



# ERO

## **U.S. Immigration and Customs Enforcement Enforcement and Removal Operations**

### COVID-19 Pandemic Response Requirements



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

ERO COVID-19 Pandemic Response Requirements (Version 8.0, April 4, 2022)

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## SUMMARY OF CHANGES

Explanation of Change	Section	Pages
<ul style="list-style-type: none"> <li>• Addition: References the ICE Health Service Corps (IHSC) interim medical guidance as a best practice.</li> </ul>	Concept of Operations	8
<ul style="list-style-type: none"> <li>• Addition: A section has been added to the PRR that defines “fully vaccinated individuals” vs “up-to-date” vaccination status.</li> </ul>	Standards for All Populations	17
<ul style="list-style-type: none"> <li>• Addition: Incorporates previously issued IHSC guidance that provides flexibility for transfer and release testing when there is a low rate of COVID-19 transmission in the facility and the surrounding community.</li> </ul>	Standards for All Populations	16
<ul style="list-style-type: none"> <li>• Addition: A section on COVID-19 boosters has been added.</li> </ul>	COVID-19 Boosters	17-18, 25
<ul style="list-style-type: none"> <li>• Addition: Revises isolation timeline consistent with current CDC guidance to reflect a 10-day isolation period for all new intakes, instead of the 14-day period for negative detainees.</li> </ul>	Standards for All Populations	21, 26, 39, 44
<ul style="list-style-type: none"> <li>• Clarification: Consistent with ERO policy memoranda issued in April 2020 regarding visitation to ICE detention facilities during the COVID-19 pandemic, the PRR section on “Visitation” has been modified to distinguish between social visitation and legal representative visitation more clearly.</li> </ul>	Visitation	36
<ul style="list-style-type: none"> <li>• Addition: Revises social distancing measures to instruct facilities to make efforts to reduce the population to approximately 75 percent of capacity, with the understanding that, in some instances, the physical layout of some facilities may permit exceeding 75 percent capacity while still following CDC guidance. In such cases, facilities may do so, so long as they continue to abide by CDC guidance.</li> </ul>	Prevention	38
<ul style="list-style-type: none"> <li>• Deletion: Based on the latest CDC <i>Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities</i> (February 10, 2022), the section in PRR 7.0 previously titled “Fully Vaccinated Individuals” has been removed.</li> </ul>		
<ul style="list-style-type: none"> <li>• Deletion: Based on the latest CDC <i>Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities</i> (February 10, 2022), which removes the distinction</li> </ul>		

<p>between fully vaccinated and unvaccinated persons in relation to intake quarantine and medical isolation requirements, the section in PRR 7.0 previously titled “Medical Isolation for Fully Vaccinated Individuals” has been removed.</p>		
<ul style="list-style-type: none"> <li>• Deletion: Based on the latest CDC <i>Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities</i> (February 10, 2022), which removed vaccination status as a variable to consider for quarantine/isolation, the previously established exception in PRR 7.0 that allowed fully vaccinated, asymptomatic detainees to forego quarantine (at intake, after transfer, or following exposure to suspected or confirmed COVID-19) is now removed.</li> </ul>		

## PURPOSE AND SCOPE

The U.S. Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) Coronavirus Disease 2019 (COVID-19) Pandemic Response Requirements (PRR) sets forth expectations and assists ICE detention facility operators in sustaining detention operations while mitigating risk to the safety and wellbeing of detainees, staff, contractors, visitors, and stakeholders due to COVID-19. The ERO PRR builds upon previously issued guidance and sets forth specific mandatory requirements to be adopted by all detention facilities, as well as recommended best practices, to ensure that detainees are appropriately housed and that available mitigation measures are implemented during this unprecedented public health crisis.<sup>1</sup> The ERO PRR has been developed in consultation with the Centers for Disease Control and Prevention (CDC) and is a dynamic document that will be updated as additional/revised information and best practices become available.

## INTRODUCTION

As the CDC has explained:

COVID-19 is a communicable disease caused by a novel (new) coronavirus, SARS-CoV-2, and was first identified as the cause of an outbreak of respiratory illness that began in Wuhan Hubei Province, People's Republic of China (China). COVID-19 spreads when an infected person breathes out droplets and very small particles that contain the virus. COVID-19 can be transmitted via both droplet and airborne transmission. These droplets and particles can be breathed in by other people, or land on their eyes, noses, or mouth. In some circumstances, they may contaminate surfaces they touch. People who are closer than 6 feet from the infected person are most likely to get infected.

COVID-19 is spread in three main ways:

- Breathing in air when close to an infected person who is exhaling small droplets and particles that contain the virus.
- Having these small droplets and particles containing the virus land on the eyes, nose, or mouth, especially through splashes and sprays such as a cough or sneeze.
- Touching eyes, nose, or mouth with hands that have the virus on them.

Symptoms may include fever, cough, and shortness of breath; they typically appear two to fourteen days after exposure. Manifestations of severe disease include severe pneumonia, acute respiratory distress syndrome (ARDS), septic shock, and multi-organ failure. As of April 1, 2022, the World Health Organization estimates that approximately 1.6 percent of reported COVID-19 cases have resulted in death globally. This mortality rate is higher

<sup>1</sup> On April 20, 2020, the U.S. District Court for the Central District of California issued a preliminary injunction requiring that ICE “issue a performance standard or a supplement to their Pandemic Response Requirements ... defining the minimum acceptable detention conditions for detainees with risk factors.” *Frailhat v. ICE*, 445 F.Supp.3d 709, 751, (C.D. Cal. 2020). The ERO PRR has accordingly been updated to define the “minimum acceptable detention conditions for detainees with risk factors.”

among older adults or those with compromised immune systems. Older adults and people who have severe chronic medical conditions like heart, lung, or kidney disease are also at increased risk for more severe COVID-19 illness. Early data suggests that older people are twice as likely to have severe COVID-19 illness.

Additionally, other symptoms may include fatigue, headache, chills, muscle pain, sore throat, new loss of taste or smell, nausea or vomiting, and diarrhea.<sup>2</sup>

Multiple variants of COVID-19 have been identified. They vary in both morbidity and mortality. COVID-19 vaccination does reduce the chance of severe disease, need for hospitalization, and death. However, studies have shown that vaccinated individuals can become infected and still transmit the virus.<sup>3</sup>

Given the seriousness and pervasiveness of COVID-19, ICE is taking necessary and prompt measures. ICE is providing guidance on the minimum measures required for facilities housing ICE detainees to implement to ensure consistent practices throughout its detention operations and the provision of medical care across the full spectrum of detention facilities to mitigate the spread of COVID-19. The ICE detention standards applicable to all facilities housing ICE detainees have long required that each such facility have written plans that address the management of infectious and communicable diseases, including, but not limited to, testing, isolation, prevention, treatment, and education. Those requirements include reporting and collaboration with local or state health departments in accordance with state and local laws and recommendations.<sup>4</sup>

The Performance-Based National Detention Standards (PBNDS) 2008 and 2011 both require facilities to “comply with current and future plans implemented by federal, state or local authorities addressing specific public health issues including communicable disease reporting requirements.”<sup>5</sup> The 2019 National Detention Standards (NDS) similarly require “collaboration with local or state health departments in accordance with state and local laws and recommendations.”<sup>6</sup> The measures set forth in the ERO PRR allow ICE personnel and detention providers to properly discharge their obligations under those standards in light of the unique challenges posed by COVID-19.

## OBJECTIVES

The ERO PRR is designed to establish requirements, as well as best practices, for all detention facilities housing ICE detainees to follow during the COVID-19 pandemic.

<sup>2</sup> See, e.g., Attachment B, Centers of Disease Control and Prevention, Symptoms of Coronavirus, <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html> (last visited February 14, 2022).

<sup>3</sup> See Attachment S, Centers for Disease Control and Prevention, Vaccines for COVID-19, <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/index.html> (last visited March 31, 2022)

<sup>4</sup> See, e.g., Attachment C, ICE National Detention Standards 2019 (NDS), Standard 4.3, Medical Care, at II.D.2 (p. 114), [https://www.ice.gov/doclib/detention-standards/2019/4\\_3.pdf](https://www.ice.gov/doclib/detention-standards/2019/4_3.pdf); Attachment D, 2011 ICE Performance-Based National Detention Standards (PBNDS), Revised 2016, Standard 4.3, Part V.C.1 (p. 261), <https://www.ice.gov/doclib/detention-standards/2011/4-3.pdf>; Attachment E, 2008 ICE PBNDS, Standard 4-22, Medical Care, V.C.1 (pp. 5-6), [https://www.ice.gov/doclib/dro/detention-standards/pdf/medical\\_care.pdf](https://www.ice.gov/doclib/dro/detention-standards/pdf/medical_care.pdf).

<sup>5</sup> Performance-Based National Detention Standards (PBNDS) 2008 and 2011, Medical Care 4.3, (C.) Communicable Disease and Infection Control, p. 261-262.

<sup>6</sup> The 2019 National Detention Standards (NDS), Medical Care 4.3, (II)(D)(2) Infectious and Communicable Diseases, p.114.

Consistent with ICE detention standards, all facilities housing ICE detainees are required to have a COVID-19 mitigation plan that meets the following four objectives:

- To protect employees, contractors, detainees, visitors, and stakeholders from exposure to the virus.
- To maintain essential functions and services at the facility throughout the pendency of the pandemic.
- To reduce movement and limit interaction of detainees with others outside their assigned housing units, as well as staff and others, and to promote social distancing within housing units; and
- To establish the means to test, vaccinate, monitor, cohort, quarantine, and isolate the sick from the well.<sup>7</sup>

<sup>7</sup> A *cohort* is a group of persons with a similar condition grouped or housed together for observation over a period of time. Isolation and quarantine are public health practices used to protect the public from exposure to individuals who have or may have a contagious disease. Cohorting, quarantining, and holding in medical isolation is not punitive in nature and must be operationally distinct from administrative or disciplinary segregation, insofar as cells and units for those forms of segregation may be used, but detainees are provided access to TV, reading materials, recreation, and telephones to the fullest extent possible. For purposes of this document, and as defined by the CDC, *quarantine* is the separation of a person or group of people reasonably believed to have been exposed to a communicable disease but not yet symptomatic, from others who have not been exposed, to prevent the possible spread of the communicable disease. For purposes of this document, and as defined by the CDC, *isolation* is the separation of a person or group of people known or reasonably believed to be infected with a communicable disease and potentially infectious from others to prevent the spread of the communicable disease.

