

**ICE's Management of
COVID-19
in Its Detention Facilities
Provides Lessons Learned
for Future Pandemic
Responses**





OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

Washington, DC 20528 / www.oig.dhs.gov

September 7, 2021

MEMORANDUM FOR: Tae D. Johnson
Acting Director
U.S. Immigration and Customs Enforcement

FROM: Joseph V. Cuffari, Ph.D. **JOSEPH V**
Inspector General **CUFFARI**

SUBJECT: *ICE's Management of COVID-19 in its Facilities Provides Lessons Learned for Future Pandemic Responses*

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Attached for your information is our final report, *ICE's Management of COVID-19 in its Facilities Provides Lessons Learned for Future Pandemic Responses*. We incorporated the formal comments from U.S. Immigration and Customs Enforcement in the final report.

The report contains six recommendations to improve ICE's future pandemic response. Your office concurred with all six recommendations. Based on information provided in your response to the draft report, we consider all six recommendations resolved and open. Once your office has fully implemented the recommendations, please submit a formal close out letter to us within 30 days so we may close the recommendations. The letter should be accompanied by evidence of completion of agreed-upon corrective actions. Please send your response or closure requests to OIGISPFollowup@oig.dhs.gov.

Consistent with our responsibility under the *Inspector General Act*, we will provide copies of our report to congressional committees with oversight and appropriation responsibility over the Department of Homeland Security. We will post the report on our website for public dissemination.

Please call me with any questions, or your staff may contact Thomas Kait, Deputy Inspector General for the Office of Inspections and Evaluations, at (202) 981-6000.

Attachment



DHS OIG HIGHLIGHTS

ICE's Management of COVID-19

in Its Detention Facilities Provides Lessons Learned for Future Pandemic Responses

September 7, 2021

Why We Did This Evaluation

Since March 2020, COVID-19 has infected more than 32.7 million people and caused more than 582,100 deaths in the United States alone. We conducted this review to determine whether ICE effectively controlled COVID-19 within its detention facilities and adequately safeguarded the health and safety of detainees and its staff.

What We Recommend

We made six recommendations to improve ICE's management of COVID-19 in its detention facilities.

For Further Information:

Contact our Office of Public Affairs at (202) 981-6000, or email us at DHS-OIG.OfficePublicAffairs@oig.dhs.gov

What We Found

In congregate environments such as U.S. Immigration and Customs Enforcement's (ICE) detention facilities, the coronavirus disease 2019 (COVID-19) can spread easily, creating unique challenges for mitigating the risk of infection and transmission of the disease. As a result, ICE took various actions to prevent the pandemic's spread among detainees and staff at its detention facilities during 2020 and into 2021. At the nine facilities we inspected remotely, these measures included maintaining adequate supplies of personal protective equipment (PPE) such as face masks, enhanced cleaning, and proper screening for new detainees and staff. However, we found other areas in which detention facilities struggled to properly manage the health and safety of detainees. For example, we observed instances where staff and detainees did not consistently wear face masks or socially distance. In addition, we noted that some facilities did not consistently manage medical sick calls and did not regularly communicate with detainees regarding their COVID-19 test results.

Although we found that ICE was able to decrease the detainee population to help mitigate the spread of COVID-19, information about detainee transfers was limited. We also found that testing of both detainees and staff was insufficient, and that ICE headquarters did not generally provide effective oversight of its detention facilities during the pandemic. Overall, ICE must resolve these issues to ensure it can meet the challenges of the COVID-19 pandemic, as well as future pandemics.

ICE Response

ICE concurred with our six recommendations, which are resolved and open.



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Abbreviations

ADP	Average Daily Population
CBP	U.S. Customs and Border Protection
CDC	U.S. Centers for Disease Control and Prevention
C.F.R.	Code of Federal Regulations
COVID-19	coronavirus disease 2019
DSCO	Detention Service Compliance Officer
DSM	Detention Service Manager
ERO	Enforcement and Removal Operations
ICE	U.S. Immigration and Customs Enforcement
IGSA	intergovernmental service agreement
IHSC	ICE Health Service Corps
PPE	personal protective equipment
PRR	Pandemic Response Requirements
U.S.C.	United States Code
WHO	World Health Organization



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Background

The World Health Organization (WHO) declared the coronavirus disease 2019 (COVID-19) a pandemic on March 11, 2020, noting that it was not just a public health crisis, but one that would affect every sector of society. On that day, roughly 118,000 people had confirmed cases of COVID-19 worldwide, and 4,291 people had died. As of May 11, 2021, more than a year later, there were about 159 million cases worldwide; in the United States alone, there were roughly 32.7 million confirmed cases and more than 582,100 deaths related to COVID-19.

COVID-19 spreads easily, particularly in congregate environments, such as U.S. Immigration and Customs Enforcement (ICE) detention centers, where housing, recreation, food service, and workplace components are present in a single physical setting. Typically, the detainee population comes from a variety of geographic locations, turns over frequently, and cannot leave the facility. In addition, detention settings may have finite medical resources, difficulty maintaining environmental cleanliness, and limited options for social distancing. Further, ICE and contractor staff, as well as approved visitors, physically entering these detention facilities daily introduce risks of additional sources of transmission. Combined, these factors create unique challenges for detention centers to mitigate the risk of infection and transmission of COVID-19.

Within the Department of Homeland Security, ICE's Enforcement and Removal Operations (ERO) is responsible for the detention of non-citizens in approximately 200 facilities that it manages in conjunction with private contractors or state or local governments. These facilities either house ICE detainees exclusively (i.e., dedicated facilities) or house ICE detainees as well as other individuals, like state or local inmates (i.e., non-dedicated facilities).¹ All facilities that hold ICE detainees are required to adhere to specific ICE standards² that establish consistent detention conditions, program operations, and management expectations within ICE's detention system. These standards

¹ Dedicated facilities include Service Processing Centers, which are DHS-owned facilities generally operated by contract detention staff; Contract Detention Facilities, which are facilities owned and operated by private companies and contracted directly by ICE; and Dedicated Intergovernmental Service Agreement facilities, which are dedicated to housing only ICE detainees under an intergovernmental service agreement (IGSA) with ICE. Non-dedicated facilities include IGSA facilities, which are facilities, such as local and county jails, housing ICE detainees (and other inmates) under an IGSA with ICE; and U.S. Marshals Service Intergovernmental Agreement facilities, which are contracted by Marshals Service but also house ICE detainees.

² Depending on their type, facilities must adhere to the *National Detention Standards* issued in 2000 or 2019; ICE's *2008 Performance-Based National Detention Standards* (PBNDS), or the 2011 PBNDS (Revised in 2016).



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also set requirements for detainee environmental health and safety (e.g., cleanliness, sanitation, security, and segregation) and medical services. Since January 2020, the Centers for Disease Control and Prevention (CDC) has issued ongoing guidance to prevent and mitigate the spread of COVID-19. Specific to detention facilities, CDC issued its *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*.³ ICE detention facilities must also comply with ICE's *Pandemic Response Requirements* (PRR),⁴ which specify mandatory requirements, as well as recommended best practices, to ensure that detainees are appropriately housed and that available mitigation measures are implemented during this unprecedented public health crisis. Appendix C summarizes key elements of the PRR.

The ICE Health Service Corps (IHSC) either provides direct care for, or oversees medical care through local government staff or private contractors to, detainees in ICE detention facilities. In addition to standards regarding detainee health and safety included in national standards, IHSC also establishes its own policies regarding detainee care and with the onset of the pandemic has provided medical directives to the detention facilities which align with CDC guidance.

During April and May 2020, we surveyed personnel at ICE detention facilities about their experiences and challenges managing COVID-19 among detainees and staff. Based on the responses from 188 ICE detention facilities, we issued a report in June 2020⁵ to describe the various actions taken to prevent and mitigate the spread of COVID-19 among detainees. These actions included increased cleaning and disinfecting of common areas, and quarantining new detainees, when possible, as a precautionary measure. Facilities also reported concerns with their inability to practice social distancing among detainees and to isolate or quarantine individuals who may be infected with COVID-19. Regarding staffing, facilities reported decreases in current staff availability due to COVID-19 but had contingency plans in place to ensure continued operations. Personnel at the facilities expressed concerns about the availability of personal protective equipment (PPE) if an outbreak of COVID-19 occurred in the facility. Overall, almost all facility personnel stated they were prepared to address COVID-19, but they expressed concerns if the pandemic continued to spread.

³ See <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>.

⁴ The ICE *Pandemic Response Requirements* set forth expectations and assist ICE detention facility operators with sustaining detention operations while mitigating risk to the safety and wellbeing of detainees, staff, contractors, visitors, and stakeholders due to COVID-19. See <https://www.ice.gov/coronavirus/prr>.

⁵ [*Early Experiences with COVID-19 at ICE Detention Facilities*](#), OIG-20-42, June 2020.



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Following our report, we received congressional requests to perform a more in-depth review to determine whether ICE effectively controlled COVID-19 within its detention facilities and adequately safeguarded the health and safety of both the detainees in its custody and its staff. In September and October 2020, we conducted unannounced, remote inspections at nine detention facilities:

- Adelanto ICE Processing Center (Adelanto) in Adelanto, California;
- Eloy Detention Center (Eloy) in Eloy, Arizona;
- El Valle Detention Facility (El Valle) in Raymondville, Texas;
- Glades County Detention Center (Glades) in Moore Haven, Florida;
- Henderson Detention Center (Henderson) in Henderson, Nevada;
- Karnes County Family Residential Center (Karnes) in Karnes City, Texas;
- Krome North Service Processing Center (Krome) in Miami, Florida;
- Mesa Verde ICE Processing Facility (Mesa Verde) in Bakersfield, California; and
- Richwood Correctional Center (Richwood) in Monroe, Louisiana.

Our remote inspections involved reviewing documentation such as facility-specific custody rosters, COVID-19 cases and deaths, cleaning intervals, visitor logs, contract discrepancy reports, general and medical grievances, requests to ICE, health care treatment logs, intake forms, transfer checklists, PPE inventories, housing unit sign-in logs, sick leave and telework policies, and local pandemic plans. We also reviewed surveillance video and images to remotely observe facility staff and detainees wearing face masks and practicing social distancing, how facilities adjusted the use of common areas for social distancing purposes, as well as the cleanliness of housing units. Further, we interviewed detainees, facility personnel, and ICE officials.

During the COVID-19 pandemic, the Office of Inspector General also conducted remote inspections of other ICE detention facilities as part of our mandated annual unannounced inspections program.⁶ These inspections evaluated compliance of the detention facilities with ICE's overall detention standards and with COVID-19 requirements. When applicable, we describe similar findings at the other facilities throughout the report.

Results of Evaluation

The health and safety of detainees and staff in ICE detention facilities, especially during the COVID-19 pandemic, are critical. With the ongoing pandemic, ICE has taken various actions to prevent the virus's spread among detainees and staff at its detention facilities. At the nine facilities we remotely

⁶ See [Violations of Detention Standards amid COVID-19 Outbreak at La Palma Correctional Center in Eloy, AZ](#), [Violations of ICE Detention Standards at Pulaski County Jail](#), and [Violations of Detention Standards at Adams County Correctional Facility](#).



