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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

ANGEL DE JESUS ZEPEDA RIVAS, *et al.*, Plaintiffs, v. DAVID JENNINGS, *et al.*, Defendants.	CASE NO. 3:20-cv-02731-VC **DEFENDANTS' RESPONSE TO THE COURT'S AUGUST 21, 2020 ORDER TO CREATE A WRITTEN PLAN TO IMPROVE MEDICAL ASSISTANCE FOR COVID-POSITIVE DETAINEES**

INTRODUCTION

In response to the Court's order of August 21, 2020 calling for Defendants "to create a written plan to improve their system of monitoring, caring for, and responding to medical assistance requests from detainees who have tested positive and who have health conditions that the CDC has identified as creating an elevated risk of complications" and to "file a final draft on the docket" (ECF No. 595), Defendants respectfully submit the attached draft written plan.

Defendants also respond to Plaintiffs' pending "request that the Court require Defendants to bring their care up to acceptable standards or release additional detainees, contingent on a satisfactory release plan, to safely isolate in their communities." Pls. Br. 12 (ECF No. 591). This effectively is a request for a new mandatory injunction. *See United States v. Oriho*, __ F.3d __, No. 19-10291, 2020 WL 4579478, at *3 (9th Cir. Aug. 10, 2020) (an order not specifically styled as a restraining order or injunction nonetheless has the "practical effect" of an injunction where it is "'directed to a party, enforceable by contempt, and designed to accord some or all of the relief sought by a complaint'") (quoting *United States v. Samueli*, 582 F.3d 988, 993 (9th Cir. 2009)). Defendants respectfully submit that the procedures in place at the Mesa Verde Detention Facility satisfy all applicable constitutional and legal requirements and that Plaintiffs have not established an entitlement to a further injunction.

As of today, all but 15 of the 101 detainees at Mesa Verde either have never tested positive for COVID-19 or have met the conditions set forth in guidance issued by the Centers for Disease Control and Prevention (CDC) for discontinuing isolation and precautions. While Defendants submit the attached draft plan in response to the Court's August 21 order (and medical staff have implemented the measures in this draft plan), a further Court order (regarding either this draft plan or any alternative plan that Plaintiffs might propose) is unwarranted.[1]

LEGAL STANDARD

I. Preliminary-Injunction Standard[2]

"A preliminary injunction is 'an extraordinary remedy never awarded as of right.'" *Benisek v.*

[1] Defendants specifically object to any conclusion that these changes or any others are constitutionally required, and reserve the right to appeal the Court's August 21 order and any further order.

[2] The standard for issuing a TRO is the same as the standard for issuing a preliminary injunction. *See Stuhlbarg Int'l Sales Co, Inc. v. John D. Brush & Co, Inc.*, 240 F.3d 832, 839 n.7 (9th Cir. 2001); *Rovio*

Lamone, 138 S. Ct. 1942, 1943 (2018) (quoting *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008)). "[P]laintiffs seeking a preliminary injunction face a difficult task in proving that they are entitled to this 'extraordinary remedy.'" *Earth Island Inst. v. Carlton*, 626 F.3d 462, 469 (9th Cir. 2010). A plaintiff's burden is a "heavy" one, *id.*, that requires "substantial proof" and a "*clear showing*" that an injunction is warranted, *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997) (emphasis in original). "The burden to prove clear entitlement to injunctive relief always stays with the party requesting that relief." *Hope v. Warden York Cty. Prison*, __ F.3d __, No. 20-1784, 2020 WL 5001785, at *5 (3d Cir. Aug. 25, 2020) (vacating TRO issued in immigration-detainee COVID-19 lawsuit where the district court placed the burden on the government to show why injunctive relief should not be entered, rather than on the immigration detainees to prove clear entitlement to injunctive relief); *accord Valentine v. Collier*, 956 F.3d 797, 801 n.1 (5th Cir. 2020) (staying preliminary injunction in prison-detainee COVID-19 lawsuit and holding that "of course, it's the Plaintiffs' burden to prove their entitlement to an injunction, not the Defendants' burden to prove the opposite"), *motion to vacate stay denied*, 140 S. Ct. 1598 (2020).

In particular, "a mandatory injunction goes well beyond simply maintaining the status quo pendente lite and is particularly disfavored." *Garcia v. Google, Inc.*, 786 F.3d 733, 740 (9th Cir. 2015) (citation, quotation marks, and brackets omitted). The burden on a plaintiff seeking a mandatory injunction "is doubly demanding: . . . she must establish that the law and facts *clearly favor* her position, not simply that she is likely to succeed." *Id.* (emphasis in original). "The district court should deny such relief unless the facts and law clearly favor the moving party." *Id.* (citations and quotation marks omitted).

Even where a clear showing has been made, "because injunctive relief must be narrowly tailored to remedy the specific harm alleged, an overbroad injunction is an abuse of discretion." *Stormans, Inc. v. Selecky*, 586 F.3d 1109, 1140–41 (9th Cir. 2009) (citations, quotation marks, brackets, and ellipsis omitted) (vacating injunction where district court "failed to tailor the injunction" to the specific alleged constitutional harm of plaintiffs and instead "issued an overbroad injunction").

"Every order granting an injunction and every restraining order must: (A) state the reasons why

Entm't Ltd. v. Royal Plush Toys, Inc., 907 F. Supp. 2d 1086, 1092 (N.D. Cal. 2012).

it issued; (B) state its terms specifically; and (C) describe in reasonable detail — and not by referring to the complaint or other document — the act or acts restrained or required." Fed. R. Civ. P. 65(d)(1). Regarding the first requirement, the reasons for the injunction must be forward-looking, as "the well-established purpose of [] preliminary injunctive relief . . . is to prevent future irreparable harm before a final judgment on the merits can be made, not to remedy past harms." *GSI Tech., Inc. v. United Memories, Inc.*, No. C 13-1081 PSG, 2013 WL 12172990, at *10 (N.D. Cal. Aug. 21, 2013). Regarding the second and third requirements, "an injunction should be phrased in terms of objective actions, not legal conclusions." *Hope*, __ F.3d __, 2020 WL 5001785, at *5 (citation and quotation marks omitted) (vacating TRO issued in immigration-detainee COVID-19 lawsuit where the district court required, among other things, that the government impose "reasonable" terms of supervision and comply with "guidance," as being vague and violating Rule 65(d)); *see Abbott v. Perez*, 138 S. Ct. 2305, 2321 (2018) (discussing the importance of Rule 65(d), which "protects the party against which an injunction is issued by requiring clear notice as to what that party must do or refrain from doing"). "'The specificity provisions of Rule 65(d) are no mere technical requirements. The Rule was designed to prevent uncertainty and confusion on the part of those faced with injunctive orders, and to avoid the possible founding of a contempt citation on a decree too vague to be understood.'" *Del Webb Cmtys., Inc. v. Partington*, 652 F.3d 1145, 1150 (9th Cir. 2011) (quoting *Schmidt v. Lessard*, 414 U.S. 473, 476 (1974)).

A court entering a preliminary injunction "must find the facts specifically and state its conclusions of law separately." Fed. R. Civ. P. 52(a); *Diouf v. Mukasey*, 542 F.3d 1222, 1235 n.7 (9th Cir. 2008).

II. Medical-Care Standard

Claims brought by immigration detainees for allegedly inadequate medical care are evaluated under an objective deliberate-indifference standard. *See Gordon v. Cty. of Orange*, 888 F.3d 1118, 1124–25 (9th Cir. 2018) (analyzing claim by pretrial detainee who had not been criminally convicted under objective deliberative-indifference standard); *Arizmendi de Paz v. Wolf*, No. 20-cv-955-WQH-BGS, 2020 WL 3469372, at *8 (S.D. Cal. June 25, 2020) (applying objective deliberate-indifference standard to immigration detainee in COVID-19 lawsuit). The elements of an inadequate-medical-care

claim under an objective deliberative-indifference standard are that:

> (i) the defendant made an intentional decision with respect to the conditions under which the plaintiff was confined; (ii) those conditions put the plaintiff at substantial risk of suffering serious harm; (iii) the defendant did not take reasonable available measures to abate that risk, even though a reasonable official in the circumstances would have appreciated the high degree of risk involved — making the consequences of the defendant's conduct obvious; and (iv) by not taking such measures, the defendant caused the plaintiff's injuries.

