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June 23, 2020

Chairman Lindsey Graham
Ranking Member Diane Feinstein
U.S. Senate Committee on the Judiciary
Washington, DC 20510

Dear Chairman Graham, Ranking Member Feinstein, and Members of the Committee:

Thank you for your questions for the record from the June 2, 2020 Hearing, "Examining Best Practices for Incarceration and Detention During COVID-19." Per your request, attached are the answers for the record to the questions posed by Senators Feinstein, Coons and Blumenthal.

I appreciate the opportunity to support the Committee's oversight efforts on this important issue. In addition to my previously submitted written testimony and the answers to these questions, I continue to be available as needed to answer questions or contribute my expertise to Congress, agency officials or others to combat the spread of COVID-19 in detention and correction settings that continues to pose a threat to workers, detainees and the public.

Sincerely,

Scott A. Allen, MD

Professor Emeritus of Medicine
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QUESTIONS FROM SENATOR FEINSTEIN

Question 1. **As you know, a large outbreak in any BOP or ICE facility will impact the surrounding community. For example, the total number of confirmed cases at the Lompoc Correctional Complex in Santa Barbara County accounted for over 60 percent of the cases in the entire county**.

a. How should correctional and detention facilities work with local public health departments to prevent and contain a public health crisis?

For purposes of public health and infection control, correctional and detention facilities must be considered as part of the local community—not islands—the same as other congregate facilities such as nursing homes or schools. Timely sharing of data about positive cases and their status consistent with community reporting requirements is essential. Including representatives from correctional and detention health as part of public health planning would also be helpful. Effective contact tracing involving staff, inmates and detainees who move in and out of the facility to and from the community will require coordination and ongoing communication. Lastly, correctional and detention facilities often lack transparency. Public reporting of number of cases, number of tests done, and containment strategies should be publicly posted as this information is essential to policy makers and the public.

Question 2. **The CDC has issued guidance specifically for correctional and detention facilities. The guidance, however, has not been updated since March 23, 2020.**

a. In your view, does this guidance need to be updated? Why?

Yes, the CDC COVID-19 guidance for correctional and detention facilities is in urgent need of an update. COVID-19 is entirely new and we continue to learn about the virus and its spread daily. In this context, March 23, 2020 is a very long time ago.

In addition to begin outdated, the March 23, 2020 guidance had three fundamental flaws. First, it failed to even contemplate the strategy of population reduction. While it talked about well-established strategies of social distancing and isolation, quarantine and cohorting, it did not address the fact that in many facilities, none of these techniques are even possible if the facility is at or above capacity. In fact, while the **population reduction** required to begin permitting such strategies can vary from facility to facility based on the architecture and layout, we are finding that reductions of at least 25-30% are necessary to allow those measures. Obviously, from an infection control point of view, population reduction in congregate settings should be maximized beyond that level if competing public safety risks allow. Second, the March 23, 2019 guidance did not adequately comment on the importance of **aggressive testing strategies** to monitor and contain spread within facilities. Finally, the guidelines fail to anticipate and provide guidance for facilities once a large-scale **outbreak** occurs in a facility.

b. Are there specific changes or improvements that the CDC should make to its guidance?

Yes. First, they need to include a discussion of the importance of population reduction as a necessary strategy to reduce risk of spread of the infection and to allow for full deployment of the strategies they already recommend. Second, in recognition of more widely available testing (and the strategic importance of controlling outbreaks in congregate settings within communities to contain spread to the surrounding community), they should provide testing guidance that follows the same public health principles used for their recent guidance for COVID in nursing homes (see https://www cdc gov/coronavirus/2019-ncov/hcp/nursing-homes-responding html and https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html) that require universal testing and ongoing surveillance of all residents and staff in facilities with confirmed COVID-19.

c. How should ICE and BOP adjust their current practices to help stem the spread of infection – for inmates and staff?

As an expert, I have not audited the Federal Bureau of Prisons (FBOP). While I have inspected and audited numerous ICE facilities since 2014, I have not inspected facilities since the outbreak of COVID-19 and I have not been provided with their policies or protocols for management of COVID-19. My knowledge is limited to reliable press reports and testimony I heard at the Senate hearing. From what I have learned, I think both agencies would be well advised to more aggressively use population reduction (if not already done) and testing strategies for inmates/detainees and staff as described above along with the standard infection control techniques recommended by the CDC. They also should minimize transfers of staff and detainees/prisoners between facilities particularly as detention and prison networks span the country and transfers could promote wide asymptomatic spread of the virus. Because their policies and practices have implications for public health, their policies and procedures should be transparent and public, as should their reporting regarding aggregate testing data, hospitalizations, and deaths.

d. What else could be done to ensure that staff have the knowledge and equipment they need to stay safe and healthy?

