UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

JANET MALAM, Petitioner-Plaintiff, and QAID ALHALMI *et al.*, Plaintiff-Intervenors, - against - REBECCA ADDUCCI, *et al.*, Respondent-Defendants.	No. 5:20-cv-10829-JEL-APP

EXPERT REPORT ON FACILITY INSPECTION

Pursuant to the Court's Order for In-Person Facility Inspection by Plaintiffs' Expert, ECF No. 439, Plaintiffs respectfully submit the attached report prepared by expert, Dr. Homer Venters. Following the recent COVID-19 outbreak, the Court ordered this expert inspection to determine the current conditions at the Calhoun County Correctional Facility ("Calhoun"). ECF No. 439, PageID.11435. The Court noted that information out of the inspection is necessary to consider whether any additional relief is needed. *Id*.

As thoroughly detailed and analyzed in Dr. Venters' report, the facility inspection confirms what this Court has previously found and Plaintiffs continue to raise: although "the facility belatedly adopted long-accepted precautions" following the October/November 2020 outbreaks, there are "fundamental, structural issues remain[ing] that Calhoun has either overlooked or explicitly chosen to ignore," including the inability to social distance, the lack of comprehensive, universal testing, and the inadequate screening for COVID-19 symptoms. Expert Report at 3. Calhoun's failure to review or even acknowledge their lack of response to multiple reports of COVID-19 symptoms in October reflects that, short of identifying cases among new admissions, Calhoun is ill-equipped to catch the next set of cases among the general population until infection has already spread. *Id.* at 4. For individuals who face a higher likelihood of serious illness or death from COVID-19, the risk of infection—particularly with the threat of a new, more transmissible strain of

COVID-19—is too high to justify their continued detention. *Id.* at 3-4. Dr. Venters concludes that:

> The current situation puts all detainees at Calhoun at risk. However, for individuals who face a higher risk of serious illness or death from COVID-19, this setting presents a serious danger because Calhoun is unlikely to prevent the entry of new infections and, more importantly, does not have the systems in place to adequately catch and prevent transmission of new infections, particularly those outside the new admissions quarantine units.

Id. at 63.

Therefore, Plaintiffs continue to raise substantial claims of law for habeas litigation group members, and COVID-19 continues to present special circumstances making bail applications exceptional. *See Dotson v. Clark*, 900 F.2d 77, 79 (6th Cir. 1990); *Yanish v. Barber*, 73 S. Ct. 1105 (1953); *Aronson v. May*, 85 S. Ct. 3 (1964) (Douglas, J., in chambers); *see also* Ninth Bail Order, ECF No. 430, PageID.11348; ECF No. 455 (Tenth Bail Order), PageID.11699; ECF No. 456 (Eleventh Bail Order), PageID.11706; ECF No. 475 (Fourteenth Bail Order). The Court should continue to adjudicate bail applications as expeditiously as possible while the rebuttal and sur-rebuttal expert reports are being completed—especially as that process will take at least another four weeks—and should thereafter address what further relief should be granted in light of these findings.

Dated: January 7, 2020

Respectfully submitted,

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*Application for admission forthcoming

CERTIFICATE OF SERVICE

I, Jeannie S. Rhee, certify that on January 7, 2020, I caused a true and correct copy of the foregoing document to be filed and served electronically via the ECF system. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system.

Respectfully submitted,

/s/ Jeannie S. Rhee

COVID-19 INSPECTION AND REPORT OF CALHOUN COUNTY CORRECTIONAL FACILITY BY DR. HOMER VENTERS

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A. Introduction

1. My name is Homer Venters. I have previously submitted various declarations in this action, *Malam v. Adducci*, No. 5:20-cv-10829-JEL-APP (E.D. Mich.) regarding the policies and practices of Immigration and Customs Enforcement ("ICE") at the Calhoun County Correctional Facility ("Calhoun") and how Plaintiffs are at risk of significant harm or death due to COVID-19.

