Farmville Detention Inspection Report of Dr. Homer Venters

A. Expert Assignment

1. I was retained by plaintiffs' counsel to conduct a facility inspection of the Farmville Detention Center ("FDC" or "the facility") in accordance with the order of Judge Leonie Brinkema.

B. Methodology

2. In order to conduct my assessment, I visited and physically inspected the Farmville Detention Center, which is administered by Immigration Centers of America-Farmville, LLC ("ICA") and where health services are provided by Armor Correctional Health Services, Inc. ("Armor"). My inspection was conducted on August 20th, 2020, from approximately 10:30 a.m. to 3:00 pm.

3. Before the facility inspection began, I met the other participants in the office of facility Director Jeffrey Crawford (ICA). The other inspection participants included Dr. William Reese, retained by defendants, the facility Health Services Administrator ("HSA"), [redacted], and Mr. Matthew Monroe (ICE). PPE supplies were available in Director Crawford's office. Approximately 45 minutes were spent discussing facility COVID-19 responses in Director Crawford's office before the physical inspection began.

4. I was able to inspect the facility freely with unfettered access to the facility, and was also empowered to speak with staff or detainees along the path of the various areas of the facility that I visited. The staff members I spoke with were helpful in answering my questions.

5. My inspection included review of the entry area, facility intake, medical clinic and several housing areas. No housing areas were being utilized for medical isolation or quarantine at

the time of the inspection. Specific housing areas inspected included the restrictive housing unit (RHU) and Dorms 1, 3, 4, 5, and 7. During my inspection I was able to have brief conversations with 22 people. Dr. Reese joined me in speaking with approximately 1/3 of these people for at least some of the discussion. A facility translator was present and assisted with 5 of these discussions. In three of the housing areas, I had brief group discussions with 4-8 people after completing the individual discussions. These discussions were not planned but occurred because many more people were eager to relate their experiences than time allowed for conducting individual discussions.

C. Outbreak Update for Farmville Detention Center

6. The census of Farmville Detention Center on the day of my inspection was 276, based on my conversation with Director Crawford and HSA [redacted]. A total of 253 detained people have tested positive in the facility, with eight people being sent for hospital evaluation based on COVID-19 symptoms and 7 admitted. One detained person has died from a COVID-19-related illness, a 72-year-old man. Each detained person has been tested for COVID-19 infection at least once, with multiple tests offered to each person who has remained COVID-19-negative. Director Crawford indicated that a total of 734 tests had been conducted. Director Crawford and HSA [redacted] indicated that no detained person has had COVID-19 symptoms since July 10th and that, pending feedback from the CDC team that conducted their own inspections last week and ongoing counsel from the VA Department of Health, they anticipated scaling back their response efforts in the coming days or weeks. When discussing the CDC inspection, Director Crawford indicated that "I don't know if they made any observations or went into any housing areas." At the time of my inspection, the CDC inspection report and the results of the CDC surveys of staff and detained people were not available. Director Crawford indicated that detained people had recently been

moved to utilize all of the available housing areas. HSA [redacted] and Director Crawford indicated that no changes had been made to medical isolation protocols or policies based on CDC observations and recommendations regarding mixing of symptomatic and COVID-19-positive patients.

7. As described in my prior declaration, a number of detained people staged a protest in June when their COVID-19 symptoms went unaddressed. Based on my interview with detained people, and as detailed in my prior declaration, the response of FDC was to utilize force, including large-scale deployment of pepper spray, and then transfer protesters into solitary confinement. During my inspection, I spoke with people currently held in the facility's restrictive housing unit, where some of these protesters remain held inside a cell for 23 hours per day. One person reported that he was initially given a disciplinary infraction for his part in the protest in June, but that Director Crawford had changed his status to administrative segregation, meaning that he could be held there indefinitely. When I asked Director Crawford about the length of time that people are held in restrictive housing area cells, he stated that for disciplinary reasons, the duration was usually less than a month, but for administrative segregation, it was indefinite. All 7 of the RHU cells were occupied at the time of my inspection.

D. Observations, Findings and Recommendations.

8. The following observations and findings are organized based on the categories of Judge Brinkema's inspection order. For each area of findings, recommendations are included at the end of the section.