Staff should be provided with detailed education regarding the COVID-19 virus including its natural history, modes of transmission, role of asymptomatic spread, importance of mitigation techniques including hygiene, proper use of personal protective equipment (PPE – and use of PPE in facilities where COVID-19 is present should be required), importance of testing and other resources. Adequate PPE should be provided to all staff and required to be used.

QUESTIONS FROM SENATOR COONS

Question 1. **You testified that "careful, risk-based population reduction in detained populations" is "a necessary tool to contain" the spread of COVID-19.**

a. Is there modeling or other information available that speaks to how much a prison or detention facility needs to reduce its population in order to adequately limit the spread of COVID-19?

I am not aware of any modeling, but anecdotally, we are starting to learn that minimal reductions of 25-30% are necessary to allow for minimal social distancing and for the flexibility to rearrange people to accommodate isolation, quarantine and cohorting strategies. However, the actual reduction depends very much on the architecture and structure of the facility as well security considerations. Also, as all congregate settings increase risk of spread, the population should be reduced as much as possible, so reductions well in excess of 30% are recommended if that can be achieved without creating other risks to public safety. For example, civil detainees in immigration detention who pose no increased criminal risk to public safety should all be released because the health and public health risks associated with detention cannot be justified in the time of a pandemic such as this one.

b. Do you believe that the Bureau of Prisons (BOP) and Immigration and Customs Enforcement (ICE) have adequately reduced their populations under these metrics?

As an expert, I have not audited the Federal Bureau of Prisons (FBOP). While I have inspected and audited numerous ICE facilities since 2014, I have not inspected facilities since the outbreak of COVID and I have not been provided with their policies or protocols for management of COVID. My knowledge is limited to reliable press reports and testimony I heard at the Senate hearing. From testimony I heard at the hearing and statistics reported in the press,[1] it appears that FBOP has not achieved significant population reduction, and ICE continues to hold thousands in custody.

c. You testified that in this pandemic, in some cases "*not releasing* individuals may give rise to a more significant threat to public safety." Are there best practices or frameworks for how to balance the public safety risks of releasing someone versus the public safety risks of continuing to detain them?

As a medical doctor and correctional/detention health expert, I can comment on the health-related risks of continued detention versus release to community. From that perspective, release to the community is clearly safer for both the detained individuals and their surrounding

[1] Ian MacDougall, "Bill Barr Promised to Release Prisoners Threatened by Coronavirus—Even as the Feds Secretly Made it Harder for Them to Get Out, *ProPublica* (May 26, 2020), available at https://www propublica org/article/bill-barr-promised-to-release-prisoners-threatened-by-coronavirus-even-as-the-feds-secretly-made-it-harder-for-them-to-get-out (noting that more than 98% of federal inmates remain incarcerated); [1] Immigration and Customs Enforcement, ICE Guidance on COVID-19, ICE Detainee Statistics, (last visited June 20, 2020), available at https://www.ice.gov/coronavirus.

communities, as congregate settings—which are not actually isolated from the community because of frequent transfers and rotating shifts of multiple workers—can promote rapid spread that can reach the wider public. The health associated risks of ongoing detention must be considered against any criminally related public safety risk of release. Assessment of those risks is made by those empowered to make those assessments, including law enforcement, the courts and ICE. These entities are aware, for instance, that immigrants are in civil detention for immigration enforcement, not because they pose public safety threats; similarly, many detained in corrections settings are near the end of their sentences, are in minimum security facilities on work-release, were convicted of minor offenses, or are parole-eligible,[2] all factors which might pose low risks to public safety. My concern is that those making release decisions are well informed about the very real health and safety risks associated with continued confinement in the presence of the COVID-19 outbreak.[3]

Question 2. **You testified to the importance of aggressive, universal testing in congregant settings like prisons and detention facilities and the need for adequate resourcing.**

a. Are there rules of thumb or other estimates that can be used to assess the costs of such universal testing for BOP, ICE, and the state/local incarcerated and detained populations more generally?