2. As explained in my prior declarations, I am a physician, internist, and epidemiologist with over a decade of experience in providing, improving and leading health services for incarcerated people. My experience in correctional health includes two years visiting immigration detention centers and conducting analyses of physical and mental health policies and procedures for persons detained by the U.S. Department of Homeland Security. This work included and resulted in collaboration with ICE on numerous individual cases of medical release, formulation of health-related policies as well as testimony before the United States Congress regarding mortality inside ICE detention

facilities. I have also worked in various leadership positions at the New York City Jail Correctional Health Service, and then at Physicians for Human Rights and Community Oriented Correctional Health Services. Since March 2020, I have served as a medical expert in the areas of correctional health and COVID-19 response in detention settings in over 30 cases. Since April 2020, I have conducted physical inspections of 19 federal, state and local detention facilities to assess the adequacy of their COVID-19 responses. I also serve as an independent court-appointed monitor for the Connecticut State Prisons to provide continuing oversight of their COVID-19 response, as well as an independent court-appointed monitor to oversee the entire health service in the Santa Barbara County Jail and the Fluvanna Women's Correctional Institution in the Virginia Department of Correction.

3. I am attaching an updated curriculum vitae (Appendix A). The only relevant change in my background and experience since November 20, 2020, when I last submitted my curriculum vitae with the declaration at ECF No. 419-4, is that I have conducted court-ordered inspections relating to COVID-19 response in additional facilities (Dallas County Jail, Texas Cheshire Correctional Institution) and I have been named as the independent health monitor of the Fluvanna Women's Correctional Center in Virginia.

4. On December 3, 2020, the Honorable Judge Judith E. Levy ordered an in-person expert inspection to assess the current conditions at Calhoun and determine whether Plaintiffs remain at risk of harm from COVID-19 following the outbreaks in October/November 2020 and the changes in Calhoun's protocols.

5. This report is submitted in response to my in-person inspection of Calhoun on December 17, 2020.

6. The report will proceed as follows: after previewing my recommendations, (i) first, I will describe my methodology, including the records I reviewed in conjunction with the facility inspection and associated interviews; (ii) next, I describe the inspection itself, including information presented by staff and detainees both during the inspection and in subsequent interviews; (iii) then, I make findings based on the inspection and records review; and, (iv) lastly, I close with my recommendations and conclusions about Calhoun.

7. As a caveat, this report is written on the assumption that COVID-19 vaccines will not be available to staff or detainees at Calhoun for at least several months, if not longer. The availability of vaccination is on the horizon but at this point, the timeline for its availability for Calhoun is not yet known and so stringent precautions against COVID-19 remain necessary, particularly as cases continue to rise and the more contagious variant of the coronavirus (known as B.1.1.7) spreads through more states. Recommendations on vaccination can be covered in a future declaration if the Court wishes.

8. As I explain further below, it is notable what Calhoun has and has not done since the outbreaks took place in late October to early November 2020. On the one hand, the facility belatedly adopted long-accepted precautions, such as mandated universal mask-wearing and somewhat more testing. There have been some improvements to social distancing through single-celled housing for high risk individuals, an increase in availability of hygiene products and personal protective equipment ("PPE"), and increased attention paid to mask compliance and quarantine practices. On the other hand, fundamental, structural issues remain that Calhoun has either overlooked or explicitly chosen to ignore. To highlight a few, the facility continues to over-rely on their new admission quarantine and testing policies even though there have been repeated violations of such policies and the fact that these policies were not enough to prevent the previous outbreaks and will not be enough to prevent future outbreaks; testing is not universal for all detainees, inmates and staff; Calhoun has discontinued COVID-19 symptom monitoring in quarantine units and fails to proactively screen for symptoms among high-risk and COVID-19 positive patients, especially in Spanish or other languages; social distancing is not possible for most detainees who are not single-celled and for all detainees receiving medication, which disproportionately impacts those with underlying conditions; and, despite never identifying the source of the outbreaks, Calhoun staff have not reviewed their medical records or undergone any assessment to determine how to improve their responses to sick call requests.