Gordon, 888 F.3d at 1125. "With respect to the third element, the defendant's conduct must be objectively unreasonable, a test that will necessarily turn on the facts and circumstances of each particular case." *Id.* (citation, quotation marks, and brackets omitted). The "mere lack of due care by a state official" does not plead a claim. *Id.* "Thus, the plaintiff must prove more than negligence but less than subjective intent — something akin to reckless disregard." *Id.* (citations and quotation marks omitted). "[A] mere difference of medical opinion is insufficient, as a matter of law, to establish deliberate indifference." *Toguchi v. Chung*, 391 F.3d 1051, 1058 (9th Cir. 2004) (citation, quotation marks, brackets, and ellipsis omitted); *see Hayes v. Williams*, No. C-05-00070 RMW, 2009 WL 3004037, at *4 (N.D. Cal. Sept. 15, 2009) (under the objective deliberative-indifference standard, "a plaintiff must [] show that the course of treatment was medically unacceptable under the circumstances. This requires showing more than a difference of medical opinion about a prisoner's treatment.") (citations, quotation marks, and ellipsis omitted); *accord Hope*, __ F.3d __, 2020 WL 5001785, at *12 (same, in immigration-detainee COVID-19 lawsuit).

APPLICATION

There currently are 101 detainees at Mesa Verde. Declaration of Dr. Richard Medrano, Regional Medical Director for Wellpath ¶ 24 (Medrano Decl.). 41 of these detainees have tested negative for COVID-19 on each of their repeated tests. *Id.* (A forty-second detainee tested negative on July 30, 2020 and subsequently refused all additional offers of testing. *Id.*) Of the remaining 59 detainees, 44 have now met the CDC's guidance for discontinuing isolation and precautions. *Id.* ¶¶ 24–25.[3] The remaining

[3] The CDC states that "For most persons with COVID-19 illness, isolation and precautions can generally be discontinued 10 days *after symptom onset* and resolution of fever for at least 24 hours, without the use of fever-reducing medications, and with improvement of other symptoms. A limited number of persons with severe illness may produce replication-competent virus beyond 10 days that may warrant extending duration of isolation and precautions for up to 20 days after symptom onset; consider

15 detainees who have tested positive for COVID-19 remain cohorted in Dorm B or housed in isolation units. *Id.* ¶ 22. Only six to eight detainees on average have active symptoms at any given time (such as headache, malaise, or diarrhea). *Id.* ¶ 21. While medical staff are routinely monitoring the detainees for changes in condition and development and/or changes for symptoms, not every detainee needs medicine for COVID-19 or other medical intervention. *Id.* Most will likely recover via rest and fluids. *Id.*; *accord* CDC, *Coronavirus Disease 2019 (COVID-19) > What to Do If You Are Sick* (May 8, 2020), https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/steps-when-sick.html (last visited Aug. 31, 2020) (*What to Do*) ("Most people with COVID-19 have mild illness and can recover at home without medical care."); *see United States v. Mays*, No. 17-cr-96-pp, 2020 WL 4048501, at *5 (E.D. Wis. July 20, 2020) (quoting CDC, *What to Do*, and applying it to correctional facility); *Chunn v. Edge*, __ F. Supp. 3d __, No. 20-cv-1590 (RPK) (RLM), 2020 WL 3055669, at *16 (E.D.N.Y. June 9, 2020) (discussing "the ordinary standard of care for COVID-19 patients, who are commonly advised to 'isolate and manage' symptoms rather than to seek daily assessments from healthcare providers").

In light of the above, Plaintiffs have not made a "*clear showing*" that an injunction is warranted, *cf. Mazurek*, 520 U.S. at 972 (emphasis in original), let alone that the law and facts "*clearly favor*" their position that they are entitled to a mandatory injunction, *cf. Garcia*, 786 F.3d at 740 (emphasis in original). 86 of the 101 detainees either have never tested positive for COVID-19 or have now met the CDC's guidance for discontinuing isolation and precautions. Medical staff at Mesa Verde — who are onsite 24 hours a day, seven days a week, and spend approximately three hours per day in Dorm B[4] — have been providing and continue to provide medical care to the remaining 15 detainees who have tested positive for COVID-19 and who have not met the CDC's guidance for discontinuing isolation and precautions, including checking each such detainee's temperature, blood pressure, heart rate, respiration rate, and oxygen-saturation level twice a day; asking each such detainee about their symptoms; and

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consultation with infection control experts. For persons who never develop symptoms, isolation and other precautions can be discontinued 10 days *after the date of their first positive RT-PCR test for SARS-CoV-2 RNA*." CDC, *Coronavirus Disease 2019 (COVID-19) > Duration of Isolation & Precautions for Adults* (Aug. 16, 2020) (emphasis in original), https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html (last visited Aug. 31, 2020); *accord* Medrano Decl. ¶ 25.

[4] Medical staff previously spent approximately four to six hours a day in Dorm B, [First] Declaration of Dr. Richard Medrano, Regional Medical Director for Wellpath ¶ 20 (ECF No. 581-1), but this number has gone down as the population in Dorm B has gone down. [Second] Medrano Decl. ¶ 20.

responding to detainee sick-call requests. Medrano Decl. ¶¶ 7, 15–20; *accord* Third Supplemental Declaration of Dr. Robert B. Greifinger ¶ 31 (ECF No. 591-4) (agreeing that medical staffing levels are adequate). Medical staff follow both the CDC's guidelines regarding COVID-19 symptoms and the ICE Health Services Corps' recommendations, and often exceed these guidelines. Medrano Decl. ¶ 3 & Ex. A. Medical staff use their experience, training, and medical judgment to determine whether to send a detainee to the hospital (and do not need ICE's or GEO's approval to do so). *Id.* ¶¶ 13, 26.[5]

The medical care provided at Mesa Verde already complies with all applicable constitutional and legal requirements. Plaintiffs have not made a clear showing that this level of medical care for the remaining 15 detainees in Dorm B or isolation units, or even for all 59 detainees who have tested positive for COVID-19 at any time, is so constitutionally deficient that a further court order is warranted. *Cf., e.g.*, *Chunn*, __ F. Supp. 3d __, 2020 WL 3055669, at *15–16 (rejecting argument by class-action prisoner plaintiffs on behalf of both prisoners and pretrial detainees that "twice-daily medical rounds are insufficient" and rejecting "[p]etitioners' preferred procedures[, which] go beyond anything the CDC has recommended" and "do not even appear to be consistent with the ordinary standard of care for COVID-19 patients, who are commonly advised to 'isolate and manage' symptoms rather than to seek daily assessments from healthcare providers"); *United States v. Billings*, No. 19-cr-00099-REB, 2020 WL 4705285, at *4 (D. Colo. Aug. 13, 2020) (discussing the federal correctional facility with the largest number of COVID-19 infections of all federal facilities in the country, and describing the facility's efforts "implementing mass testing of all inmates and staff, checking inmates' temperature twice daily, and providing cloth masks to all inmates" with approval as "sweeping"); *Duvall v. Hogan*, No. ELH-94-2541, 2020 WL 3402301, at *5, *13 (D. Md. June 19, 2020) (addressing lawsuit brought by pretrial detainees under the Fourteenth Amendment involving a detention facility where 60 detainees and staff members had tested positive and one staff member had died, and describing the

[5] According to Google Maps, Mercy Hospital on Truxtun Avenue in Bakersfield is eight minutes away from Mesa Verde. Google Maps, https://www.google.com/maps/dir/Mesa+Verde+ICE+Processing+Facility,+425+Golden+State+Ave,+Bakersfield,+CA+93301/Mercy+Hospital+Downtown+-+Bakersfield,+2215+Truxtun+Ave,+Bakersfield,+CA+93301 (last visited Aug. 31, 2020); *accord* Medrano Decl. ¶ 13. Of the last five detainees sent to the hospital, only one was admitted; the other four detainees were returned to Mesa Verde without being admitted to the hospital, and with prescriptions for the same medications they were already prescribed by Mesa Verde medical staff. Medrano Decl. ¶ 14.

facility's efforts, including "creat[ing] a quarantine housing unit for infected detainees" who "are monitored twice per day by medical staff and remain there for at least 14 days," as "a reasonable response to the unforeseen, rapidly evolving COVID-19 pandemic"); *Engelund v. Doll*, No. 4:20-CV-00604, 2020 WL 1974389, at *10–11 (M.D. Pa. Apr. 24, 2020) (addressing lawsuit brought by immigration detainees and holding that conditions of confinement that included daily temperature checks and screenings for COVID-19 symptoms "do not amount to punishment in violation of the Constitution" or deliberate indifference); *see also Valentine*, 956 F.3d at 802 (staying COVID-19 preliminary injunction in prisoner class action where the district court had issued its injunction because "it wanted to see 'extra measures'" that "go beyond [the facility's] and CDC policies" but where plaintiffs cited no precedent holding that the facility's and CDC policies were insufficient to satisfy the Constitution).

