Hannah Rapple, “ICE keeps transferring detainees around the country, leading to COVID-19 outbreaks,” *NBC News* (May 31, 2020), available at <https://www.nbcnews.com/politics/immigration/ice-keeps-transferring-detainees-around-country-leading-covid-19-outbreaks-n1212856>; Hamed Aleaziz, “ICE Moved Dozens Of Detainees Across the Country During the Coronavirus Pandemic. Now Many Have COVID-19.” *BuzzFeed News* (April 29, 2020), available at <https://www.buzzfeednews.com/article/hamedaleaziz/ice-immigrant-transfer-jail-coronavirus>; Yeganeh Torbati, Dara Lind and Jack Gillum, “In a 10-Day Span, ICE Flew This Detainee Across the Country — Nine Times,” *ProPublica* (March 27, 2020), available at <https://www.propublica.org/article/coronavirus-ice-flights-detainee-sirous-asgari>; Monique Maden, “Coronavirus cases skyrocket at ICE detention center in Broward after transfer from Miami,” *Miami Herald* (May 19, 2020), available at <https://www.miamiherald.com/news/local/immigration/article242844451.html> .

³ See, fn. 1, supra.

⁴ Erin McCauley, “COVID-19 Case Watch May 27, 2020,” *the COVID Prison Project Blog* (May 30, 2020), available at <https://covidprisonproject.com/blog/>.

⁵ Irvine, M., Coombs, D., Skarha, J. *et al.* Modeling COVID-19 and Its Impacts on U.S. Immigration and Customs Enforcement (ICE) Detention Facilities, 2020. *J Urban Health* (2020). <https://doi.org/10.1007/s11524-020-00441-x>

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experienced in fighting tuberculosis, influenza, viral hepatitis, and HIV among other infectious diseases that disproportionately affect our patients. Correctional health workers and officers are at the front lines of this pandemic, with many working on units with COVID-19 rates as high or higher than in many health care settings.⁶

This virus is different than infectious threats that came before. As we first learned about this novel coronavirus, those of us in correctional health were alarmed because easy, asymptomatic spread of a potentially fatal respiratory virus is a nightmare scenario for facilities with congregate living, such as cruise ships, college and university dorms, nursing homes, and military barracks. In detention, jails, and prisons, there is often overcrowding. There are shared living spaces including shared dining areas, communal bathrooms, and small community recreation spaces. Many facilities have dormitory housing with up to seventy people in closely placed double bunked beds. People are confined, one upon another. Social distancing is near impossible. While many facilities have provided adequate access to handwashing and sanitizer, other have fallen short.⁷

It is no surprise correctional and detention centers have been hit hard by this virus. In my own county of Riverside, California, where I am a Federal Court appointed monitor, we have lost two deputies and two inmates in the course of an ongoing outbreak within our jail. In nearby Lompoc Federal Prison, over 60% of the 1707 inmates have tested positive, three have died and the Lompoc prison cases account for 60% of all coronavirus infections documented in Santa Barbara County.⁸ About 70% of the Terminal Island Federal Prison in San Pedro population has tested positive and nine inmates have died at that facility alone.⁹ Meanwhile, in ICE's nearby Otay Mesa Detention Facility in San Diego, 158 detainees have tested positive for COVID-19.¹⁰

As of April 21, 2020 (over a month ago), 86% of the 37 jurisdictions reporting to the CDC had documented COVID-19 within their facilities.¹¹ As of May 28, 2020, according to the COVID

⁶ See, fn. 4, supra, <https://covidprisonproject.com/blog/>.

⁷ See, e.g., Casey Tolan, "Hand sanitizer is still considered contraband in some prisons around the country," *CNN* (May 5, 2020), available at <https://www.cnn.com/2020/05/05/us/coronavirus-prison-hand-sanitizer-contraband-invs/index.html>

⁸ Santa Barbara County Public Health Department, COVID-19 in Santa Barbara Dashboard (last visited May 31, 2020), available at <https://publichealthsb.org/dashboard/>; Tyler Haden, "Third Inmate Dies as Families Protest Against Lompoc Prison COVID Conditions," *Santa Barbara Independent* (May 26, 2020), available at <https://www.independent.com/2020/05/26/third-inmate-dies-as-hundreds-protest-against-lompoc-prison-covid-conditions/>