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inspected, these measures included maintaining adequate supplies of PPE such as face masks, enhanced cleaning, and proper screening for new detainees and staff. However, we found other areas in which detention facilities struggled to properly manage the health and safety of detainees. For example, we observed instances where staff and detainees did not consistently wear face masks or socially distance. In addition, we noted that some facilities did not consistently manage medical sick calls and did not regularly communicate with detainees regarding their COVID-19 test results.

Although we found that ICE was able to decrease the detainee population to help mitigate the spread of COVID-19, information about detainee transfers was limited. We also found that testing of both detainees and staff was insufficient, and that ICE headquarters did not generally provide effective oversight of its detention facilities during the pandemic. Overall, ICE must resolve these issues to ensure it can meet the challenges of the COVID-19 pandemic, as well as future pandemics.

Inspected Facilities Did Not Consistently Follow CDC and ICE Guidance

As part of ICE's efforts to mitigate COVID-related risks, the nine facilities we inspected remotely generally maintained sufficient protective equipment, performed enhanced cleaning procedures, and implemented detainee and staff screening processes. However, we could not assess whether facilities appropriately grouped detainees to prevent the spread of COVID-19. In addition, facility personnel and detainees did not always wear face masks and detainees did not regularly maintain social distancing. We also noted that some of these facilities did not consistently manage detainee sick calls, and they did not fully inform detainees of their COVID-19 test results.

Most Inspected Facilities Maintained an Adequate Supply of Facemasks and Other Protective Equipment

Generally, the detention facilities we reviewed reported sufficient supplies of protective equipment for detainees and staff since the onset of COVID-19, and had contingency plans in place to secure more of these items, if necessary. The nine locations we inspected remotely provided us with inventory lists and/or photos of their protective supplies. The detainees we interviewed also confirmed adequate supplies were available.



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We noted that each facility differed in the type and quantity of protective equipment provided to detainees and staff, but all generally complied with the requirements contained in the PRR by having sufficient supplies of masks for both detainees and staff. For example, some facilities such as Adelanto, Glades, Krome, and Mesa Verde provided surgical masks to detainees; Karnes and Richwood issued both washable, reusable cloth masks and surgical masks to detainees. At Henderson, detainees reported having facial masks and additional masks were provided to detainees upon request.

Some detainees at the facilities we inspected stated they wanted more masks on a regular basis, while others stated they were able to request additional masks if necessary and that masks were made available throughout the housing units. As with detainees, staff at some facilities said they were issued cloth masks with access to N95⁷ and/or surgical masks, as needed, while others suggested they only had access to N95 or surgical masks.

Detention facilities also differed in detainee and staff access to hand sanitizer. One facility we inspected added hand sanitizer stations throughout the housing units for both detainees and staff, as shown in Figures 1 and 2. Two facilities limited access to hand sanitizer to staff, while detainees had liquid soap for hygiene purposes.⁸



Figures 1 and 2. Hand sanitizer at detention officer stations at Krome on 10/20/2020
Source: Photos provided by Krome

⁷ An N95 respirator is a respiratory protective device designed to achieve a very close facial fit and efficient filtration of airborne particles.

⁸ Based on the PRR, regularly washing hands with soap and water for at least 20 seconds is the preferred method of maintaining proper hygiene. The PRR also recommends providing alcohol-based hand sanitizer with at least 60 percent alcohol, where permissible, based on security restrictions.

PRR Guidance

“ENSURE THAT SUFFICIENT STOCKS OF HYGIENE SUPPLIES (SOAP, HAND SANITIZER, TISSUES); PERSONAL PROTECTIVE EQUIPMENT (PPE) ARE ON HAND AND THERE IS A PLAN IN PLACE TO RESTOCK AS NEEDED IF COVID-19 TRANSMISSION OCCURS WITHIN THE FACILITY.”



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Facilities reported having enough protective equipment on hand during the course of the pandemic. Some facility staff we spoke to stated they had concerns at the beginning of the pandemic regarding potential shortages but never had to use contingency plans to obtain protective equipment. In the event there were shortages, facilities reported they had partnerships with local health departments and the ability to reach out to other facilities to obtain equipment, if needed.

Inspected Facilities Generally Performed Enhanced Cleaning

Before we initiated our review in September 2020, various media reports⁹ indicated detainees complained about the cleanliness of some detention facilities. At the time of our review and based on interviews with detainees and staff, along with supporting images and video, we did not identify any issues with cleanliness or complaints regarding the products used. The facilities we inspected remotely reported cleaning had increased since the onset of COVID-19; detainees we interviewed also confirmed the increased cleaning.

At almost every facility we inspected, we noted various efforts to enhance facility cleanliness, as required by the PRR. First, based on interviews with staff, as well as our review of facilities' cleaning schedules, we learned that facilities had increased the frequency of cleaning. At Adelanto, staff cleaned high-touch surfaces every 30 minutes; at Karnes, high-touch areas were cleaned hourly. El Valle doubled its cleaning from two to four times each day. The air filters in suites at Karnes,¹⁰ which used to be changed every 30 days, were instead changed after detainees moved out and before new ones moved in. Second, we learned that facilities instituted new cleaning methods. For example, Krome and Glades transitioned to using fogger machines that allowed staff to better disinfect larger areas in less time. We requested video footage based on Krome and Glades' cleaning schedules and confirmed the use of the foggers, as shown in use at Krome in Figure 3.

During our detainee interviews, we specifically asked whether they had concerns with the cleanliness of the facilities. Detainees acknowledged that the cleanliness of the housing units was sufficient and that they were given cleaning supplies to help maintain the sanitation of their living areas, as

PRR Guidance

"[ENSURE]... THAT CLEANING SUPPLIES AND FREQUENCY OF CLEANING SCHEDULE ARE SUFFICIENT TO MAINTAIN A HIGH LEVEL OF SANITATION WITHIN HOUSING AREAS WITHOUT NEGATIVELY IMPACTING THE HEALTH OF DETAINEES OR STAFF."

⁹ See <https://www.desertsun.com/story/news/politics/immigration/2020/06/27/immigrants-members-congress-decry-chemical-use-ice-facility-adelanto/3273095001/>.

¹⁰ Suites are smaller housing units of roughly 300 square feet and contain 8 bunk beds. According to Karnes staff, each family resides in its own suite.



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demonstrated in Figure 4 at Karnes. In our observations of photos and video footage, the facilities we inspected appeared clean.



Figure 3. Hand foggers in use at Krome on 10/20/2020
Source: Video surveillance footage provided by Krome



Figure 4. Cleaning and sanitation supplies for detainees in Karnes recreation areas on 10/8/2020
Source: Photo provided by Karnes



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Inspected Facilities Reported They Conducted COVID-19 Screening of Incoming Detainees and Staff

All nine facilities we inspected reported screening detainees for COVID-19 prior to entering the detention facility. Generally, screening involved asking screening questions, physical observations to check for COVID-19 symptoms, and taking detainees' temperatures.

Facility staff we interviewed described the process of meeting detainees in an outdoor area before entering the facility. As they entered, staff reported the detainees underwent temperature checks and a verbal screening for COVID-19 symptoms. This verbal screening included questions to determine if the detainee had been exposed to other individuals with COVID-19; if detainees had any symptoms such as fever, chills, temperature, cough; or if they had tested positive for the virus.

By reviewing video surveillance footage, we were able to observe portions of the intake screening process in some facilities. For example, at Glades we observed the arrival of new detainees at the facility. Prior to entry into the intake area, detainees were required to put on face masks. Then medical personnel took each detainee's temperature before allowing the detainee to enter the facility, as shown in Figures 5 and 6.

PRR Guidance

"SCREENING SHOULD TAKE PLACE BEFORE STAFF AND NEW INTAKES ENTER THE FACILITY OR JUST INSIDE THE FACILITY, WHERE PRACTICABLE. FOR NEW ADMISSIONS, THIS SHOULD OCCUR BEFORE BEGINNING THE INTAKE PROCESS.... THIS SHOULD INCLUDE TEMPERATURE SCREENING OF ALL ... NEW ENTRANTS AS WELL AS A VERBAL SYMPTOMS CHECK."



Figures 5 and 6. Pre-intake screening of detainees for COVID-19 at Glades on 10/10/2020
Source: Video surveillance footage provided by Glades

According to our interviews with staff, if at any time a detainee exhibited symptoms associated with COVID-19, the detainee was isolated to prevent the



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spread of the virus. We requested COVID-19 intake screening forms from the facilities we inspected and confirmed they had been completed. We also asked detainees about their screening experience when they arrived at facilities, and they stated they were temperature checked, medically evaluated, and provided face masks.

Additionally, we reviewed the screening processes for facility employees. Facilities reported that both ICE and contractor staff entering facilities underwent COVID-19 screening, including temperature checks twice a day and visual inspections for COVID-19 symptoms. We were able to confirm portions of the screening processes in some facilities as we observed employees entering facilities undergoing temperature checks through video and images. For example, at Adelanto, we observed temperature checks of some staff members in the lobby area as shown in Figure 7. We noted that not all individuals passing through the lobby checkpoint were temperature screened, but we cannot assess whether these people had already been screened prior to the video we reviewed. We observed the same screening processes at other facilities, including El Valle and Glades. We were unable to verify from videos whether facilities conducted verbal screening for staff.



Figure 7. Temperature screening of facility staff on 09/22/2020
Source: Video surveillance footage provided by Adelanto

Although Reported, We Could Not Confirm Whether Inspected Facilities Appropriately Grouped Detainees to Prevent the Spread of COVID-19

ERO defines a cohort as a group of detainees “with a similar condition grouped or housed together for observation over a period of time.” During the pandemic, facilities have used cohorts as a means to quarantine and isolate



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groups of detainees.¹¹ Staff at the detention facilities we inspected reported that all newly arriving detainees were cohorted for 14 days, as recommended by the CDC. For detainees who tested positive for COVID-19, facilities generally reported that they placed symptomatic detainees in medical isolation and cohorted asymptomatic detainees in the same housing units. Detainees suspected of having or being exposed to COVID-19 were also cohorted together. We learned that these cohorts usually comprised an entire housing unit, as opposed to smaller housing areas, unless a facility had enough single person cells to allow for isolation of a suspected COVID-19 infected individual. In addition, the cohorts were generally kept and moved together for meals, recreation time, and medical care.

PRR Guidance

“FOR SUSPECTED OR CONFIRMED COVID-19 CASES: ONLY INDIVIDUALS WHO ARE LABORATORY-CONFIRMED COVID-19 CASES SHOULD BE ISOLATED AS A COHORT. DO NOT COHORT CONFIRMED CASES WITH SUSPECTED CASES OR CASE CONTACTS.”