Plaintiffs and their experts might prefer a different plan. But as courts in this district and elsewhere have recognized:

> Defendants' approach may not be the plan that Plaintiffs think best; it may not even be the plan that the Court would choose, if it were sufficiently informed to offer an opinion on the subject. But the Fourteenth Amendment does not afford litigants and courts an avenue for de novo review of the decisions of prison officials.

Gonzalez v. Ahern, No. 19-cv-07423-JSC, 2020 WL 3470089, at *8 (N.D. Cal. June 25, 2020) (quotation marks and brackets omitted) (addressing COVID-19 claims of plaintiffs, whom the court assumed to be pretrial detainees, under the objective deliberative-indifference standard and denying TRO) (quoting *Money v. Pritzker*, __ F. Supp. 3d __, No. 20-cv-2093, 2020 WL 1820660, at *18 (N.D. Ill. Apr. 10, 2020)). As the Third Circuit recently held in vacating a TRO issued in an immigration-detainee COVID-19 lawsuit, "'mere disagreement' as to the response to the risk to Petitioners in light of their medical condition will not support constitutional infringement." *Hope*, __ F.3d __, 2020 WL 5001785, at *12. As the Fifth Circuit similarly held in staying a district court's preliminary injunction in a COVID-19 prisoner class action, "[a]lthough the district court might do things differently, mere 'disagreement' with [the facility's] medical decisions does not establish deliberate indifference." *Valentine*, 956 F.3d at 803. As another court similarly explained in denying a motion for a TRO and preliminary injunction challenging cohorting of prisoners who tested positive for COVID-19, including

the medical care they provided received:

> [T]he existence of an alternative plan — even a better plan — is not evidence that the challenged plan is unconstitutional or illustrative of deliberate indifference. Whether the Plaintiffs' proffered alternative plan . . . is feasible and better than Defendants' plan is not the inquiry. Plaintiffs must offer evidence that the challenged plan is unconstitutional, and they have not done so.

Gumns v. Edwards, No. 20-231-SDD-RLB, 2020 WL 2510248, at *15 (M.D. La. May 15, 2020).

CONCLUSION

Plaintiffs have not shown that the medical care at Mesa Verde is constitutionally deficient, let alone made the required clear showing that the law and facts clearly favor them such that they are entitled to a mandatory injunction. Defendants thus respectfully submit that no further Court order is warranted.

If the Court were to enter a further order, Defendants respectfully request that the Court state specifically in objective terms what the constitutional requirements are for treating COVID-19 patients. For example, if the Court were to determine that twice-daily temperature and vital-sign checks are constitutionally insufficient,[6] Defendants respectfully request that the Court state specifically in objective terms exactly what the constitutional requirements are and what Defendants must do to meet those requirements. *Cf.* Fed. R. Civ. P. 65(d). Defendants further respectfully submit that any order must be "narrowly tailored" to constitutional requirements and that an order directing Defendants to go beyond constitutional requirements would be inappropriate.[7] Plaintiffs' requested order — an order for "Defendants to bring their care up to acceptable standards" or otherwise to release additional detainees — is too vague to satisfy the requirements of Rule 65(d)(1) and would leave Defendants unclear as to how to comply. *Cf. Hope*, __ F.3d __, 2020 WL 5001785, at *5 (vacating TRO issued in immigration-

[6] *But see Chunn*, __ F. Supp. 3d __, 2020 WL 3055669, at *15–16; *Billings*, 2020 WL 4705285, at *4; *Duvall*, 2020 WL 3402301, at *5, *13; *Engelund*, 2020 WL1974389, at *10–11.

[7] *Cf. Valentine*, 956 F.3d at 802 (staying COVID-19 preliminary injunction where plaintiffs cited no precedent that facility's policies were constitutionally deficient); *Stormans*, 586 F.3d at 1140–41 (vacating as "overbroad" an injunction where district court "failed to tailor the injunction to remedy the specific harm alleged by the [plaintiffs]"); *see also Gonzalez*, 2020 WL 3470089, at *8 (COVID-19 medical-care claim, even under "the more stringent objective deliberative indifference standard," "does not afford litigants and courts an avenue for de novo review of the decisions of prison officials"). Defendants maintain that the current medical care practices and procedures at Mesa Verde satisfy all constitutional requirements.

detainee COVID-19 lawsuit that required the government impose "reasonable" terms of supervision and comply with "guidance," as being vague and violating Rule 65(d)); *see also, e.g.*, *Columbia Pictures Indus., Inc. v. Fung*, 710 F.3d 1020, 1048 (9th Cir. 2013) (vacating injunction prohibiting copyright defendant from targeting a user base "generally understood" to be engaging in infringement, because "[h]ow is one to determine what is 'generally understood' — whose knowledge matters, and how widespread must the understanding be? . . . . Unless it can be rewritten to comply with the requirements of Rule 65(d) for fair notice through adequate specificity and detail, [that requirement] must be excised.").

DATED: August 31, 2020

Respectfully submitted,

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* In compliance with Civil Local Rule 5-1(i)(3), the filer attests that all signatories have concurred in the filing of this document.

MEDICAL COVID-19 RESPONSE PLAN – MESA VERDE

Providing excellent health care services to our detainees is of paramount importance to our company. Our ability to properly and effectively identify patients who are at highest risk for developing serious complications due to coronavirus remains a top priority in our patients well-being.

To accomplish this, this we implement the following actions based on the guidance offered by the CDC:

At intake into the facility, all detainees go through a thorough and complete evaluation of their medical history as well as a review of any ongoing signs and symptoms of an illness and medications they have been prescribed.

Once a high risk detainee is identified, such as those with diabetes, cancer, asthma, heart disease, chronic kidney disease, HIV, obesity, liver disease, COPD, they undergo a complete physical examination and are placed in the appropriate chronic care clinic for timely follow-up appointments.

Treatments for their conditions are initiated and /or continued such as dialysis for those with kidney failure, chemotherapy or radiation therapy for cancer, lab analysis for diabetics and those with liver disease, HIV medications and pulmonary hygiene for those with asthma or chronic obstructive lung disease (COPD).

The detainees are also educated, in their language, for better understanding their underlying illnesses.

Or pharmaceutical vendor makes sure that there are adequate supplies of medication in case of the occurrence of an emergent situation, such as a natural disaster.

Additional details are provided below.

Before Infection

High Risk Non-Positive Patients:

- Adhere to CDC guidelines (https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/shared-housing/index.html) for high risk patients based on CDC's recommendations for high risk patients in congregate housing to prevent COVID-19.
- Decrease in population has occurred to allow for appropriate social distancing to continue.
- Social distance when possible
- Masks have been issued to all detainees to prevent the spread when other social distancing measures are difficult to maintain.
- Enhanced cleaning throughout the facility (refer to Operations).
- Keep up-to-date lists of medical conditions and medications.
- Ensure adequate stock of necessary medications on hand.
- Educate detainees regarding serious and concerning symptoms and how to seek immediate help if needed.
- Non-essential visitors/volunteers will be limited or avoided.
- Staff will limit entry into living quarters unless it is necessary.
- Isolate sick or positive cases of COVID-19 away from those not infected.
- In addition to access to the sick call request process noted below, a nurse will make rounds on a daily basis to high risk patients who have CDC listed preexisting conditions monitoring for elevated temperature and symptoms.
- Any concerning clinical findings will be immediately addressed by an on-site or on-call provider 24/7.