9. Screening for temperature and symptoms.

a. **Observations.** During our initial discussion in Director Crawford's office, HSA [redacted] stated that every detained person was currently screened at least once per

day and that each screening consisted of a temperature check plus asking about the presence of COVID-19 symptoms. When I asked whether the questioning about symptoms was structured, including asking about the presence of specific symptoms, she stated that it was simply a question about whether or not the person being screened had COVID-19 symptoms. When I asked whether people know what the symptoms of COVID-19 are, she and Director Crawford both stated that the symptoms of COVID-19 are known by everyone because of a visit conducted by Dr. Moore in June into each housing area, as well as because of signs that had been posted and videos that had been played for detainees. I did not observe any of the video reports or briefings mentioned by Director Crawford. During my 30-minute wait in the facility staff and visitor entry area, I did observe that the monitor was playing religious (Christian) programming. I did not learn whether the programming playing in the entry area was the same as what was playing in detainee areas. When I asked about how the nurses conducting these screenings elicit or document symptoms during screening for people who do not speak English, I was told that this is not a problem because the nurse can call for an interpreter whenever needed or utilize a language line phone. I asked about needs and resources for interpretation and was told that approximately 50% of the detainees are Spanish-only speakers and that none of the 30-40 Armor health staff speak Spanish. In 21 of my 22 discussions with detainees, I asked about the daily COVID-19 screenings that occur. In 19 of these 21 discussions, people responded that nurses do not ask any questions at all about symptoms, and in the remaining 2, they responded that nurses sometimes ask a general question, either about how they are

doing, or whether they have any symptoms of COVID-19, without asking about any specific symptoms. These screenings were reported to occur in the housing areas and by a sole nurse, without an interpreter.

b. **Findings.** The Armor staff do not appear to elicit the presence of symptoms in their daily COVID-19 screenings. This is a critical departure from CDC guidelines, which make clear that eliciting the presence of symptoms in detention settings is essential, since people may present elevated temperatures later in their disease course. CDC guidelines for verbal screening include the following questions:

Today or in the past 24 hours, have you had any of the following symptoms?

1. Fever, felt feverish, or had chills?
2. Cough?
3. Difficulty breathing?[1]

This need has been underscored by Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases, who has recently discussed the unreliability of noncontact thermometers, the type being utilized by Armor staff.[2] In addition, the symptoms of COVID-19 are extremely unlikely to be elicited or documented when health staff do not speak the language of the patients they are screening and when they do not conduct screenings with an interpreter. Both HSA [redacted] and Director Crawford indicated that they were likely to scale back current screening efforts because they believe that nobody in FDC has any COVID-19 symptoms in the past two weeks. Because the FDC system for finding or eliciting

[1] https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention html#Screening.
[2] https://www forbes.com/sites/lisettevoytko/2020/08/13/fauci-says-coronavirus-temperature-checks-notoriously-inaccurate/#7c99bf9433f0.

COVID-19 symptoms during screenings is so deficient and at odds with CDC recommendations, I do not believe that the facility actually knows the extent of current COVID-19 symptoms.

c. **Recommendations.** FDC and Armor should immediately:

i. Adopt a daily screening tool that explicitly asks each person about the presence of COVID-19 symptoms.

ii. Conduct screenings with a Spanish language interpreter and ensure that screenings for patients who speak other languages occur in clinic settings with appropriate language line interpretation.

iii. Continue current frequency of screenings for at least one month after the most recent COVID-19 case.

iv. Conduct weekly briefings on COVID-19 symptoms, prevention measures and outbreak updates in person with Armor health staff. The one briefing conducted by Dr. Moore in each housing area in June is a good model for a regular process. My experience in conducting these types of briefings during outbreaks is that when they are weekly, in person, and conducted with interpreters, all aspects of the facility response are more successful, not only the screenings.

10. Identification and protection of COVID-19 cases, including high-risk patients.

a. **Observations.** HSA [redacted] indicated in our discussions that approximately 50 people in the facility were considered to be high-risk. She indicated that no special measures were in place to create increased screening, clinical encounters or other changes in their health assessments and care because of COVID-19 based on their high-risk status. She stated that the sole facility physician would assess and care for

these patients as needed. When I asked whether there was any affirmative effort to have structured encounters to determine whether high-risk patients were experiencing ongoing COVID-19 symptoms after they were cleared from medical isolation, she stated that although there were no such encounters, there were no people currently experiencing COVID-19 symptoms. When I clarified that I was interested in whether there was a protocol to ensure that high-risk patients who had become infected with COVID-19 (but who were no longer considered infectious) were being seen to assess the presence of ongoing symptoms, she stated that no such protocol or process existed. Among the 21 detained people I spoke with, 19 reported testing positive for COVID-19 and 7 reported having a chronic health problem that would merit potentially being at high risk for serious illness or death from COVID-19 infection based on CDC criteria.[3] Among the 19 people I spoke with who had tested positive for COVID-19, 8 of them reported ongoing symptoms of COVID-19, including headaches, chest pain, shortness of breath, facial paralysis, and weakness. Only one of these people reported seeing a physician since his release from medical isolation.

b. **Findings.** Armor, ICA and ICE do not appear to have any plan for creating specialized surveillance and protection of high-risk patients, despite having knowledge of who they are. At the time of my inspection, one person who was high-risk was in a medical isolation cell for increased surveillance, but it was not clear that any additional health assessments were being conducted or any additional care was being provided to him.