## COMPLIANCE MEASURES

To ensure that detention facilities comply with the detention requirements set forth in the ERO PRR, ICE federal compliance personnel will conduct onsite, in-person monthly spot checks at over 72-hour ICE detention facilities during the COVID-19 pandemic.<sup>8</sup> Upon identification of a deficiency, ICE will provide written notice to the facility and allow seven business days for submission of a corrective action plan to ICE for approval. Life/safety issues identified by ICE will be corrected during the COVID-19 spot checks, if possible, or the facility will be required to submit a corrective action plan within three business days.

- For dedicated ICE detention facilities, which operate under Quality Assurance Surveillance Plans, ICE will issue a Contract Discrepancy Report (CDR), which may include contract sanctions, for failure to bring the facility into compliance with the minimum requirements of the ERO PRR within the ICE-approved timeframe. The CDR may become part of the supporting documentation for contract payment deductions, fixed fee deductions, award fee nonpayment, or other contractual actions deemed necessary by the Contracting Officer. If the detention facility continues to have deficiencies despite the issuance of CDRs, ICE may seek to terminate the contract and/or decline to renew the contract.
- For non-dedicated ICE detention facilities that fail to meet the minimum requirements of the ERO PRR, ICE will issue a Notice of Intent indicating that the intergovernmental service agreement is in jeopardy due to non-compliance with the ERO PRR and ICE may take appropriate action, including removing its detention population from the facility or reducing its detention population at the facility on a temporary or permanent basis, depending on the nature of the non-compliance.

## CONCEPT OF OPERATIONS

The ERO PRR is intended for use across ICE's entire detention network, applying to all facilities housing ICE detainees, including ICE-owned Service Processing Centers, facilities operated by private vendors and facilities operated by local government agencies that have mixed populations of which ICE detainees comprise only a small fraction.

Due to the nature of the pandemic, medical and public health issues may require rapid changes and notifications faster than a new PRR version can be developed and approved. Therefore, the ICE Health Service Corps (IHSC) will issue interim medical guidance through their "[Interim Reference Sheet](#) on 2019-Novel Coronavirus (COVID-19): Detainee Care" or other medical notifications. This guidance sets forth best practices for all facilities and will be distributed by IHSC leadership directly to IHSC staff and to facilities not staffed by IHSC through Field Medical Coordinators (FMCs).

<sup>8</sup> A *spot check* is an in-person visit to a detention facility by an ICE Detention Service Manager (DSM) or Detention Standards Compliance Officer (DSCO) for the purpose of assessing whether the facility is complying with the requirements of the ERO PRR. DSMs and DSCOs review policies, logs, and records; observe facility operations; speak with facility staff and detainees; and complete a standardized form to note observations and findings.

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## DEDICATED ICE DETENTION FACILITIES

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All dedicated ICE detention facilities<sup>9</sup> must:

- Comply with the provisions of their relevant ICE contract or service agreement.
- Comply with the ICE national detention standards applicable to the facility according to the contract, generally [PBNDS 2011](#).
- Comply with the [CDC's \*Interim Guidance on Management of Coronavirus Disease 2019 \(COVID-19\) in Correctional and Detention Facilities\*](#). (Attachment F).
- Implement plans to comply with the Safer Federal Workforce Task Force's *COVID-19 Workplace Safety: Guidance for Federal Contractors and Subcontractors*, issued pursuant to Executive Order 14042, *Ensuring Adequate COVID Safety Protocols for Federal Contractors*, dated September 9, 2021 (published in the Federal Register on September 14, 2021, 86 FR 50985). Ensure that contractors are familiar with the guidance which is available at <https://www.saferfederalworkforce.gov/contractors/> and which also includes *Frequently Asked Questions for Federal Contractors*.
- Follow ICE's March 27, 2020, Memorandum to Detention Wardens and Superintendents on COVID-19 Action Plan Revision 1, and subsequent updates (Attachment G).
- Report all confirmed and suspected COVID-19 cases to the local ERO Field Office Director and Deputy Field Office Director (or their designees), Field Medical Coordinator, and local health department immediately.
- Evaluate all new admissions within five days of entering ICE custody to determine whether the detainees fall within the populations identified by the CDC as being at increased risk for severe illness<sup>10</sup> from COVID-19 and/or the subclasses certified in *Frailhat v. ICE*, 445 F. Supp. 3d 709 (C.D. Cal. 2020) and notify the local ERO Field Office Director and Deputy Field Office Director (or their designees) and the Field Medical Coordinator, as well as the detainee, as soon as practicable, but in no case more than twelve hours of determining whether the detainee meets the criteria. The local ERO Field Office will notify the detainee's counsel. These populations and subclasses include:

<sup>9</sup> Dedicated ICE detention facilities are facilities that house only ICE detainees. Dedicated ICE detention facilities may be ICE-owned Service Processing Centers, privately owned Contract Detention Facilities, or facilities operated by state or local governments that hold no other detention populations except ICE detainees.

<sup>10</sup> Severe illness from COVID-19 is defined as hospitalization, admission to the ICU, intubation or mechanical ventilation, or death. Adults of any age with the following conditions are at increased risk of severe illness from the virus that causes COVID-19:

- Older Adults (55 and over).
- People who are pregnant.
- People of all ages with chronic health conditions, including:
  - o Cancer;
  - o Chronic kidney disease;
  - o COPD (chronic obstructive pulmonary disease);
  - o Down syndrome;
  - o Immunocompromised state (weakened immune system) from solid organ transplant;
  - o Overweightness (body mass index (BMI) > 25 but less than 30) and Obesity (BMI of 30 or higher);
  - o Heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies;
  - o Sickle cell disease;
  - o Type 2 diabetes mellitus;
  - o Asthma;
  - o Cerebrovascular disease (affects blood vessels and blood supply to the brain);
  - o Cystic fibrosis;
  - o Hypertension or high blood pressure;
  - o Immunocompromised state (weakened immune system) from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune weakening medicines;
  - o Neurologic conditions, such as dementia;
  - o Liver disease;
  - o Pulmonary fibrosis (having damaged or scarred lung tissues);
  - o Smoking (current and former);
  - o Thalassemia (a type of blood disorder);
  - o Type 1 diabetes mellitus.

- People of all ages who are detained with a physical or mental impairment that substantially limits one or more major life activities or who has a record of physical or mental impairment that substantially limits a major life activity.
  - Severe psychiatric illness, including Psychotic Disorder, Bipolar Disorder, Schizophrenia or Schizoaffective Disorder, Major Depressive Disorder with Psychotic Features, Dementia and/or a Neurocognitive Disorder, or Intellectual Development Disorder (moderate, severe, or profound or that make it difficult for the individual to participate in their own care, that make it unlikely the individual will express symptoms, or that increase the risk of complications from the virus.)
- Detainees who claim (or on whose behalf a claim is made by an attorney, family member, or other advocate) that the detainees meet the above criteria or are suspected to meet the criteria must be evaluated by the medical staff for presence of the risk factors within five days of making the claim.
  - Upon evaluation, the local ERO Field Office Director and Deputy Field Office Director (or their designees), the Field Medical Coordinator, and the detainee must be notified whether the detainee meets the criteria as soon as practicable, but always within twelve hours after the evaluation has occurred. The local ERO Field Office will notify the detainee’s counsel.
  - Notification shall be made, via email, from the facility’s Health Services Administrator (HSA) (or equivalent) to the local ERO Officer in Charge, Clinical Director and Nurse Manager, and contain the following subject line for ease of identification: “Notification of COVID-19 Increased Risk Detainee (A- Number).” At a minimum, the HSA email message will provide the following information:
    - Detainee name;
    - Detention location;
    - Current medical issues and medications currently prescribed;
    - Facility medical Point of Contact (POC) and phone number.

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**NON-DEDICATED ICE DETENTION FACILITIES**

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All non-dedicated ICE detention facilities and local jails housing ICE detainees must:

- Comply with the provisions of their relevant ICE contract or service agreement.
- Comply with the ICE national detention standards applicable to the facility

according to the contract, generally [PBNDS 2011](#).

- Comply with the [CDC's Interim Guidance on Management of Coronavirus Disease 2019 \(COVID-19\) in Correctional and Detention Facilities](#).
- Implement plans to comply with the Safer Federal Workforce Task Force's *COVID-19 Workplace Safety: Guidance for Federal Contractors and Subcontractors*, issued pursuant to Executive Order 14042, *Ensuring Adequate COVID Safety Protocols for Federal Contractors*, dated September 9, 2021 (published in the Federal Register on September 14, 2021, 86 FR 50985). Ensure that contractors are familiar with the guidance which is available at <https://www.saferfederalworkforce.gov/contractors/> and which also includes *Frequently Asked Questions for Federal Contractors*.
- Report all confirmed and suspected COVID-19 cases to the local ERO Field Office Director and Deputy Field Office Director (or their designees), Field Medical Coordinator, and local health department immediately.
- Evaluate all new admissions within five days of entering ICE custody to determine whether the detainees fall within the populations identified by the CDC as being at increased risk for severe illness from COVID-19 and/or the subclasses certified in *Fraihat v. ICE*, 445 F. Supp. 3d 709 (C.D. Cal. 2020), and notify both the ERO Field Office Director and Deputy Field Office Director (or their designees) and Field Medical Coordinator, as well as the detainee, as soon as practicable, but always within twelve hours after identifying any detainee who meets the CDC's identified populations being at increased risk for severe illness from COVID-19 and/or falls under any of the categories enumerated below. The local ERO Field Office will notify the detainee's counsel:
  - Older Adults (55 and over);
  - People who are pregnant;
  - People of all ages with chronic health conditions, including:
    - o Cancer;
    - o Chronic kidney disease;
    - o COPD (chronic obstructive pulmonary disease);
    - o Down syndrome;
    - o Immunocompromised state (weakened immune system) from solid organ transplant;
    - o Overweight (BMI > 25 but less than 30) and obesity (BMI of 30 or higher);
    - o Heart conditions, such as heart failure, coronary artery

- disease, or cardiomyopathies;
    - o Sickle cell disease;
    - o Type 2 diabetes mellitus;
    - o Asthma;
    - o Cerebrovascular disease (affects blood vessels and blood supply to the brain);
    - o Cystic fibrosis;
    - o Hypertension or high blood pressure;
    - o Immunocompromised state (weakened immune system) from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune weakening medicines;
    - o Neurologic conditions, such as dementia;
    - o Liver disease;
    - o Pulmonary fibrosis (having damaged or scarred lung tissues);
    - o Smoking (current and former);
    - o Thalassemia (a type of blood disorder);
    - o Type 1 diabetes mellitus.
  - People of all ages who are detained with a physical or mental impairment that substantially limits one or more major life activities or who have a record of physical or mental impairment that substantially limits a major life activity.
  - Severe psychiatric illness, including Psychotic Disorder, Bipolar Disorder, Schizophrenia or Schizoaffective Disorder, Major Depressive Disorder with Psychotic Features, Dementia and/or a Neurocognitive Disorder, or Intellectual Development Disorder (moderate, severe, or profound or that make it difficult for the individual to participate in their own care, that make it unlikely the individual will express symptoms, or that increase the risk of complications from the virus).
- Detainees who claim (or on whose behalf a claim is made by an attorney, family member, or other advocate) that they meet the above criteria or are suspected to meet the criteria must be evaluated by the medical staff for presence of the risk factors within five days of making the claim.
  - Upon evaluation, both the local ERO Field Office Director and Deputy Field Office Director (or their designees), the Field Medical Coordinator, and the

detainee must be notified whether the detainee meets the criteria as soon as practicable, but always within twelve hours after the evaluation has occurred. The local ERO Field Office will notify the detainee's counsel.