Before Infection

Access to Care and Sick Call Process:

- All detainees are provided a copy of the access to care memo at intake and it is posted in all the housing units in English and Spanish. The access to care memo includes information on how to submit a sick call, sick call triage, sick call scheduling process, provider schedules, pill call schedules, insulin schedule, medication re-fill process, emergency care "code blue", mental health care, dental care and the medical grievance process.
    - Sick call policy:
        - Sick calls are collected at midnight every night and triaged.
        - Sick calls are scheduled to be seen within 24 hours for urgent matters. Emergent matters are seen immediately.
        - Providers are advised of any positive symptom screens and see detainees accordingly.
        - Nursing protocols are in place and can be utilized to address any positive symptom screens as well.
- CDC posters are posted throughout the facility and in each housing unit in both English and Spanish regarding COVID-19, hand hygiene. CDC hand hygiene and “Cover Your Cough” are in the intake education packet routinely, even prior to COVID.
- A detainee will be referred to a provider any time there are concerns regarding a detainee’s health status. A provider evaluation consists of a typical office visit in which the underlying issue is addressed and treated if necessary.
- Treatment for moderate illness is very vast and depends on the presenting issue. This would be at provider discretion based on the presentation of the patient.

Post Infection

Detainees who have tested positive for COVID-19 will be provided written or verbal communication in their respective language via use of a medical translator or the language line translation service regarding the monitoring and management of COVID-19 symptoms as well as how to request care should symptoms arise or worsen. Wellpath response goes above and beyond CDC criteria.

CDC treatment guidelines for COVID-19	Wellpath Medical response/treatment
Asymptomatic or Presymptomatic Infection • People who test positive for SARS-CoV-2 by molecular diagnostic or antigen testing (see Testing for SARS-CoV-2) and who are asymptomatic should self- isolate at home and "take care of yourself" with rest and hydration. • If they remain asymptomatic, they can discontinue isolation 10 days after the date of their first positive SARS-CoV-2 test. • Individuals who become symptomatic should contact their health care provider for further guidance. • Current CDC recommendations for individuals who develop symptoms are to self- isolate for at least 10 days from the onset of their symptoms and until they have no fever and improvement in respiratory symptoms for at least 24 hours.	• Twice daily vital signs monitoring ○ Blood Pressure ○ Pulse ○ Oxygen Saturation ○ Respirations ○ Temperature • Twice daily symptom and Mental health screening. • M-F medical provider review of vitals/symptoms screening forms to screen for detainees requiring an urgent same day visit. • M-F medical provider walk through. • M-F medical provider sick call appointments/routine appointments/ follow up on those with symptoms. • 24/7 nursing on-site • 24/7 on-call providers • Sick call • Emergency response- "code blue" ○ All staff are trained in CPR/AED ○ 4-minute response

Post Infection

CDC treatment guidelines for COVID-19	Wellpath Medical response/treatment
Mild Illness • Patients may have mild illness defined by a variety of signs and symptoms (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea on exertion, or abnormal imaging. Most mildly ill patients can manage themselves with OTC medication or at home through telemedicine or remote visits. • All patients with symptomatic COVID-19 and risk factors for severe disease should be closely monitored. In some patients, the clinical course may rapidly progress. • No specific laboratory evaluations are indicated in otherwise healthy patients with mild COVID-19 disease.	• Twice daily vital signs monitoring ○ Blood Pressure ○ Pulse ○ Oxygen Saturation ○ Respirations ○ Temperature • Twice daily symptom and Mental health screening. • M-F medical provider review of vitals/symptoms screening forms to screen for detainees requiring an urgent same day visit. • M-F medical provider walk through. • M-F medical provider sick call appointments/routine appointments/ follow up on those with symptoms. • 24/7 nursing on-site • 24/7 on-call providers • Sick call • Emergency response- “code blue” ○ All staff are trained in CPR/AED ○ 4-minute response

Post Infection

CDC treatment guidelines for COVID-19	Wellpath Medical response/treatment
Moderate Illness ● Moderate COVID-19 illness is defined as evidence of lower respiratory disease by clinical assessment or imaging with $SpO_2 \geq 94\%$ on room air at sea level. Given that pulmonary disease can rapidly progress in patients with COVID-19, close monitoring of patients with moderate disease is recommended. ● If bacterial pneumonia or sepsis is strongly suspected, administer empiric antibiotic treatment for community-acquired pneumonia, re-evaluate daily, and if there is no evidence of bacterial infection, de-escalate or stop antibiotics.	● Prepare detainee for emergent evaluation by a nurse or provider. ● Follow nursing practice protocols or provider orders and implement immediate interventions as indicated. ● Refer detainee to Emergency room for further evaluation and treatment if on- site interventions are not successful.

Criteria for hospital send-out

- Severe dyspnea (dyspnea at rest, and interfering with the ability to speak in complete sentences).
- Oxygen saturation on room air of ≤90 percent, regardless of severity of dyspnea.
- Concerning alterations in mentation (eg, confusion, change in behavior, difficulty in rousing) or other signs and symptoms of hypoperfusion or hypoxia (eg, falls, hypotension, cyanosis, anuria, chest pain suggestive of acute coronary syndrome)

This list is not all-inclusive and a patient may be sent out emergently basely solely upon provider discretion.

Recovery

Patient shall be deemed recovered with the meet IHSC and CDC criteria per below (note that a negative test is NOT required unless severely immunocompromised).

Symptomatic Patients:

I. At least 10 days have passed since symptom onset and;
II. At least 24 hours have passed since resolution of fever without the use of fever-reducing medications and;
III. Other symptoms have improved.

Asymptomatic Patients:
Detainees infected with SARS-CoV-2 (positive test result) who never develop COVID-19 symptoms may discontinue isolation and other precautions 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA (so long as they remain afebrile and asymptomatic). Again, a negative test is NOT required unless severely immunocompromised.

Ongoing Care:
Detainees will continue to have the same access to care and sick call process outlined above should any unexpected complications occur. High risk patients will continue to be monitored by a medical provider at an appropriate interval deemed appropriate by the medical provider.

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Attorneys for Respondents-Defendants
THE GEO GROUP, INC. (Sued herein as GEO GROUP, INC.) and NATHAN ALLEN

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

ANGEL DE JESUS ZEPEDA RIVAS, BRENDA RUIZ TOVAR, LAWRENCE MWAURA, LUCIANO GONZALO MENDOZA JERONIMO, CORAIMA YARITZA SANCHEZ NUÑEZ, JAVIER ALFARO, DUNG TUAN DANG,

Petitioners-Plaintiffs,

v.

DAVID JENNINGS, Acting Director of the San Francisco Field Office of U.S. Immigration and Customs Enforcement; MATTHEW T. ALBENCE, Deputy Director and Senior Official Performing the Duties of the Director of the U.S. Immigration and Customs Enforcement; U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT; GEO GROUP, INC.; NATHAN ALLEN, Warden of Mesa Verde Detention Facility,

Respondents-Defendants.

Case No. 3:20-cv-02731-VC

DECLARATION OF RICHARD MEDRANO, M.D., REGARDING MEDICAL CARE FOR COVID+ PATIENTS AT MESA VERDE

Judge: Hon. Vince Chhabria

I, RICHARD MEDRANO, M.D. declare as follows:

1. I am the Regional Medical Director for Wellpath, overseeing facilities in the area including Mesa Verde and Adelanto ICE Detention Facilities. My role

is to oversee the clinical care provided within the region and to provide guidance. I am often on-call and/or serve as a backup Physician for Mesa Verde when needed. I visit Mesa Verde in person at least every two months and more if needed. I am in contact with the medical leadership there multiple times per week and always available to them. In 2016, I briefly filled in at Mesa Verde in the capacity of a Physician when they were between physicians, and I am cleared and available to fill in again when and if I am needed.

2. I previously worked for Correct Care Solutions beginning in 2015, before it combined with CMGC to form Wellpath. I went to medical school at the University of Southern California, Keck School of Medicine, and graduated in 2006. Thereafter, I did a 3 year combined internship/residency in Family Medicine at Kaiser Los Angeles Medical Center. I am a licensed Physician in the State of California. I have personal knowledge of the statements herein, and if called upon to do so, I could and would testify competently thereto.