9. My most serious concerns are that the recent outbreaks in the G and H housing units reflect a lack of response to multiple people reporting clear COVID-19 symptoms to health and security staff, that the facility's health service does not recognize the danger of this inaction almost one year into the pandemic, and that after many rounds of Centers for Disease Control and

Prevention ("CDC") guidance on the necessary life-saving measures, Calhoun has still failed to implement those measures.

10. These lapses mean that, short of identifying cases among new admissions—a step that is necessary but incomplete by itself—Calhoun is ill-equipped to catch the next set of cases among the general population, which could quickly lead to further infection. While Calhoun was fortunate not to have seen any hospitalizations or deaths from the recent outbreaks, detainees are still experiencing long-term side effects from their illnesses (which the facility is also failing to monitor), and Calhoun may not be so lucky in future outbreaks. The threat of the new, more transmissible strain of COVID-19 provides even more cause for concern for high-risk individuals in a setting like Calhoun.

11. For these reasons and others elaborated below, my top recommendation is to continue prioritizing those at higher risk for serious illness or death from COVID-19 to be released from detention. High-risk people should not be detained at Calhoun unless there is no safe way for them to be supervised in the community.

12. While my report includes many recommendations, which are summarized in Section B and set out more fully in Section H, not all recommendations will have equal impact. In addition to release of high-risk individuals, the most important changes, in my opinion are:

    a. Implementing a system that timely and adequately identifies all high-risk people at Calhoun.

    b. Promptly identifying all infected individuals by ensuring a timely response to individuals reporting COVID-19 symptoms, tracking all such sick call requests, and implementing daily COVID-19 screening for high-risk individuals and for quarantine and isolation units that includes questioning about symptoms with adequate provisions for translation.

    c. Ensuring that Calhoun is consistently following all of its protocols related to COVID-19.

    d. Reducing population levels to allow for greater social distancing.

B. Summary of Recommendations

13. The following is a chart summarizing the recommendations I make in this report under Section H, organized into three categories: (i) recommendations in response to structural issues at Calhoun; (ii) new policies and protocols that Calhoun should adopt; and, (iii) existing policies that should be consistently implemented.

SUMMARY OF RECOMMENDATIONS	

Structural Issues to Address	Because of the inherent dangers of Calhoun's congregate setting, coupled with the shortcomings outlined in this report, and short of changing the physical structure of Calhoun:
	• Do not detain high-risk people unless there is no safe way for them to be supervised in the community.
	• Implement a system that timely and adequately identifies all high-risk people at Calhoun, including:
	  • Accurately define "high-risk" to include all CDC factors and individuals with multiple threshold risk factors.
	  • Comprehensively screen all incoming detainees.
	  • Ensure prompt physician or physician assistant review of risk determination, including review of medication prescriptions.
	  • Ensure prompt reassessment upon new diagnosis or prescription.
	  • Maintain separate list of high-risk individuals.
	  • Conduct regular dedicated medical encounters for high-risk individuals.
	• Reduce population levels to allow for a minimum of six feet of social distancing for all detainees:

SUMMARY OF RECOMMENDATIONS	
	• Limit new intakes and transfers. • Implement single-celled housing for all detainees in a non-punitive manner. • Train staff on effective social distancing for meal times, medication lines, and general usage of common spaces.
New Policies and Practices to Adopt	Calhoun has never adopted or discontinued certain policies and practices that are necessary to prevent or slow the introduction and transmission of COVID-19 inside the facility. In this category, I recommend: • Ensure that all individuals reporting any COVID-19 symptom and all close contacts (both staff and detainees/inmates) are promptly tested and fully quarantined while awaiting test results. • Inform detainees and inmates of test results within 24 hours of their receipt. • Administratively track and monitor all cases in which an individual has reported COVID-19 symptoms. • Restart daily COVID-19 screening for all individuals in new admission quarantine. • Explicitly develop protocols for contact tracing, including adopting the CDC definition of close contact. • Test and provide daily symptom monitoring for all close contacts and suspected cases of COVID-19. • Provide regular biweekly testing of all individuals detained at Calhoun.

