Mount Sinai Human Rights Program
Icahn School of Medicine at Mount Sinai
℅ Elizabeth Singer MD, MPH Program Director
Department of Medical Education
One Gustave Levy Place
New York, NY 10029
mountsinaihrc@icahn.mssm.edu

Declaration of Dr. Elizabeth Singer (MD, MPH, FACEP)

Pursuant to 28 U.S.C. § 1746, I hereby declare as follows:

I. Background

1. I am Dr. Elizabeth Singer, an Associate Professor of Emergency Medicine and Medical Education at the Icahn School of Medicine at Mount Sinai, where I am faculty in the Global Health Division. As a fellow of the American College of Emergency Physicians, I am board certified in Emergency Medicine and completed residency training in both Internal Medicine and Emergency Medicine, at NYU School of Medicine/Bellevue and Mount Sinai School of Medicine, respectively. I received my medical degree from the State University of New York at Brooklyn, Downstate, and a Masters of Public Health degree from Columbia University's Mailman School of Public Health in the Forced Migration and Health Program, with a certificate in Public Health and Humanitarian Action (focusing on complex emergencies and post conflict environments).

2. I am the Executive Director of the Mount Sinai Human Rights Program, within the department of Medical Education at the Icahn School of Medicine, which provides direct services and medical care to asylum seekers to the United States, both in the community and in immigration detention centers and the prison system. I have also worked as a physician in the Manhattan Detention Complex in New York City, a jail facility which houses nearly 900 adult males. In addition, I am a cofounder of the New York City Refugee and Asylee Health Coalition, which creates a platform of communication between clinicians who treat refugees and asylum seekers, and disseminates information on emerging diseases, and I serve as a member on the American College of Emergency Physicians national committee on Public Health and Injury Prevention. I have written extensively on issues facing asylum seekers and those in immigration detention centers, and have served as a medical advisor to the ACLU in the assessment of the health rights and status of care for women and HIV-infected prisoners in the New Orleans Parish Prison.

3. As an attending physician in the Emergency Department at the Icahn School of Medicine at Mount Sinai, I work with underserved and vulnerable populations including those who are un-domiciled, incarcerated, trafficked, and those who are refugees and asylum seekers.

4. As a health care provider in an emergency department of a large urban healthcare system in New York City, I have been on the front lines treating patients with COVID-19 during the global pandemic and have a deep understanding of community spread of the disease, as well as epidemiologic models which predict a continued surge in cases and an increased case fatality rate.

5. My CV is attached as exhibit A and includes a full list of my experience, publications, and honors.

6. I am not being compensated in any fashion for my time preparing this declaration.

II. Profile of COVID-19

7. The novel coronavirus (SARS-CoV-2), and the resultant disease that has been given the name coronavirus disease 2019 (COVID-19), is now a global pandemic. As of April 15, 2020, there have been 2,016,020 confirmed cases of COVID-19 globally and 130,528 deaths, with the majority of new cases now occurring outside of mainland China.[1] In the United States there are currently 613,187 confirmed or presumptive cases of COVID-19 and 24,582 deaths, with 28,163 of those cases in Massachusetts.[1,2] The number of infections and deaths in the United States are likely underestimated due to lack of availability of widespread testing.

8. The transmission of SARS-CoV-2 is expected to grow exponentially, meaning that deaths will double at a constant rate.[3] The Centers for Disease Control and Prevention (CDC) has projected that 200,000 to 1.7 million people in the United States may die over the course of the pandemic without effective and proactive health interventions.[4]

9. The novel coronavirus is part of a family of viruses which gets its name from the characteristic crown-like viral particles (virions) that dot their surface.[5] The virus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) and may also survive on inanimate objects for a period of up to 72 hours. It is also possible to spread the virus through fecal-oral transmission which may result from poor handwashing or in close living quarters and shared bathroom spaces.[6] It is possible that people can transmit the virus when they are asymptomatic, before they show symptoms, or for weeks after their symptoms resolve. In epidemiology, the R0 value ("R-naught") is the expected number of cases generated directly by 1 case in a population, where all individuals are susceptible to infection, as is the case with COVID-19, because the human immune system has never been exposed to or developed protective responses to this virus. In China, where COVID-19 originated, the average infected person passed the virus on to 2-3 other people, a number higher than that of influenza, with transmission occurring at a distance of 3-6 feet.[7] Yet R0, the "contagiousness" of the virus, is a

---

[1] Johns Hopkins University Center for Systems Science and Engineering. *Coronavirus COVID-19 global cases by Johns Hopkins CSSE,* https://gisanddata.maps.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6. Accessed Apr. 15, 2020.