3. I am familiar with the CDC guidelines regarding COVID-19 symptoms, ways to minimize infection, and recommended protocol for detention facilities. I am also familiar with IHSC guidelines, which govern ICE facilities. We continue to implement IHSC guidelines as they evolve for care of COVID patients and prevention of the spread of infection, including the August 2020 IHCS recommendations[1]. The medical staff is required to follow both CDC and IHSC guidelines, and we often exceed these guidelines. All medical staff is required to wear PPE when interacting with detainees and/or in close contact with other staff.

4. Based on my supervision, observations, and experience working for CCS and now Wellpath at Mesa Verde Detention Facility, it is my informed professional opinion that the current standard of care at Mesa Verde for COVID-19 positive patients exceeds the standard of community care in the United States.

[1] Attached as Exhibit A is a true and correct copy of the August 2020 IHSC recommendations (v. 12), which we follow at Mesa Verde.

Testing, care, and monitoring are also more readily available and accessible at Mesa Verde than in the community.

5. Even with COVID-19 infections on the rise in many communities, and mortality rates for this novel virus, it has been my experience and observation that it still takes time to obtain appointments for a COVID test (sometimes 1-2 weeks unless symptoms are severe) and the results can take as long as 7-10 days. Same day appointments are rare outside the correctional environment, and same day results for COVID-19 tests are uncommon. People who test positive with COVID-19 are told to stay at home and isolate and not go to the hospital unless they have severe symptoms such as chest pain, shortness of breath, or other concerning symptoms. They are not routinely checked by any medical provider in person unless there is a concern.

6. In my medical opinion, detainees who are COVID+ are at no greater risk for complications than if they were in the community, and if anything they are at less risk. There is an increased level of access to care and monitoring provided in the facility, timely intervention for complications is more likely. Further, a person who tests positive in the community is most likely to be isolated at home without any routine checks on their vital signs and oxygen saturation. Most lay persons are also less likely to recognize warning signs than trained medical professionals.

7. In contrast, detainees have 24/7 access to medical care and even asymptomatic COVID-positive patients are seen and evaluated several times a day. Mesa Verde currently has 1 full time physician, 1 full-time Nurse Practitioner, 1 full time Physician's Assistant[2], 4 full-time Registered Nurses, and 7 full-time Licensed Vocational Nurses. From 7:00 a.m. to 8:00 p.m. Mondays – Fridays, there is always a provider on duty at the facility; on weekends and evenings, one medical provider (above the level of R.N.) is always on call. Nurses are staffed on

[2] Currently the P.A. is on FMLA leave (non-COVID related), and a second M.D. is covering full-time hours for the P.A. in their absence.

12-hour shifts. On day shift, there are 2 LVNs on duty and at night there is 1 RN and 1 LVN on duty.

8. Detainees can submit sick call requests on their Tablets or on paper forms that are picked up daily in the units by a nurse. A Registered Nurse triages the sick call slips based on the reported symptoms, with the most severe symptoms resulting in the shortest turnaround time. Most detainees are seen the same day, though routine requests (such as refills of Tylenol or fungal powder) may be done within the following day or two. Sick call slips averaged 600 to 700 per month before the pandemic, and with the reduced population are now approximately 200-250 or less per month.

9. Currently, the population at Mesa Verde is greatly reduced (approximately 101 detainees) but we have not reduced the level of medical staffing, so there is a greater ratio of medical providers to detainees. Between the reduction in sick call requests, the reduction in detainees, and the same level of medical staffing, detainees are seen very quickly for any medical issues.

10. Detainees are educated about their health care access upon intake and orientation, in both English and Spanish.

11. Bilingual staff are usually available for Spanish translation if needed. If a translator is needed in another language to communicate with a detainee, they are escorted to medical and the translation line is called to assist.

12. Custody officers within the housing units often communicate to the medical clinic the need for care for a particular detainee, and they can either call the medical unit if it is an emergency ("code blue") or escort/send the detainee to the clinic as appropriate. Staff and detainees are both taught to say something if they are having an emergency or observe one, whether medical or otherwise.

13. Medical staff are expected to use their experience, training, and discretion in determining whether to send a detainee to the hospital, either via custody staff or by ambulance if emergent. I advise medical staff to do what is

correct, medically speaking, and to use their medical judgment. Nurses have discretion to call 911, but they can also reach a provider on-call if they have any questions. Mercy Hospital is very close to the Facility, on Truxtun Avenue, so they can be transported quickly and ambulances respond quickly if needed. I do not feel it is appropriate to set specific criteria or list the symptoms to trigger specific care or a certain diagnosis, as it is preferred to use medical judgement in diagnosing and treating patients. Similarly, it is not appropriate to dictate that detainees should be sent to the hospital if they have certain symptoms or complaints, as this decision must be left within the medical providers' judgment and discretion.

14. Wellpath medical staff errs on the side of caution in sending detainees out to the hospital. In fact, of the last 5 detainees sent to the hospital, only detainee Zamora Guzman ended up being admitted. He was retained at the hospital longer than he would have been simply to wean him off oxygen. We do not administer continuous oxygen at Mesa Verde, though we have supplies and the training and capability to provide oxygen in the short term if needed. The other 4 detainees were returned to the Facility without being admitted, and with prescriptions for the same medication they were already prescribed by Mesa Verde medical staff.

15. For the B dorm, which contains detainees who have tested positive for COVID-19, nurses check on each detainee at least twice per day and chart their findings in the person's chart. This involves taking the detainee's temperature, blood pressure, heart rate, respiration rate, and Oxygen saturation level. The person is also asked about symptoms and how they feel, and any significant comments are noted on the patient's chart.

16. In addition to these twice-daily checks by nurses in B dorm, doctors also do rounds daily in the B dorm and ask patients how they are doing. They routinely select a few patients to do a full assessment on, with the selection based on factors such as if someone is medically vulnerable and of concern to them, or if someone has been putting in sick call slips or complaining to nurses. A full

assessment might include an interview, review of systems and symptoms, review of medications and adjustment as needed, heart and lung examination, etc.

17. The medical plan also adds a rover, which is a nurse who will patrol the dorms to check on high-risk patients with pre-existing conditions to monitor them for elevated temperature and other COVID symptoms. Any detainee who exhibits signs and symptoms of COVID is tested with the Abbott ID Now.

18. Detainees at Mesa Verde have now been provided hard copies of their individual laboratory results for all of their August 2020 COVID tests. I am informed and believe that enhanced cleaning protocols have been instituted, with cleaning done by staff three times per week of B Dorm.

19. Nurses are in B dorm approximately 3 times per 12-hour shift (or 6 times per day). In addition to taking vitals and other measurements, nurses also conduct pill call, passing out medications to detainees including giving insulin. Nurses also administer any treatments prescribed to detainees such as nebulizer/breathing treatments. During these times, detainees often speak with nurses about any concerns or questions.

20. Now that the population has recently dropped in B dorm, Nurses are in the dorm providing care approximately 3 hours per day, depending on the day and what needs to be done, as well as the population in the unit. For the vitals, it takes about 1-2 hours per day with 2 nurses doing them. Medical providers (above the level of RN) currently spend 1-3 hours per day in B dorm. This is in addition to custody staff, on duty 24 hours per day in the dorm.

21. In B dorm, although all of the detainees housed in that dormitory are positive, only 6-8 persons on average have active symptoms at any one time (such as headache, malaise or diarrhea). Thus, while medical staff is routinely monitoring the detainees for changes in condition and development and/or changes of symptoms, not every detainee in the unit needs medicine for COVID-19 or other medical intervention. Most will likely recover from COVID via rest and fluids.

22. Given that the dorms have different COVID-19 statuses, medical staff is currently following a protocol to make their rounds in a particular order: D and A dorms first (where everyone tested negative on the last round), then C dorm (with persons considered recovered from COVID), then lastly B dorm (mostly positive detainees plus a few detainees who have refused to move). The positive detainees who are not considered recovered yet per CDC guidelines are all housed in B dorm, plus 1 person in medical isolation.