[3] https://www.cdc.gov/media/releases/2020/p0625-update-expands-covid-19 html.

c. Recommendations.

i. Every person who has a positive COVID-19 test should be seen by a physician to assess them for the presence of ongoing symptoms and health problems relating to COVID-19 infection. Basic elements of a post-COVID-19 assessment include asking patients whether they experienced any of the CDC-listed symptoms during their COVID-19 infection, and whether they continue to experience any of those symptoms, or any other symptoms. These efforts will likely include pulmonary rehabilitation and physical therapy or exercise as part of what patients need to recover from COVID-19.[4] At a baseline, any patient who experienced shortness of breath or other pulmonary symptoms should have his respiratory status and symptoms documented and be considered for incentive spirometry.[5] Patients with chest pain should be evaluated for cardiac complications of COVID-19, have an EKG conducted and be referred for cardiology consultation. Because COVID-19 is associated with high rates of blood clots, as well as kidney and liver damage, these recovery encounters should also include structured questions to elicit information about these symptoms, and when indicated, laboratory testing should follow. Implementing these basic and required elements of COVID-19 care will require adequate staff as well as training. While high-risk patients are especially in need of this type

[4] https://rehabmed.weill.cornell.edu/sites/default/files/post_covid_rehab_-_patient_guide_0.pdf; https://www healthline.com/health-news/what-to-do-after-recovering-from-covid-19#Walking.

[5] https://lunginstitute.com/blog/incentive-spirometry-benefits/.

of recovery assessment and care, any patient who is diagnosed with COVID-19 must be assessed for ongoing symptoms.

ii. Every high-risk patient should be seen by a physician to assess the presence of post-COVID-19 symptoms or create a plan for his potential care should he contract COVID-19.

iii. FDC should consider housing high-risk patients together so as to prioritize their COVID-19 response, and influenza response efforts. The risk factors for serious illness and death from COVID-19 and seasonal influenza are similar, and with both COVID-19 and seasonal influenza likely to impact detained people in the coming months, there is an urgent need to protect those most likely to experience morbidity or mortality. These patients can be housed in 2 separate housing areas based on their COVID-19 status. Also, because immunizations for both COVID-19 and seasonal influenza will be important considerations in the coming months, cohorting high-risk patients allows for increased education and engagement and since 2012, has been identified as part of protecting high risk patients such as those with diabetes, by the Federal Bureau of Prisons.[6]

iv. High-risk patients should be considered for release. The multiple and systematic deficiencies in the FDC approach to health services are unlikely to be addressed quickly, and from a medical standpoint, being detained in FDC represents a significant health risk for high-risk patients.

11. Ability to report and receive care for COVID-19 symptoms through sick call.

[6] https://www.bop.gov/resources/pdfs/pan_flu_module_3.pdf.

a. **Observations.** During my discussion with HSA [redacted], she indicated that all detained people have access to sick call and that the facility follows the common standard of every report of a medical or health symptom via sick call resulting in a face-to-face encounter with health staff within 24 hours, including weekends. When I asked how Armor and ICA measure the percentage of sick call requests (or the subset of COVID-19-related sick call requests) that actually result in a patient being seen within 24 hours, she stated that there was no tracking or quality assurance monitoring but that "it's 100%." When I asked to confirm that her position was that 100% of people who submit a sick call request are seen within 24 hours, both she and Director Crawford stated yes, that this was the case in FDC, despite no tracking of this process occurring. When I asked whether a COVID-19 symptom tracking tool had been created that at least identified every COVID-19 symptom reported to health staff via sick call and via screenings, HSA [redacted] stated that no such tool was utilized or contemplated. I asked 20 of the 21 detained people I spoke with about the timeliness of sick call responses and every one of them reported that sick call requests either take several days to result in being seen, or that they go unanswered altogether. Among the 20 people I asked about sick call, 14 of them reported personally submitting sick call requests, 10 of them for COVID-19-related symptoms, and not one of them reported being seen within 24 hours. Among the people who reported COVID-19 symptoms, there was consistency that during the initial days of the outbreak, they reported their symptoms via sick call, as well as by telling security staff. They reported that health staff came to the housing areas and gave out Tylenol for three days, but that they were not receiving actual health