Cost-effectiveness of testing as a preventive strategy for addressing the COVID-19 is well established. It is helpful when thinking about this to look at corrections and detention facilities as being no different than other parts of the community, and in fact, like nursing homes, as facilities that should be high priority for testing. In recent congressional testimony, the CDC's Dr. Robert Redfield acknowledged this in saying, "One of the areas that we've prioritized for surveillance, and when we talked about the $10 billion to go off for each of the states to come out with their testing strategy, the priorities that we have given them, one of the priorities that we've given them is a comprehensive surveillance strategy. All nursing home residents to be tested and then weekly testing for the workers in the nursing home to develop their prison guidelines. And again, that's being debated back and forth right now, but I think there's a strong sense of, again, getting everybody tested in the prison and, obviously, new people coming in. I can't tell you where that's going to land, but we are hotly discussing that now and obviously encouraging states to use these new testing resources to accomplish that. And obviously, the same goes for homeless shelters and homeless settings. These are critical areas. And in certain industries like meat packing plants and where we congregate living. So we're on board with you that we need expanded testing in these circumstances."

b. In addition to funding, are there any other current bottlenecks to universal testing that would need to be considered by BOP and ICE? For instance, would availability of testing kits, personal protective equipment, other testing supplies, or logistical issues limit the ability to comprehensively test even with adequate funding?

[2] Peter Wagner and Emily Widra, "Five ways the criminal justice system could slow the pandemic," *Prison Policy Initiative* (March 27, 2020), available at https://www.prisonpolicy.org/blog/2020/03/27/slowpandemic/.
[3] *See*, e.g., Irvine, M., Coombs, D., Skarha, J. *et al.*, "Modeling COVID-19 and Its Impacts on U.S. Immigration and Customs Enforcement (ICE) Detention Facilities, 2020." *J Urban Health* (2020). https://doi.org/10.1007/s11524-020-00441-x.

No doubt there are logistical challenges including availability of testing kits, testing supplies and PPE. However, these limitations are decreasing with time and I think now cannot be used to justify lack of aggressive testing and surveillance. Also, there is an ethical and legal requirement to provide adequate health care for serious medical illnesses for people who are imprisoned (see *Estelle v. Gamble*, 429 U.S. 97 (1976) and *Brown v. Plata*, 563 U.S. 493 (2011)). If proper care cannot be provided, the population must be released to a level where proper care can be provided.

Question 3. **Assuming that comprehensive testing is not currently available, please comment on how correctional and detention facilities should be prioritizing testing resources generally, and please comment in particular on your perception of how BOP and ICE are currently choosing to do so.**

Again, as an expert, I have not audited the Federal Bureau of Prisons (FBOP). While I have inspected and audited numerous ICE facilities since 2014, I have not inspected facilities since the outbreak of COVID and I have not been provided with their policies or protocols for management of COVID. My knowledge is limited to reliable press reports and testimony I heard at the Senate hearing. From testimony I heard at the hearing, and from publicly available information, ICE reports testing of approximately 36% of its total population,[4] and FBOP reports testing approximately 16.2% of its populations,[5] even in the face of outbreaks at multiple facilities. These crude calculations are generous as they assume no re-testing and also assume no population turnover - bot extremely unlikely scenarios. But even with this generous interpretation, they are still low, which **suggests serious undertesting.**

In resource limited settings, highest priority in testing should be for symptomatic individuals, known contacts of positive cases, and individuals who are medically at higher risk per the CDC,[6] including older adults, individuals with asthma, those who are immunocompromised, have severe obesity, have diabetes, those with chronic liver or kidney disease, people with disabilities, and people with development and behavioral disorders, as well as those from racial and ethnic minority groups, which we know to make up large majorities of those in FBOP and ICE detention.

Question 4. **At the hearing, Dr. Jeffrey Allen testified that there was no reason for BOP not to provide data about the number of tests administered at each facility or further transparency to the case-counts by facility that BOP currently publishes on its website. Is there any other information that BOP or ICE are not providing on their websites that, per**

[4] Immigration and Customs Enforcement, ICE Guidance on COVID-19, ICE Detainee Statistics (last visited June 23, 2020), available at https://www.ice.gov/coronavirus (reporting 8,858 detainees tested as of June 19, 2020 out of a total population of 24,041)

[5] Federal Bureau of Prisons, COVID-19 Cases (last visited June 23, 2020), available at https://www bop gov/coronavirus/index jsp (reporting 21,506 inmates tested or pending testing out of a total population of 132,587, with 6,259 of the total 19,030 completed tests showing positive results for COVID-19, A **nearly 33% rate of infection**).