- Notification must be made via email from the facility's HSA, or equivalent, to the local ERO Officer in Charge, Clinical Director and Nurse Manager, and must contain the following subject line for ease of identification: "Notification of COVID-19 Increased Risk Detainee (A-Number)." Other standardized means of communicating this information to ICE, as established by agreement between the local ERO Field Office Director and Deputy Field Office Director (or their designees) and the Warden or Superintendent, are acceptable. At a minimum the HSA communication to ICE will provide the following information:
  - Detainee name;
  - Detention location;
  - Current medical issues and medications currently prescribed;
  - Facility medical POC and phone number.

As indicated above, the CDC and the court order in *Fraiht v. ICE*, 445 F. Supp. 3d 709 (C.D. Cal. 2020), define certain populations that are at increased risk of severe illness from COVID-19. These conditions include the elderly (*see* CDC Guidance for Older Adults) and individuals with certain medical conditions (*see* CDC Guidance for People with Certain Medical Conditions).

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## ALL FACILITIES HOUSING ICE DETAINEES

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In addition to the specific measures listed above, all detention facilities housing ICE detainees must comply with the following:

### STANDARDS FOR INCREASED RISK POPULATIONS

#### Applicability

The *Fraiht* court order requirements apply to all detainees in ICE custody. Individuals being held under Title 42 authority, who are housed in ICE facilities, are also subject to *Fraiht* requirements and must be identified, reported, and monitored as such.

Dedicated staging facilities, under 72-hour facilities, and facilities that have a temporary or usual staging aspect to their mission are required to comply with *Fraiht* identification, reporting, and twice daily symptom and temperature monitoring requirements as long as a detainee remains in such facility for a period over 72 hours.

- If the detainee exceeds the 72-hour staging period, *Fraiht* identification, reporting, twice daily symptom and temperature monitoring requirements (as described in detail below) must begin for subclass members, and such individuals should be offered the COVID-19 vaccine within 14 days of intake

screening, subject to availability.

- Detainees held in staging status must be housed separately from other detainees at the facility.

Increased risk detainees must be provided the following services for identification, testing and screening as described below:

### **Identification**

All new admissions must be evaluated within five days of entering ICE custody to determine whether the detainees fall within the populations identified by the CDC and/or by the *Fraihat* court's order as being at increased risk for severe illness, and the local ERO Field Office Director and Deputy Field Office Director (or their designees) and the Field Medical Coordinator must be notified within twelve hours of the determination whether the detainee meets the criteria.

Detainee medical information and files on arrival might be incomplete. A detainee or his/her counsel may request and should be promptly provided with a copy of the medical file and may supplement medical records at any time during detention. Requests for inclusion of these files in the detainee's medical records, are submitted to the facility medical staff through a local operating procedure (LOP) established by that facility. The facility medical staff shall review newly submitted records within five days of receipt and inform the detainee and local ERO of the result of the review. The communication process is included in the facility's LOP. The local ERO Field Office will inform the detainee's counsel of the result of the review.

### **Testing for COVID-19**

- See "Standards for All Populations" below for additional information on testing.
- Testing all new admissions upon intake to an ICE facility:
  - Detained persons who are fully vaccinated should continue to be tested for SARS-CoV-2 following exposure to suspected or confirmed COVID-19 or if they develop any symptoms of COVID-19.
  - Intake testing should continue to be conducted on all incoming detainees regardless of vaccine status as described in this document.
- Testing as directed by medical personnel based on CDC requirements and clinical presentation of COVID-19 related illness.
- Testing upon removal as dictated by the requirements of the receiving country of record.
- Testing upon release to the community or transfer to another detention facility.
- Detainees who test positive will be isolated as described in the PRR until medically cleared in accordance to CDC guidelines; a detainee who is still considered to be infectious may be released from custody in accordance with guidance under the section entitled Considerations For Detainee Release in the [memorandum from Executive Associate Director Enrique Lucero, Enforcement and Removal Operations, Memorandum on Coronavirus 2019 \(COVID-19\) Action Plan, Revision 1 \(Mar. 27, 2020\)](#):
  - Detainees who test positive during detention should be isolated as described in this document regardless of vaccination status.
- Increased risk detainees who have a documented positive COVID-19 test within the last three months and were cleared in accordance with CDC guidelines do not need to be retested.

- 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.
- When there is a low rate of COVID-19 transmission in the facility and the surrounding community but a high number of detainees being processed for detention and to assist staff with meeting testing requirements when transfer and release testing cannot reasonably be accomplished:
  - If a detainee had their COVID-19 test performed less than 48 hours earlier at intake screening, staff are not required to perform transfer or release COVID-19 testing for detainees who have no symptoms consistent with COVID-19.
  - If a detainee had their COVID-19 test performed more than 48 hours earlier at intake screening, medical staff must complete transfer or release COVID-19 testing.
  - Any detainee with symptoms consistent with COVID-19 will require testing before transfer or release.
  - Consistent with current guidance, a detainee who exhibits symptoms consistent with COVID-19 cannot be transferred until the individual is no longer symptomatic.
  - Staff may perform transfer or release COVID-19 testing for asymptomatic detainees if resources permit.

### Screening for COVID-19

- Increased risk detainees must receive all normally prescribed screening for COVID-19 including:
  - Temperature screening and verbal screening for symptoms of COVID-19 and contacts with COVID-19 cases of all new entrants.
    - A fever is considered 100.4 degrees Fahrenheit or higher.
  - Verbal screening for symptoms of COVID-19 and close contact with COVID-19 cases must include the following questions based on the CDC Interim Guidance: Managing COVID-19 in Correctional/Detention Facilities:

*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 ache?
- Headache?
- Sore throat?
- New loss of taste or smell?
- Congestion or runny nose?
- Nausea, vomiting or diarrhea?
- In the past fourteen days, have you had close contact with a person known to be infected with COVID-19 where you were not wearing the recommended proper PPE? [Close contact is defined as being within 6 feet of an infected person for a cumulative total of 15 minutes or more over a

24-hour period\* starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the patient is isolated.]

- A detainee with a fever (temperature of 100.4 degrees Fahrenheit or higher) or positive COVID-19 symptom screening will be referred to a medical provider for further evaluation for COVID-19 infection. Appropriate PPE and isolation procedures must be utilized as necessary.
- This temperature and verbal screening of increased risk detainees will be conducted twice daily during detention utilizing the structured screening tool developed by IHSC and will be entered into the *Fraihat* Compliance System platform by the FMC or IHSC facility medical staff.
- Detention facility custody staff may assist their medical staff with *Fraihat* subclass twice daily temperature and COVID-19 symptom monitoring. Each facility's ERO Field Operations, medical, and custody components should discuss whether such assistance may be possible at their facility. Documentation on the IHSC *Fraihat* Compliance System spreadsheet must be completed by the medical staff.
  - Documentation must be completed on the latest version of the IHSC *Fraihat* Compliance System spreadsheet. For non-IHSC-staffed facilities, the detention facility medical staff must transmit the spreadsheet to the FMC weekly as directed.
- Any increased risk detainee who has tested positive for COVID-19 still requires twice daily temperature and COVID-19 symptom screening.

## STANDARDS FOR ALL POPULATIONS

### Identification

All new admissions must be evaluated within five days of entering ICE custody to determine whether the detainees fall within the populations identified by the CDC and/or by the *Fraihat* court's order as being at increased risk for severe illness, and the local ERO Field Office Director and Deputy Field Office Director (or their designees) and the Field Medical Coordinator must be notified within twelve hours of the determination whether the detainee meets the criteria. (*See above.*)

### Fully Vaccinated

A fully vaccinated detainee is defined by the CDC as a detainee that has:

- Written documentation (medical record or COVID vaccination card) of vaccination; and
- The vaccine received has been approved by the CDC/FDA; and an appropriate time period has passed after their second dose in a 2-dose series, or after a single-dose vaccine. vaccine; and
- Is not immunocompromised (immunocompromised individuals are not considered fully protected even after vaccination and should maintain COVID precautions).
- Possibly Other World Health Organization (WHO) -approved vaccines, which must be evaluated on a case-by-case basis based on WHO and/or CDC guidance.

### Up-to-Date Vaccinations

A detainee is considered boosted and "up-to-date" on their vaccinations if they have

received a booster dose of the vaccine:

- Written documentation (medical record or COVID vaccination card) of vaccination and booster dose; and
- Booster was administered as directed based on CDC booster dose and scheduled guidance for the individual.

### Testing for COVID-19

- Detainees will be tested as described regardless of *Frailhat* status, facility type, Title 42 status, or other conditions.<sup>11</sup> The only exceptions to this are:
  - Testing prior to removal only if required by the country to which the detainee is being removed.
  - Detainees who test positive within three 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.
  - Vaccination status has no impact on testing requirements. *Frailhat v. ICE*, No. 19-1546 (C.D. Cal. filed August 19, 2019), 445 F. Supp. 3d 709 (C.D. Cal. 2020).
- All detainees will receive COVID-19 services including:
  - Testing upon intake to any ICE facility:
    - All new admissions to ICE detention facilities require COVID-19 testing within 12 hours of arrival. Collection timeframe may extend to 24 hours if facility collection logistics require additional time. When additional time is required, the facility's medical provider shall notify the Facility Administrator as soon as possible.
    - Testing of all new admissions before they join the rest of the population in the facility, and housing them individually or in cohorts while test results are pending help prevent potential transmission.
    - Detainees who are fully vaccinated should continue to be tested for SARS-CoV-2 following exposure to suspected or confirmed COVID-19 or if they develop any symptoms of COVID-19.
    - Intake testing should continue to be conducted on all incoming detainees regardless of vaccine status as described in the PRR.
  - Testing as directed by medical personnel based on CDC requirements and clinical presentation of COVID-19 related illness.
  - Testing upon removal as dictated by the requirements of the receiving country of record.
  - Testing upon transfer/release from ICE facilities.
- Detainees who test positive will be isolated as described in the PRR until medically cleared in accordance to CDC guidelines; a detainee who is still considered to be infectious may be released from custody in accordance with guidance under the section entitled Considerations For Detainee Release in the [memorandum from Executive Associate Director Enrique Lucero, Enforcement and Removal Operations, Memorandum on Coronavirus 2019 \(COVID-19\) Action Plan, Revision](#)

<sup>11</sup> Pursuant to *Frailhat*, ICE's testing and transfer protocols as well as its performance standard contained in ICE's Pandemic Response Requirements (PRR) must remain consistent with CDC guidance. Further interim guidance and revisions to the PRR will be issued as the CDC further updates its guidance.