We analyzed IHSC weekly cohort reports, which is data collected by IHSC and reported to ERO to assess how the use of cohorts affects bedspace availability at facilities. The cohort reports track the number of cohorts in detention facilities by location, type of exposure, and length of time. We wanted to confirm that the same cohort did not include both individuals with confirmed COVID-19 and suspected COVID-19 cases, as the PRR requires. However, the cohort reports did not capture this information. We asked IHSC officials how they ensured confirmed COVID-19 cases were not cohorted with suspected cases and they said some facilities might use the comments field in the report to annotate this information, but it was not consistently tracked. Therefore, we could not independently confirm whether cohorts of detainees who tested positive for COVID-19 were separated from detainees suspected to have COVID-19. Without accurate tracking information, ICE also cannot validate that facilities followed PRR guidance and appropriately utilized cohorts to limit the spread of COVID-19.

Inspected Facilities Did Not Manage Detainee Sick Calls Consistently

Medical personnel across the facilities we inspected remotely used various methods to track detainee sick-call requests and the corresponding treatment. For example, both Adelanto and Henderson used proprietary software,¹² while

¹¹ According to the PRR, quarantine and isolation are public health practices used to protect the public from exposure to individuals who have or may have a contagious disease. Quarantine is the separation of a person or group of people reasonably believed to have been exposed to a communicable disease, but are not yet symptomatic, from others who have not been exposed, to prevent the possible spread of the communicable disease. Isolation is the separation of a person or group of people known or reasonably believed to be infected with a communicable disease and potentially infectious from others to prevent the spread of the communicable disease.

¹² Adelanto used “eClinicalWorks” while Henderson utilized “NaphCare.”



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Mesa Verde and Richwood tracked requests in handwritten logs. When we requested documentation to review the facilities' responses to sick-call requests, we received disparate information from each facility. The facilities varied greatly in documenting dates and details about the resolution of detainee COVID-19 or other health care issues in their respective tracking systems. Because of this, we were unable to determine for all the facilities we inspected remotely whether detainees were sufficiently treated in a timely manner.

When we could analyze sick-call requests, we found that facility staff did not always include necessary information to ensure they responded to the requests.

Specifically, we examined sick-call requests submitted by detainees at Krome during a 3-month time period and found that 184 detainees who tested positive for COVID-19 had submitted a sick-call request. While many of the sick-call requests were unrelated to COVID-19, we determined that 29 of the 184 detainees submitted complaints that could have been reasonably determined to be COVID-19 symptoms.¹³ Some of the complaints directly referenced COVID-19. Detainee sick-call request comments included:

- “Please, I need urgent medical attention.... I have all the symptoms of coronavirus and I’m going to infect everyone here.”¹⁴
- “My head, throat and body hurt a lot.... Please I need to see a doctor.”¹⁵
- “I would like to be tested for COVID-19.”
- “For the past 3 days, I have been experiencing various symptoms of covid 19 [sic]. I previously submitted a request asking to be tested. That request was closed promptly and without a response. I NEED TO BE TESTED. I spoke to guards as well yesterday telling them I have been experiencing covid 19 [sic] symptoms.”
- “I have sorethroat [sic], fever and body ache. I need to be checked as soon as possible. Thank u [sic].”
- “(I think I have been neglected by the staff...This symptoms [sic] every single day are getting worst [sic]): dry caught [sic], headaches ... short of breathing, constant fatigue, diarrhea. Please take me serious.”

PRR Guidance

“EDUCATE THE DETAINEE ON SYMPTOMS OF COVID-19 INFECTION AND INSTRUCT DETAINEES TO REPORT IF THEY HAVE ANY SYMPTOMS TO MEDICAL STAFF AT SICK CALL OR TO THE CUSTODY OFFICER (WHO WILL NOTIFY MEDICAL STAFF). PERFORM DAILY SICK CALL ROUNDS.”

¹³ These symptoms included fever, feeling feverish, chills, cough, difficulty breathing, muscle or body pain, headache, sore throat, new loss of taste or smell, congestion, nausea or vomiting, and diarrhea.

¹⁴ Translated from Spanish.

¹⁵ Translated from Spanish.



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Although the tracking system used by Krome for sick-call requests allows staff to enter the date when they responded, we found that the staff did not fill out this information for 77 percent of the requests. Therefore, we could not adequately determine whether Krome responded to the requests within a reasonable amount of time. Ultimately, the 29 detainees were tested for COVID-19, with positive results. In some instances, the detainees were not tested for more than a week after submitting their requests.

Staff and Detainees at Inspected Facilities Did Not Always Wear Face Masks

We requested photographs and video footage from each of the nine facilities to verify whether staff and detainees were wearing masks. Specifically, we requested visual evidence of housing units, medical units, cafeterias, recreational areas, visiting areas, and lobbies. We requested videos at various times of the day, such as during meal preparation and service, recreation, employee shift changes, and roll call.

Based on our review of the photographs and video footage, we determined that staff at most facilities were generally wearing masks appropriately.

However, at Richwood, we observed video of staff, particularly medical personnel, not wearing face masks while interacting with detainees during sick calls. Specifically, we requested video imaging of specific operations to ensure staff and detainees were wearing masks and maintaining social distancing. One of our requests included a 10-minute span of sick-call operations in which we observed unmasked medical personnel screening detainees, who were also unmasked.

PRR Guidance

“FACE COVERINGS SHOULD BE WORN BY DETAINEES AND STAFF. REQUIRE ALL STAFF ... TO WEAR PPE WHEN ENCOUNTERING OR INTERACTING WITH ANY ICE DETAINEE AT A DISTANCE OF LESS THAN SIX FEET.”

As shown in Figures 8 and 9, Richwood detainees were seated in chairs lining the hallway. Along the hallway, where detainees were waiting to be seen, several doors appeared to lead to private medical screening rooms. Medical staff entered and exited these rooms often during the 10-minute video provided. As seen in the images, these medical staff walked down the hallway and came in and out of the medical rooms without any personal protective equipment.



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Figures 8 and 9. Medical staff walking the hall outside sick-call area and conducting medical screening on 10/08/2020

Source: Video surveillance footage provided by Richwood

We observed employees not wearing face masks at other inspected facilities, but not to the extent seen at Richwood. Overall, our review of videos from the other detention facilities showed staff generally wearing masks in the presence of detainees, but there are instances, such as in the lobby or other areas where detainees were not present, when staff members were either not wearing the mask correctly or not wearing it at all.

Both ICE and facility officials explained that, consistent with the PRR, staff should generally wear masks in the detention facilities and definitely when interacting with detainees. They further stated that this safety practice was communicated through training and with reminder signage throughout the facilities. We requested copies of the signage from our inspected facilities and confirmed signs were posted reminding staff and detainees to wear masks. We could not determine whether punitive measures existed at these detention facilities to effectively deter staff from not wearing masks.

ICE guidance states that detainees should wear face coverings to help slow the spread of COVID-19. In specific instances, such as during medical and isolation situations or when participating in voluntary work programs, detainees are required to wear face masks. During our remote inspections, we found that detainees did not consistently wear face masks, despite their availability. In our review of photographs and video footage, we noted that this noncompliance typically occurred within the housing units, as shown in Figures 10 and 11. Staff told us that detainees considered their housing units to be like their homes and chose not to wear masks in these spaces. Facility staff also stated it was easier to enforce mask wearing outside the housing units as detainees moved between various areas. Detainees that we



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interviewed confirmed what staff told us — that they typically chose not to wear masks in their housing units but did so when outside the housing areas.¹⁶



Figure 10. Some detainees in housing unit not wearing face masks on 10/20/2020

Source: Photo provided by Krome



Figure 11. Detainees in housing unit not wearing face masks on 10/08/2020

Source: Photo provided by Eloy

ICE and contractor staff reported to us they could not determine and implement effective solutions to deter this behavior by detainees for several reasons. At Krome, for example, staff stated that there was no specific disciplinary charge for not wearing masks, and they would have to charge detainees with something else, such as defying orders. Further, if they chose to discipline detainees, they would have to place them in administrative segregation and the facility would quickly run out of physical space. Therefore, it likely was not feasible to hold detainees accountable for not wearing masks.

Detainees at Inspected Facilities Did Not Always Maintain Social Distancing

In addition to wearing face masks, maintaining social distancing is critical to preventing the spread of COVID-19 in congregate settings. During our field work, we found detainees did not consistently maintain social distancing, particularly in housing units, as shown in Figure 12. In some instances, detainee beds were permanently affixed less than 6 feet apart, which made it difficult to maintain social distancing. Conversely, we observed through video

PRR Guidance

“WHENEVER POSSIBLE, ALL STAFF AND DETAINEES SHOULD MAINTAIN A DISTANCE OF SIX FEET FROM ONE ANOTHER.”

¹⁶ OIG noted similar issues regarding the wearing of face coverings by detainees at La Palma Correctional Center, Pulaski County Jail, and Adams County Correctional Facility during our unannounced inspections.



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and images, detainees who chose not to socially distance from each other, even when there was adequate space to do so and the furniture was clearly marked to promote distance between each detainee.¹⁷ As with mask-wearing among detainees, ICE and contractor staff reported to us they could not determine and implement effective solutions to enforce social distancing.



Figure 12. Lack of social distancing by detainees on 10/08/2020

Source: Video surveillance footage provided by Richwood

Regardless of compliance by detainees, we observed in video and images that some facilities made efforts to encourage social distancing between detainees.

Specifically, at El Valle (Figure 13), meal tables had every other seat marked off, and in hallways at Richwood (Figure 14) where detainees waited for medical care, stickers on the floor marked every 6 feet to promote social distancing. In addition, even when beds were permanently affixed, facilities spaced out detainees to increase social-distancing. As shown in Figure 15, at Krome, detainees slept one person per bunk and alternated the use of top and bottom bunk.

¹⁷ OIG noted similar issues regarding social distancing among detainees at La Palma Correctional Center, Adams County Jail, and Pulaski Correctional Facility during our unannounced inspections.



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Figure 13. Dining hall seats marked to promote social distancing on 10/13/2020
Source: Photo provided by El Valle

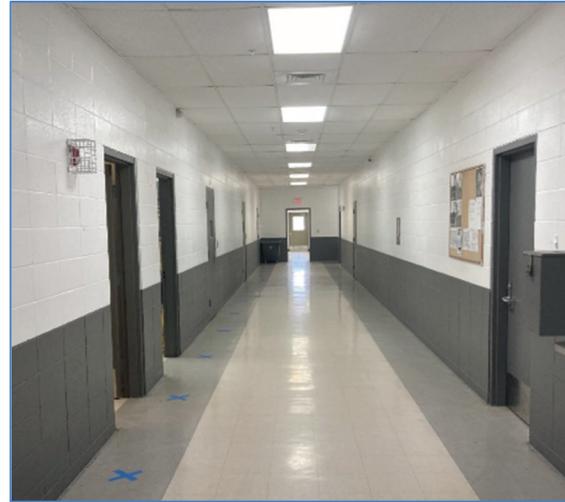


Figure 14. Floor marked to promote social distancing on 10/08/2020
Source: Photo provided by Richwood



Figure 15. Beds configured to promote social distancing on 10/20/2020
Source: Photo provided by Krome

Finally, we found facilities made efforts to increase social distancing when detainees were outside their housing units. For example, Karnes limited the number of families who could use the outdoor playgrounds and inside day rooms at the same time. At Karnes and Mesa Verde, recreation times in outdoor spaces were limited to detainees from the same housing unit to minimize interaction with detainees from other housing units.