[6] CDC website, *People Who Need to Take Extra Precautions*, available at https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/index html (last visited June 20, 2020).

best practices, would help to inform the public and help experts evaluate likely outbreaks or other concerns?

For purposes of public health and infection control, correctional and detention facilities must be considered as part of the local community—not as islands—the same as other congregate facilities such as nursing homes. Timely sharing of data about positive cases and their status consistent with community reporting requirements is essential. Including representatives from correctional and detention health as part of public health planning would also be helpful. Effective contact tracing involving staff, inmates and detainees who move in and out of the facility to and from the community will require coordination and communication. Lastly, correctional and detention facilities often lack transparency. For example, the ICE website only reports numbers of ICE employees who have tested positive for COVID-19, even though the majority of staff working in immigration detention of ICE contractors.[7] Similarly, there is no reporting of the numbers of ICE employees (or contractors) tested, or for immigrant detainees, how frequently tested are being administered or to whom.[8] Public reporting of number of cases, number of tests done and containment strategies should be publicly posted as this information is critical to policy makers and the public.

Question 5. **Do you have comments on the adequacy of the BOP action plan or ICE's pandemic response requirements as to the management of potential spread within a facility (e.g., regarding cleaning, social distancing, or protective equipment)?**

Again, as an expert, I have not audited the Federal Bureau of Prisons (FBOP). While I have inspected and audited numerous ICE facilities since 2014, I have not inspected facilities since the outbreak of COVID and I have not been provided with their policies or protocols for management of COVID. My knowledge is limited to reliable press reports and testimony I heard at the Senate hearing. However, the reality is that whatever they are doing has not been effective given the number and scope of infections and deaths among staff and inmates and detainees across multiple facilities, let alone likely impact on community spread.[9] In the face of these failures, more aggressive use of testing and population reduction must be pursued to compensate for the difficulties of implementing and enforcing complementary protective methods such as adequate sanitizing and consistent use of effective PPE.

Question 6. **Do you believe that the Centers for Disease Control and Prevention (CDC) interim guidance adequately captures all of the categories of individuals who are vulnerable to COVID-19 complications and should be considered for potential release or home confinement?**

[7] Immigration and Customs Enforcement, ICE Guidance on COVID-19, Employee Confirmed Cases, (last visited June 20, 2020), available at https://www.ice.gov/coronavirus https://www.ice.gov/coronavirus

[8] Immigration and Customs Enforcement, ICE Guidance on COVID-19, ICE Detainee Statistics, (last visited June 20, 2020), available at https://www.ice.gov/coronavirus

[9] Eric Reinhart and Daniel Che, "Incarceration And Its Disseminations: COVID-19 Pandemic Lessons From Chicago's Cook County Jail," *Health Affairs* (June 4, 2020), https://www healthaffairs org/doi/10 1377/hlthaff 2020 00652 (finding that that cycling through Cook County Jail—which accounts for the period of time from arrest to awaiting hearings and trials—is associated with 15.9% of all documented COVID-19 cases in Chicago and 15.7% of those in Illinois).

The CDC list of high risk medical conditions (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk html) omits those with intellectual and developmental disabilities, as well as those in racial and ethnic minority groups, although these categories of individuals are noted as "other populations" at risk (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/other-at-risk-populations.html). Individuals with developmental disabilities are four times more likely to aquire the infection and twice as likely to die from it if infected.[10] Similarly, new research confirms that black people are 3 5 times more likely to die of COVID-19 than white people, and Latino people are more than twice as likely to die [11] Given the nature of populations in prison and immigration detention, these "other populations" should be considered for release given their high risk for infection and complications.

Question 7. **Please comment on the practice of "cohorting." CDC guidance contemplates cohorting but only as a "last resort."**

a. What alternatives should a facility consider before resorting to cohorting?

The preferred method of separating individuals with infection or individuals under investigation (i.e. those not yet tested or tested awaiting results) is individual isolation or individual quarantine. The CDC strongly recommends single rooms for persons isolated and quarantined. Cohorting of groups of persons should be done as a last resort. I do agree with this recommendation. However, in some facilities, there is not adequate availability of single cells to accommodate individual isolation or quarantine, and cohorting may have to be considered as a last resort. If used, the cohort should be as small as possible.

b. What is an appropriate maximum size for a cohort, if any, to be effective?