SUMMARY OF RECOMMENDATIONS	
	• Employ additional infection control staff to do COVID-19 screenings and timely respond to sick call requests. • Retain an infection control nurse to review the recent outbreaks and make recommendations to the facility on improving current practices. • Design and implement a cleaning/disinfecting protocol for responding to new cases of COVID-19 that meets CDC criteria and does not rely on untrained and unequipped detained people to do this work. • Ensure that all health and security staff are fit-tested for N95 masks.
Existing Policies to Implement	Calhoun states that it has adopted the following protocols, but there are reports to the contrary arising out of the inspection. Thus, in this category, I recommend that the facility ensure that the following measures are consistently implemented in practice: • Ensure that all incoming detainees and inmates are not placed into the general population until they have cleared two rounds of COVID-19 testing and two weeks (or current CDC guidelines) of proper quarantine. • Ensure all COVID-19 screenings include proactive questioning regarding COVID-19 symptoms with adequate provisions for translation during these encounters. • Provide daily COVID-19 screenings and bi-weekly testing for individuals in work crews.

SUMMARY OF RECOMMENDATIONS	
	• Ensure all individuals who test positive for COVID-19 are cared for in medical isolation in a manner that is consistent with CDC standards, based on days without symptoms or follow-up testing. • Ensure that detainees have regular access to soap, paper towels, and hand sanitizer. • Provide all detainees with two cloth masks that are regularly laundered (twice a week), as well as the offer of one new surgical mask each day. • Clean and disinfect pulse oximeters and other medical equipment utilized in daily screenings and other health services between uses. • Ensure that all individuals who have tested positive for COVID-19 have a dedicated post-COVID-19 encounter with a physician or physician assistant one to two weeks after leaving medical isolation. • Ensure that detainees are not retaliated against for "over-kiting" or requesting COVID-19 protection, testing, and/or medical treatment. • Provide regular biweekly testing of all staff, including contractors, working at Calhoun.

C. Methodology

14. The goal of my inspection of Calhoun was to assess the adequacy of the facility's current response to COVID-19. In order to achieve this goal, I focused on three basic questions:

    a. Does the facility adequately identify and respond to individual cases of COVID-19?

    b. Does the facility adequately implement infection control, social distancing and other measures to prevent and slow the spread of the virus?

    c. Does the facility adequately identify and protect high-risk patients?

    These questions are interrelated in that all three domains are essential to an adequate COVID-19 response and they rely on each other to be effective. Adequacy is determined using guidelines of the CDC relating to COVID-19 in detention settings as well as basic correctional health standards.[1] Policies reported or produced by Calhoun have also been utilized to assess adequacy, and many of the questions I posed to staff and detained people were framed to elicit their understanding of the policies in place, and whether and how they were being implemented. The adequacy of Calhoun's response to COVID-19 is presented under the Findings section of this report, and suggestions for addressing the deficiencies are set out in the Recommendations section.

15. Physical inspection of Calhoun was conducted on December 17, 2020 with Chief Deputy Randy A. Hazel, other security staff members (Lieutenant Tracy Chambers, Lieutenant Kevin Hirakis, Deputy Brandi Luedecking, and Deputy Zachary Fenner), the Health Service Administrator ("HSA"), Jessica Patrick, a Physician's Assistant ("PA"), Ron Applebey, and the expert retained by Defendants, Dr. Owen Murray. I was also accompanied by a Spanish-English interpreter, Tamara Brubaker. Counsel for Plaintiffs, Defendants, Calhoun and Corizon Inc. ("Corizon") (the contracted health care provider) were able to

[1] Centers for Disease Control and Prevention, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* (updated Dec. 31, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.

observe the inspection via video feed, with the exception of confidential detainee interviews. None of the counsel asked questions during the inspection, although Plaintiffs' counsel repeatedly raised concerns about the difficulty of hearing what was said. In addition to the zoom recording, which was done on a tablet, a Calhoun staff member videotaped the inspection.