[2] Centers for Disease Control and Prevention. *Coronavirus Disease 2019 (COVID-19): Cases in the U.S.,* https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html. Accessed Apr. 15, 2020.

[3] Our World in Data. *Coronavirus Disease (COVID-19)- Statistics and Research,* https://ourworldindata.org/coronavirus. Accessed Apr. 15, 2020.

[4] Sheri Fink, *Worst-Case Estimates for U.S. Coronavirus Deaths* (Mar. 13, 2020), https://www.nytimes.com/2020/03/13/us/coronavirus-deaths-estimate.html.

[5] N van Doremalen, et al. *Aerosol and surface stability of HCoV-19 (SARS-CoV-2) compared to SARS-CoV-19*. The New England Journal of Medicine (2020), DOI: 10.1056/NEJMc2004973.

[6] Xiao F, Tang M, Zheng X, Liu Y, Li X, Shan H, *Evidence for gastrointestinal infection of SARS-CoV-2*, Gastroenterology (2020), DOI: 10.1053/j.gastro.2020.02.055.

[7] Riou J, Althaus CL. *Pattern of early human-to-human transmission of Wuhan 2019 novel coronavirus (2019-nCoV), December 2019 to January 2020*. Eurosurveillance (2020) DOI: 10.2807/1560-7917.ES.2020.25.4.2000058.

reflection of both virus behavior and human behavior, so with the correct societal and behavioral interventions this R0 value can be reduced.

10. COVID-19 may result in severe disease. Preliminary evidence suggests two strains of SARS-2-CoV are circulating: one associated with milder illness (~30%), the other with severe illness (70%).[8] Additionally, emerging data from China suggests that serious illness occurs in up to 16% of cases, including death.[9] Death from COVID-19 may results from respiratory failure, organ failure, and co-infection with other pathogens leading to sepsis.[10] Older patients and those with underlying diseases are at particularly high risk of severe disease.[11] The CDC and the American College of Cardiology have recognized that the following medical conditions may place anyone of any age at a greater risk of severe infection and death: cancer: 5.6% case fatality rate, hypertension: 6.0% case fatality rate, chronic respiratory disease: 6.3% case fatality rate, diabetes: 7.3% case fatality rate, cardiovascular disease: 10.5% case fatality rate.[12] In addition, current pregnancy or recent pregnancy may predispose women to a serious disease with COVID-19. In some people, even those without underlying medical issues, the disease may begin as a mild one and progress at a rapid rate resulting in acute respiratory distress syndrome (ARDS) and/or an over-reaction of the immune system leading to diffuse inflammation.[13]

11. At this time, there are no FDA-approved antiviral medications available, no vaccine exists, and there will likely not be one available to the general public for at least a year.

III. Effects on the Healthcare System and Community

12. Severe and even moderate COVID-19 disease does not only result in death. More often, it results in a prolonged illness which requires expensive hospital resources, supplemental oxygen support, intravenous fluids, antibiotics, the care of emergency medicine physicians, intensivists, respiratory therapists, and in severe cases ventilators, of which there are a severe national shortage. Those who recover may face long recovery periods, including chronic respiratory problems, and the need for rehabilitation. The emergence of COVID-19 during influenza season has also overwhelmed the healthcare system and means that people are also at risk of serious illness and death due to flu while this global COVID-19 pandemic is raging. The health care

---

[8] Johns Hopkins Medicine Point of Care–IT Guide. *Coronavirus COVID-19 (SARS-CoV-2)* https://www.hopkinsguides.com/hopkins/view/Johns_Hopkins_ABX_Guide/540747/all/Coronavirus_COVID_19__SARS_CoV_2. Accessed Mar. 24, 2020.