1 (Mar. 27, 2020).

- Detainees who test positive during detention should be isolated as described in the PRR regardless of vaccination status.
- 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.
- Tests for COVID-19 fall under three broad categories: PCR based (“molecular,” “RT-PCR based,” “NAAT”), Antigen (“rapid”), and Antibody (“serology”).
  - All tests that rely on the amplification of COVID-19 genetic material are RT-PCR based. RT-PCR stands for “reverse transcriptase polymerase chain reaction”; it is a type of PCR test conducted on viruses that have RNA instead of DNA. A “PCR” test for COVID-19 MUST be RT-PCR. Direct PCR on COVID-19 is not possible.
  - RT-PCR based tests (also referred to broadly as “molecular” tests) are considered the “gold standard” of testing.
  - Antigen based tests detect viral antigen, do not use PCR, and are generally much faster, yielding results in minutes vs hours-days. Abbott BINAXNOW® is an example of an antigen-based test.
  - Antigen based tests are considered less accurate than RT-PCR based tests; however, the CDC does allow for their use in screening (*see* below).
  - Antibody tests measure antibodies produced against COVID-19 in the bloodstream; due to a lack of research, presently antibody-based tests are not recommended for use for screening and are not utilized in a correctional setting.
- In accordance with CDC guidance and in recognition of increased intakes, the potential shortages in Abbott IDNow test kits and BinaxNow testing resources, IHSC recommends the following process be considered for intakes at all facilities where intake testing is required:
  - RT-PCR based tests must be used for removals as required by the receiving country.
  - For the purpose of intakes (staging and non-staging facilities) any EUA approved or licensed antigen-based tests can be used initially in the place of RT-PCT based tests. However, under certain circumstances, the CDC recommends the results of the antigen test be confirmed by a RT-PCR based test.
  - CDC has recommended this approach in their antigen testing algorithm:
    - [Antigen Test Algorithm for Congregate Settings \(cdc.gov\)](https://www.cdc.gov/media/releases/2020/s111820-antigen-testing.html)
  - For asymptomatic detainees: a negative antigen test can be considered a “negative” result for intake purposes; positive antigen tests should be confirmed with a RT-PCR based test.
    - For symptomatic detainees, a negative result with an antigen-based tests must be confirmed by RT-PCR based testing. Otherwise manage the detainee as a confirmed positive.

**Screening for COVID-19**

- Detainees will be screened upon intake at all ICE facilities for COVID-19 including:

- Temperature screening and verbal screening for symptoms of COVID-19 and contacts with COVID-19 cases.
  - A fever is considered 100.4 degrees Fahrenheit or higher.
- Verbal screening for symptoms of COVID-19 and close contact with COVID-19 cases must include the following questions based on the CDC Interim Guidance: *Managing COVID-19 in Correctional/Detention Facilities: 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 ache?
  - Headache?
  - Sore throat?
  - New loss of taste or smell?
  - Congestion or runny nose?
  - Nausea, vomiting or diarrhea?
  - In the past fourteen days, have you had close contact with a person known to be infected with COVID-19 where you were not wearing the recommended proper PPE? [Close contact is defined as being within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period\* starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the patient is isolated.]
- A detainee with a fever or positive COVID-19 symptom screening will be referred to a medical provider for further evaluation for COVID-19 infection. Appropriate PPE and isolation procedures must be utilized as necessary.

➤ **Medical Care and Hospitalization**

- At a minimum:
  - All detainees are to be provided medical care as described within the PRR.
  - Detention facilities must follow the CDC's [Interim Guidance on Management of Coronavirus Disease 2019 \(COVID-19\) in Correctional and Detention Facilities](#), dated [here](#) as of February 10, 2022, and the [Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease](#), updated [here](#) on February 12, 2021, for care recommendations.

➤ **Asymptomatic COVID-19 Positive**

Note: Fully vaccinated detainees who test positive or develop symptoms consistent with COVID-19 are to be managed in the same manner as other detainees who are positive or symptomatic. Vaccination status does not impact testing or isolation in these circumstances.

A nurse or medical provider must verify the absence of COVID-19 symptoms. If asymptomatic:

- Educate the detainee on symptoms of COVID-19 infection and instruct detainees to report if they have any symptoms to medical staff at sick call or to the custody officer (who will notify medical staff).
- Perform daily sick call rounds.
- Obtain daily vital signs to include blood pressure, pulse, respiratory rate, temperature, and pulse oximetry.

Have the detainee complete the 10-day isolation period and fulfill criteria required to release from isolation.

### ➤ **Symptomatic COVID-19 Positive**

Note: Fully vaccinated detainees who test positive or develop symptoms consistent with COVID-19 are to be managed in the same manner as other detainees who are positive or symptomatic. Vaccination status does not impact testing or isolation in these circumstances.

If a detainee is noted to have symptoms of COVID-19, the following care elements are advised:

- A medical provider will perform initial evaluation to determine their care and treatment plan and housing placement.
- Nurse or medical provider assessment will be performed daily.
- Vital signs will be performed more frequently as ordered by the medical provider to include pulse oximetry for detainees with medical conditions that place them at increased risk for complications of COVID-19 infection and those detainees manifesting more severe symptoms.

Have the detainee complete the 10-day isolation period until criteria required to release from isolation has been met. A detainee who was severely ill with COVID-19 or who has a severely weakened immune system (immunocompromised) due to a health condition or medication may require a longer period of isolation (up to 20 days) and may require consultation with infectious disease specialists and testing to determine when the detainee can be released from isolation.

COVID-19 positive detainees determined to be at increased-risk of complications from COVID-19 or more severely affected symptomatic detainees may require a higher level of monitoring or care and should be housed in the medical housing unit or infirmary area of the facility or, if unavailable, hospitalized as detailed below.

### ➤ **Hospitalized COVID-19 Positive**

Detainees who require a higher level of care than can be safely provided at the detention facility must be referred to community medical resources when needed. Facility staff will defer medical care management decisions to the off-site medical provider caring for the detainee.

The following information is taken from the CDC's [\*Interim Guidance on Management of Coronavirus Disease 2019 \(COVID-19\) in Correctional and Detention Facilities:\*](#)

➤ **Medical Isolation of Individuals with Confirmed or Suspected COVID-19**

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. Facilities without onsite healthcare capacity, or without sufficient space to implement effective medical isolation, must follow local public health options to ensure that individuals with confirmed or suspected COVID-19 will be appropriately isolated, evaluated, tested, and given care.

Note: Any vaccinated detainees who test positive or develop symptoms consistent with COVID-19 are to be managed in the same manner as other detainees who are positive or symptomatic. Vaccination status does not impact testing or isolation in these circumstances.

As soon as an individual develops symptoms of COVID-19 or tests positive for SARS-CoV-2, the individual must be provided with a face mask, if not already wearing one and provided that it can be worn safely, and immediately placed under medical isolation in a separate environment from other individuals, and medically evaluated.

Ensure that medical isolation for COVID-19 is distinct from administrative or disciplinary segregation. Due to limited housing units within many correctional facilities, individuals may be medically isolated in spaces used for administrative or disciplinary segregation; however, medical isolation shall be operationally distinct from administrative or disciplinary segregation to provide access to programs and services to the fullest extent possible as clinically permitted. For example:

- Ensure that individuals under medical isolation receive regular visits from medical staff and have access to mental health services.
- Make efforts to provide access to radio, television, reading materials, personal property, telephones, recreation, and commissary to the fullest extent possible.
- Consider allowing increased telephone privileges without a cost barrier to maintain mental health and connection with others while isolated.
- Communicate regularly with isolated individuals about the duration and purpose of their medical isolation period.

**Keep the individual's movement outside the medical isolation space to a clinically necessary minimum.**

- Provide medical care to isolated individuals inside the medical isolation space unless they need to be transferred to a healthcare facility.
- Serve meals inside the medical isolation space.
- Refrain from group activities.

Assign isolated individual(s) to dedicated bathrooms with regular access to restrooms and showers. Housekeeping staff should [clean and disinfect areas](#) used by infected individuals frequently on an ongoing basis during medical isolation with an approved cleaning solution

used in the strength and in a manner as recommended by the product label. Ensure that the individual is wearing a face mask if s/he must leave the medical isolation space for any reason, and whenever another individual enters. Provide clean face masks as needed. Face masks must be washed daily and changed when visibly soiled or wet.

If the facility is housing individuals with confirmed COVID-19 as a cohort:

- Only individuals with laboratory-confirmed COVID-19 should be placed under medical isolation as a cohort. If an antigen or antibody test is utilized, negative results must be confirmed with a molecular, PCR based assay. Do not cohort those with confirmed COVID-19 with those with suspected COVID-19, or with close contacts of individuals with confirmed or suspected COVID-19.
- Do not house individuals with undiagnosed respiratory infection (who do not meet the criteria of suspected COVID-19) with individuals with suspected COVID-19.
- Ensure that cohorted groups of people with confirmed COVID-19 wear face masks whenever anyone (including staff) enters the isolation space. (Anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable to remove the mask without assistance should not wear a face mask.)
- Designate space for cohort medical isolation in a manner that reduces the chance of cross-contamination across different parts of the facility.

If the facility is housing individuals with confirmed COVID-19 as a cohort, use a well-ventilated room with solid walls and a solid door that closes fully.

If possible, limit medical transfers to another facility or within the facility to those necessary for care. *See [Transporting Detained Individuals](#) section for safe transport guidance.*

Staff assignments to medical isolation should remain as consistent as possible with limited movements to other parts of the facility. Staff shall wear recommended PPE as appropriate for their level of contact with the individual under medical isolation.

Staff shall ensure that they change PPE when leaving the isolation space to prevent cross contamination. If PPE supplies necessitate reuse, ensure that staff move only from areas of low to high exposure risk while wearing the same PPE. Ensure that staff are [trained in infection control practices](#), including use of [recommended PPE](#).

Minimize transfer of individuals with confirmed or suspected COVID-19 between spaces within the facility.