assessments during this time. One person was able to show me his initial sick call form submitted on the first day he was having COVID-19 symptoms, which elicited a written response from Armor that he was receiving medications. He also showed me a grievance he submitted on the fourth day of his COVID-19 symptoms, which also elicited a similar reply. Only after five days of COVID-19 symptoms and these multiple requests for care was he seen by a nurse. During this time he reported that the people around him were ill, and that those too weak to get out of bed were being cared for by other detainees. Sick call appeared to be more difficult to access for people held in the restrictive housing unit, with multiple detained people reporting that their sick call requests went completely unanswered.

b. **Findings.** People who report COVID-19 and other health symptoms through sick call do not appear to receive timely assessment or care. This lack of timely sick call response undoubtedly increased the spread of COVID-19 throughout the facility and the lack of any quality assurance regarding sick call timeliness makes this an ongoing deficiency. Without addressing this issue, FDC will continue to mount an insufficient response to any future COVID-19 symptoms as well as seasonal influenza and other basic health problems being reported by detained people.

c. Recommendations.

i. Armor staff should immediately create a COVID-19/influenza symptoms tracking tool. This tool can be a simple spreadsheet that relies on daily review of sick call forms and daily screening sheets of a nurse to record (by clerical staff) any symptoms of COVID-19. I have utilized such a tool in prior outbreak responses as an additional tool to ensure that outbreak symptoms result in

timely assessment/care and also track the trends in symptoms in between rounds of testing. This type of tool is even more critical because FDC lacks any basic tracking of whether sick call requests result in timely care.

ii. FDC should immediately initiate a monthly quality assurance review of sick call responses. The gross disparity between the facility administration's contention that 100% of sick call requests result in timely care and the reports of patients that none of their sick call requests result in timely care merits immediate remedy.

iii. ICE should initiate a review of any cases in which patients at FDC required hospitalization for COVID-19 or other reasons in the past year, including the case of the 72-year-old man who died, and assess whether the lack of access to timely sick call represents a violation of detention standards or policies and procedures of ICA or Armor.

iv. ICE and FDC should review the use of solitary confinement and RHU placement to ensure that detention standards are not being violated in how people are placed into this unit, how long they are held in these cells, and how their access to health services and other basic services are impacted.

12. FDC efforts to control the spread of COVID-19 (combining PPE, social distancing and other infection control efforts).

a. **Observations.** During my discussions with HSA [redacted] and Director Crawford, we discussed each of the areas of infection control contemplated in Judge Brinkema's order, including social distancing, PPE use and cleaning/disinfecting. They described additional signage and new changes to seating areas in the housing

areas of FDC in pursuit of social distancing. When I inspected the housing areas, I was able to see that the longer tables had individual seats removed to increase distance between detained people seated at the tables, and that individual seats in the smaller tables had been marked off with tape (see photos). I also observed that the bunks of detained people had been staggered to keep a top/bottom alteration between adjacent bunks (see photos). I also observed that in some housing areas, individual toilets were blocked off with plastic chairs. I was also able to see that in housing areas, most detainees were not observing social distancing and that the plastic chairs were arranged so that groups of 4-10 detainees were sitting close enough to be touching elbows in almost every housing area. Similarly, detained people were standing in close proximity to each other. During my inspection, I did not observe any security staff ask or encourage detained people to spread apart, except for Director Crawford, when we would enter a unit. In every housing area, I asked detained people whether any social distancing occurred when lines form to receive medications and every person stated no, that no such social distancing occurred, and none of the people I asked had ever seen a security officer encourage or mention social distancing for people in line for medications.

b. I observed all staff wearing masks, most often N95 masks in conjunction with face shields. Some staff wore their N95 masks with straps incorrectly placed or with clear seal problems, but I did not observe any staff without a mask or wearing a masks that did not cover their nose or mouth. HSA [redacted] and Director Crawford indicated that health staff had been fit-tested for N95 masks but not security staff. Among detainees, fewer than 1/4 were wearing masks during my inspection. I

asked individual detainees and several small groups of detainees about their attitudes regarding masks and social distancing and received several consistent replies. Most often, detained people stated that the facility had caused them to become infected with COVID-19 because of the mass transfer in June of people from facilities with known COVID-19 cases and that COVID-19 symptoms and requests for health care had been ignored in the following weeks. As a result, they reported not believing and not being interested in whatever the facility suggested regarding COVID-19. Several detainees also stated that the signs and discussion of social distancing, as well as the changes to bunks and seats, had only been initiated in the 24 hours before my inspection, so they were skeptical that the facility was interested in making these changes last. Several people also reported to me that they viewed masks as less important since they had become infected with COVID-19 and that nobody had explained to them why masks were still important.