[9] Centers for Disease Control and Prevention. *Coronavirus Disease 2019 (COVID-19): Situation Summary*. Updated Mar. 21, 2020. https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html. Accessed Mar. 24, 2020.

[10] Hassan S, Sheikh F N, Jamal S, et al. *Coronavirus (COVID-19): A Review of Clinical Features, Diagnosis, and Treatment* (Mar. 21, 2020). Cureus 12(3): e7355. doi:10.7759/cureus.7355

[11] Fei Zhou, et al., *Clinical Course and Risk Factors for Mortality of Adult Inpatients with COVID-19 in Wuhan, China*. The Lancet (published online Mar. 11, 2020) https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext.

[12] *The Epidemiological Characteristics of an Outbreak of 2019 Novel Coronavirus Disease (COVID-19)*. *China CDC Weekly* 2020. 2(8): 1 DOI: 10.3760/cma.j.issn.0254-6450.2020.02.003.

[13] Mehta, P. et al., *COVID-19: Consider cytokine storm syndromes and immunosuppression*. The Lancet (published online Mar. 16, 2020) DOI: 10.1016/S0140-6736(20)30628-0.

system cannot support the weight of additional disease burden at this time. Every additional person who falls ills and requires medical care brings the entire system closer to collapse.

13. COVID-19 prevention strategies include containment and mitigation. Containment includes strict hand washing practices, decontamination of surfaces and intensive cleaning practices, identifying and isolating people who are ill, quarantining those who have had a known or probable exposure, and contact tracing. Most public health experts believe that in many parts of the United States, where the rates of disease spread are exceedingly high, containment strategies will no longer be effective. As infectious diseases spread in the community, public health demands intensified mitigation strategies such as social distancing, closures of communal and public spaces such as schools, workplaces, courts, sports arenas, and theaters in order to protect the most vulnerable from disease.

14. To effectively continue to support patients and limit the transmission of COVID-19, the healthcare system has deployed a public health strategy that is centuries old. This involves isolating those with a communicable disease from others who are healthy and uninfected and "grouping together patients who are colonized or infected with the same organism to confine their care to a single area and prevent contact with other patients." [14] The Health Care Infection Control Practices Advisory Committee (HICPAC) defines this as cohorting. In the hospital setting, patients whose symptoms are sufficiently severe to require hospital admission are tested for COVID-19 prior to admission. Once a patient is confirmed to have COVID-19, typically through a nasal or pharyngeal swab test, they are kept together with other patients who have tested positive for COVID-19 ("the COVID cohort"). Patients in the COVID cohort are always then kept fully separate from patients without the disease. Staff who treat the COVID cohort do so in full personal protective equipment (PPE) to reduce the risk of transmission to themselves, to their families, and to interrupt the spread of infection to non-COVID patients.

15. To expand capacity for isolation and cohorting, healthcare systems have set up floors or wards in hospitals where feasible. In order to accommodate the recent surge of COVID positive patients, new, temporary facilities have also been established in which COVID-19 positive patients are housed. For instance, the NGO Samaritan's Purse, in conjunction with Mount Sinai Health System, has deployed an emergency field hospital for seriously ill COVID-19 patients in New York's Central Park. The Javits Center and U.S.N.S. Comfort serve a similar population in order to treat COVID-19 patients while protecting non-COVID patients from risks of transmission.

IV. Immigration Detention Centers, Prisons, and Jails

16. On March 22, 2020 John Sanweg, the former acting director of Immigration and Customs Enforcement made a plea to release the thousands of nonviolent, low-flight-risk detainees currently in ICE custody.[15] On April 2, 2020, it was announced that a member of the medical staff at Bristol County House of Correction tested positive for coronavirus, the first case confirmed by the facility of an employee contracting the virus. On April 8, two additional staff members tested positive for the novel coronavirus (COVID-19).[16] On April 14, a fourth staff member was

---

[14] Siegel JD. Rhinehart E. Jackson M. Chiarello L. *Guideline for isolation precautions: Preventing transmission of infectious agents in health care settings*. Am J Infect Control. 2007;35:S65–S164.