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Inspected Facilities Did Not Always Notify Detainees of Their COVID-19 Test Results

During our remote inspections, we determined that the facilities did not consistently communicate with detainees regarding the outcomes of their COVID-19 tests. Specifically, some detainees we interviewed alleged they had been tested for COVID-19, with positive results, but were not notified of the test results. Without adequate communication regarding COVID-19 testing and testing results in particular, detainees are not able to fully understand their medical condition or options for care.

During our interviews with Krome detainees, for example, we found they were not notified that they had tested positive for COVID-19. In one instance, a detainee expressed surprise when we told him he had tested positive for COVID-19 3 months prior. He stated that he remembered being tested but was never told the results. Another detainee also stated that he was never informed of his test results, and that he and other detainees figured out they had tested positive only after they were moved to another housing unit. Facility officials acknowledged instances in which detainees were not informed of their test results because they were moved to medical isolation or another location before they could be notified. As a result of this lack of communication, one detainee stated he and other detainees were “scared and confused” because they had to “guess whether they had” COVID-19.

PRR Guidance

“COMMUNICATE REGULARLY WITH ISOLATED INDIVIDUALS ABOUT THE DURATION AND PURPOSE OF THEIR MEDICAL ISOLATION PERIOD.”

At El Valle, two detainees reported arriving at the facility and being immediately quarantined after intake. It was not until they were released from quarantine that both detainees learned they had tested positive for COVID-19. Neither reported feeling ill or having any COVID-19 symptoms.

ERO Decreased Its Detainee Population to Limit the Spread of COVID-19, but Data about Detainee Transfers Was Limited

ICE was able to mitigate the spread of COVID-19 in its detention facilities by decreasing its detainee populations through several actions. First, ICE limited its enforcement activities at the start of the pandemic to focus on individuals who posed public safety risks. Second, apprehensions¹⁸ from U.S. Customs

¹⁸ When CBP encounters individuals without valid documents for entry into the United States either between or at ports of entry, CBP apprehends them and determines whether the apprehended individuals are admissible into the country. If the individual is determined to be inadmissible, he or she is processed for appropriate removal proceedings and may be detained



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and Border Protection (CBP) dropped at the same time, resulting in fewer individuals entering into ICE custody. ICE also continued to release individuals from custody or remove them from the United States. Specifically, ICE worked to release detainees who were at higher risk of illness from COVID-19 because of various health factors. For those still in custody, we were unable to determine whether ICE had reviewed their custody status, as required. Finally, we were unable to determine how many detainees were transferred between facilities and for what reasons.

Limited Enforcement Activities and Decreased CBP Apprehensions Helped ICE Decrease Its Detainee Population

Between January and December 2020, according to ICE's Average Daily Population (ADP) detainee data, detention facilities were able to reduce their overall population by 59 percent, from about 38,045 to roughly 15,680 detainees in custody. ICE reduced its detainee population through a combination of decreased arrests and apprehensions, as well as continued releases and removals.

ICE Limited Its Enforcement Activities

In response to the pandemic, ICE adjusted its enforcement activities to reduce the detainee population in its detention facilities. On March 18, 2020, ICE announced that it would “temporarily adjust its enforcement posture” and that its “highest priorities [were] to promote life-saving and public safety activities.”¹⁹ ICE also stated that it would narrowly focus enforcement on public safety risks and individuals subject to mandatory detention based on criminal grounds; otherwise, “ERO will exercise discretion to delay enforcement actions.”

After the March 2020 announcement, administrative arrests²⁰ plummeted. From March to April 2020 alone, the number decreased by 44 percent from 10,431 to 5,793. During the first 3 months of 2020, administrative arrests averaged around 11,500 per month; this number dropped to about 6,200 from April through September 2020. See Figure 16 for the number of administrative arrests ICE made each month from January to September 2020.

during the proceedings. If immigration proceedings are not resolved quickly, ERO is responsible for the longer-term detention of some inadmissible individuals.

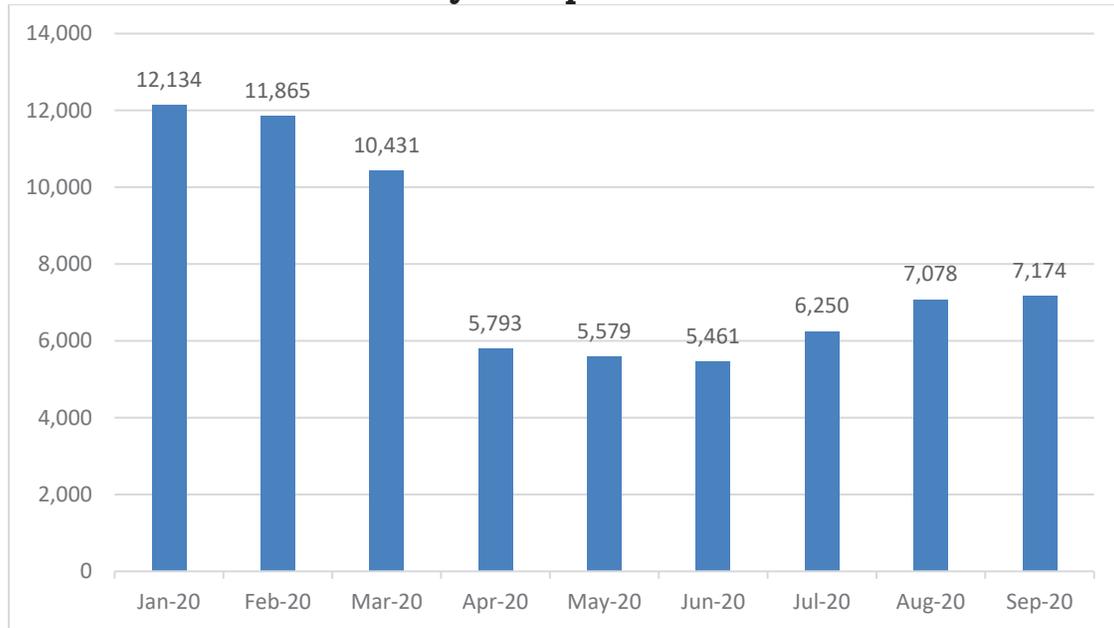
¹⁹ <https://www.ice.gov/news/releases/updated-ice-statement-covid-19>.

²⁰ Administrative arrests are arrests of non-citizens by ERO for administrative violations of U.S. immigration law.



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Figure 16. Number of Administrative Arrests by Month, January to September 2020



Source: DHS OIG analysis of ICE data

CBP’s Apprehensions Decreased and Title 42 Expulsions Increased

During the pandemic, CBP also apprehended fewer migrants. Title 42, Section 265 of the United States Code allows the Government to suspend the introduction of individuals from foreign countries to prevent the spread of communicable diseases. On March 20, 2020, under that authority and in response to COVID-19, the CDC issued an order²¹ temporarily prohibiting the introduction of certain persons from foreign countries traveling from Canada or Mexico, regardless of their countries of origin, and who would otherwise be introduced into congregate settings.²² Under Title 42 and the CDC Order, CBP has expelled (i.e., Title 42 expulsions) thousands of inadmissible migrants back to their home countries. Additionally, CBP ports of entry and Border Patrol stations experienced major declines in apprehensions along the Southwest and Northern borders. Combined, this resulted in far fewer detainees from CBP entering into ICE detention facilities. Figure 17 shows the decrease in apprehensions, as well as the increase in Title 42 expulsions.

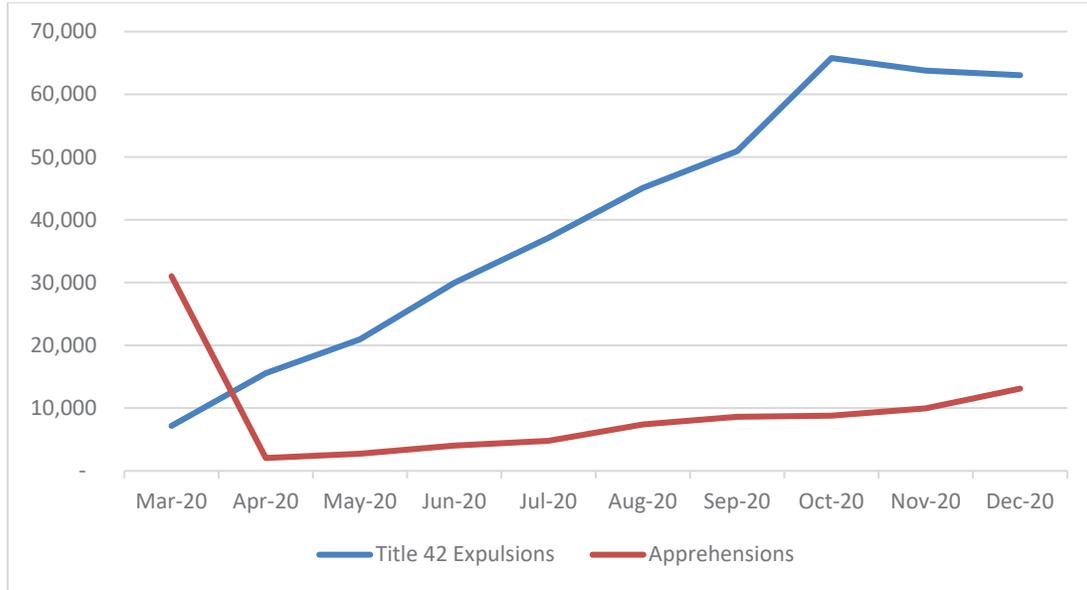
²¹ U.S. Department of Health and Human Services CDC, Order Under Sections 362 & 365 of the *Public Health Service Act* (42 U.S.C. 265, 268), Order Suspending Introduction of Certain Persons From Countries Where a Communicable Disease Exists. The original order was extended for 30 days on April 20, 2020, and indefinitely on May 19, 2020.

²² Specifically, the order prohibited the following individuals from entering the United States: migrants seeking to enter the country at ports of entry who do not have proper travel documents; individuals whose entry is otherwise contrary to law; and migrants apprehended near the border who are seeking to unlawfully enter the country between ports of entry.



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Figure 17. CBP Title 42 Expulsions and Apprehensions, March to December 2020



Source: DHS OIG analysis of CBP data

ICE Continued to Release and Remove Detainees

In addition to fewer individuals entering detention facilities due to arrests or apprehensions, ICE also continued to release detainees from its facilities and remove detainees back to their countries. These continued releases and removals helped maintain lower detainee populations in ICE facilities. Table 1 shows the number of releases and removals in 2020.