As above, cohorting should only be used as a last resort, and when used, with as small a number of individuals grouped together as possible.

c. How can cohorting be safely implemented in light of the need of staff to interact with the detainees in the cohort?

Ideally, a very limited number of staff would be assigned to the cohort and only they would routinely interact with the cohort.

[10] James T. Mulder, "Covid-19 death rate higher among developmentally disabled, Syracuse study shows," *Syracuse.com* (June 4, 2020), available at https://www.syracuse.com/coronavirus/2020/06/covid-19-death-rate-higher-among-developmentally-disabled-syracuse-study-shows html

[11] Cary P Gross, Utibe R Essien, Saamir Pasha, Jacob R Gross, Shi-yi Wang, Marcella Nunez-Smith, "Racial and Ethnic Disparities in Population Level Covid-19 Mortality," medRxiv (May 11, 2020), https://doi.org/10.1101/2020.05.07.20094250.

d. Are you familiar with BOP and ICE policies and practices on cohorting, and do you believe that they comply with applicable guidance and best practices?

Again, as an expert, I have not audited the Federal Bureau of Prisons (FBOP). While I have inspected and audited numerous ICE facilities since 2014, I have not inspected facilities since the outbreak of COVID and I have not been provided with their policies or protocols for management of COVID or as they relate to cohorting protocols.

Question 8. **You testified that we have underutilized and under-supported our best tools, including "collaboration and data sharing between correctional and detention centers (including state and local jails and prisons, FBOP and ICE) and public health departments."**

a. What particular data are BOP and ICE not sharing with public authorities (or vice versa) that would assist in addressing the pandemic?

Again, as an expert, I have not audited the Federal Bureau of Prisons (FBOP). While I have inspected and audited numerous ICE facilities since 2014, I have not inspected facilities since the outbreak of COVID and I have not been provided with their policies or protocols for management of COVID or specific information about what they are sharing or not sharing with public health authorities. But see my answer to Question 4 above, noting that the ICE website only reports numbers of ICE employees who have tested positive for COVID-19, even though the majority of staff working in immigration detention of ICE contractors,[12] and that there is no reporting of the numbers of ICE employees (or contractors) tested, or for immigrant detainees, how frequently tested are being administered or to whom.[13] This data is essential for tracking and minimizing the spread of COVID-19 between prisons and immigration detention and the public.

b. Are there models for how this data sharing should operate that BOP and ICE should look to?

Data sharing between BOP and ICE should be no different than for other congregate settings in the community. Minimally, facilities should be reporting all data as required by public health authorities for other community facilities such as nursing homes. Public and timely disclosure of aggregate data regarding positive cases, hospitalizations and deaths of both detainees and all staff by date and facility should regularly be posted publicly.

[12] Immigration and Customs Enforcement, ICE Guidance on COVID-19, Employee Confirmed Cases, (last visited June 20, 2020), available at https://www ice gov/coronavirus https://www.ice.gov/coronavirus
[13] Immigration and Customs Enforcement, ICE Guidance on COVID-19, ICE Detainee Statistics, (last visited June 20, 2020), available at https://www ice gov/coronavirus

QUESTIONS FROM SENATOR BLUMENTHAL

1. **There have been reports that ICE is using solitary confinement both to isolate detainees with symptoms and as a form of retaliation against detainees who speak out about the lack of adequate safety measures. Detainees at the Pine Prairie ICE processing center in Louisiana reported being placed in solitary confinement if they report staff for not wearing masks and for engaging in a hunger strike. A person detained at the detention center in Calexico, California reportedly spent 30 days in solitary confinement for raising concerns about the inability of detainees to practice social distancing. Those placed in solitary confinement for showing symptoms report major difficulties receiving medical care.**

   These reports are all the more disturbing in light of reporting that use of solitary confinement in ICE facilities has increased dramatically since President Trump took office. Last summer, the non-partisan, independent Project on Government Oversight published a report indicating that the use of solitary confinement in ICE detention facilities has risen by over 15% since the final months of the Obama administration and that 40% of ICE detainees placed in solitary confinement have a mental illness. Many experts agree that prolonged solitary confinement—defined as anything over 15 days—is tantamount to torture. This report found that ICE has kept at least 4,000 people in prolonged solitary confinement. Since 2017, at least three detainees with schizophrenia took their own lives after being placed in solitary confinement.[14]

   a. Can you explain the difference between solitary confinement and medical isolation?