[15] John Sandweg, *I Used to Run Ice. We Need to Release the Nonviolent Detainees*. The Atlantic (Mar. 22, 2020), https://www.theatlantic.com/ideas/archive/2020/03/release-ice-detainees/608536.

[16] Andrew Martinez, *Two Bristol County Sheriff's officers test positive for coronavirus, office says*, Boston Herald (Apr. 8, 2020, 12:49 PM), https://www.bostonherald.com/2020/04/08/two-bristol-county-sheriffs-officers-test-positive-for-coronavirus-office-says.

announced to have tested positive.[17] The risk posed by infectious diseases in detention centers, prisons, and jail settings is significantly higher than in the community in terms of transmission, exposure, and harm to individuals who become infected. There are several reasons that this is the case, as is delineated further below.

17. Globally, outbreaks of contagious diseases are common in confined detention settings and are more common than in the general community population. Although confined from the outside world, prisons and jails are not isolated communities and there is a steady stream of staff, contactors, and, until ICE suspended social visits, visitors.[18] All may bring illness into a facility, and there is no ability to thoroughly screen those who may be asymptomatic but propagating disease. Rapid turnover in jails and detention centers and transportation to court hearings or transfers between facilities may exacerbate the situation and increase exposure to those inside these communities.

18. Reduced prevention opportunities:
Immigration detention settings and jails are environments in which it is nearly impossible to avoid close contact and follow social distancing to stop the spread of the virus or disease. Person-to-person spread of disease, especially those passed by droplets through coughing, sneezing, is common when people live in close quarters sharing dining halls, showers, sleeping areas, and common spaces. Spaces within jails and detention centers are often poorly ventilated, a factor which promotes highly efficient transmission of disease through droplets. In addition, the fact that COVID-19 is also spread through the fecal-oral route makes shared bathroom spaces a nidus of infection. Placing someone in such a setting increases their susceptibility to an infectious disease and decreases their ability to protect themselves to exposure.

19. Reduced mitigation opportunities:
Although strict handwashing is recommended to prevent the spread of COVID-19, detention centers and prisons do not provide adequate opportunities to promote basic hygiene measures, such as handwashing or the use of alcohol-based sanitizers if handwashing is unavailable. Detention centers, prisons, and jails are often under-resourced with sufficient hand soap and alcohol-based cleaning products for both staff and detainees. High-touch surfaces, such as doorknobs and light switches, should also be cleaned and disinfected regularly with a bleach-based solution to prevent virus spread. However, this is often not done in these facilities.

20. Lack of containment and isolation areas:
Isolation and containment strategies for people who are symptomatic are necessary in an infectious disease outbreak. However, detention centers, prisons, and jails often lack a sufficient number of isolation rooms, including negative pressure rooms, which specifically prevent infection from droplet-borne diseases. In cases where a facility may have a negative pressure room, it may already be in use for people with other highly infectious conditions, such as tuberculosis or influenza, thus preventing containment. In addition, these facilities are often ill equipped to provide sufficient personal protective equipment, such as gloves, masks, protective gowns, and face shields or goggles to inmates and to care-giving staff. This in turn increases everyone's disease exposure and the chance of widespread outbreak of disease, and makes caring for incarcerated people more difficult. Solitary confinement that is not conducted in a negative

[17] Kate Robinson, *Fourth worker at Dartmouth jail tests positive for Covid-19*, Dartmouth Week (Apr. 14, 2020), https://dartmouth.theweektoday.com/article/fourth-worker-dartmouth-jail-tests-positive-covid-19/47488.

[18] U.S. Immigration and Customs Enforcement. *ICE Guidance on COVID*-19 (Mar. 18, 2020), https://www.ice.gov/news/releases/updated-ice-statement-covid-19. Accessed Mar. 24, 2020.

pressure room is not an effective disease containment strategy since droplets are still spread to the rest of the facility placing staff and other inmates at risk.