Provide individuals under medical isolation with tissues and, if permissible, a lined no-touch trash receptacle. Instruct them to:

- Cover their mouth and nose with a tissue when they cough or sneeze.
- Dispose of used tissues immediately in the lined trash receptacle.

Wash hands immediately with soap and water for at least 20 seconds. If soap and water are not available, clean hands with an alcohol-based hand sanitizer that contains at least 60% alcohol (where security concerns permit). Ensure that hand washing supplies are continually restocked.

Maintain medical isolation until the most current CDC criteria for discontinuing home-based isolation have been met. These criteria have changed since CDC corrections guidance was originally issued and may continue to change as new data become available.

- CDC's recommended strategy for release from non-medical care-based isolation can be found in the [Discontinuation of Isolation for Persons with COVID-19 Not in Healthcare Settings Interim Guidance](#).
- Detailed information about the data informing the symptom-based strategy, and considerations for extended isolation periods for persons in congregate settings including corrections, can be found [here](#).
- If persons will require ongoing care by medical providers, discontinuation of transmission-based precautions (PPE) should be based on similar criteria found [here](#).

### ➤ **Clinical Care for Individuals with COVID-19**

Facilities must ensure that detained individuals receive medical evaluation and treatment at the first signs of COVID-19 symptoms.

- If a facility is not able to provide such evaluation and treatment, a plan must be in place to safely transfer the individual to another facility or local hospital (including notifying the facility/hospital in advance). See *Transporting Detained Individuals* section. The initial medical evaluation must determine whether a symptomatic individual is at increased risk for severe illness from COVID-19. Persons [at increased risk](#) may include older adults and persons of any age with serious [underlying medical conditions](#), including chronic kidney disease, serious heart conditions, and Type-2 diabetes. See the *Fraihat* and CDC combined list in this PRR and the CDC's website for a [list](#), and check the PRR and CDC regularly for updates as more data become available to inform this issue.
- Much remains unknown about the risks of COVID-19 to the pregnant person, the pregnancy, and the unborn child. Prenatal and postnatal care is important for all pregnant individuals, including those who are detained. Visit the CDC website for more information on [pregnancy](#) and [breastfeeding](#) in the context of COVID-19.

Staff evaluating and providing care for individuals with confirmed or suspected COVID-19 must 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.

Healthcare staff must 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 face mask.

- If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having symptomatic individuals walk through the facility to be evaluated in the medical unit.

Clinicians are strongly [encouraged to test for other causes of respiratory illness](#) (e.g., influenza). However, presence of another illness such as influenza does not rule out COVID-19.

When evaluating and treating persons with symptoms of COVID-19 who do not speak English, use a language line, or provide a trained interpreter.

In addition to the specific measures listed above, all detention facilities housing ICE detainees must also comply with the following guidance found in the [Interim Guidance on Management of Coronavirus Disease 2019 \(COVID-19\) in Correctional and Detention Facilities](#).

## **MONOCLONAL ANTIBODY THERAPY**

Infection with SARS-CoV-2, the virus that causes COVID-19, can lead to severe symptoms, hospitalization, and death. The FDA has issued Emergency Use Authorizations for several monoclonal antibody products for treatment of COVID-19 patients with mild to moderate symptoms and risk factors for severe illness due to COVID-19 infection.

Treatment with monoclonal antibodies known to be effective against a particular variant of SARS-CoV-2 reduces the risk of progression to severe disease, decreases the need for hospitalization, and reduces the severity of disease thereby improving survival. Treatment appears to work best when started early after the diagnosis is made in appropriately selected patients. For this reason, ICE recommends that each detainee newly diagnosed with COVID-19 be assessed for possible treatment with this medication.

For more information about COVID-19 monoclonal antibody treatment, please see the [National Institutes of Health COVID-19 Treatment Guidelines](#).

## **COVID-19 VACCINE**

While ICE cannot mandate individuals in detention consent to be vaccinated, all detention facilities are responsible for ensuring their ICE detainees are **offered** the COVID vaccine in accordance with state priorities and guidance. A detainee's vaccine status, including whether they have received a booster, must be identified during intake. If eligible, vaccines should be offered as close to intake as possible but always within 14 days of arrival, subject to vaccine eligibility. Detention facility staff should contact their state's COVID-19 vaccine resource (i.e., state or county department of health) to obtain vaccine. The process to register to obtain the vaccine may involve several steps, and each state health authority will likely require detainee demographic reporting for those detainees who are vaccinated. Alternatively, sites may request that ICE ship a COVID-19 vaccine directly to the facility by sending an email request to [vaccinerequest@ice.dhs.gov](mailto:vaccinerequest@ice.dhs.gov). Please reference the CDC [COVID-19 Vaccine FAQs in Correctional and Detention Centers](#) for additional information.

Non-IHSC-staffed detention facilities must notify the field medical coordinator (FMC) for their facility once COVID-19 vaccination begins at the facility to help keep ICE abreast of detainee vaccine access and must report all detainee vaccines administered and refused.

The [IHSC COVID-19 Vaccine Guidelines and Protocol operations memorandum](#) may be utilized by non-IHSC staffed facilities for their reference. The operations memorandum is regularly updated and distributed to detention facilities.

Detention facilities may choose to utilize the IHSC COVID-19 Vaccine Consent/Declination Form to document whether a detainee accepts or declines the vaccine. See Attachment Q for English, Spanish,

Bengali, French, Haitian Creole, Portuguese, and Punjabi versions of this form. Where practicable, provisions for written translation of the form shall be made for other significant segments of the population with limited English proficiency. Oral interpretation or assistance shall be provided to any detainee who speaks another language in which the written material has not been translated or who is illiterate.

ICE requires all detention facilities to post educational materials in different languages about the COVID-19 vaccine to help improve vaccine knowledge and to decrease the number of detainees who may choose to refuse the vaccine.

- For frequently asked questions about COVID-19 vaccination in correctional and detention facilities, please see the CDC's COVID-19 Vaccine FAQs in Correctional and Detention Centers found [here](#). Detainees with a prior positive test should receive a vaccine dose as soon as they are clinically recovered (no longer symptomatic) and have cleared their isolation period which is currently 10 days. If they are moderately or severely immunocompromised, there may be some additional clinical guidance.

### **CUSTODY DETERMINATIONS**

- For those cases identified as meeting any of the subclass criteria, the Field Office Director must validate the cases with assistance from the Field Medical Coordinator (FMC) and/or facility medical staff to ensure the conditions listed are still present and complete a custody review.
- **All detainees aged 55 and older** already should have been identified, tracked, and have a custody review completed in a timely manner.
- **All new detainees aged 55 and older** who are identified as meeting any of the subclass criteria must have a custody review completed within 5 days of entering ICE custody.
- Detainees aged 55 and older, or pregnant, who are otherwise healthy and have none of the disabilities listed in Subclass Two, are only members of Subclass One. Therefore, **only** the RF1 alert code (RF1 – COVID-19 Risk Factor – Subclass One) should be assigned to the case in EARM.
- All detainees determined to have any of the disabilities listed in Subclass Two should be assigned BOTH the RF1 and RF2 alert codes (RF2 – COVID-19 Risk Factor—Subclass Two) in EARM.
- **Alert codes must stay in EARM for tracking.** They should not be removed by the Field.
  - **Important:** Class member information is being provided to the plaintiffs in this case. Removing the alert codes compromises future reporting and the integrity of our data quality.
- Class membership continues upon any release from custody, so the alert codes should not be removed upon release.
- The custody review must consider for the appropriateness of detention given the current COVID-19 pandemic; therefore, the COVID-19 Special Class code in EARM has been disabled/retired and should not be used.
  - Cases are now tracked using one or both of the **RF1 – COVID-19 Risk Factor – Subclass One** and **RF2 – COVID-19 Risk Factor—Subclass Two** alert codes only.
- When making a custody re-determination for a *Frailhat* subclass member, the SDDO shall ensure that the presence of a Risk Factor is given significant weight. Only in rare cases should a *Frailhat* subclass member not subject to mandatory detention remain detained, and as previously instructed in the ongoing docket review, a justification for continued detention is required. *Frailhat* subclass members subject to INA § 236(c) mandatory detention must also receive

custody determinations. The SDDO must not apply the Docket Review Guidance rule against release of aliens detained pursuant to INA § 236(c) detainees so inflexibly that none of the *Frailhat* subclass members are released. Although traditional factors, such as danger to the community and risk of flight, may be considered, under the terms of the PI, aliens subject to detention pursuant to INA § 236(c) should continue to be detained only after individualized consideration of the risk of severe illness or death, with due regard to the public health emergency. Blanket or cursory denials do not comply with the court's requirement that ERO make individualized determinations. *Frailhat* subclass members that are released should be enrolled into a GPS program when possible.

In addition to the specific measures listed above, all detention facilities housing ICE detainees must also comply with the following:

## **PREPAREDNESS**

Administrators should plan and prepare for COVID-19 by ensuring that all persons in the facility know the symptoms of COVID-19 and how to respond if they develop symptoms. Other essential actions include developing contingency plans for reduced workforces due to absences, coordinating with public health and correctional partners, and communicating clearly with staff and detainees about these preparations and how they may temporarily alter daily life.

- Develop information-sharing systems with partners.
  - Identify points of contact in relevant state, local, tribal, and/or territorial public health department before cases develop.
  - Communicate with other correctional and detention facilities in the same geographic area to share information including disease surveillance and absenteeism patterns among staff.
- Review existing pandemic, influenza, all-hazards, and disaster plans, and revise for COVID-19, and ensure that they meet the requirements of ICE's detention standards.
- Offer the seasonal influenza vaccine to all detained persons (existing populations and new admissions) and staff throughout the influenza season, where possible.
- Staffing:
  - Review sick leave policies to ensure that staff can stay home when sick and determine which officials will have the authority to send symptomatic staff home. Staff who report for work with symptoms of COVID-19 must be sent home and advised to follow CDC-recommended steps for persons exhibiting COVID-19 symptoms.
  - Management should consider requiring asymptomatic staff who have been identified as close contacts of a confirmed COVID-19 case to home quarantine to the maximum extent possible, while

understanding the need to maintain adequate staffing levels of [critical workers](#). Workers in [critical infrastructure sectors](#) (including correctional and detention facilities) may be permitted to work if they remain asymptomatic after a potential exposure to SARS-CoV-2, provided that [worker infection prevention recommendations and controls](#) are implemented, including requiring the staff member to wear a face mask (unless contraindicated) at all times while in the workplace for 14 days after the last exposure (if not already wearing one due to universal use of face masks). If the exposed staff members test positive, they should follow local health department and health care provider instructions regarding home isolation.