c. Regarding cleaning, disinfecting and basic infection control measures, Director Crawford reported that the facility relies on detainees to clean housing areas and officers to clean their own workstations and other officer areas. When I asked how this differed when it involved a person identified as having COVID-19, Director Crawford stated that the same approach was utilized as for all other cleaning and disinfecting tasks, that cleaning occurred multiple times per day of all common areas and surfaces. In the medical clinic, there were two holding cells where all patients wait to be seen. HSA [redacted] states that 20-40 patients could be seen per day and that they all wait in these areas and that one housing area at a time is called for sick call and other health encounters. I asked whether these rooms were cleaned

in between groups of housing area patients and Director Crawford stated that the cleanings were regular and that they were documented. I asked whether these cleanings would be in the logbooks of the officer stationed there and he initially stated that "everything's in the book," but when we looked, there was no mention of any cleaning despite patients having been seen already. I spoke with several detained people who had the job of cleaning in their housing areas and they all stated that no special training occurs and no PPE is utilized for cases of cleaning property or bedding of people with suspected or known COVID-19. I also spoke with several people who were not on any cleaning assignment who had been ordered to gather and clean the personal effects of patients who had left the housing area to be hospitalized with COVID-19, including one person who was ordered to clean and gather the effects of the patient who ultimately died wearing only gloves and a cloth mask. One other area of infection control involved food service staff. I spoke with several detainees who reported that food service staff who were ill with COVID-19 continued to work in their jobs even while ill. I spoke with one such worker who confirmed this, stating that most of the food service workers were housed in his dorm and that they continued to go to their food service jobs while ill with COVID-19 unless they were too weak to get out of bed.

d. <u>Findings.</u>

i. FDC has made improvements to the physical layout of bunks and the seating at tables in the facility, and has reduced overall density of detained people by utilizing more housing areas.

ii. FDC has failed to initiate basic infection control efforts identified by the CDC since March, including social distancing in medication lines and creating specialized teams and training for cleaning of effects of people suspected to have COVID-19.

iii. FDC lacks basic monitoring or quality assurance tools to ensure that cleanings are occurring as required by policies.

e. <u>Recommendations.</u>

i. FDC should consult with the CDC and other experts to create a specialized cleaning protocol and team for responding to potential COVID-19 cases. The basic elements of this approach are detailed by the CDC in its detention guidelines. No detainee or staff member should engage in cleaning or handling of bedding, equipment or personal effects of a suspected or known COVID-19 case without completion of this training and without utilization of appropriate PPE.

ii. FDC should implement weekly briefings in every housing area regarding all aspects of the COVID-19 response. The level of animosity and disengagement among detainees is more acute at FDC than any other facility I have inspected, and flows directly from the reality that widespread COVID-19 was caused by the mass transfers into the facility in June and that the predicable consequences of these transfers, detainees becoming ill, were ignored by staff. If there is to be any improvement in the engagement of detained people in infection control and, ultimately, immunization efforts, there must be a concerted effort to make meaningful improvement to the health services in the facility and that weekly

briefings be initiated to both deliver information and also elicit feedback. The reliance of the facility primarily on posting signs and playing videos reflects a lack of interest in addressing these issues and should be addressed immediately.

iii. FDC should initiate recording of all routine cleanings in the logbooks of housing areas and other officer stations, and these logs, along with video surveillance, should be reviewed regularly by supervisors.