21. Increased susceptibility:
People incarcerated in jails and prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the general population.[19] This is because people in these facilities are more likely than people in the community to have chronic underlying health conditions, such as diabetes heart disease, chronic lung disease, and lower immune system functioning secondary to HIV disease. In addition, language barriers often encountered in immigration detention centers present an additional barrier to care and may decrease the likelihood of someone with symptoms of disease being discovered. This in turn limits the ability to monitor these people and increases the chance that they will progress to more severe disease.

22. Lack of access to resources:
Some detention centers, jails, and prisons lack 24-hour medical care and none have access to community health resources that are crucial to identifying and managing widespread outbreaks of infectious diseases, such as laboratories and testing equipment. Detention centers, prisons, and jails can provide a basic level of care, but rely upon hospitals and emergency departments to provide more comprehensive care. During a pandemic, such places providing higher care are overburdened and may be unable to accept additional patients which may lead to poor outcomes or even death.

23. Supply chain, health, and safety:
Global pandemics, such as COVID-19, disrupt the supply chain of medicines and pose a risk of food insecurity. Without medications to treat chronic diseases and with decreased nutrition in detention centers, prisons, and jails people within the system may see their underlying chronic medical and mental health conditions deteriorate. Medical personnel within the facilities may also fall ill, adding to the unsafe circumstances and reducing the level of care provided. As an outbreak spreads throughout a detention center or jail, correctional officers and security personnel may also fall ill and not be able to work. Absenteeism and understaffing pose risks to those inside the facilities as well as to the general public.

24. These risks have all been borne out in prior epidemics of influenza in prison populations. For example, in 2012 the CDC reported an outbreak of influenza in two facilities in Maine, resulting in two inmate deaths.[20] A subsequent CDC investigation of 995 inmates and 235 staff members across the two facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for those who were exposed. During the H1N1-strain flu outbreak in 2009 (known as the "swine flu"), jails and prisons experienced a disproportionately high number of cases.[21] H1N1 is far less contagious than COVID-19, and these situations occurred in the "best case" of influenza, a viral infection for which there was an available vaccine and antiviral medication. COVID-19 has neither available.

---

[19] *Active case finding for communicable diseases in prisons,* 391 The Lancet 2186 (2018), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31251-0/fulltext.

[20] *Influenza Outbreaks at Two Correctional Facilities-Maine, March 2011*, Centers for Disease Control and Prevention (Apr. 6, 2012), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm

[21] David M. Reutter, *Swine Flu Widespread in Prisons and Jails, but Deaths are Few*, Prison Legal News (Feb. 15, 2010), https://www.prisonlegalnews.org/news/2010/feb/15/swine-flu-widespread-in-prisons-and-jails-but-deaths-are-few/.

25. Based upon all the available facts about detention centers, prisons, and jails and based upon the precedents of prior infectious disease epidemics within correctional facilities, there is more than sufficient evidence to suggest that these facilities are ill equipped to handle the rapid spread of SARS-CoV-2. In fact, the Hubei Provincial Health Committee reported that over 500 prisoners fell ill at the peak of the COVID-19 outbreak in China. We have already seen an example of rapid spread of COVID-19 in a facility with close living quarters: the Life Care Center of Kirkland, Washington at which two-thirds of residents have tested positive for the virus.[22] The first confirmed case was identified on February 18, 2020; by March 18, 167 confirmed cases were tied to the facility, with 54.5% of facility residents hospitalized.[23] We can expect spread of COVID-19 in a similar manner in detention centers, prisons, and jails.

26. ICE detention centers are extremely susceptible to outbreaks of infectious diseases. The design of these facilities, like prisons and jails, requires inmates to remain in close contact with one another—the opposite of the social distancing now recommended for stopping the spread of the often fatal COVID-19.

27. Based on my experience working with detainees in local jails and immigration detention centers, my experience evaluating HIV disease in a prison system, my experience working with vulnerable populations, my training in public health, and thorough review of the pertinent literature, it is my professional judgment that these facilities are underequipped to prevent an outbreak of disease and that individuals detained there are at an exceptionally high risk of infection with COVID-19 and are at a greater risk of harm, should they become infected, than the community at large. In addition, any outbreak within the detention and jail system would also affect staff members, and would have disastrous consequences on the already overburdened health care system at the very moment when public health measures have been instituted to attempt to flatten the curve of disease and decrease its incidence.