⁹ Richard Winton, "Inmate labeled as 'recovered' from coronavirus dies at Terminal Island," *Los Angeles Times* (May 28, 2020), available at <https://www.latimes.com/california/story/2020-05-28/ninth-inmate-dies-coronavirus-terminal-island-prison>

¹⁰ ICE Guidance on COVID-19, Confirmed Cases (updated May 29, 2020), available at <https://www.ice.gov/coronavirus>

¹¹ CDC Morbidity and Mortality Weekly Report, *COVID-19 in Correctional and Detention Facilities — United States, February–April 2020, Weekly* / May 15, 2020 / 69(19);587–590, available at <https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e1.htm> (noting "The findings in this report are subject to at least six limitations, each of which could result in an **underestimation** [emphasis added] of the number of COVID-19 cases in correctional facilities. First, only 69% of jurisdictions reported data; therefore, these results are not

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Prison Project, there were 34,730 infections and 470 deaths among prisoners, and another 7,781 cases among prison staff resulting in 31 staff deaths.¹² The Federal Bureau of Prisons has reported 66 federal inmate deaths from over 5000 cases so far across its facilities.¹³ In ICE detention, there are 1406 confirmed cases out of only 2781 tested in a total detained population of 25,911 individuals.¹⁴

We will hear a lot today about the extraordinary efforts my colleagues have gone to confront this virus, mobilizing the traditional infectious disease containment strategies endorsed by the CDC in their March 23, 2020 Interim COVID guidelines for correctional facilities. But there are gaping holes in those guidelines, including failure to contemplate population reduction and failure to provide adequate guidelines for testing. The fact is, in the real world, the guidelines—and accordingly their implementation by BOP and ICE—are failing to stop the spread. The number of cases and deaths continues to grow. Even though many facilities can report that they have not yet experienced significant outbreaks, it is far too soon for anyone to declare victory.

According to the COVID Prison Project, in the last two weeks, confirmed case rates in the prison population increased in nearly all states. The largest increase in the confirmed case rate among the prison population occurred in New Jersey where there was a 300% increase (from 19 per 1,000 to 77 per 1,000). Other states with large increases in the confirmed case rate among the prison population are Tennessee (increase of 40 per 1,000), Michigan (increase of 30 per 1,000), Connecticut (increase of 23 per 1,000), Texas and Kansas (increase of 13 per 1,000), and West Virginia (increase of 12 per 1,000).¹⁵

It is also important to note that even in the best circumstances, the provision of medical care in correctional and detention facilities is unfortunately inconsistent and inadequate. The national

representative of the entire United States. Second, many facilities do not provide testing to staff members, making data completeness dependent on staff members self-reporting their diagnosis to their employer after being tested by their personal health care providers. Third, some jurisdictions received data only from state prisons and were missing data from local jails and federal or privately operated facilities. Fourth, data on the total number of facilities, the total number of incarcerated and detained persons, and the total number staff members were not available; thus, proportions of facilities and persons affected could not be determined. Fifth, one jurisdiction reported only collecting data on facility outbreaks (defined by the jurisdiction as >1 COVID-19 case per facility). Finally, data are not available to determine the extent to which variations in testing availability and testing practices across states influenced the number of COVID-19 cases reported among staff and incarcerated and detained persons.”)

¹² The COVID Prison Project, (May 28, 2020), available at <https://covidprisonproject.com>

¹³ As of May 30, 2020, “The BOP has **135,739** federal inmates in BOP-managed institutions and **12,529** in community-based facilities. The BOP staff complement is approximately **36,000**. There are **1649 federal inmates** and **192 BOP staff** who have confirmed positive test results for COVID-19 nationwide. Currently, **3582** inmates and **420** staff have recovered. There have been **66** federal inmate deaths and **0** BOP staff member deaths attributed to COVID-19 disease.” The figure of “over 5000 cases” comes from adding those reported as “confirmed positive (1649) to those reported as “recovered” (3582) for a total of all reported cases to date of 5231. See Federal Bureau of Prisons, COVID-19 Coronavirus, COVID-19 Cases (May 30, 2020), available at <https://www.bop.gov/coronavirus/>.