Table 1. Number of ICE Releases and Removals, 2020

	Releases	Removals	Total
January	6,239	23,270	29,509
February	5,972	22,353	28,325
March	6,809	19,249	26,058
April	5,238	9,992	15,230
May	3,305	7,872	11,177
June	2,711	7,222	9,933
July	2,235	6,789	9,024
August	2,153	6,903	9,056
September	2,089	6,868	8,957
October	2,536	10,223	12,759
November	2,923	5,758	8,681
December	3,567	5,682	9,249
Total	45,777	132,181	177,958

Source: DHS OIG analysis of ICE data



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Overall Average Daily Population of Detainees in ICE Detention Facilities Declined

As a result of decreased ICE enforcement actions and CBP apprehensions, the initiation of Title 42 expulsions, and continued releases and removals, ICE was able to decrease detainee populations in its facilities. We examined the ADP for ICE facilities from January through December 2020 and determined that the overall ADP dropped by 59 percent, from about 38,000 to roughly 15,700 detainees in custody. Specifically, 138 of 183²³ facilities were able to decrease their ADP. In contrast, 27 facilities' ADP actually increased during this time period while the detainee population for 18 locations did not change. ICE officials told us that some facilities likely increased their populations during the pandemic to help prevent overcrowding and increase social distancing at other facilities in the same region.

ICE Identified High-Risk Detainees for Release but Had Incomplete Data about Their Custody Redeterminations

Certain individuals are considered to be at higher risk for serious illness from COVID-19 based on underlying health factors. Throughout the pandemic, ICE directed officials at its detention facilities to determine whether continued detention was the appropriate course of action for these higher-risk individuals. Initially, on March 18, 2020, ICE instructed the facilities to determine whether continued detention was appropriate for detainees older than age 70 or those who were pregnant. On April 4, 2020, ICE expanded the criteria to include:

- detainees older than 60 years,
- detainees who had given birth in the last 2 weeks, and
- detainees of any age who had chronic illnesses that would make them immune-compromised, such as having heart or lung disease, chronic kidney disease, or a compromised immune system.

Beginning on April 20, 2020, a court order required ICE to reassess custody for a broader class of high-risk detainees, such as those older than age 55.²⁴ The court order also required ICE to conduct the custody redeterminations within a certain timeframe — within 10 days for existing detainees or within 5 days of a

²³ Per ICE's ADP data, we determined that 183 detention facilities were operational and held detainees during any month from January through December 2020.

²⁴ *Fraihat v. ICE*, No. 5:19-cv-01546 (C.D. Cal. filed Aug. 19, 2019), 445 F. Supp. 3d 709 (C.D. Cal. 2020). The district court ordered that two types of detainees be re-assessed for release: (1) Subclass One: All people detained in ICE custody who have one or more risk factors placing them at heightened risk of severe illness and death upon contracting COVID-19. The risk factors include being older than age 55, being pregnant, or having chronic health conditions; and (2) Subclass Two: All people detained in ICE custody whose disabilities place them at heightened risk of severe illness and death upon contacting the COVID-19 virus.



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new detainee’s arrival — and also required ICE to identify and track these detainees. ICE defined these detainees as being “*Fraihat* subclass members.” According to ICE’s guidance:

[the] presence of one of the [health] factors ... should be considered a significant discretionary factor weighing in favor for release. To be clear, however, it may not always be determinative.

For example, detainees subject to mandatory detention,²⁵ certain criminal or terrorist detainees, and those with arrests or convictions for crimes involving high risk to the public, as well as detainees whose release would pose a danger to property or persons may not necessarily be released, even if they have one of the risk factors.

We examined ICE data and found that since April 2020, detention facilities had identified 12,801 detainees who were *Fraihat* subclass members because they were at higher-risk for serious illness from COVID-19 due to their health factors. As of mid-December 2020, 77 percent (9,892) of these *Fraihat* subclass detainees were no longer in custody. Table 2 shows the custody decisions for these detainees:

Table 2. Outcome of Custody Redeterminations for Detainees Who Were No Longer in Custody, December 2020

Custody decision	Number	Percentage
Detainee removed	5,220	52.8%
Detainee released	4,406	44.5%
Other	266	2.7%
Grand Total	9,892	100.00%

Source: DHS OIG analysis of ICE data

For the 2,909 detainees who remained in ICE custody, we attempted to determine whether ICE had conducted a custody redetermination. Because of incomplete data, we were unable to fully identify whether or not ICE completed the majority (87 percent) of redeterminations for this group as shown in Table 3.

²⁵ Migrants who arrive in, attempt to enter, or have entered the United States without having been admitted or paroled following inspection by an immigration officer at a designated port of entry are subject to detention pending determination of their admissibility or removal. See 8 U.S. Code (U.S.C.) §§ 1225(b)(2)(A), 1226(a)(1) and 8 Code of Federal Regulations (C.F.R.) § 235.3(b)(2)(iii), (b)(4)(ii), (c).



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Table 3. Outcome of Custody Redeterminations for Detainees Who Remained in Custody, December 2020

Custody decision	Number	Percentage
Continued detention	369	12.7%
Other	9	0.3%
Information missing	2,531	87.0%
	2,909	100%

Source: DHS OIG analysis of ICE data

On three occasions, ERO sent broadcast e-mails to all field offices with an attached list of *Fraihat* subclass members who still needed custody re-determinations. Based on the most recent e-mail from March 11, 2021, it appears the custody status for 1,810 detainees had still not been reviewed to determine whether continued detention was justified.

Of the 12,801 detainees who were identified as *Fraihat* subclass members, 1,757 (14 percent) ultimately tested positive for COVID-19 while in ICE custody and 7 died. We asked ICE officials why individuals who were identified as *Fraihat* subclass members remained in detention, despite the presence of high-risk health factors. The officials told us that ERO field office directors made custody determinations on a case-by-case basis, and in some instances, these detainees had criminal histories or were considered security risks. In other cases, they stated that if *Fraihat* subclass members were likely to be removed or were close to imminent removal, ICE chose not to release them. In these instances, even in the presence of health risks, ICE would not release the detainee. We reviewed the records of the seven *Fraihat* subclass members who died in custody. The records indicated that ICE reconsidered detention for six of the detainees, all of whom had prior criminal convictions, and determined they should remain in custody, either due to public safety threats or flight risks, or because the detainee was scheduled for imminent removal. However, for the seventh detainee, it is unclear from the documentation we reviewed whether ICE completed a custody redetermination. Without reviewing and tracking custody determinations of high-risk detainees, ICE cannot ensure it evaluated these detainees' cases regarding whether continued detention was appropriate, as required.

ERO Was Unable to Provide Information about Detainee Transfers

To prevent the spread of COVID-19 throughout its facilities, ERO has attempted to limit detainee transfers. Originally, the PRR instructed ICE facilities to limit transfers only of non-ICE populations²⁶ unless necessary for medical evaluation, isolation/quarantine, clinical care, or extenuating security concerns. In July 2020, the guidance was revised to suspend transfer of both ICE and non-ICE detainees for reasons other than “medical evaluation, medical

²⁶ Non-ICE populations refer to non-ICE detainees, such as state or local inmates.



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isolation/quarantine, clinical care, extenuating security concerns, to facilitate release or removal, or to prevent overcrowding.” The guidance was further updated in October 2020 to state that transfer for reasons other than the six exceptions had to be pre-approved by the field office director.

We asked ICE officials for information regarding detainee transfers in calendar year 2020, but they stated they were unable to provide the data because it had not been “completed/validated.” We then asked for further details regarding the pre-approval process begun in October 2020. The ICE officials responded that the pre-approval process involved “a discussion describing the reason for the transfer that is routed through the chain of command up to the [field office director] for a decision.” Because ICE was unable to provide any further information about transfers that occurred, we could not independently validate the number of transfers, or the reasons for these transfers.

COVID-19 Testing of Detainees and Staff Was Insufficient

The testing of detainees and staff for COVID-19 is paramount to the safety and well-being of all occupants in an ICE detention facility, especially given that medical studies indicate more than half of known COVID-19 cases stem from asymptomatic individuals.²⁷ During our remote inspections we found that the testing of detainees and staff was inconsistent across the nine inspected facilities. We also analyzed information regarding testing of detainees and staff at all detention facilities. Overall, some facilities conducted whole-facility testing in an effort to quickly identify COVID-19 positive detainees and staff. However, ERO did not require immediate COVID-19 testing of all detainees upon arrival at detention facilities until October 2020. In addition, ERO and the detention facilities still do not have a strategy for COVID-19 testing of ERO staff located in detention facilities.

Detention Facilities Do Not Test All New Detainees for COVID-19 as Required

The PRR describes various measures meant to help prevent potential transmission of COVID-19 from newly arrived detainees to those already housed in detention facilities. ERO guidance issued on June 4, 2020, directed all ICE IHSC-staffed facilities to begin testing detainees for COVID-19 during the intake screening process. For all other facilities, COVID-19 testing of detainees during intake screening was not required until updated guidance was issued on October 27, 2020. According to the revised PRR guidance, “[a]ll

²⁷ SARS-CoV-2 Transmission from People without COVID-19 Symptoms. See https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774707?utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_term=010721.



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new arrivals to ICE detention facilities require COVID-19 testing within 12 hours of arrival.” Regardless of this requirement, we found that facilities were still not testing all new detainees when they arrived at a facility.

Our analysis determined every IHSC facility conducts intake testing of its detainees, as required. However, IHSC facilities accounted for only 17 (9 percent)²⁸ of the 183 detention facilities that were operational and held detainees during January through December 2020. In December 2020, for those facilities without IHSC staff, only 27 percent (44 of 166) were conducting intake testing. By February 2021, IHSC staff reported that the number of non-IHSC facilities conducting intake testing had risen to 67 facilities. IHSC staff also stated they “had received intake testing data from 67 [non-IHSC] facilities. This does not mean only 67 facilities are doing intake testing, it means we have data from 67 of them.”

Our analysis of data and interviews with ICE officials indicates that ERO did not have a full picture of which facilities were actually conducting COVID-19 testing on detainees as they arrived at the facilities, as required by the PRR. ICE must receive and track intake testing data to ensure all detention facilities conduct the required testing, which is an important method to prevent the spread of COVID-19 throughout its facilities.

Detention Facilities Appeared to Have Conducted Whole Facility Testing without Approval from ICE

In June 2020, ERO headquarters staff notified detention facility staff that it was aware of situations where facilities had implemented whole-facility testing (i.e., voluntary testing of all detainees in a detention facility at one time). Because IHSC had not provided guidance or requirements for whole-facility testing at that time, ERO stated that whole-facility testing could be implemented, but only with the approval of ERO leadership. In an e-mail to all field offices, ERO described procedures for detention facilities that wished to implement whole-facility testing of its detainees. Specifically, in order to participate in whole-facility testing, detention facilities had to comply with COVID-19 testing requirements and submit a written plan detailing how they would implement testing procedures for approval by both ERO and IHSC staff.

²⁸ According to ICE, there are currently 19 IHSC facilities. However, the Alexandria Staging Facility in Alexandria, Louisiana, and 26 Federal Plaza Processing Center in New York City, New York, do not typically hold detainees for more than 72 hours and 24 hours, respectively. Consequently, these two locations were not included in ICE’s ADP tracking of detainees held at 183 operational facilities during January through December 2020.



