Open Letter to ICE From Medical Professionals Regarding COVID-19

Acting Director Matthew T. Albence
U.S. Immigration and Customs Enforcement
500 12th St. SW
Washington, D.C. 20536

Dear Acting Director Albence,

As concerned clinicians, we are writing this letter to urge U.S. Immigration and Customs Enforcement (ICE) officials to release individuals and families from immigration detention while their legal cases are being processed to prevent the spread of COVID-19 and mitigate the harm of an outbreak.

In light of the rapid global outbreak of the coronavirus disease 2019 (COVID-19), we want to bring attention to the serious harms facing individuals in immigration detention facilities under the custody of ICE. Health and Human Services Secretary Azar declared a public health emergency on January 31, 2020. As of March 13, 2020, there have been over 132,000 confirmed cases worldwide with nearly 5,000 deaths.

Conditions of Detention Facilities

Detention facilities, like the jails and prisons in which they are housed, are designed to maximize control of the incarcerated population, not to minimize disease transmission or to efficiently deliver health care. This fact is compounded by often crowded and unsanitary conditions, poor ventilation, lack of adequate access to hygienic materials such as soap and water or hand sanitizers, poor nutrition, and failure to adhere to recognized standards for prevention, screening, and containment. The frequent transfer of individuals from one detention facility to another, and intake of newly detained individuals from the community further complicates the prevention and detection of infectious disease outbreaks. A timely response to reported and observed symptoms is needed to interrupt viral transmission yet delays in testing, diagnosis and access to care are systemic in ICE custody. Further, given the patchwork regulatory system, it is unclear whether ICE or the county and state health departments are responsible for ensuring public health oversight of facilities.

For these reasons, transmission of infectious diseases in jails and prisons is incredibly common, especially those transmitted by respiratory droplets. It is estimated that up to a quarter of the US prison population has been infected with tuberculosis,[4] with a rate of active TB infection that is 6-10 times higher than the general population.[2] Flu outbreaks are regular occurrences in jails and prisons across the United States.[3],[4] Recent outbreaks of vaccine-preventable illnesses including mumps, influenza, and varicella have similarly spread throughout immigration detention facilities. From September of 2018 to August 2019, 5 cases of mumps ballooned to nearly 900 cases among staff and individuals detained in 57 facilities across 19 states, a number that represents about one third of the total cases in the entire US in that time frame.[5] With a mortality rate 10 times greater than the seasonal flu and a higher R0 (the average number of individuals who can contract the disease from a single infected person) than Ebola, an outbreak of COVID-19 in immigration detention facilities would be devastating.

Risks of a COVID-19 Outbreak in Detention

Emerging evidence about COVID-19 indicates that spread is mostly via respiratory droplets among close contacts[7] and through contact with contaminated surfaces or objects. Reports that the virus may be viable for hours in the air are particularly concerning.[8] Though people are most contagious when they
are symptomatic, transmission has been documented in absence of symptoms. We have reached the point where community spread is occurring in the United States. The number of cases is growing exponentially, and health systems are already starting to be strained. Social distancing measures recommended by the Centers for Disease Control (CDC)\[9\] are nearly impossible in immigration detention and testing remains largely unavailable. In facilities that are already at maximum capacity large-scale quarantines may not be feasible. Isolation may be misused and place individuals at higher risk of neglect and death. COVID-19 threatens the well-being of detained individuals, as well as the corrections staff who shuttle between the community and detention facilities.

Given these facts, it is only a matter of time before we become aware of COVID-19 cases in an immigration detention system in which detainees live in close quarters, with subpar infection control measures in place, and whose population represents some of the most vulnerable. In this setting, we can expect spread of COVID-19 in a manner similar to that at the Life Care Center of Kirkland, Washington, at which over 50% of residents have tested positive for the virus and over 20% have died in the past month. Such an outbreak would further strain the community’s health care system. Considering the extreme risk presented by these conditions in light of the global COVID-19 epidemic, it is impossible to ensure that detainees will be in a “safe, secure and humane environment,” as ICE’s own National Detention Standards state.

In about 16% of cases of COVID-19 illness is severe including pneumonia with respiratory failure, septic shock, multi organ failure, and even death. Some people are at higher risk of getting severely sick from this illness. This includes older adults over 60 and people who have serious chronic medical conditions like heart disease, liver disease, diabetes, lung disease, and who are immunocompromised. There are currently no antiviral drugs licensed by the U.S. Food and Drug Administration (FDA) to treat COVID-19, or post-exposure prophylaxis to prevent infection once exposed.

As such, we strongly recommend that ICE implement community-based alternatives to detention to alleviate the mass overcrowding in detention facilities. Individuals and families, particularly the most vulnerable—the elderly, pregnant women, people with serious mental illness, and those at higher risk of complications—should be released while their legal cases are being processed to avoid preventable deaths and mitigate the harm from a COVID-19 outbreak.