¹⁴ ICE Guidance on COVID-19, Confirmed Cases (updated May 29, 2020), available at <https://www.ice.gov/coronavirus>

¹⁵ See, fn. 4, supra, <https://covidprisonproject.com/blog/>.

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correctional and detention hodge-podge network is a patchwork of federal, state, local and private facilities.¹⁶ I have spent much of the last decade inspecting and working local jails and immigration detention facilities. While some do a very good job in providing care, others perform poorly.¹⁷

We have asked our correctional health colleagues to manage this unprecedented pandemic, but we have not properly armed them in this fight. Specifically, we have underutilized and under-supported our best tools: aggressive containment-based testing strategies, reducing populations in detention, and collaboration and data sharing between correctional and detention centers (including state and local jails and prisons, FBOP and ICE) and public health departments.

Robust Testing is Essential in Correctional and Detention Facilities

The March interim CDC guidelines for COVID-19 in corrections appropriately recommended traditional control measures including symptom-based screening¹⁸ – against a virus that often is carried and passed from individuals who are pre-symptomatic or never have symptoms. For every one prisoner identified and isolated using symptom-based screening, one, two, or maybe even eight or nine pass into – and eventually out of – the facility without symptoms.¹⁹ Therefore,

¹⁶ According to the ICE website, “The U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) provides *direct care* to approximately 13,500 detainees housed at 21 designated facilities throughout the Nation to include medical, dental and mental health care, and public health services. IHSC also provides *medical case management and oversight* for an additional 15,000 detainees housed at approximately 119 non-IHSC staffed detention facilities across the country.” Many of the non-IHSC staffed facilities are local jails or privately-run detention facilities. Department of Homeland Security Immigration and Customs Enforcement, Immigration Enforcement/ICE Health Service Corps website (last visited May 28, 2020), available at <https://www.ice.gov/ice-health-service-corps#wcm-survey-target-id>.

¹⁷ See, e.g., Department of Homeland Security Office of Inspector General, *Concerns about ICE Detainee Treatment and Care at Four Detention Facilities* (June 3, 2019), available at <https://www.oig.dhs.gov/sites/default/files/assets/2019-06/OIG-19-47-Jun19.pdf>; Department of Homeland Security Office of Inspector General, *Concerns about ICE Detainee Treatment and Care at Detention Facilities* (December 11, 2017), available at <https://www.oig.dhs.gov/sites/default/files/assets/2017-12/OIG-18-32-Dec17.pdf>; Department of Justice Office of the Inspector General, *Review of the Federal Bureau of Prisons’ Medical Staffing Challenges* (March 2016), available at <https://oig.justice.gov/reports/2016/e1602.pdf#page=1>

¹⁸ CDC, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* (March 23, 2020), available at <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>.

¹⁹ In four U.S. state prisons, nearly 3,300 inmates test positive for coronavirus -- 96% without symptoms. Linda So and Grant Smith, “four U.S. state prisons, nearly 3,300 inmates test positive for coronavirus -- 96% without symptoms,” *Reuters* (April 25, 2020), available at <https://www.reuters.com/article/us-health-coronavirus-prisons-testing-in/in-four-u-s-state-prisons-nearly-3300-inmates-test-positive-for-coronavirus-96-without-symptoms-idUSKCN2270RX>; Lisa Riordan Seville and Hannah Rappleye, “ICE keeps transferring detainees around the country, leading to COVID-19 outbreaks,” *NBC News* (May 31, 2020), available at <https://www.nbcnews.com/politics/immigration/ice-keeps-transferring-detainees-around-country-leading-covid-19-outbreaks-n1212856>; also see Gandhi M, Yokoe D, Havlir D., *Asymptomatic transmission, the Achilles’ heel of current strategies to control Covid-19*, *NEJM* (April 24, 2020), available at <https://www.nejm.org/doi/full/10.1056/NEJMe2009758>.

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we must test aggressively so we can isolate infected individuals, monitor them and break the chain of transmission as early as possible.