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ERO headquarters officials reported that, as of December 2020, 41 facilities had developed and submitted a plan for whole-facility testing, and that all plans had been approved. However, ERO officials also reported 54 facilities had conducted whole-facility testing at some point. Of the 54 facilities, 15 (28 percent) had not submitted plans for pre-approval; 4 of the 15 facilities conducted whole-facility testing before ERO disseminated the June 2020 guidance. It is unclear whether the remaining 11 facilities submitted the required plans. Although testing is a critical method for preventing the spread of COVID-19 in facilities, it is equally important that facilities have the correct procedures in place — ones approved by ERO and IHSC staff — to ensure appropriate protocols are followed.

ERO Field Offices and Detention Facilities Do Not Test Staff for COVID-19, and Are Unaware of Testing Requirements for Contract Staff

Although the PRR clearly outlines the testing procedures for detainees, it is less clear regarding testing for staff. Specifically, according to the PRR guidance for staff testing, detention facilities are to:

[f]ollow guidance from the Equal Employment Opportunity Commission,²⁹ when offering testing to staff. Any time a positive test result is identified, ensure that the individual is rapidly notified, connected with appropriate medical care, and advised how to self-isolate.

Of the nine facilities we inspected, we learned that Glades, Eloy, Adelanto, and Karnes had tested all contract employees; Karnes tested its ERO field office staff as well. However, none of the facilities we inspected made testing available to their staff on a routine basis. Although all nine facilities described staff COVID-19 screening procedures, including temperature checks, visual inspections, and completing COVID-19 symptoms questionnaires prior to entry, screening does not identify asymptomatic individuals who may have COVID-19 and expose staff and detainees unwittingly.

We asked ERO headquarters officials whether they gathered or tracked information regarding testing of contractor staff at detention facilities, as well as the results of those tests. They told us while contractor staff who tested positive should report their status through their chain of command to local ERO field offices, this information was not tracked across all detention facilities by ERO headquarters. As contractor staff typically make up the majority of

²⁹ See <https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws>.



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personnel at detention facilities, it is concerning that ERO headquarters does not track this information.

All ICE personnel are required to report, through their chain of command, if they have tested positive for COVID-19. However, no guidance has been provided to identify which tests³⁰ are acceptable, resources for who provides COVID-19 tests, or how to pay for the tests. In addition, we learned that ERO field office staff at the detention facilities did not have guidance regarding reimbursement for COVID-19 testing due to workplace exposure. One ICE official we spoke to at a detention center was exposed to COVID-19 after interaction with a COVID-19 positive detainee. Upon learning of his exposure, the ICE official immediately went to the local urgent care to be tested. Health insurance covered some of the cost. However, the ICE official was required to pay an out-of-pocket co-pay. When asked if there were procedures in place to cover the cost of co-pays or COVID-19 tests not covered under insurance, the ICE official was unsure. When addressing this concern at other detention facilities we inspected, along with ERO headquarters staff, we learned that there was no consistency regarding how to reimburse employees for tests after exposure to COVID-19 in the workplace. Interviewees told us various ways they might be reimbursed, such as filing a Workman's Compensation claim, adding the cost to a travel voucher, or filing a claim under the CARES Act.³¹ This inconsistency renders an entire population of the ICE ERO workforce, who are required to provide oversight at detention facilities, vulnerable to multiple exposures which could lead to considerable out of pocket costs.

ERO Practiced Limited Oversight of COVID-19 in Its Detention Facilities

During our review we found that ERO practiced limited oversight of COVID-19 in its detention facilities. Detention facilities were required to complete a biweekly questionnaire and report deficiencies and corrective action plans, but we found ERO headquarters did not track the reported information. To monitor compliance with detention facility requirements, ERO field office staff were required to conduct facility walk-throughs on a routine basis, but we found these in-person inspections rarely occurred.

³⁰ Viral tests are used to look for current infection. Two types of tests can be used: nucleic acid amplification tests (NAATS) and antigen tests. See <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html>.

³¹ Public Law No. 116-136, *Coronavirus Aid, Relief, and Economic Security Act* or the CARES Act, responds to the COVID-19 outbreak and its impact on the economy, public health, state and local governments, individuals and businesses. See <https://www.congress.gov/bill/116th-congress/house-bill/748>.



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ERO Did Not Track Bi-weekly Spot Check Deficiencies or Associated Corrective Actions

ICE provides COVID-19 oversight of its detention facilities through on-site monitoring by detention service compliance officers (DSCO) and detention service managers (DSM).³² During our fieldwork, the PRR required ERO's DSMs or DSCOs at detention facilities to conduct bi-weekly spot checks. In doing so, DSMs and DSCOs used checklists with questions about facility compliance with various criteria related to COVID-19. For example, the 14-page questionnaire covered protective equipment and cleaning supplies stocks; signage addressing COVID-19 protocols throughout the facility; cleaning procedures; social distancing and mask wearing for detainees and staff; and screening procedures. The PRR also required that, upon identification of a deficiency, ERO headquarters staff would provide written notice to the facility and allow 7 business days for the facility to submit a corrective action plan to ERO headquarters for approval.

Facilities reported to us that the DSMs and DSCOs completed the bi-weekly checklists in accordance with the PRR. Typically, the bi-weekly checklists were completed virtually. We learned that the DSMs and DSCOs submitted the completed checklists to the Office of Principal Legal Advisor (OPLA) in ICE headquarters. We asked ICE officials what was done with the results of the bi-weekly checklists, including how deficiencies were identified and addressed. ERO headquarters officials were unable to provide documentation to show the results from bi-weekly spot checks were monitored to track deficiencies and stated that the Custody Management Division was developing a process to track reported deficiencies and the corresponding corrective actions plans.

On October 27, 2020, the PRR guidance was updated to change the bi-weekly requirement to "onsite in-person monthly spot checks." These monthly in-person spot checks began in November 2020. Following implementation, we again asked ERO headquarters officials how deficiencies and corrective actions were tracked; they stated they were "unsure."

ERO Staff Did Not Conduct In-Person Oversight of Detention Facilities during the Pandemic

Although not a new requirement for ERO staff, the PRR requires frequent internal and external inspections of detention facility areas to help ensure safety and security. These inspections may be conducted by the DSCOs or DSMs who are located at the facilities. At the onset of the pandemic, ERO

³² ICE officials explained that DSCOs and DSMs have similar duties. However, DSCOs are typically law enforcement officers while DSMs are not.



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directed its oversight personnel, including deportation officers, to work virtually and to avoid physically entering detention facilities for several months during the first half of 2020. As a result, ICE employees were unavailable to answer detainee questions and concerns in person. Prior to this order, ERO did not conduct a risk analysis related to reducing the presence of ERO employees, including DSMs and DSCOs, in detention facilities during the pandemic.

We asked ICE officials if they had concerns regarding the limited presence of deportation officers and other ICE employees in the facilities. One ICE headquarters official remarked that ERO went too far with telework. He stated that a main responsibility for detention officers was to walk around and be a visual presence for detainees, and that ICE personnel should physically be in the facilities because it was the only true method of monitoring detention conditions. Another ICE official in the field said he had “serious concerns” with staffing during the pandemic, as it introduced vulnerabilities in detention oversight. Although he believed the safety of staff was paramount, he stated that oversight was lacking because of the remote work. For example, he stated that segregation reviews were not being completed in a timely manner, and that removal checks were delayed. Ultimately, he said “[t]oo many little things are going to come back to bite us.”

Further, detainees told us they did not see ICE personnel in their housing units during the pandemic. Several detainees recounted rarely seeing their deportation officer at the start of the pandemic. Some detainees said they had not seen ICE personnel prior to our unannounced inspection. One detainee at Krome told us he remembered ICE staff used to walk through the housing units on a weekly basis, but during the pandemic, he only saw them when they needed to escort a detainee out of the facility for a court date.

Conclusion

Since the onset of the pandemic in March 2020, ICE has implemented various measures to control the spread of COVID-19 in its detention facilities. Some measures, such as enhanced cleaning and access to protective equipment, have been successful, while others, such as wearing face masks and social distancing by detainees, are still a work in progress, even after a full year. In addition, testing of both detainees and staff, while improved, is still inconsistent. Finally, ERO headquarters’ oversight of its facilities during the pandemic is lacking in some areas. ICE has managed to maintain a decreased detainee population to this point, which has helped mitigate the spread of COVID-19. However, the situation could, and has, quickly changed. In the last 3 months alone, the number of detainees who have tested positive for COVID-19 has risen from 345 on March 1, 2021, to 860 on June 1, 2021, a 149 percent increase. ICE must continue to exercise due diligence and apply caution to ensure the safety of detainees in its custody, as well as staff. In



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response to our findings and recommendations regarding COVID-19 in specific facilities during our unannounced inspection program, we noted that some facilities have already taken action to address COVID-19, including the vaccination of detainees. Accordingly, we are providing the following recommendations to improve ICE's overall detention planning and operations nationwide at its facilities to continue to address the current COVID-19 pandemic and any future pandemics.

Recommendations

We recommend the Director, U.S. Immigration and Customs Enforcement:

Recommendation 1: Ensure detention facilities meet ICE's COVID-19 requirements in the PRR, including:

- wearing of masks by detention facility staff;
- testing of all new arrivals to ICE detention facilities for COVID-19; and
- transfers of detainees for reasons allowed by the PRR only.

Recommendation 2: Revise the cohort tracking report to differentiate between cohorts of detainees with confirmed cases of contagious diseases and those with suspected cases or who have been in contact with confirmed cases of contagious diseases.

Recommendation 3: Develop specific guidance regarding communication with detainees regarding their medical conditions and care and ensure facilities implement this guidance.

Recommendation 4: Ensure completion of custody redeterminations for high-risk detainees and appropriately track custody redeterminations in ICE's data systems.

Recommendation 5: Ensure all detention facilities that conduct whole-facility testing have submitted plans to ICE and that these plans have been approved.

Recommendation 6: Implement and track corrective action plans related to discrepancies found during the monthly spot checks.

OIG Analysis of ICE Comments

We have included a copy of ICE's Management Response in its entirety in Appendix B. We also received technical comments to the draft report and revised the report where appropriate.

ICE concurred with the six recommendations, which are resolved and open. A summary of ICE's responses and our analysis follows.



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ICE's Comments to Recommendation 1: Concur. IHSC provides guidance and outlines requirements for all ICE detention facilities through the PRR. For example, in June 2021, IHSC partnered with ERO's Custody Management Division (CMD) to update the PRR to align with revised CDC guidance. IHSC issues guidance through the PRR, and CMD ensures its implementation and compliance. Further, DSMs and DSCOs address compliance within facilities. ICE estimates these actions to be completed by October 29, 2021.

OIG Analysis: We consider these actions responsive to Recommendation 1, which is resolved and open. We will close this recommendation when we receive documentation showing that ICE is able to ensure detention facilities meet COVID-19 requirements in the PRR.

ICE's Comments to Recommendation 2: Concur. IHSC will modify the weekly cohort report to ensure cohorts of confirmed cases are tracked separately from cohorts of suspected cases. IHSC will also ensure data entry procedures are more clear.