- Staff who test positive for COVID-19 must inform their workplace and personal contacts immediately. If a staff member has a confirmed COVID-19 infection, the relevant employers will inform other staff of their possible exposure to COVID-19 in the workplace consistent with any legal limitations on the sharing of such information. Exposed employees must then self-monitor for symptoms (e.g., fever, cough, or shortness of breath).
- Identify staff whose duties would allow them to work from home to promote social distancing and further reduce the risk of COVID-19 transmission.
- Determine minimum levels of staff in all categories required for the facility to function safely.
- Follow the Public Health Recommendations for Community-Related Exposure.<sup>12</sup>
- Follow guidance from the Equal Employment Opportunity Commission, available [here](#), when offering testing to staff. Any time a positive test result is identified, ensure that the individual is rapidly notified, connected with appropriate medical care, and advised how to self-isolate.
- Staff who are fully vaccinated and do not have symptoms of COVID-19 do not need to quarantine or be excluded from work following exposure to suspected or confirmed COVID-19. However, testing and symptom monitoring following an exposure are still recommended.
- Vaccinated and unvaccinated staff should follow CDC domestic and international travel requirements and recommendations before, during and after travel; state and local government travel recommendations; and their employer's policies on returning to work after work-related or personal travel.

<sup>12</sup> Attachment H, Centers of Disease Control and Prevention, *Public Health Guidance for Community-Related Exposure*, <https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html> (last visited February 14, 2022).

➤ Supplies:

- Ensure that sufficient stocks of hygiene supplies (soap, hand sanitizer, tissues); personal protective equipment (PPE) including facemasks, N95 respirators, eye protection, disposable medical gloves, and disposable gowns/one-piece coveralls; and medical supplies (consistent with the healthcare capabilities of the facility) are on hand and there is a plan in place to restock as needed if COVID-19 transmission occurs within the facility.
- Note that shortages of N95 respirators are anticipated during the COVID-19 response. Based on local and regional situational analysis of PPE supplies, face masks should be used when the supply chain of N95 respirators cannot meet the demand.
- Follow COVID-19: Optimizing Supply of PPE and Other Equipment.<sup>13</sup>
- Ensure that staff and detainees are trained to don, doff, and dispose of PPE they will need to use while performing duties within the scope of their responsibilities.
- Soiled PPE items should be disposed in leak-proof plastic bags that are tied at the top and not re-opened. Bags can be disposed of in the regular solid waste stream.
- Cloth face masks should be worn over the nose and mouth by detainees and staff (when PPE supply is limited) to help slow the spread of COVID-19. Cloth face masks should:
  - o Fit snugly but comfortably against the side of the face be secured with ties or ear loops where possible or securely tied.
  - o Include multiple layers of fabric.
  - o Allow for breathing without restriction.
  - o Be able to be laundered and machine dried without damage or change to shape.
  - o Be provided at no cost to detainees.
- After vaccine is administered, detained individuals and correctional and detention staff should still wear a well-fitted mask that covers the nose and mouth. Masking in these settings is still recommended due to the high turnover of people and a

<sup>13</sup> Attachment I, Centers for Disease Control and Prevention, *Optimizing Personal Protective Equipment (PPE) Supplies*, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/> (last visited February 14, 2022).

higher risk of transmission.

- Cloth face masks are contraindicated for children under two years of age, anyone who has trouble breathing, is unconscious, incapacitated or otherwise unable to remove the mask without assistance.

➤ Hygiene:

- Reinforce healthy hygiene practices, and provide and restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms, common areas, medical, and staff-restricted areas (e.g., break rooms).
- Require all persons within the facility to cover their mouths and noses with their elbows (or ideally with a tissue) rather than with their hands when they cough or sneeze, and to throw all tissues in the trash immediately after use.
- Provide detainees and staff no-cost access to tissues and no-touch receptacles for disposal.
- Require all persons within the facility to maintain good hand hygiene by regularly washing their hands with soap and water for at least 20 seconds, especially after coughing, sneezing, or blowing their noses; after using the bathroom; before eating or preparing food; before taking medication; and after touching garbage.
- Provide detainees and staff no-cost, unlimited access to supplies for hand cleansing, including liquid or foam soap, running water, hand drying machines or disposable paper towels, and no-touch trash receptacles. If bar soap is used, ensure that it does not irritate the skin as this would discourage frequent hand washing and ensure that individuals are not sharing bars of soap.
- Where handwashing, water and soap are not available, provide alcohol-based hand sanitizer with at least 60 percent alcohol where permissible based on security restrictions and as applicable to the ICE national detention standards applicable to the facility, generally PBNDS 2011.
- Require all persons within the facility to avoid touching their eyes, noses, or mouths without cleaning their hands first.
- If possible, inform potential visitors, including inspectors and auditors, before they travel to the facility that they should expect to be screened for COVID-19 and will be unable to enter the facility if they do not clear the screening process or if they decline screening.

- Post signage throughout the facility reminding detained persons and staff to practice good hand hygiene and cough etiquette (printable materials for community-based settings can be found on the [CDC website](#)). Signage must be in English and Spanish, as well as any other common languages for the detainee population at the facility.
  - Prohibit sharing of eating utensils, dishes, and cups.
  - Prohibit non-essential personal contact such as handshakes, hugs, and high-fives.
- Provide individuals about to be released from ICE custody with COVID-19 prevention information, hand hygiene supplies, and face masks.
- Cleaning/Disinfecting Practices:
- Facilities must adhere to CDC recommendations for cleaning and disinfection during the COVID-19 response.<sup>14</sup>
  - All cleaning and disinfecting materials must be stored in secure areas, in their original containers, and with the manufacturer's label intact on each container.
  - Safe cleaning products must be used in the quantities and in a manner as indicated on the manufacturer's product label.
  - Several times a day using household cleaners and Environmental Protection Agency-registered disinfectants, clean and disinfect surfaces and objects that are frequently touched, especially in common areas (e.g., doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment). The EPA's list of certified cleaning products is located here.
    - o When no individuals with confirmed or suspected COVID-19 are known to have been in a space, cleaning once a day is usually enough to sufficiently remove virus that may be on surfaces and help maintain a healthy facility. Consider the type of surface and how often the surface is touched.
      - Generally, the more individuals who touch a surface, the higher the risk.
      - Prioritize cleaning high-touch surfaces at least once a day.
      - If the space is a high traffic area, or if certain conditions apply, clean more frequently or disinfect in addition to

<sup>14</sup> Attachment J, Centers for Disease Control and Prevention, *Cleaning and Disinfection for Community Facilities*, <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html> (last visited February 14, 2022).

- cleaning.
  - o If there has been a sick person or someone who tested positive for COVID-19 in the facility within the last 24 hours, clean and disinfect the space.
  - o Continue cleaning intake, testing, and patient care areas as described in the PRR.
- Staff should clean shared equipment several times per day and on a conclusion-of-use basis (e.g., radios, service weapons, keys, handcuffs).
- The facility designee for environmental health is responsible for ensuring that cleaning supplies and frequency of cleaning schedule are sufficient to maintain a high level of sanitation within housing areas without negatively impacting the health of detainees or staff.
- Ensure that transport vehicles are thoroughly cleaned after carrying a confirmed or suspected COVID-19 case.
- Facility leadership will ensure that there is adequate oversight and supervision of all individuals responsible for cleaning and disinfecting these areas.
- Facilities shall report confirmed or suspected cases of detainees suffering adverse reactions to cleaning supplies or chemicals to the local ERO Field Office Director and Deputy Field Office Director (or their designees) and Field Medical Coordinator. ICE will promptly investigate reports of adverse reactions to cleaning supplies or chemicals used for disinfection of COVID-19.

### **CDC Recommended Cleaning Tips**

- Hard (Non-porous) Surfaces:
  - If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
  - For disinfection, most common EPA-registered household disinfectants should be effective.
    - o A list of products that are EPA-approved for use against the virus that causes COVID-19 is available [here](#). Follow the manufacturer's instructions for all cleaning and disinfection products for concentration, application, method, contact time, etc.
    - o Additionally, diluted household bleach solutions (at least 1000 ppm sodium hypochlorite) can be used if

appropriate for the surface. Follow manufacturer's instructions for application, ensuring a contact time of at least one minute and allowing proper ventilation during and after application. Check to ensure the product is not past its expiration date. Never mix household bleach with ammonia or any other cleanser. Unexpired household bleach will be effective against coronaviruses when properly diluted.

- Prepare a bleach solution by mixing:
  - 5 tablespoons (1/3 cup) bleach per gallon of water; or
  - 4 teaspoons bleach per quart of water.

➤ Soft (Porous) Surfaces:

- For soft (porous) surfaces, such as carpeted floor, rugs, and drapes, remove visible contamination if present and clean with a product containing soap, detergent, or other type of cleaner appropriate for use on these surfaces. After cleaning:
  - o If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely.
  - o Otherwise, use products that are EPA-approved for use against the virus that causes COVID-19 and that are suitable for porous surfaces.<sup>15</sup>

➤ Electronics:

- For electronics such as tablets, touch screens, keyboards, remote controls, and ATM machines, remove visible contamination if present.
  - o Follow the manufacturer's instructions for all cleaning and disinfection products.
  - o Consider use of wipeable covers for electronics.
  - o If no manufacturer guidance is available, consider the use of alcohol-based wipes or sprays containing at least 70 percent alcohol to disinfect touch screens. Dry surfaces thoroughly to avoid pooling of liquids.

<sup>15</sup> Attachment K, U.S. Environmental Protection Agency, *List N: Disinfectants for Coronavirus (COVID-19)*, <https://www.epa.gov/pesticide-registration/list-n-disinfectants-coronavirus-covid-19> (last visited February 14, 2022).

- Linens, Clothing, and Other Items That Go in the Laundry:
  - To minimize the possibility of dispersing virus through the air, do not shake dirty laundry.
  - Wash items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely. Dirty laundry that has been in contact with an ill person can be washed with other people's items.
  - Clean and disinfect hampers or other carts for transporting laundry according to guidance above for hard or soft surfaces.
  - Consider establishing an on-site laundry option for staff so that they can change out of their uniform, launder them at the facility, and wear street clothes and shoes home. If on-site laundry for staff is not feasible, encourage them to change clothes before they leave the work site, and provide a location for them to do so.