23. Medical staff has separate equipment to check vitals for the D and A dorms, C dorm, and the B dorm, so that it is not shared even though it's routinely disinfected after use. Medical staff also wears full PPE – gown gloves, face shield, bouffant plastic cap to cover hair, shoe covers, and a N95 mask with surgical mask over it to all pods. This PPE is changed/replaced between dorms to limit cross-contamination.

24. There currently are 101 detainees at Mesa Verde. 41 of these detainees have tested negative on each of their repeated tests. One detainee tested negative on July 30, 2020 and subsequently refused all additional offers of testing. Of the remaining 59 detainees, 44 detainees are considered recovered from COVID. Apart from detainee Boar (who tested positive on 8/18/20), all detainees in A and D dorms have tested negative twice in a row now, suggesting the population is stable. There have been no fatalities at Mesa Verde from COVID-19, and no one has been intubated (even at the hospital). While 5 detainees were sent to the hospital with COVID symptoms, only 1 person was admitted, and he has now been discharged.

25. The criteria to be considered recovered for COVID-19, according to IHSC and CDC criteria, is as follows: For symptomatic patients: i. At least 10 days have passed since symptom onset; ii. At least 24 hours have passed since resolution of fever without the use of fever-reducing medications and; iii. Other symptoms have improved. For asymptomatic patients: Detainees infected with SARS-CoV-2 (positive test result) who never develop COVID-19 symptoms may discontinue

isolation and other precautions 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA (so long as they remain afebrile and asymptomatic). Again, a negative test is NOT required unless severely immunocompromised.

26. I rely on my medical judgment, training, experience and discretion about whether to send someone to the hospital and I instruct and expect all Wellpath medical staff at Mesa Verde to do the same. Wellpath medical staff do not need or seek ICE or GEO's approval before sending someone to the hospital, and if they feel a detainee needs to go to the hospital, they do it forthwith.

I declare under penalty of perjury that the foregoing is true and correct. Executed on August 31, 2020, at Carlsbad, California.

RICHARD MEDRANO, M.D.

EXHIBIT A

Immigration and Customs Enforcement
Washington, DC 20536

ICE
ICE Health Service Corps

Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19): Detainee Care

Version 12.0, August 7, 2020

Key changes

Version 12.0

- Added more detailed information on testing.
- Added information on retesting and isolating people who tested positive within the last 3 months.
- Revised the intake process to include testing and routine cohorting for all new intakes.
- Changed the isolation time period to 10 days to be in line with revised CDC guidance.
- Detainee face coverings must not contain metal pieces.

Situation Summary

The CDC is closely monitoring a pandemic caused by a novel (new) coronavirus (COVID-19). The situation is evolving and expanding with community transmission occurring in multiple countries including the United States. For the most current information, check the CDC information pages at https://www.cdc.gov/coronavirus/2019-ncov/index.html frequently for updates. CDC interim guidance for health care professionals, including clinical criteria, is available at https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html

ICE Health Service Corps Recommendations

Note: recommendations will be updated if and as necessary to address the evolving public health situation. Always review current CDC guidance in addition to IHSC documents. See also 2019 Novel Coronavirus Resource Page and CDC Guidance for Dental Settings.

1. ***During intake medical screening:***

- Perform pre-intake screening on all new arrivals which includes asking verbal screening questions for COVID-19 symptoms, contact with known cases, and obtain a safe temperature check.
- Detainees should be provided cloth face coverings (unless contraindicated)
- This screening should take place before staff and new intakes enter the facility or just inside the facility, where practicable in order to identify and immediately isolate any detainee with symptoms of COVID-19.
- Verbal screening for symptoms of COVID-19 and contact with COVID-19 cases should include the following questions:
    i. Today or in the past 24 hours, have you had any of the following symptoms:
        - Fever, felt feverish, or had chills
        - Cough
        - Shortness of breath or difficulty breathing
        - Fatigue
        - Muscle or body aches
        - Headache
        - Sore throat
        - Congestion or runny nose
        - New loss of taste or smell
        - Nausea or vomiting
        - Diarrhea
    ii. In the past 14 days, have you had close contact with a person known to be infected with (COVID-19) where you were not wearing the recommended PPE?
    iii. If the detainee has a fever and/or symptoms consistent with COVID-19, require the individual to wear a facemask, ensure that staff interacting with the symptomatic individual wears recommended PPE and isolate the individual; refer to ISOLATION below.

2. COVID-19 testing during the intake screening process:

- All new arrivals require COVID-19 testing within 12 hours of arrival and quarantine for 14 days upon intake screening. Collection timeframe may extend to 24 hours if facility collection logistics require additional time.

Some exceptions to COVID-19 testing and quarantine requirements may include:

Detainees who arrive at a facility to stage for movement to another detention facility and are held at the site for less than 72 hours, do not require this COVID-19 testing.

Asymptomatic detainees with a documented positive COVID-19 test in the last 3 months who have been appropriately cleared with either a test-based, symptom-based, or time-

based strategy, at another detention facility do not require testing or cohorting for 14 days upon intake.

Detainees who test positive within 3 months of their original positive COVID-19 test, cleared isolation precautions, and who remain asymptomatic do not need to be isolated or quarantined due to recurrent or persistent positive results.

Detainees who test positive greater than 3 months after their original positive test result or develop new or worsening symptoms that are consistent with COVID-19 infection should be isolated and evaluated in conjunction with infectious disease experts and the health department for possible re-infection.

- Housing and exposure based cohorting: Cohort all new arrivals, preferably in a cell by themselves, for 14 days after their arrival. An alternate housing option may include housing detainees arriving within 48 hours of each other together for the 14-day cohorting period, as their security level permits. If new arrivals are added to a cohort group, the 14 day cohort period is restarted.
- Cohort detainees who refuse testing for 14 days and monitor for symptoms consistent with COVID-19. Document the refusal. Staff may offer the COVID-19 test again during their cohort period in the event the detainee reconsiders testing. If the detainee is asymptomatic after 14 days, staff may release the detainee to general population.
- A field office may choose to house new arrival detainees in a specific detention facility to best manage available bed space for single cell housing during the cohort period. In such a situation, a detainee who has been cleared to be released from cohort may be transferred from the cohorting/testing facility to another nearby facility for longer term housing and is not required to undergo cohorting and testing again upon arrival at the new facility as long as the detainee was never placed in general population at the cohorting/testing facility.
- Isolate COVID-19 positive symptomatic detainees with other positive symptomatic detainees, and isolate COVID-19 negative symptomatic individuals with other COVID-19 negative symptomatic individuals.
- Avoid mixing individuals quarantined due to exposure to someone with COVID-19 with individuals undergoing routine intake quarantine.
- Utilize all appropriate administrative, engineering, or PPE controls as needed to minimize potential person-to-person spread.
- Healthcare staff should evaluate persons with COVID-19 symptoms and those who are close contacts of someone with COVID-19 in a separate room, with the door closed if possible, while earing recommended PPE and ensuring that the individual being evaluated is wearing a cloth face covering.
- Testing should not be used to release detainees from exposure based cohorting before completion of the most recent incubation period.
- Educate all detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they

feel ill. Illness Prevention and Patient Education resources in multiple languages are available on the 2019 Novel Coronavirus Resource Page.