This is especially true once an outbreak has started within a facility. While we await updated CDC guidelines for correctional facilities, we certainly hope that they will apply the same public health standards and strategies that they are recommending for nursing home outbreaks.²⁰ Those newly issued standards call for universal testing of all residents and staff where even a single case of COVID has been identified and ongoing surveillance of residents and staff going forward. This is an appropriate public health-based standard, and there is no reason there should be a lesser standard for correctional and detention facilities, especially as control of outbreaks in all congregate environments impact the public's health.

Testing will require resources. This at a time when state and local governments are cash-strapped. In the face of an outbreak in Riverside, the jails are facing likely budget cuts in response to the economic slowdown. To support this critical frontline effort against the coronavirus, Congress must ensure agencies urgently direct resources to aggressive testing in support of containment efforts within correctional and detention facilities, and this testing effort must be supported by guidelines consistent with and equal to the standards issued for other congregate settings in the community.

Significant Reduction of Populations in Detention is Possible and Protects the Public Health

The second strategy to reduce the spread of COVID-19 in detention, population reduction, is understandably controversial when first considered. But it is simply a matter of science: the biology of the virus plus physics and geometry driving its spread makes this a necessary strategy to consider. Jails, prisons, and detention centers at, near, or above capacity simply do not have the flexibility to move, cohort, and isolate individuals in the face of an outbreak. Populations must drop to create space for distancing and separation.

The immigration and judicial systems make risk-based decisions every day about who should remain confined and who should be released. But it is important to note that my colleagues in correctional health and my colleagues on the custody side don't control who comes and who goes. The judicial system largely does.

²⁰CDC, *Testing Guidance for Nursing Homes* (Updated May 19, 2020), available at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html> and echoed by Centers for Medicare & Medicaid Services, *Nursing Home Reopening Recommendations for State and Local Officials*, (May 18, 2020), available at <https://www.cms.gov/files/document/nursing-home-reopening-recommendations-state-and-local-officials.pdf>

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All we are recommending is that the risk analysis of keeping people confined respects the need to reduce facility populations in order to permit the necessary isolation, quarantine and cohorting strategies required to contain the virus.²¹

For example, Riverside County achieved significant population reduction that allowed for flexibility for isolating, quarantining and cohorting largely through reduced arrests. Attorney General William Barr has directed the Bureau of Prisons to prioritize home confinement as a means to address the coronavirus pandemic.²² The Prison Policy Initiative has collected a detailed list of strategies that have been successfully employed across the country to rationally achieve population reduction, including releasing people near the end of their sentences, in minimum security facilities who are on work-release, those convicted of minor offenses, and those who are older or medically vulnerable; paroling those who are parole-eligible; and accelerating the time between decision and release.²³

In addition, the use of existing compassionate release mechanisms should be expanded for those individuals most vulnerable to severe COVID-19, including the elderly and those with certain high-risk chronic conditions. One of the most common arguments against releasing incarcerated or detained individuals is that doing so could threaten public safety. But in this case, *not releasing* individuals may give rise to a more significant threat to public safety. This is because of the heightened risk of the disease's spread from frequent ingress and egress of workers and detainees and the predicted overrun of local public health facilities.

Immigration detention is an especially unique case because it has the combination of housing the population at lowest risk for criminal behavior—indeed, *all* population members are civil, not criminal, detainees²⁴—while at the same time having the greatest discretion to control the size of

²¹ I elaborated with other correctional health experts on the need to reduce incarcerated and detained populations in March 2020. See, Josiah Rich, Scott Allen, and Mavis Nimon, “We must release prisoners to lessen the spread of coronavirus,” *Washington Post* (March 17, 2020), available at

<https://www.washingtonpost.com/opinions/2020/03/17/we-must-release-prisoners-lessen-spread-coronavirus/>.

²² Office of the Attorney General, *Memorandum for Director of Bureau Prisons [sic] RE: Prioritization of Home Confinement As Appropriate Response to COVID-19 Pandemic* (March 26, 2020), available at

https://www.bop.gov/resources/news/pdfs/20200405_covid-19_home_confinement.pdf; Office of the Attorney General, *Memorandum for Director of Bureau of Prisons RE: Increasing Use of Home Confinement at Institutions Most Affected by COVID-19* (April 3, 2020), available at

https://www.bop.gov/coronavirus/docs/bop_memo_home_confinement_april3.pdf. Weaknesses. *But see* Ian MacDougall, “Bill Barr Promised to Release Prisoners Threatened by Coronavirus—Even as the Feds Secretly Made it Harder for Them to Get Out,” *ProPublica* (May 26, 2020), available at

<https://www.propublica.org/article/bill-barr-promised-to-release-prisoners-threatened-by-coronavirus-even-as-the-feds-secretly-made-it-harder-for-them-to-get-out> (noting that more than 98% of federal inmates remain incarcerated).