## PREVENTION

Detention facilities can mitigate the introduction of COVID-19 from the community and reduce transmission if it is already inside by reinforcing good hygiene practices among detained persons, staff, and visitors (including increasing access to soap and paper towels), intensifying cleaning/disinfection practices, and implementing social distancing strategies. Because many individuals infected with COVID-19 do not display symptoms, the virus could be present in facilities before cases are identified. Both good hygiene practices and social distancing are critical in preventing further transmission:

- Perform pre-intake temperature and screening for new entrants for COVID-19 symptoms, including those who are fully vaccinated.
- Screening should take place before staff and new admissions enter the facility or just inside the facility, where practicable. For new admissions, this should occur before beginning the intake process, to identify and immediately isolate any detainee with symptoms before the individual comes in contact with others or is placed in the general population. This should include temperature screening of all staff and new entrants as well as a verbal symptoms check.
  - A fever is considered a temperature of 100.4 degrees Fahrenheit or higher.
  - Verbal screening for symptoms of COVID-19 and close contact with COVID-19 cases should include the following questions based on the CDC [\*Interim Guidance: Managing COVID-19 in Correctional/Detention Facilities\*](#):

- 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 ache?
  - Headache?
  - Sore throat?
  - New loss of taste or smell?
  - Congestion or runny nose?
  - Nausea, vomiting or diarrhea?
  - In the past fourteen days, have you had close contact with a person known to be infected with COVID-19 where you were not wearing the recommended proper PPE? [Close contact is defined as being within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the patient is isolated].
  
- If staff have symptoms of COVID-19 (e.g., fever, cough, shortness of breath), they must be denied access to the facility.
  
- If any new intake has symptoms of COVID-19:
  - o Request the individual to wear a face mask.
  - o Ensure that staff interacting with the symptomatic individual wears recommended PPE.
  - o Isolate the individual and refer to healthcare staff for further evaluation.
  - o Facilities without onsite healthcare staff must contact their state, local, tribal, and/or territorial health department to coordinate effective isolation and necessary medical care.
  
- If an individual is a close contact of a known COVID-19 case or has traveled to an affected area, but has no COVID-19 symptoms, quarantine the individual and monitor for symptoms two times per day for ten days.
  
- Detainees with symptoms of COVID-19, regardless of vaccination status, should be given a mask (if not already wearing one and if it can be worn safely), immediately

placed under medical isolation in a separate environment from other individuals, tested for SARS-Cov-2, and medically evaluated.

- Test newly detained persons before they join the rest of the population in the detention facility. For further information, refer to the TESTING section below and CDC Interim Considerations for SARS-CoV-2 Testing in Correctional and Detention Facilities, available [here](#).
- Visitation:
  - Legal Visitation continues to be permitted unless and until it is determined to pose a risk to the safety and security of the facility.
    - Non-contact legal visitation should be offered first to limit exposure to detainees.
    - If the legal visitation requires direct personal contact, ICE will permit the visit but reinforce the recommendation for non-contact visitation.
    - When virtual visitation is not feasible, facilities will verbally screen all visitors on entry for symptoms of COVID-19 and perform temperature checks, when possible.
    - Legal representatives must wear PPE for an in-person visit with a detainee. If an in-person visit occurs and the legal representative does not have his or her own personal protective equipment (PPE), the facility should provide the PPE free of charge, based on availability.
    - ICE will continue to ensure that remote communication with legal representatives continues unimpeded via access to telephones, WebEx, Teams, or teleconference as available.
    - Facilities are required to establish a process for detained noncitizens/attorneys to schedule appointments and facilitate the calls. ICE ERO field offices should ensure such procedures are updated on [facility pages on ICE.gov](#).
    - Working with the various detention contractors and telephone service providers to ensure that all detainees receive some number of free calls per week.
  - For facilities at which immigration hearings are conducted, facility staff shall provide legal representatives in-person access to the court proceedings consistent with facility screening protocols and compliance with PPE requirements.
  - If social visitation programs are suspended, the facilities should provide access to virtual visitation options where available. When virtual visitation is not feasible, verbally screen all visitors on entry for symptoms of COVID-19 and perform temperature checks, when possible.

- Communicate with the public about any changes to facility operations, including both social and legal visitation programs.
- Facilities are required to suspend all volunteer work program (VWP) assignments for detainees assigned to food service and other VWP assignments, where applicable, that require individuals to interact with each other at distances of less than six feet. Any detainee participating in a VWP assignment is required to wear appropriate PPE for the position at all times (e.g., disposable gloves, masks, goggles). Detainees in isolation or quarantine may not be assigned to a VWP detail.

➤ Transporting Detained Individuals

- Transfers and transport of ICE detainees are discontinued unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, release or removal, or to prevent overcrowding.
  - Detainee transfers for any other reason require pre-approval from the local ERO Field Office Director.
  - All detainees who are transferred, removed, or released must be cleared medically in accordance with ERO guidelines.
    - o While medical clearance is still required, detainees who are fully vaccinated and do not have symptoms of COVID-19 do not require quarantine at intake, after transfer, or following exposure to suspected or confirmed COVID-19.
- When necessary to transport individuals with confirmed or suspected COVID-19, if the vehicle is not equipped with emergency medical service (EMS) features, at a minimum, drive with the windows down and ensure that the fan is set to high, in non-recirculating mode. If the vehicle has a ceiling hatch, keep it open. Everyone in the vehicle must wear a mask.
- Transport vehicles must be thoroughly cleaned after carrying a confirmed or suspected COVID-19 case.
- The CDC recommends use of the same precautions when transporting individuals under quarantine as close contacts of someone with COVID-19.
- See [here](#) for recommended PPE for staff transporting individuals with COVID-19.

➤ Require all staff (both medical and correctional) to wear PPE when encountering or interacting with any ICE detainee at a distance of less than six feet.

➤ Required PPE should always be worn by staff, even if separated by a distance of six feet or more, if the individual appears feverish or ill and/or with respiratory symptoms while interviewing, escorting, or interacting in other ways.

➤ Additional Measures to Facilitate Social Distancing:

- Although strict social distancing may not be possible in congregate settings such as detention facilities, all facilities housing ICE detainees should implement the

following measures to the extent practicable.

Efforts should be made to reduce the population to approximately 75 percent of capacity, with the understanding that, in some instances, the physical layout of some facilities may permit exceeding 75 percent capacity while still following CDC guidance. In such cases, facilities may do so, so long as they continue to abide by the CDC guidance.

- o Where detainee populations are such that cells are available, to the extent possible, house detainees in individual rooms.
- o Recommend that detainees sharing sleeping quarters sleep “head-to-foot.”
- o Extend recreation, law library, and meal hours and stagger detainee access to the same in order to limit the number of interactions between detainees from other housing units.
- o Staff and detainees should be directed to avoid congregating in groups of ten or more, employing social distancing strategies at all times.
- o Whenever possible, all staff and detainees should maintain a distance of six feet from one another.
- o If practicable, beds in housing units should be rearranged to allow for six feet of distance between the faces of detainees.
- If group activities are discontinued, it is important to identify alternative forms of activity to support the mental health of detainees
- Extended lockdowns must **not** be used as a means of COVID-19 prevention.

## **MANAGEMENT**

If there has been a suspected COVID-19 case inside the facility (among detained persons, staff, or visitors who have recently been inside), facilities shall begin implementing management strategies while test results are pending. Essential management strategies include placing cases and individuals with symptoms under medical isolation, quarantining their close contacts, and facilitating necessary medical care while observing relevant infection control and environmental disinfection protocols and wearing recommended PPE.

### *ICE Custody Review for Potentially Increased-Risk Detainees*

Upon being informed of a detainee is at increased risk for severe illness from exposure to COVID-19, ERO will review the case to determine whether continued detention is appropriate. ICE will make such custody determinations on a case-by-case basis, pursuant to the applicable legal standards, with due consideration of the public health considerations implicated.

- All new admissions will be tested, screened, and isolated as described in the above sections upon arrival.

- To do this, facilities should consider cohorting daily admissions; two days of new admissions, or multiple days of new admissions, in designated areas prior to placement into the general population. The Facility Administrator will determine the designated areas where new admissions will be held pending admission test results and any additional cohorting necessary if detainees are positive and those with direct contact to laboratory confirmed positives. Given significant variations among facilities, cohorting options and capabilities will differ across ICE's detention network. ICE encourages all facilities to adopt the most effective cohorting methods practicable based on the individual facility characteristics, taking into account the number of new admissions anticipated per day.
- Based on the results of testing and clinical evaluation, detainees at intake should be separated into multiple groups: Detainees who tested negative and have no symptoms, detainees who test positive but have no symptoms, and detainees who either test positive for COVID-19 and have symptoms or are diagnosed with COVID-19 based on symptoms.
- All new arrivals to ICE detention facilities require COVID-19 testing within 12 hours of arrival. Collection timeframe may extend to 24 hours if facility collection logistics require additional time. When additional time is required, the facility's medical provider shall notify the Facility Administrator as soon as possible.
- Detainees pending test results who are asymptomatic should be placed in a routine intake quarantine. Detainees pending test results who are symptomatic should be placed in isolation. Detainees who test negative during the intake process will complete the routine 10-day quarantine prior to release to general population.
- Detainees who test positive during the intake process must be isolated and can be released from isolation once they meet the criteria for discontinuing isolation described below using either a time-based strategy or symptom-based strategy.
- For suspected or confirmed COVID-19 cases:
  - Isolate the individual immediately in a separate environment from other individuals. Facilities should make every possible effort to isolate persons individually. Each isolated individual should be assigned his or her own housing space and bathroom where possible. Isolating ill detainees as a group should only be practiced if there are no other available options.
  - If single isolation rooms are unavailable, individuals with laboratory-confirmed COVID-19 should be isolated together as a cohort separate from other detainees, including those with pending tests. Febrile detainees who are pending testing or are waiting for test results should be isolated together as a group separate from laboratory-confirmed COVID-19 cases and other detainees. Confirmed COVID-19 cases must not be cohorted with suspected cases or case contacts.
  - Housing must maintain separation of groups by common criteria (e.g., COVID-19 test results positive, febrile, or symptomatic)

pending testing or results, asymptomatic/exposed).