3. ***ENCOUNTER. During sick call, intake, health assessment, or other clinical encounter in which a detainee presents with or complains of fever and/or symptoms of COVID-19 infection, or is observed with signs of fever and/or symptoms of COVID-19 infection:***
    a. Require the individual to wear a cloth face covering (as much as possible, use cloth face coverings in order to reserve surgical masks for situations requiring PPE). Anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable to remove the mask without assistance should not wear a cloth face covering.
    b. Face coverings for detainees must not have metal pieces built into the mask (for example, the nose bridge). Detainees should either be issued a cloth face mask or any metal pieces must be removed before distribution.
    c. Ensure that staff who have direct contact with the symptomatic individual wear recommended PPE.
    d. Place the individual under medical isolation and refer to healthcare staff for further evaluation.
        - Medical isolation is private medical housing room, ideally in an airborne infection isolation room if available. If no single occupancy medical housing unit room is available, placement in other areas of the facility may be utilized to house the ill detainee separately from the general detention population
    e. During medical evaluation the provider:
        i. Should assess whether the detainee is at increased risk for severe illness from COVID-19
        ii. Will determine the appropriate monitoring care plan based on the detainee's signs and symptoms.
        iii. Is strongly encouraged to test for other causes of respiratory illness, including infections such as influenza. However, presence of another illness such as influenza does not rule out COVID-19.
        iv. Staff evaluating and providing care for individuals with confirmed or suspected COVID-19 should follow the CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) and monitor the guidance website regularly for updates to these recommendations.
        v. Healthcare staff should evaluate persons with COVID-19 symptoms and those who are close contacts of someone with COVID-19 in a separate room, with the door closed if possible, while wearing recommended PPE and ensuring that the individual being evaluated is wearing a cloth face covering.

vi. Perform COVID-19 LabCorp RT-PCR testing (see specimen collection and testing information below)
vii. Educate detainees on symptoms of COVID-19 and to report any new or worsening symptoms to medical staff at sick call or to the custody officer
    i. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
    ii. Illness Prevention and Patient Education resources in multiple languages are available on the 2019 Novel Coronavirus Resource Page

f. The detainee will receive at minimum daily sick call, daily vital signs to include pulse oximetry for the duration of isolation/quarantine. (refer to the Clinical Services Reference Sheet for more details on clinical management)
    i. Consider more frequent vital sign collection if the patient is medically vulnerable (age or comorbidities) and/or is complaining of lower tract symptoms (cough, shortness of breath or chest pain). If oxygen saturation is below 95% on room air, consult with your CD or designee for emergency department referral.
    ii. Patients with COVID-19 may have symptoms and even complications after the acute illness, including thromboembolic phenomena; evaluate patients with a history of recent COVID-19 infection (the past 30 days) with close attention to their distal extremities, heart and lung examination. Promptly seek consultation with your CD, RCD and/or Infectious Disease Program as necessary.
    iii. Use the eCW templates (ACUTE: COVID-19 Medical Provider Template or ACUTE: Nurse COVID-19 Template) to help guide and optimally document clinical observations and care
g. If the detainee has underlying illness or is acutely ill, or symptoms do not resolve, consult with the Regional Clinical Director, and/or Infectious Disease program.
h. If the detainee is referred to a local hospital, call the hospital in advance to notify of the recent relevant travel history and respiratory symptoms and to coordinate how manage the detainee safely.
i. Promptly notify the facility's staff responsible for infection prevention and control (e.g., in IHSC facilities, notify the Infection Prevention Officer, or the Facility Healthcare Program Manager (if the facility does not have an Infection Prevention Officer position); if the Infection Prevention Officer or Facility Healthcare Program Manager is not available, IHSC staff should notify the Infection Prevention Group at #IHSC_PHSP_IPO@ice.dhs.gov.
j. Facilities without IHSC medical staffing should notify their assigned Field Medical Coordinator.
k. IHSC Infection Prevention Officers, Facility Healthcare Program Managers, Field Medical Coordinators, or designees should notify the Regional Infection Prevention Supervisory Nurse immediately.

l. Detainees isolated for respiratory illness and who have epidemiologic risk for COVID-19 exposure should wear a cloth face covering when outside of the isolation room.
m. The duration of the contagious period for COVID-19 is still uncertain.
n. A person with COVID-19 is thought to be contagious starting 48 hours before symptom onset
o. If the detainee tests negative for COVID-19 and fever and/or symptoms persist, consult with the Regional Clinical Director and/or Infectious Disease Program
p. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, requesting sick call if they feel ill, and social distancing to maintain 6 feet (2 meters) between individuals when possible.
q. Illness Prevention and Patient Education resources in multiple languages are available on the 2019 Novel Coronavirus Resource Page.

4. CRITERIA FOR DISCONTINUING ISOLATION

- Detainees with COVID-19 (positive test result) who reported symptoms consistent with COVID-19 may discontinue isolation under the following conditions:
    i. At least 10 days have passed since symptom onset and;
    ii. At least 24 hours have passed since resolution of fever without the use of fever-reducing medications and;
    iii. Other symptoms have improved.
- A limited number of persons with severe illness may produce replication-competent virus beyond 10 days, that may warrant extending duration of isolation for up to 20 days after symptom onset. Consider consultation with infection control experts. See Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (CDC Interim Guidance). Such patients are generally considered to have required hospitalization.
- Detainees infected with SARS-CoV-2 (positive test result) who never develop COVID-19 symptoms may discontinue isolation and other precautions 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.
- RT-PCR testing for detection of SARS-CoV-2 RNA for discontinuing isolation could be considered for detainees who are severely immunocompromised, in consultation with infectious disease experts. For all others, a test-based strategy is no longer recommended except to discontinue isolation or other precautions earlier than would occur under the symptom-based strategy outlined above.
- The test-based strategy for severely compromised detainees requires negative results using RT-PCR for detection of SARS-CoV-2 RNA under an FDA Emergency Use Authorization (EUA) for COVID-19 from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) (see CDC

Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019).

- All test results should be final before isolation is ended.
- In the event detainees are being considered for transfer or release during a period of medical isolation or medical hold, see #7 below for requirements.

5. SPECIMEN COLLECTION AND TESTING for COVID-19

- Only molecular assays for detection of SARS-CoV-2 with an FDA EUA should be used for diagnosis and clinical decisions (laboratory-based, and point-of-care molecular tests are acceptable).
- Laboratory testing for COVID-19 is available through commercial laboratories including LabCorp and through local and/or state health departments.
- Point-of-care testing using the Abbott ID NOW is currently used for removal testing
- Testing is recommended for all detainees with signs or symptoms of COVID-19
- Testing is recommended for all close contacts of a detainee or staff member who tested positive for COVID-19
- It is recommended that the facility work with their local health department to determine if broad based testing is indicated for the facility if a staff member or detainee tests positive for COVID-19
- All new intakes will receive testing prior to release to general population
- For laboratory-based tests the following samples are acceptable:
    i. Nasopharyngeal
    ii. Oropharyngeal
    iii. Nasal mid-turbinate (supervised self-collected or collected by a healthcare professional)
    iv. Anterior nares specimen (self-collected or collected by a healthcare professional
    v. Nasopharyngeal wash/aspirate
    vi. Nasal wash or aspirate
    vii. Sputum sample (non-induced)
- Laboratory-based samples should be in viral transport medium (VTM)/saline and stored frozen at -20° C (preferred). Refrigerated specimens acceptable (if received for testing within 72 hours of collection). Room temperature swabs are acceptable (if received within 24 hours of collection).
- LabCorp testing for removals is required by certain countries. LabCorp test results are good for 10 days after testing
- LabCorp ordering codes are 2019 Novel Coronavirus (COVID-19), NAA; TEST: 139900.
- Abbott ID NOW testing (FDA instructions for use)
- Acceptable specimens include:

i. Throat swab (for optimal test performance use the swabs provided in the test kit)
    - Collect patient specimen by swabbing the posterior pharynx, tonsils and other inflamed areas. Avoid touching the tongue, cheeks and teeth with the swab.

ii. Nasal swab (for optimal test performance use the swabs provided in the test kit)
    - To collect a nasal swab sample, carefully insert the swab into the nostril exhibiting the most visible drainage, or the nostril that is most congested if drainage is not visible. Using gentle rotation, push the swab until resistance is met at the level of the turbinate (less than one inch into the nostril). Rotate the swab several times against the nasal wall then slowly remove from the nostril. Using the same swab, repeat sample collection in the other nostril.

iii. Nasopharyngeal swab (use sterile rayon, foam, polyester or flocked flexible-shaft NP swabs)
    - To collect a nasopharyngeal swab sample, carefully insert the swab into the nostril exhibiting the most visible drainage, or the nostril that is most congested if drainage is not visible. Pass the swab directly backwards without tipping the swab head up or down. The nasal passage runs parallel to the floor, not parallel to the bridge of the nose. Using gentle rotation, insert the swab into the anterior nares parallel to the palate advancing the swab into the nasopharynx, leave in place for a few seconds, and then slowly rotate the swab as it is being withdrawn.