²³ Peter Wagner and Emily Widra, “Five ways the criminal justice system could slow the pandemic,” *Prison Policy Initiative* (March 27, 2020), available at <https://www.prisonpolicy.org/blog/2020/03/27/slowpandemic/>.

²⁴ Immigration and Customs Enforcement, Immigration Enforcement, Detention Management, *Overview* (last visited May 28, 2020), available at <https://www.ice.gov/detention-management>.

that population.²⁵ In this case, where detention is associated with greater risk of harm due to outbreak and spread of the virus within the facility and to the community, the detention of civil detainees who represent low to no risk of criminality simply cannot be justified by the public safety argument.²⁶

We also continue to hold children in immigration detention. While children are less likely to suffer complications from COVID-19, they are not without risk of serious complications. Moreover, my colleague Dr. Pamela McPherson and I warned Congress in 2018 that detention of children carries high risk of serious harm to their long term physical and mental health,²⁷ a view shared by broad consensus in the medical profession.²⁸ The coronavirus has only heightened the risks associated with the detention of children.

This virus has changed how we do everything. Colleges and universities, the food industry, health care settings—every field is adapting to this virus. As we move forward, corrections and immigration detention must adapt as well by enhancing aggressive testing strategies and maximizing safe alternatives to incarceration and detention.²⁹

²⁵ Release of immigrants from detention to control the coronavirus outbreak has been recommended by John Sandweg, former acting head of ICE during the Obama administration, who further noted, “The overwhelming majority of people in ICE detention don’t pose a threat to public safety and are not an unmanageable flight risk...Unlike the Federal Bureau of Prisons, ICE has complete control over the release of individuals. ICE is not carrying out the sentence imposed by a federal judge...It has 100% discretion.” See Camilo Montoya-Galvez, “‘Powder kegs’: Calls grow for ICE to release immigrants to avoid coronavirus outbreak,” *CBS News* (March 19, 2020), available at <https://www.cbsnews.com/news/coronavirus-ice-release-immigrants-detention-outbreak/>.

²⁶ Keller A, Wagner B. COVID-19 and immigration detention in the USA: Time to Act. *The Lancet Public Health*. March 31, 2020. Available at [https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(20\)30081-5/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(20)30081-5/fulltext)

²⁷ Letter to Senators Grassley and Wyden from Drs. Allen and McPherson (July 17, 2018), available at <https://www.wyden.senate.gov/imo/media/doc/Doctors%20Congressional%20Disclosure%20SWC.pdf>; Miriam Jordan, “Whistle-blowers Say Detaining Migrant Families ‘Poses High Risk of Harm’” *New York Times* (July 18, 2018), available at <https://www.nytimes.com/2018/07/18/us/migrant-children-family-detention-doctors.html>.

²⁸ See Letter from Fourteen Medical Professional Associations to House Judiciary Committee, House Energy and Commerce Committee, House Homeland Security Committee, and House Appropriations Committee (July 24, 2018), available at https://www.acponline.org/acp_policy/letters/letter_house_oversight_request_on_child_detention_centers_2018.pdf; Letter from Fourteen Medical Professional Associations to Senate Judiciary Committee, Senate HELP Committee, Senate HSGAC Committee, and Senate Appropriations Committee (July 24, 2018), available at <https://www.psychiatry.org/newsroom/news-releases/apa-joins-health-care-community-in-calling-on-congress-to-hold-hearings-on-treatment-of-children-separated-from-parents-at-border>.

²⁹ See, e.g., Freedom For Immigrants, Physicians for Human Rights and Women’s Refugee Commission, *Recommendations for Safe Release Procedures from Immigration Detention during the COVID-19 Pandemic* (May 2020), available at <https://s33660.pcdn.co/wp-content/uploads/2020/05/COVID-19-immigration-safe-release-procedures.pdf>; Council of State Governments Justice Center, *Preparing People for Reentry, Checklist for Correctional Facilities* (May 2020), available at https://csgjusticecenter.org/publications/preparing-people-for-reentry/?mc_cid=1daac1d15f&mc_eid=65620f3184.