- Ensure that the individual is always wearing a face mask (if it does not restrict breathing) when outside of the isolation space, and whenever another individual enters the isolation room. If wearing masks will negatively impact breathing, facilities should ensure caregivers are aware of that fact and implement restrictions on contact as appropriate during isolation (e.g., increased social distancing, PPE use by people who enter space, moving and handling people separately, increased cleaning, etc.). Masks must be changed at least daily, and when visibly soiled or wet.
- In the event that a facility requires more isolation beds for detainees, ICE must be promptly notified so that transfers to other facilities, transfers to hospitals, or releases can be coordinated immediately. Until such time as the transfer or release is arranged, the facility must be especially mindful of cases that are at increased risk of severe illness from COVID-19. Ideally, symptomatic detainees should not be isolated with other individuals. If isolating of symptomatic COVID-positive detainees as a group is unavoidable, make all possible accommodations until transfer occurs to prevent transmission of other infectious diseases to the increased-risk individual (e.g., allocate more space for an increased-risk individual within a shared isolation room).
- Review the CDC's preferred method of medically isolating COVID-19 cases [here](#), depending on the space available in a particular facility. In order of preference, individuals under medical isolation should be housed:
  - Separately, in single cells with solid walls (i.e., not bars) and solid doors that close fully
  - Separately, in single cells with solid walls but without solid doors.
  - As a cohort, in a large, well-ventilated cell with solid walls and a solid door that closes fully. Employ social distancing strategies related to housing in the Prevention section above.
  - As a cohort, in a large, well-ventilated cell with solid walls but without a solid door. Employ social distancing strategies related to housing in the Prevention section above.
  - As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)

- As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies related to housing in the Prevention section above.
- When detainees must be housed in the spaces used for administrative segregation, ensure that medical isolation, which is not punitive in nature, is **operationally** distinct from administrative or disciplinary segregation, even if the same housing spaces are used for both. For example:
  - Ensure that individuals under medical isolation receive regular visits from medical staff and have access to mental health services.
  - Ensure that detainees are provided similar access to radio, television, reading materials, personal property, telephone, recreation, and commissary to the fullest extent possible.
  - Consider allowing increased telephone privileges without a cost barrier to maintain mental health and connection with others while isolated.
  - Communicate regularly with isolated individuals about the duration and purpose of their medical isolation period.
- **Keep the individual’s movement outside the medical isolation space to an absolute minimum.**
  - Provide medical care to isolated individuals inside the medical isolation space unless they need to be transferred to a healthcare facility. See [Infection Control](#) and [Clinical Care](#) sections for additional details.
  - Serve meals inside the medical isolation space.
  - Exclude the individual from all group activities.
  - Assign the isolated individual(s) a dedicated bathroom when possible. When a dedicated bathroom is not feasible, do not reduce access to restrooms or showers as a result. Clean and disinfect areas used by infected individuals frequently on an ongoing basis during medical isolation.
- Meals should be provided to COVID-19 cases in their isolation rooms. Isolated cases should throw disposable food service items in the trash in their isolation room. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items must clean their hands after removing gloves.
- Laundry from a COVID-19 case can be washed with another individuals’ laundry.

- Individuals handling laundry from COVID-19 cases should wear disposable gloves, discard gloves after each use, and clean their hands after handling.
  - Do not shake dirty laundry. This will minimize the possibility of dispersing the virus through the air.
  - Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
  - Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that either is disposable or can be laundered.
- **Ensure that the individual is wearing a face mask if s/he must leave the medical isolation space for any reason, and whenever another individual enters.** Provide clean masks as needed. Masks should be washed routinely and changed when visibly soiled or wet.
  - **Maintain isolation until all the CDC criteria have been met.** These criteria have changed since CDC corrections guidance was originally issued and may continue to change as new data become available. Monitor the sites linked below regularly for updates. This content will not be outlined explicitly in this document due to the rapid pace of change.
    - CDC's recommended strategy for release from home-based isolation can be found in the [Ending Isolation and Precautions for People with COVID-19 Interim Guidance](#).
    - Detailed information about the data informing the symptom-based strategy, and considerations for extended isolation periods for persons in congregate settings including corrections, can be found [here](#).
    - If persons will require ongoing care by medical providers, discontinuation of transmission-based precautions (PPE) should be based on similar criteria found [here](#).

## TESTING

- With the increased availability of testing supplies and the increased understanding of the epidemiology of COVID-19 transmission, expanded testing strategies are a critical tool in the prevention and management of COVID-19 infections. This is especially true in congregate settings such as detention facilities.
  - All new admissions (including those fully vaccinated) to ICE detention facilities require COVID-19 testing within 12 hours of arrival. Collection timeframe may extend to 24 hours if facility collection logistics require additional time. When additional time is required, the facility's medical provider shall notify the Facility Administrator as soon as possible.

- Testing of all new admissions before they join the rest of the population in the facility, and housing them individually or in cohorts while test results are pending help prevent potential transmission.
- Consistent with CDC recommendations, facilities “considering diagnostic testing of people with possible COVID-19 should continue to work with their local and state health departments to coordinate testing through public health laboratories, or work with commercial or clinical laboratories using diagnostic tests authorized for emergency use by the U.S. Food and Drug Administration.”<sup>16</sup> Before testing large numbers of asymptomatic individuals without known or suspected exposure, facility leadership should have a plan in place for how they will modify operations based on test results. In addition, COVID-19 testing can be utilized at any time during detention to detect new cases of COVID-19, confirm detainee diagnosis, or in conjunction with other public health actions to control outbreaks of COVID-19. CDC recommendations on planning for facility wide testing may be found [here](#).
- CDC recommends SARS-CoV-2 testing with [viral tests](#) (i.e., nucleic acid or antigen tests) for:
    - Individuals with signs or symptoms consistent with COVID-19.
    - Asymptomatic individuals with recent known or suspected exposure to SARS-CoV-2 to control transmission.
      - To prevent continued transmission of the virus within a quarantined cohort, retesting those who originally tested negative every 3 to 7 days could be considered, until no new cases are identified for 10 days after the most recent positive result. The specific re-testing interval that a facility chooses could be based on the stage of the ongoing outbreak, the availability of testing supplies and capacity of staff to perform repeat testing, financial resources, the capacity of contract laboratories that will be performing the tests, and the expected wait time for test results.
    - Asymptomatic individuals without known or suspected exposure to SARS-CoV-2 for early identification in special settings.
      - While not mandated, the CDC recommends facilities consider quarantine before release or transfer of asymptomatic individuals without known or suspected exposure to COVID-19 when appropriate based on detainee history.
      - Detainees who previously tested positive for COVID-19 and were medically cleared could continue to test positive for a significant

<sup>16</sup> Attachment O, Centers of Disease Control and Prevention, *Overview of Testing for SARS-CoV-2 (COVID-19)*, <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html> (last visited February 14, 2022).

period of time.

- Individuals being tested to determine resolution of infection (i.e., [interim infection prevention and control recommendations for healthcare personnel, HCP Return to Work](#), and [Discontinuation of Home Isolation](#));
- Individuals being tested for purposes of public health surveillance for SARS-CoV-2.
- CDC recommends using [authorized nucleic acid or antigen detection assays](#) that have received an FDA EUA to test persons **with** symptoms when there is a concern of potential COVID-19.
- Testing is recommended for all close contacts of persons with SARS-CoV-2 infection. In some settings, broader testing, beyond close contacts, is recommended as a part of a strategy to control transmission of SARS-CoV-2. Expanded testing might include testing of individuals on the same unit or shift as someone with SARS-CoV-2 infection, or even testing all individuals within a shared setting (e.g., facility-wide testing). In areas where testing resources are limited, CDC has established a testing hierarchy for [close contacts](#).
- The CDC recommends that before release from quarantine, all detainees quarantined as [close contacts](#) of someone with COVID-19 (whether quarantined individually or as a cohort) should be re-tested at the end of the 10-day quarantine period, before quarantine precautions are lifted and before persons return to general housing areas. This can prevent transmission to others outside of quarantine in the event that an infection was not detected earlier in the quarantine period.
- CDC does not currently recommend [using antibody testing](#) as the sole basis for diagnosis of acute infection, and antibody tests are not authorized by FDA for such diagnostic purposes. For the most current information on CDC recommendations for antibody testing, please see [Interim Considerations for SARS-CoV-2 Testing in Correctional and Detention Facilities](#) and [Using Antibody Tests for COVID-19](#). For the most current CDC recommendations for viral testing and specimen collection, please see [Overview of Testing for SARS-CoV-2 \(COVID-19\)](#).

## ATTACHMENTS

ATTACHMENT LETTER	DOCUMENT NAME AND CITATION
A	U.S. Immigration and Customs Enforcement, <i>Updated ICE statement on COVID-19</i> (Mar. 18, 2020), <a href="https://www.ice.gov/news/releases/updated-ice-statement-covid-19">https://www.ice.gov/news/releases/updated-ice-statement-covid-19</a> .
B	Centers for Disease Control and Prevention, <i>Symptoms of Coronavirus</i> , <a href="https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html">https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html</a> (last visited February 14, 2022).
C	ICE National Detention Standards 2019, Standard 4.3, Medical Care, <a href="https://www.ice.gov/doclib/detention-standards/2019/4_3.pdf">https://www.ice.gov/doclib/detention-standards/2019/4_3.pdf</a> .
D	2011 ICE Performance-Based National Detention Standards, Revised 2016, Standard 4.3, <a href="https://www.ice.gov/doclib/detention-standards/2011/4-3.pdf">https://www.ice.gov/doclib/detention-standards/2011/4-3.pdf</a> .
E	2008 ICE Performance-Based National Detention Standards, Standard 4-22, Medical Care, <a href="https://www.ice.gov/doclib/dro/detention-standards/pdf/medical_care.pdf">https://www.ice.gov/doclib/dro/detention-standards/pdf/medical_care.pdf</a> .
F	Centers for Disease Control and Prevention, <i>Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities</i> (February 10, 2022), <a href="https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html">https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html</a> (last visited February 14, 2022).
G	Memorandum from Executive Associate Director Enrique Lucero, Enforcement and Removal Operations, <i>Memorandum on Coronavirus 2019 (COVID-19) Action Plan, Revision 1</i> (Mar. 27, 2020).
H	Centers for Disease Control and Prevention, <i>Quarantine and Isolation</i> (January 27, 2022), <a href="https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html">https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html</a> (last visited February 14, 2022).
I	Centers for Disease Control and Prevention, <i>Optimizing Supply of PPE, and Other Equipment during Shortages</i> , <a href="https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/">https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/</a> (last visited February 14, 2022).

ATTACHMENT LETTER	DOCUMENT NAME AND CITATION
J	Centers for Disease Control and Prevention, <i>Cleaning and Disinfecting Your Facility</i> , <a href="https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html">https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html</a> (last visited February 14, 2022).
K	U.S. Environmental Protection Agency, <i>List N: Disinfectants for Use Against SARS-CoV-2</i> , <a href="https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2">https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2</a> (last visited February 14, 2022).
L	Assistant Director Peter Berg, Enforcement and Removal Operations, <i>Updated Guidance: COVID-19 Detained Docket Review</i> (Apr. 4, 2020).
M	Centers for Disease Control and Prevention, <i>Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic</i> , <a href="https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html">https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html</a> (last visited February 14, 2022).
N	Centers for Disease Control and Prevention, <i>Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for COVID-19</i> , <a href="https://www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html">https://www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html</a> (last visited February 14, 2022).
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