OIG Analysis: We consider these actions responsive to Recommendation 2, which is resolved and open. We will close this recommendation when we receive evidence showing the cohort tracking report has been modified to include separate tracking of cohorts of confirmed and suspected COVID-19 cases, clearer data entry requirements, and use by detention facilities for reporting cohort status.

ICE's Comments to Recommendation 3: Concur. On March 17, 2021, IHSC published IHSC Directive 02-07, "Treatment Consent and Refusal," which requires clinicians to explain the detainee's condition and any clinical treatments. Providers within IHSC-staffed facilities inform detainees of their medical status, when possible and under applicable conditions. Further, IHSC informs detainees of their health status, if known, while in custody, although it is important to note that the detainee might move or transfer before test results return. ICE asked that the recommendation be closed.

OIG Analysis: We consider these actions responsive to Recommendation 3, which is resolved and open. While the Directive states that IHSC providers must provide "sufficient information and education regarding medical treatment to permit detainees to make informed decisions concerning their medical care," it does not adequately address how providers will inform detainees in non-IHSC-staffed facilities. As described in the report, IHSC facilities accounted for only 9 percent of operational facilities during the time of our evaluation. In addition, while it may not be feasible for IHSC to inform detainees of test results if they leave the facility where they were tested, every effort should be made to inform detainees of their test results if they change housing locations within the same facility where they were tested. We will close this recommendation when we receive documentation showing how ICE



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will ensure detainees at non-IHSC-staffed facilities are appropriately informed of their medical conditions and care, as well as documentation confirming that detainees will be informed of test results while at the facility where they were tested, regardless of whether they change housing units.

ICE's Comments to Recommendation 4: Concur. ICE tasks the field with completion of custody redeterminations, and provided OIG with examples of Custody Redetermination Taskings sent to the field to act on or conduct pending custody redetermination for those still in custody. ICE asked that the recommendation be closed.

OIG Analysis: We consider this recommendation resolved and open. The most recent Custody Redetermination Tasking provided by ICE shows the custody redetermination for 2,016 *Fraihat* subclass detainees was still missing as of July 13, 2021. While the majority of these detainees entered into ICE custody in June or July 2021, almost 300 of them have been in custody since at least May 2021. We will close this recommendation when we receive documentation showing that ICE's field offices have completed custody redeterminations for those who have been in longer-term ICE custody.

ICE's Comments to Recommendation 5: Concur. As of July 2021, IHSC no longer requires whole-facility testing and only conducts such testing as clinically indicated, on a case-by-case basis, or when the local public health authority recommends it. As of the date of the response, all IHSC facilities but three have completed whole-facility testing and the last whole-facility testing was conducted at Port Isabel Service Processing Center on July 10, 2020. ICE asked that the recommendation be closed.

OIG Analysis: We consider this recommendation resolved and open. It is OIG's understanding that whole-facility testing was never required and was always done on a case-by-case basis by facilities. We will close this recommendation when we receive documentation showing how ICE will ensure facilities that conduct whole-facility testing when clinically indicated, on a case-by-base basis, or when the local public health authority recommends it have appropriately developed and submitted written plans for approval by ERO and IHSC staff that describe the steps for appropriately conducting whole-facility testing.

ICE's Comments to Recommendation 6: Concur. On December 21, 2020, ERO issued a broadcast message clarifying the process for conducting monthly in-person COVID-19 checks in detention facilities and providing instruction on how to process and document corrective action plans for facilities. Once the assigned DSM, DSCO, or other trained compliance officer identified a deficiency, the field office was directed to notify the facility of the non-compliance and direct facility staff to take corrective action. In addition, facilities were expected to immediately address life safety issues, and have no



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more than three [3] business days to address these issues and seven [7] business days to address other deficiencies. The guidance directed that all documentation be finalized and submitted to the Assistant Field Office Director and uploaded to SharePoint by the first day of each month. Finally, the guidance stated that deficiencies not corrected within the established timeframe trigger a notification to the Contracting Officer's Representative, which could potentially initiate a contract-related action, as appropriate. ICE provided the OIG with a copy of the December 2020 broadcast message. ICE asked that the recommendation be closed.

OIG Analysis: We consider this recommendation resolved and open. While the updated guidance in the December 2020 broadcast message describes the process for conducting monthly, in-person COVID-19 checks, it does not indicate whether ICE has implemented or tracked the corrective action plans related to any identified discrepancies. We will close this recommendation when ICE provides documentation submitted to the Assistant Field Office Director and uploaded to SharePoint showing actions of the compliance officers, the corrective actions taken, and the timeliness of actions taken to address deficiencies on a monthly basis, starting in March 2021, for 6 consecutive months.



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Appendix A Objective, Scope, and Methodology

The Department of Homeland Security, Office of Inspector General was established by the *Homeland Security Act of 2002* (Public Law 107-296) by amendment to the *Inspector General Act of 1978*.

We initiated this review in response to congressional requests to determine whether ICE effectively controlled COVID-19 within its detention facilities and adequately safeguarded the health and safety of detainees in its custody and staff. We conducted our inspections remotely because of the inherent risks associated with in-person site visits.

The nine detention facilities we inspected remotely were:

- Adelanto ICE Processing Center (Adelanto) in Adelanto, California;
- Eloy Detention Center (Eloy) in Eloy, Arizona;
- El Valle Detention Facility (El Valle) in Raymondville, Texas;
- Glades County Detention Center (Glades) in Moore Haven, Florida;
- Henderson Detention Center (Henderson) in Henderson, Nevada;
- Karnes County Family Residential Center (Karnes) in Karnes City, Texas;
- Krome North Service Processing Center (Krome) in Miami, Florida;
- Mesa Verde ICE Processing Facility (Mesa Verde) in Bakersfield, California; and
- Richwood Correctional Center (Richwood) in Monroe, Louisiana.

We initiated our remote fieldwork with Adelanto on September 23, 2020, the remaining eight locations on October 7 and 8, 2020, and concluded this overall review, including ICE headquarters, in May 2021.

To assist with selecting site visit locations, we scored all ICE detention facilities reporting COVID-19 cases. This scoring considered detainee deaths; various aspects of a facility's current and historic detainee caseload; DHS OIG Hotline complaints; and congressional interest. This score became the basis of the team's selection pool. We categorized facilities by type (Service Processing Center; Contract Detention Facility; Family Residential Center; Dedicated Intergovernmental Service Agreement; and Non-Dedicated Intergovernmental Service Agreement). Within each facility type group, we generally selected a high scoring facility. Depending on group size, we made additional selections, including another high scoring facility, a medium scoring facility, and a low scoring facility.

We exercised professional judgment to achieve a balance of operators, diverse geographic locations, and to select facilities that were ideally suited for



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inspection based on the project team's experience with in-person inspections, related concurrent OIG projects, congressional interest, or potentially unique conditions relating to the pandemic. Further, we avoided duplicating selections made by the Government Accountability Office, which was also engaged in a COVID-19 related review using site visits. The Government Accountability Office issued its final report in June 2021.³³ Where appropriate, we identified alternate sites and provided rationale for making the substitution.

To evaluate how ICE detention facilities were controlling COVID-19 and their compliance with ICE and CDC guidance, we reviewed documentation such as facility specific custody rosters, COVID-19 cases and deaths, organizational charts with key points of contact, floor plans, schedules for meals and other daily activities, cleaning intervals, camera locations, visitor logs, contract discrepancy reports, general and medical grievances, requests to ICE, health care treatment logs, signage, intake forms, transfer checklists, PPE inventories, housing unit sign-in logs, sick leave and telework policies, and local pandemic plans. We also reviewed surveillance video and images to remotely observe facility staff and detainees wearing face masks and practicing social distancing as well as the cleanliness of housing units.

Additionally, we interviewed facility administrators or wardens, as well as detention supervisors and officers. We also interviewed detainees, primarily those who had tested positive for COVID-19. Within ICE, we interviewed field office leadership and personnel, as well as headquarters ICE and IHSC officials. Further, we reviewed ICE nationwide detainee and other COVID-19 related data.

We conducted this review under the authority of the *Inspector General Act of 1978*, as amended, and according to the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

³³ [ICE Efforts to Address COVID-19 in Detention Facilities](#), GAO-21-414, June 2021.



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Appendix B
ICE Comments to the Draft Report

Office of the Chief Financial Officer

U.S. Department of Homeland Security
500 12th Street, SW
Washington, DC 20536



**U.S. Immigration
and Customs
Enforcement**

August 4, 2021

MEMORANDUM FOR: Joseph V. Cuffari, Ph.D.
Inspector General

FROM: Stephen A. Roncone
Chief Financial Officer and
Senior Component Accountable Official

**STEPHEN A
RONCONE**
Digitally signed by
STEPHEN A
RONCONE
Date: 2021.08.04
18:19:00 -04'00'

SUBJECT: Management Response to Draft Report: “ICE’s Management
of COVID-19 in Its Detention Facilities Provides Lessons
Learned for Future Pandemic Responses”
(Project No. 20-051-SRE-ICE)

Thank you for the opportunity to comment on this draft report. U.S. Immigration and Customs Enforcement (ICE) appreciates the work of the Office of Inspector General (OIG) in planning and conducting its review and issuing this report.

ICE is pleased to note OIG’s recognition of ICE’s successful measures to control the spread of coronavirus disease 2019 (COVID-19) in its detention facilities, such as the issuance of standards that established requirements for detainee environmental health and safety and medical services, as well as “Pandemic Response Requirements” (PRR), dated March 16, 2021, that specify requirements and best practices to ensure that detainees are appropriately housed, and that available mitigation measures are implemented during this public health crisis. In addition, the OIG describes a range of actions taken by ICE to prevent the pandemic’s spread among detainees and staff, such as:

- Maintaining sufficient supplies of protective equipment for detainees and staff throughout the course of the pandemic;
- Enhancing cleanliness by increasing the frequency of cleaning and instituting new cleaning methods;
- Screening detainees prior to entering facilities and isolating detainees who exhibited symptoms associated with COVID-19;
- Cohorting all newly arrived detainees for 14 days;
- Encouraging staff and detainees to wear masks and social distance; and

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Management Response to Draft Report: “ICE’s Management of COVID-19 in Its Detention Facilities Provides Lessons Learned for Future Pandemic Responses”
(Project No. 20-051-SRE-ICE)
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- Taking action to decrease the detainee population.

It is also important to note that the ICE Health Service Corps (IHSC) proactively navigated the complexities of the COVID-19 pandemic and swiftly implemented solutions to continue its direct care of affected patients. IHSC achieved the measures outlined in the OIG’s report through advanced planning, as well as a proactive posture that resulted in ensuring provision of supplies of personal protective equipment amidst national shortages, early implementation of screening and testing procedures to prevent disease spread among the detained population, and actions to identify detainees at the highest risk for COVID-19.

In addition, IHSC communicated public health science to ICE stakeholders that influenced behaviors, decision-making, and policies. For example, their collaboration with the Federal Bureau of Prisons, U.S. Marshals Service, other ICE entities, and the Centers for Disease Control and Prevention (CDC) resulted in publishing the Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities,” dated June 9, 2021. IHSC will update guidance as the pandemic continues and science evolves, to protect and address the health care needs of those in ICE custody.