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Collaboration, Data Collection, and Data Sharing Between Federal Agencies, Detention Facilities, Public Health Authorities and Correctional Health Professionals is Necessary

We are facing one of the greatest and most fast-moving infectious disease threats ever to strike our modern public health system. Correctional and detention facilities are both disproportionately at risk and disproportionately impacted. As with other congregate settings like nursing homes, they can become the epicenters of community outbreaks.

However, to date, correctional and detention facilities have largely been omitted from national, state and local COVID response plans, with no correctional health experts appointed to the White House Coronavirus Task Force,³⁰ and different states issuing reopening guidelines that fail to account for often dramatically disproportionate infection rates in prisons and detention facilities.³¹ Further, data collection and sharing is inconsistent and frequently nontransparent, making assessments of the spread of COVID-19 difficult and likely underestimated.³²

It is critical that public health authorities—federal, state and local—include corrections and detention representation on COVID task forces and actively include them in COVID response planning. Likewise, data should be freely shared back and forth between facilities and public health authorities in real time to best support effective containment efforts. Finally, because infection can spread both ways—from facility to community and from community to facility—both intake screening, release planning and release execution will need to accommodate COVID containment strategies developed through collaboration between FBOP and ICE, correctional and detention facilities, public health authorities, correctional health professionals, and post-release service providers.

³⁰ Abby Goodnough, “Who’s on the U.S. Coronavirus Task Force,” *New York Times* (February 29, 2020), available at <https://www.nytimes.com/2020/02/29/health/Trump-coronavirus-taskforce.html>; The White House, *New Members of the White House Coronavirus Task Force Announced*, Statements and Releases (May 15, 2020), available at <https://www.whitehouse.gov/briefings-statements/new-members-white-house-coronavirus-task-force-announced/>

³¹ See, e.g., Abbie Vansickle, “How To Hide a COVID-19 Hotspot? Pretend Prisoners Don’t Exist,” *The Marshall Project* (May 27, 2020), available at <https://www.themarshallproject.org/2020/05/27/how-to-hide-a-covid-19-hotspot-pretend-prisoners-don-t-exist>

³² Katie Park, Tom Meagher, Weihua Li, “Tracking the Spread of Coronavirus in Prisons,” *The Marshall Project* (April 24, 2020), available at <https://www.themarshallproject.org/2020/04/24/tracking-the-spread-of-coronavirus-in-prisons>; Eunice Cho, “ICE’s Lack of Transparency About COVID-19 in Detention Will Cost Lives,” *ACLU News & Commentary* (last visited May 31, 2020), available at <https://www.aclu.org/news/immigrants-rights/ices-lack-of-transparency-about-covid-19-in-detention-will-cost-lives/>; Tyler Hayden, “Lompoc Prison’s COVID-19 Crisis Threatens to Pop,” *Santa Barbara Independent* (April 29, 2020), available at <https://www.independent.com/2020/04/29/lompoc-prisons-covid-19-crisis-threatens-to-pop/>

Conclusion

I urge you to recognize that this virus does not care who you are or what uniform you wear. It can easily move in and out of facilities undetected in the absence of aggressive testing-based surveillance and containment. Inmates, detainees, corrections officers and correctional healthcare staff are not biologically different from everyone else. Therefore, there should be parity in the public health standards driven by solid public health principles and evidence of best practices as they evolve.

To those ends, I urge you to support the following:

1. Appropriate resourcing to allow aggressive testing in support of containment efforts within correctional and detention facilities linked to testing guidelines that are consistent with and equal to the standards issued for other congregant settings in the community;
2. Careful, risk-based population reduction in detained populations as a necessary tool to contain institutional and community spread of COVID-19 during a pandemic, with protocols that facilitate the safe release of detained individuals into the community;
3. Inclusion of correctional and detention facilities in federal, state and local COVID response plans and promote greater collaboration between public health departments and correctional and detention health officials including transparent and timely sharing of data.