iv. Used for removal to countries requesting testing and not requiring LabCorp tests prior to removal

v. Abbott ID NOW samples should NOT be stored in VTM or saline after collection

vi. The specimen can be stored in the original package or in a tightly capped conical tube at room temperature for less than 2 hours prior to testing

vii. The specimen can be stored in the original package or in a tightly capped conical tube in the refrigerator (2-8° C) for less than 24 hours prior to testing.

viii. Result must be documented on the transfer summary

ix. Detainees with inconclusive results can be tested an additional 1 time with the Abbott ID NOW machine; repeat inconclusive results require the detainee be tested with a laboratory-based RT-PCR test

x. Detainees who previously tested positive and cleared isolation precautions using the symptom-based criteria, within the last 3 months DO NOT need to be tested with Abbott ID NOW prior to deportation

- See **Specimen Collection instructions on the 2019 Novel Coronavirus Resource Page.**

6. ***Recommendations to the Field Office Director or Designee and the Facility Administrator or Warden for routine intake cohorting***
   a. Cohort all new arrivals, preferably in a cell by themselves, for 14 days after arrival. An alternate housing option may include housing detainees who arrive within 48 hours of each other together for the 14-day cohorting period, as their security level permits. (SEPARATELY from other individuals who are cohorted due to contact with a COVID-19 case).
   b. Cohort detainees who refuse testing for 14 days and monitor for symptoms consistent with COVID-19. Document the refusal. Staff may offer the COVID-19 test again during their cohort period in the event the detainee reconsiders testing. If the detainee is asymptomatic after 14 days, staff may release the detainee to general population.
   c. If any person in the routine intake cohort does develop fever or symptoms, the cohort status would be changed to an *exposure-based cohort*
   d. Routine intake cohorts do not require tracking or reporting

7. ***Recommendations to the Field Office Director or Designee Regarding Detainee Release and Special Circumstance Movement***
   - All requirements on the ERO Checklist for Removals, Releases or Transfers should be met before a detainee is released unless the movement is to facilitate a medically- or behaviorally necessary placement
   - Recommend all detainees being released be given the fact sheets *Steps to help prevent the spread of COVID-19 if you are sick* and *Stop the spread of germs*.
   - **Recommend the following considerations if decisions are made to release in the U.S. detainees with confirmed or suspected COVID-19 and detainees exposed to a person with confirmed or suspected COVID-19:**
     i. For all detainees that have tested positive for COVID-19 (including detainees that have completed the isolation period) and for afebrile and asymptomatic detainees that must be released before the recommended cohorting period is complete, discuss release of the individual with state or local health department with as much advance notice as possible, preferably at least 24 hours advance notice
        - **Provide the health department with the detainee's name, intended address, email address, all available telephone numbers, and planned mode of transportation to their intended destination**
        - **Coordinate with the health department to facilitate any needed public health actions; examples of public health actions include but are not**

limited to delivering health officer orders and making the detainee available for transportation if arranged by the health department.

ii. Facilitate safe transport, continued shelter, and medical care, as part of release planning.
- Make direct linkages to community resources to ensure proper medical isolation and access to medical care if needed.
- Coordinate with the detainee for a family member or friend to provide transportation
- Advise the detainee to avoid public transportation, commercial ride sharing (e.g., Uber, Lyft), and taxis

iii. Give the detainee the CDC's *What To Do if You Are Sick* fact sheet (see https://icegov.sharepoint.com/sites/ihsc/phspunit/2019-nCoV/PHSPMostCurrentGuidance/patient%20education)

- Detainees under isolation or cohort should be permitted to attend other medically necessary appointments with advance coordination with the receiving facility
- Detainees under isolation or cohort should not be restricted from movement to facilitate a medically- or behaviorally necessary placement
- If a detainee under isolation or cohort must be moved to another facility; the receiving facility must be notified of the isolation or cohort end dates

i. Recommend to Field Office Director or designee that detainees that are in isolation, are febrile, symptomatic, have pending test results or that were exposed to a person with confirmed or suspected COVID-19 in the past 14 days NOT BE TRANSFERRED OR TRANSPORTED UNLESS MEDICALLY NECESSARY.

ii. See IHSC Interim COVID-19 Risk Assessment on the 2019 Novel Coronavirus Resource Page.

- **If a detainee is inadvertently removed that is febrile and/or symptomatic, that tests positive for COVID-19, that has a pending test result for COVID-19, or that was exposed to a person with confirmed or suspected COVID-19 in the past 14 days, recommend that the Field Office Director or designee notify the respective consulate so notifications and public health actions can occur.**

8. REPORTING

- Document any detainee who tests positive for COVID-19 on the Lower Respiratory Illness Tracking Tool.

i. Only document tests and results performed using molecular assays for detection of SARS-CoV-2 with an FDA EUA; do not document antibody tests or results that are not approved for diagnosis.

- Document exposure-based cohorting through routine IHSC cohort reporting protocols using the Cohort Tracker.
- Any employee known to have a positive test result for COVID-19 must be promptly reported to the local or state health department in accordance with local or state

public health laws and permissible exemptions under the Health Insurance Portability and Accountability Act (HIPAA) requiring notifications to public health departments for conducting investigations and interventions and to avert a serious threat to public health and safety. Reported must include the employee's name, date of birth, address, phone number, and testing location.

[1]**Close contact** is defined as:

a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case
– or –
b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)

If such contact occurs while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.

Resources and references

- 2019 Novel Coronavirus Resource Page on SharePoint
- ERO Pandemic Response Requirements (PRR)
- Illness Prevention and Patient Education resources in multiple languages are available on SharePoint.

IHSC Official Guidance

Guidance number	Guidance name	Type
05-02	Occupational Health Directive	Policy
05-02 G-04	Occupational Health Guide: Workforce Health	Guide
05-02 G-1	Occupational Health Guide: Bloodborne Pathogens and Other Potentially Infectious Materials	Guide
05-02 G-2	Occupational Health Guide: Personal Protective Equipment Program	Guide
05-02-G-03	Occupational Health Guide: Respiratory Protection Program	Guide
05-04	Environmental Health Directive	Policy
05-04 G-01	IHSC Environmental Health Guide	Guide
05-06	Infectious Disease Public Health Actions Directive	Policy

Guidance number	Guidance name	Type
05-06 G-01	Infectious Disease Public Health Actions Guide: Contact and Outbreak Investigation Guide	Guide
05-06 G-02	Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms	Guide
05-06 G-03	Infectious Disease Public Health Actions Guide: Surveillance and Reporting	Guide

- **Infection Control: Novel Coronavirus 2019 (COVID-19) | CDC**
- **Information for Healthcare Professionals about Coronavirus (COVID-19)|CDC**
- **Resources for Correctional and Detention Facilities | CDC**
- Overview of COVID-19 Testing | CDC
- CDC COVID-19 What's New?
- People who are at increased risk for COVID-19 | CDC
- Clinical Questions about COVID-19: Questions and Answers| CDC
- Duration of Isolation and Precautions for Adults with COVID-19| CDC

Points of contact for questions

- IHSC Staff: Regional Infection Prevention Supervisory Nurses, PHSP Unit Senior Public Health Analyst, PHSP Unit Chief

- Facilities without IHSC Medical Staffing: Assigned Field Medical Coordinators

- Public health agencies: IHSC InfectionPrevention@ice.dhs.gov

Appendix A: Intake Screening Questions

Updated August XX, 2020

1. **Have you had fever and/or symptoms consistent with COVID-19 in the past 14 days?**
   - Signs and symptoms include fever, feeling feverish, chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body ache, headache, sore throat, new loss of taste or smell, congestion or runny nose, nausea or vomiting, and diarrhea
   - **If yes, what date did you first notice symptoms?: mm/dd/yyyy**
   - **If yes,** isolate in a single room (preferred) if available, implement daily vital signs including oxygen saturation, and refer to a medical provider, add Medical Hold, notify FHPM, IPO, or designee.
   - See Reducing the Risk of COVID-19 Transmission
   - Proceed with intake COVID-19 testing
   - **If no, implement intake quarantine;** house in single room (preferred) if available, implement daily checks for 14 days after initial intake, add Medical Hold, notify FHPM, IPO, or designee, and proceed with intake COVID-19 testing
2. Does the detainee have any of the High-Risk Conditions?
   - Yes: Schedule an appointment with a provider within the next 5 days
   - No: Routine PE-S/PE-C process