ICE remains committed to effectively managing the risk of transmission of infectious diseases and providing safe, secure, and humane confinement for detained individuals.

The draft report contained six recommendations with which ICE concurs. Attached find our detailed response to each recommendation. ICE previously submitted technical comments addressing several accuracy, contextual, and other issues under a separate cover for OIG’s consideration.

Again, thank you for the opportunity to review and comment on this draft report. Please feel free to contact me if you have any questions. We look forward to working with you again in the future.

Attachment

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Management Response to Draft Report: “ICE’s Management of COVID-19 in Its Detention Facilities Provides Lessons Learned for Future Pandemic Responses”
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Attachment: Management Response for Recommendations Contained in 20-051-SRE-ICE

OIG recommended that the ICE Director:

Recommendation 1: Ensure detention facilities meet ICE’s COVID-19 requirements in the PRR, including:

- wearing of masks by detention facility staff;
- testing of all new arrivals to ICE detention facilities for COVID-19; and
- transfers of detainees for reasons allowed by the PRR only.

Response: Concur. IHSC already provides up-to-date guidance and outlines requirements for both IHSC- and non-IHSC-staffed facilities through the ICE Enforcement and Removal Operations’ (ERO) PRR. For example, in June 2021, IHSC partnered with the ICE ERO Custody Management Division to begin the update process for the PRR to align with revised CDC guidance regarding COVID-vaccinated detainees (Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities, dated June 9, 2021). IHSC issues guidance through the PRR, and the Custody Management Division ensures its implementation and compliance. Further, Detention Service Managers (DSM) and Detention Standards Compliance Officers (DSCO) address compliance within facilities. Estimated completion date (ECD): October 29, 2021.

Recommendation 2: Revise the cohort tracking report to differentiate between cohorts of detainees with confirmed cases of contagious diseases and those with suspected cases or who have been in contact with confirmed cases of contagious diseases.

Response: Concur. IHSC actively tracks cohorts with confirmed and suspected infectious disease, and generates weekly reports that are widely shared with IHSC, ERO, ICE, and DHS Secretary and Chief Medical Officer, and that IHSC uses to monitor and track cohorts of detainees with mumps, varicella, influenza, COVID-19, unspecified respiratory illness, unspecified rash, and epidemiological risk with no known exposure. The weekly cohort report includes both suspected and confirmed disease. Further, IHSC modifies the report, as needed, when a new disease that requires cohorting is found. Under a separate cover, ICE provided a sample IHSC weekly report on July 23, 2021.

ICE requests the OIG consider this recommendation resolved and closed, as implemented.

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Management Response to Draft Report: “ICE’s Management of COVID-19 in Its Detention Facilities Provides Lessons Learned for Future Pandemic Responses”
(Project No. 20-051-SRE-ICE)
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Recommendation 3: Develop specific guidance regarding communication with detainees regarding their medical conditions and care and ensure facilities implement this guidance.

Response: Concur. On March 17, 2021, IHSC published IHSC Directive 02-07, “Treatment Consent and Refusal,” which requires clinicians to explain the detainee’s condition and any clinical treatments. Consequently, providers within IHSC-staffed facilities inform detainees of their medical status, when possible and under applicable conditions. Further, IHSC informs detainees of their health status, if known, while in custody, although it is important to note that the detainee might move or transfer before test results return.

ICE requests the OIG consider this recommendation resolved and closed, as implemented.

Recommendation 4: Ensure completion of custody redeterminations for high-risk detainees, and appropriately track custody redeterminations in ICE’s data systems.

Response: IHSC currently maintains a listing of all non-citizens that are determined to be Fraihat subclass members, which are the individuals that are at higher risk of complications if exposed to COVID-19. Those individuals are assessed at intake, at which point a determination is made by a provider who designates a clinical diagnosis. For IHSC staffed facilities, global alerts are also entered in electronic health records to facilitate data collection. IHSC’s list of high-risk detainees is provided to ICE ERO twice a week to comply with a five-day requirement (Fraihat court order) for identification of subclass members. Further, ICE ERO Law Enforcement Systems and Analysis (LESA) also maintains a larger list of high-risk detainees that includes non-IHSC staff facilities utilizing information provided by the Field Medical Coordinators. LESA currently inputs Fraihat members in detention and those released based on the COVID-19 Risk Factor - Subclass One and Two alerts in the Enforce Alien Removal Module into this list based on age and current medical conditions. LESA’s Data Quality Integrity Unit tasks the field with completion of custody redeterminations. Under a separate cover, ICE provided the OIG with examples of Custody Redetermination Taskings sent to the field to take action or conduct any pending custody redeterminations for those currently in custody on July 30, 2021.

ICE requests the OIG consider this recommendation resolved and closed, as implemented.

Recommendation 5: Ensure all detention facilities that conduct whole-facility testing have submitted plans to ICE, and that these plans have been approved.

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Management Response to Draft Report: “ICE’s Management of COVID-19 in Its Detention Facilities Provides Lessons Learned for Future Pandemic Responses”
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Response: Concur. As of July 2021, IHSC no longer requires whole facility testing. Currently, IHSC only conducts whole-facility testing as clinically indicated, and on a case-by-case basis, or when the local public health authority recommends testing. As of the date of this response, all IHSC facilities completed whole facility testing except for the, Alexandria Staging Facility, York Staging Facility, and Varick Street. The last IHSC whole facility testing was conducted by Port Isabel Service Processing Center on July 10, 2020. IHSC’s decision to not require whole facility testing is based on current testing and vaccination guidance.

ICE requests the OIG consider this recommendation resolved and closed.

Recommendation 6: Implement and track corrective action plans related to discrepancies found during the monthly spot checks.

Response: Concur. On December 21, 2020, ICE ERO issued a broadcast message to all Field Office Directors and Deputy Field Office Directors clarifying the process for conducting monthly in-person COVID-19 checks in ICE detention facilities and providing instruction on how to process and document corrective action plans for facilities. Once the assigned DSM, DSCO, or other trained compliance officer identifies a deficiency, the field office will notify the facility of the non-compliance and direct facility staff to take corrective action. In addition, facilities are apprised to immediately address life safety issues, but have no more than three business days to address these issues and seven business days to address other deficiencies. All documentation (e.g., notices of non-compliance, corrective action plans, notices of intent) must be finalized, submitted to the Assistant Field Office Director, and uploaded to SharePoint by the first day of each month. Finally, deficiencies that have not been corrected within the established timeframe trigger a notification to the Contracting Officer’s Representative, which will potentially initiate a contract-related action, as appropriate. Under a separate cover, ICE provided the OIG with documentation of its process for conducting in-person checks on July 23, 2021.

ICE requests the OIG consider this recommendation resolved and closed, as implemented.

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Appendix C Summary of Key Elements of ICE’s Pandemic Response Requirements

ICE ERO headquarters first provided pandemic response guidance through the *ICE Memorandum on Coronavirus Disease 2019 (COVID-19) Action Plan, Revision 1* (Action Plan), dated March 27, 2020. The Action Plan was designed to establish consistency across ICE detention facilities by explaining mandatory requirements and best practices, which all detention facilities housing ICE detainees were expected to follow during the pandemic. Originally, the guidance only applied to IHSC-staffed and non-IHSC-staffed, ICE-dedicated facilities, but progressed to all dedicated and non-dedicated facilities.

ERO headquarters transitioned from the Action Plan to the *Pandemic Response Requirements* (PRR), with six versions from April 2020 to March 2021. The following table reflects a summary of key revisions in the PRR that occurred.

PRR Enhancements Since March 2020

Version	Key Changes
Action Plan (March 27, 2020)	<ul style="list-style-type: none"> ICE COVID-19 pandemic guidance initiated. Provided the inception for many requirements including PPE.
PRR 1.0 (April 10, 2020)	<ul style="list-style-type: none"> PRR initiated to establish consistency on COVID-19 mitigation efforts across all ICE detention facilities.
PRR 2.0 (June 22, 2020)	<ul style="list-style-type: none"> Expanded the list of COVID-19 symptoms. Identified additional vulnerable populations. Clarified that detainees confirmed or suspected with COVID-19 should be grouped together.
PRR 3.0 (July 28, 2020)	<ul style="list-style-type: none"> Identified additional populations potentially at higher risk. Provided updated guidance on PPE. Clarified CDC guidance for individuals in medical isolation in detention facilities. Included an updated testing section based on latest CDC guidance.
PRR 4.0 (September 4, 2020)	<ul style="list-style-type: none"> Updated the list of COVID-19 symptoms recognized by the CDC. Provided protocols for asymptomatic staff identified as close contacts of a confirmed COVID-19 case. Clarified that ICE would limit transfers of both ICE detainees and non-ICE detained populations to and from other jurisdictions and facilities unless necessary. Updated isolation protocols for COVID-19 cases to incorporate the latest CDC guidance on discontinuing transmission-based precautions using a symptom-based or time-based strategy rather than a testing-based strategy. Provided additional information on testing asymptomatic individuals with known or suspected recent exposure.
PRR 5.0 (October 27, 2020)	<ul style="list-style-type: none"> Updated the procedures surrounding detainees with severe psychiatric illness and resulting in higher risk of severe illness from COVID-19. Added the management of vulnerable populations at high risk to include screening, testing, custody determinations, and requiring



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	<p>that all new detainees be tested for COVID-19 within 12 hours of arrival.</p> <ul style="list-style-type: none">• Updated procedures for the use of safe cleaning products, as well as reporting requirements and ICE investigations if adverse reactions to cleaning products are experienced by detainees.• Generally discontinued the transfer of detainees with exceptions.• Highlighted that extended lockdowns must not be used as a means of COVID-19 prevention and medical isolation is operationally distinct from administrative or disciplinary segregation, or any punitive form of housing.
PRR 6.0 (March 16, 2021)	<ul style="list-style-type: none">• Clarified the deputy field office director, field office director, and detainees with their counselors should be notified no more than 12 hours after an evaluation has occurred, as to whether a detainee meets the criteria for increased risk for severe illness from COVID-19.• Added that detainees shall be tested as described in the ERO PRR regardless of <i>Fraihat</i> class membership, facility type, Title 42 status, or other conditions.• Added that a detainee with a fever or positive COVID-19 symptom screening shall be referred to a medical provider for further evaluation for COVID-19 infection.• Added that if a point of care/rapid COVID-19 test is utilized for detainees, the result must be confirmed with a laboratory-based test.• Introduced a section on COVID-19 vaccines that clearly states detainees cannot be forced, but only offered, to take them.

Source: DHS OIG analysis of ICE information.

In addition to the PRR, we noted that, between revisions of the PRR, ERO provided updates to detention facilities through broadcast emails.



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Appendix D
Inspections and Evaluations Major Contributors to This Report

Erika Lang, Chief Inspector
Brendan Bacon, Lead Inspector
Donna Ruth, Senior Inspector
Ryan Nelson, Senior Inspector
Ronald Hunter, Senior Inspector
Michael Brooks, Senior Inspector
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Appendix E
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