V. Conditions at Bristol County House of Correction

28. I have reviewed materials submitted in this case to inform my opinion about the safety of continued confinement in BCHOC. The materials I reviewed include Defendant's videos of C. Carlos Carreiro ICE Unit A produced on April 8, the Court's April 8 order regarding the facility (ECF 64) and declarations of detained individuals (ECF 12-4, 12-8, 33-2), an attorney (ECF 12-3), the Sheriff (ECF 26-1), Superintendent Souza (ECF 83-1) and scale diagrams of the facilities (Declaration of Jen Shin, Exhibits B, C, D).

29. Based on my review of the diagrams of the BCHOC and the declarations from BCHOC officials, it is is my opinion that it is impossible for detained individuals to maintain social distancing in the congregate living quarters in the C. Carlos Carreiro ICE Units A and B, Shin Decl., Exh. B, and the congregate living quarters in the 2 East Unit, id., Exh. C.

30. The diagrams clearly show that the current density of individuals in these congregate living quarters makes it physically impossible for detained individuals to maintain 6-feet of distance from others at all times. The physical impossibility of maintaining social distancing is necessarily

---

[22] Jack Health and Serge F. Kovaleski, *The Coronavirus's Rampage Through a Suburban Nursing Home* (Mar. 21, 2020), https://www.nytimes.com/2020/03/21/us/coronavirus-nursing-home-kirkland-life-care.html.

[23] McMichael, T. et al. *Epidemiology of Covid-19 in a Long-Term Care Facility in King County, Washington*, The New England Journal of Medicine (2020), doi: 10.1056/NEJMoa2005412.

true during the night when individuals are forced to sleep in an open environment, densely packed with bunk beds.

31. Moreover, it is impossible for the current density of detained individuals to maintain social distancing in the shared bathrooms in each of the four BCHOC facilities. See Shin Decl., Exh. B, C, D.

32. I agree with the Court's finding that social distancing is impossible in the 2 East Unit. ECF 64, at 6 ("In one unit the 'cell size' is listed as 30 feet by 10 feet (300 square feet), and the photo shows three bunk beds (sleeping six people) lining the wall. Other images supplied include a photo labeled 'Bunk Area' that shows a large room packed with rows of bunk beds. None appears to maintain the minimum six feet of isolation").

33. Neither is cohorting of COVID-19 infected individuals a viable option for preventing the spread of the virus in BCHOC. It is important to reiterate that the above description of cohorting requires mass testing for a pathogen in all individuals in a given population or isolating affected individuals based upon symptoms experienced, at which point COVID-19 is already transmissible to others. Presently, I see no indication that any testing of detained individuals is taking place at all. Even if there were to be mass testing available (which, as described below, is unlikely given current resource constraints and the limited access to such resources in jail settings), another notable issue is that the sensitivity of a single nasopharyngeal swab COVID-19 RT-PCR test early in the course of disease is only 70%.[24] Thus, even if BCHOC were to radically change its practices and institute mass testing to implement cohorting, such a move is unlikely to be effective because the high rate of false negatives could lead to continued spread of the disease among the vulnerable and captive population.

34. My conclusions about the physical impossibility for detainees to engage in social distancing given the inherent features of the congregate living quarters and current population densities in the C. Carlos Carreiro Units and 2 East Unit confirm what individuals who have been inside those facilities have described in court filings. See e.g., ECF 12-8 ¶ 6 ("I am not able to engage in 'social distancing").