13. Ongoing need for COVID-19 testing.

a. **Observations.** The FDC facility staff indicated that their approach to COVID-19 testing has been limited by an initial shortage of tests and also changing guidance from the Department of Health and CDC. Director Crawford stated that every detained person at FDC has been tested multiple times, and each of the people I spoke with confirmed that he had been tested at least once initially, and a second time during the CDC visit. Both Director Crawford and HSA [redacted] expressed that the intensity of COVID-19 testing, as well as the screening efforts, could soon be decreased based on their report of no detained people having any COVID-19 symptoms for many weeks. However, as of today, FDC does not know and has not assessed how many people in the facility had COVID-19 symptoms in relation to whether and when they had COVID-19 symptoms. Many people reported to me that they had and reported COVID-19 symptoms more than a week before being tested en masse, and that they never received any clinical assessments or care for their symptoms while they were ill. Others reported that screenings and testing encounters were not conducted by staff who spoke their language. As a result, many of the people who became ill with COVID-19 in FDC are documented as having

no symptoms simply because they were only asked about symptoms when tested (as opposed to when they reported being ill) or because of the lack of adequate interpreter services.

b. **Findings.** Any plans to decrease or reduce a mass testing approach to FDC detainees are premature. People (detainees and staff) who have not tested positive should be offered at least monthly testing. Several of the COVID-19-negative patients reported that they were housed with COVID-19-positive patients, even after they received a negative test.

c. **Recommendations.**

i. People (detainees and staff) who have not tested positive for COVID-19 should be offered at least monthly testing. The CDC has recently published data from detention settings showing that mass testing of detainees finds twelve times more cases than symptom-based protocols alone.[7] This approach is especially crucial while FDC works to address deficiencies in its screening and sick call processes. These deficiencies are essential even with ongoing and expended testing, since they represent the best means to prevent morbidity and mortality in early cases of COVID-19.

ii. FDC should have a clinical encounter with every detained person to ask whether they had symptoms of COVID-19 and what those symptoms were. These reports should be documented along with COVID-19 test results and integrated into post-COVID-19 assessments mentioned above.

[7] https://www.cdc.gov/mmwr/volumes/69/wr/mm6933a3.htm.

iii. The CDC has recently conducted surveys of detainees and staff. The information in these surveys represents some of the first data about the group experiences of people at FDC, and reporting these results back to detained people in a readout or briefing would be an important first step in promoting engagement and would offer FDC an opportunity to show how the perspectives of detained people are being utilized to improve the COVID-19 response.

iv. Detained people and staff who have not tested positive for COVID-19 and who are not suspected of having COVID-19 should not be housed together with those who have positive COVID-19 results or who are suspected of having COVID-19 based on symptoms. FDC should not resume new admissions without re-establishing its 14-day quarantine process.

v. FDC should track the time since last positive tests for detained people and consider antibody testing given recent CDC reporting on the three-month estimate of limited immunity from COVID-19 infection.[8]

E. Summary and Conclusions.

14. My assessment of the FDC facility is that the leadership of ICA and Armor, as well as ICE officials, violated their own policies and basic standards of infection control by allowing the transfer of detained people from facilities with COVID-19 cases into FDC. Director Crawford explained the system that was developed in April to avoid this possibility by having newly arrived detained people held at another facility for a 14-day quarantine. He further gave examples of transfers into the facility that he and/or Armor staff had blocked based on COVID-19 concerns. For reasons that are not clear to me, Director Crawford, HSA [redacted] and ICE leadership chose to

[8] https://www.cdc.gov/media/releases/2020/s0814-updated-isolation-guidance html.

ignore this process and the policies that mandate it, and the result of the transfer of 72 detainees into the facility in June is that over 90% of detainees quickly became infected with COVID-19, resulting in multiple hospitalizations and one death.

15. It is also my assessment that basic standards of care for people who became ill with COVID-19 were ignored, leaving individuals to endure their illness with little or no health assessments or care. My assessment of the FDC COVID-19 response is that the daily screenings and sick call systems are not only insufficient, but that health and security leadership appear unaware of these deficiencies. I was very concerned that both Director Crawford and HSA [redacted] emphatically stated that 100% of sick call requests result in timely assessments when none of the detained people I spoke with and documents I reviewed indicated this to be true. I have requested access to two weeks of sick call, medical grievance and screening forms to better quantify these deficiencies. These deficiencies are central to the welfare and survival of people detained in FDC because they represent the means by which they can access care.

16. The facility had addressed some of the social distancing recommendations made by the CDC in the day before my inspection, but the profound mistrust of the facility by detained people, and the lack of efforts to engage them, leaves me concerned that social distancing will not be implemented in a meaningful manner.

17. I believe that in light of these considerations, it is of the utmost urgency that the facility implement an immediate plan to address shortcomings in screening, assessment, delivery of medical services, protection of high-risk patients, and procedures for preventing and controlling the spread of COVID-19 at the facility. Ongoing monitoring of the facility to ensure proper implementation is highly recommended.

Dated: August 25th, 2020

Montauk, New York

Dr. Homer Venters