Solitary confinement is a method of punishment involving extreme social isolation and sensory deprivation. It is designed and intended to punish. It is also associated with very high risk of significant psychological harm. Because of the harms associated with it, it is widely discredited. From a medical and human rights perspective, it should be banned (I say this as a physician who has personally cared for patients held in solitary confinement). It absolutely should not ever be used on individuals with mental illness, and clearly is never appropriate for individuals in civil detention—the the vast majority of ICE detainees.

Medical isolation is isolation of an infected individual solely for the purpose of limiting spread of infection and for providing monitoring and care. It is not done with the intent to punish and therefore must not involve extreme social isolation, deprivations of access to phone calls, or restrictions to cell (in other words, medical isolation should involve time out of cell and recreation time well in excess of the minimal protocols associated with solitary).

[14] Nick Schwellenbach et al, *Isolated: ICE Confines Some Detainees with Mental Illness in Solitary for Months*, Aug. 14, 2019, available at https://www.pogo.org/investigation/2019/08/isolated-ice-confines-some-detainees-with-mental-illness-in-solitary-for-months/.

b. What kinds of medical care should someone placed in medical isolation receive? Is ICE providing that care for those it places in solitary confinement?

A patient in medical isolation for COVID should receive monitoring and care commensurate with their clinical situation and should minimally involve the type of monitoring typically used for patients requiring infirmary level of care, including measurements of vital signs and pulse oximetry once per shift. They should not be subjected to the deprivations associated with solitary confinement, but it should be noted that the National Commission on Correctional Health Care Standards require at least a daily medical assessment for those isolated in solitary confinement.

2. The State Department and the CDC continue to strongly advise against international travel and the CDC has even specified that transfers of detainees be restricted unless absolutely necessary. Yet, in just a two-month period, ICE ran 112 flights to 13 countries.[15] Over 100 people have tested positive for COVID-19 after being deported from the United States.[16] In his testimony before the Committee, Henry Lucero, Executive Associate Director for Enforcement and Removal Operations at ICE, confirmed that it is not standard procedure to test people for COVID-19 before they are deported unless there is an agreement with the receiving country. Even when countries have conditioned receipt of deportees on testing, ICE is still deporting people who test positive for the virus. For example, some 15-20% of all COVID-19 cases in Guatemala are attributable to deportations.[17]

a. Do you agree that ICE should commit to suspending deportations during the pandemic?

As a medical expert, I will not comment on immigration policy per se, but from a public health perspective, I and my colleagues have recommended against all transfer and travel where possible because taking individuals from high risk settings and transporting them creates risk of exposure to COVID-19 for everyone involved in transport—fellow passengers, officers, bus drivers, flight attendants, etc., as well as the communities the individuals will be returned to in the receiving countries. From this perspective, deportation of individuals from high risk congregate settings in a country with high rates of COVID-19 would predictably be associated with effective spread of the virus, not containment.

[15] Jake Johnston, *ICE Confirms More than 100 Deportation Flights to 13 Countries in an Eight-Week Period*, CEPR (May 21, 2020), https://cepr net/ice-confirms-more-than-100-deportation-flights-to-13-countries-in-an-eight-week-period/.
[16] Arshad Mohammed et al, *Two dozen people deported to Colombia on U.S. flight found to have coronavirus: sources*, REUTERS (Apr. 29, 2020), https://www reuters com/article/us-health-coronavirus-usa-colombia/two-dozen-people-deported-to-colombia-on-u-s-flight-found-to-have-coronavirus-sources-idUSKBN22B3DB.
[17] Cindy Carcamo and Molly O'Toole, *Migrants deported by U.S. make up more than 15% of Guatemala's coronavirus cases*, L.A. TIMES (May 4, 2020), https://www.latimes.com/world-nation/story/2020-05-04/u-s-deportation-flights-to-guatemala-resume-with-assurances-of-coronavirus-testing.

i. If ICE refuses to make such a commitment, what steps do you believe they would have to take to prevent their deportation program from spreading the virus internationally?

All detainees who are to be transported should be tested for coronavirus. As the test is not 100% accurate, and individuals early in infection might not test positive, everyone involved in transport should be provided with PPE (especially masks) and hand sanitizer. Everyone involved (staff and detainees) should receive appropriate education about COVID-19.