35. Furthermore, based on my review of the materials provided to me, it is my opinion that the practices and procedures for sanitation and hygiene currently in place at the facility are inadequate to adequately ensure the safety of individuals detained at BCHOC. The following statements inform my view:

    a. "Only four out of six showers work." ECF 33-2 at ¶17.

    b. "My clients have informed me that the Unit has access to six showers, of which four are currently operational. Additionally, they have access to four urinals, of which two are operational. My clients have told me that soap is watered down and inadequate for proper hygiene." ECF 12-3 at ¶7.

    c. "There's no toilet paper, no napkins in the bathroom. No one has been able to wipe any surfaces. The soap that we use is watered down. When the officers bring it out for us to

[24] Fang Y, Zhang H, Xie J, et al. *Sensitivity of chest CT for COVID-19: comparison to RT-PCR*. Radiology. 2020:200432. [PMID: 32073353] doi:10.1148/radiol.2020200432

wash our hands, we are pretty much just washing our hands with water." ECF 12-4, at ¶7.

d. Although it has been stated by those in charge of BCHOC that "All housing units are sanitized no less than three times per day. Fresh air is constantly circulated by opening windows and utilizing handler/vents throughout the day," ECF 26-1 at ¶6(f), detained individuals dispute that characterization. "We do not have any supplies to keep things clean here – no bleach, no disinfectant, nothing. I help out with sweeping and mopping before lunch and I help clean the bathroom, so I know the cleaning supplies. When you clean bathrooms, you are supposed to use bleach." ECF 12-4 at ¶8. See also ECF 12-3 at ¶8 ("My clients and the other Unit B detainees are responsible for cleaning the unit. My clients have informed me that until the past few days, they were not allocated bleach, adequate scrub-brushes, or sufficient soap for this purpose. Despite this recent improvement, my clients do not believe they have the training or supplies necessarily to disinfect their living space to prevent spread of COVID-19").

36. Because detained individuals are tasked with cleaning the facility, and are given insufficient personal protective equipment and inadequate cleaning supplies, the procedures above heighten the risk of exposing a large number of individuals to infection. Individuals may be asymptomatic carriers of the infection and Defendant has not described any testing procedures that are currently taking place among detained individuals. Based on the materials filed in this case, Defendant has failed to indicate whether they have tested even a single detained individual. Therefore, there is no way to know who and how many individuals are infected. Moreover, at least 4 staff members at the facility have tested positive for infection with COVID-19. In light of these circumstances and because untested, potentially infected, detained individuals are required to clean and otherwise manipulate the surfaces that all other share without proper equipment and supplies, the risk of exposure to the virus and disease is substantial.

VI. Conclusions and Recommendations:

37. It is my professional judgement that individuals placed in ICE detention at Bristol County House of Correction—especially those in the C. Carlos Carreiro Units A and B and the 2 East Unit—are at a significantly higher risk of COVID-19 infection compared with the general community, and given the underlying medical vulnerabilities known to exist in many detainees, that they are at higher risk of complications and poor outcome if they do become infected.

a. The most critical factor increasing the risk of harm to individuals at BCHOC is that many—including all of the individuals in the C. Carlos Carreiro Units A and B and 2 East Unit —are forced to sleep in the congregate settings in bunk beds. These dense, dormitory-style settings enable transmission of COVID-19.

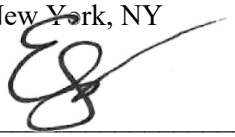
b. Moreover, the use of communal toilets, sinks and showers, of which only some are functional, enables transmission of COVID-19.

c. Lack of access to personal hygiene products, including hand soap, prevents these individuals from practicing correct handwashing procedures, enabling the transmission of COVID-19.

d. Lack of access to appropriate sanitizing products and/or correct sanitizing procedures risks enabling the transmission of COVID-19.

38. Given that no vaccine or evidence-based treatment exists for COVID-19, that the only viable public health strategy available in the U.S. currently is risk mitigation, and that such risk mitigation cannot be achieved at the current population density level at BCHOC, it my professional opinion that the facility cannot adequately protect individuals in its custody from the harmful risks of infection. This is particularly true in the C. Carlos Carreiro Units A and B and the 2 East Unit because those units are dense, congregate living environments in which it is physically impossible to maintain social distancing.

I declare under penalty of perjury that the forgoing is true and correct.
Executed this 15th day of April, 2020
New York, NY



Elizabeth Singer, MD., MPH