16. During the inspection, staff permitted me access to any part of the facility that was included in the inspection protocol and were helpful in orienting me to the overall layout and operations of the facility. Facility leadership inquired several times to ensure that all of the areas I intended to inspect and which were covered by the Court's order were made available and there was no effort by leadership or staff to hurry or otherwise limit my ability to conduct the inspection. The scope of my inspection was, however, constrained by the eight-hour time limit on the inspection, and there are additional areas I would have viewed and more people I would have interviewed in-person had I had more time. I was able to have brief confidential conversations in housing areas with detained people, able to speak with staff along the path of the inspection, and also meet with detained people in an office in the intake area. I spoke with a total of 27 detained people during the inspection itself. Translation services for Spanish were provided by Ms. Brubaker, who was an extremely skilled in-person interpreter, and I used a language line phone when appropriate in speaking with other detained people (for Mandarin Chinese). The interpreter also assisted in instances when I reviewed the kiosk submissions in housing units of detained people who were Spanish-speaking.

17. In preparation for this report, in addition to the inspection itself, interviews, and documents I had reviewed for prior declarations, I reviewed the following documents:

    a. Documents produced by Defendants pursuant to the Court's pre-inspection order (INSP 1-2424)[2];

    b. Defendants' Memorandum Submitting Documents Requested in Eleventh Bail Order, dated December 23, 2020, and attached exhibits;

    c. Defendants' Supplemental Sealed Exhibit Submitting Documents Requested in Eleventh Bail Order, dated January 6, 2021;

[2] An index of these documents is provided in Appendix B.

d. Emails from Defendants' counsel, dated December 28, 2020, and January 4, 5 and 6, 2021;

e. Calhoun ICE detainee lists showing housing assignments (i.e., housing reports), dated September 18, 30, October 7, 14, 21, 28, November 4, 11, 18, 25, and December 2, 9, 16, 23, and 30, 2020;

f. Calhoun ICE detainee COVID-19 testing logs, dated November 2, 18, 25, and December 2, 9, 16, 23, and 30, 2020;

g. Declaration of Aaron Haier, dated January 7, 2021, regarding housing reports and testing logs, attached as Exhibit A;

h. Declaration by Sarah Maneval, dated January 7, 2021, regarding documents produced by Defendants like sick call requests and COVID-19 screening forms, attached as Exhibit B; and

i. Declaration by Darren Gardner, dated January 7, 2021, regarding conceded high-risk individuals, attached as Exhibit C.

18. I understand that the Court order required many of these documents to be provided five days in advance of the inspection. Only some of the documents were provided in advance (INSP 1-1176), requiring a delay in the preparation of this report. After Plaintiffs' counsel identified the deficiencies, Defendants produced some additional documents (INSP 1177-2424) over multiple, separate installments between December 21, 2020 and January 6, 2021—the day before the report deadline. There still appear to be many records missing, including sick call requests and health care encounter reports. I discuss further below what could be discerned from the records that were actually produced.

19. Lastly, following the inspection, I also conducted further interviews with Calhoun staff and detainees by phone.

D. Inspection

20. The inspection of Calhoun was conducted over approximately eight hours. Chief Deputy Hazel, HSA Patrick, and PA Applebey were present in-person, along with at least one or two security staff members for each area of inspection. Counsel for the parties were present via a remote video feed. Chief Deputy Hazel stated that as of the morning of the inspection, there were

approximately 353 people detained in the jail, approximately 140 of whom were detained by ICE. The remainder were primarily criminal detainees under local jurisdiction, along with a few other criminal detainees that Calhoun houses for other entities. (For ease of reference, the non-ICE population will be referred to below as "local detainees.")

21. The inspection of Calhoun began with entry through the visitor's entrance, where myself, the interpreter, and Defendant's expert, Dr. Murray, met with leadership and several staff. Before entering the facility, staff conducted a COVID-19 screening that included temperature checks as well as asking questions about symptoms of COVID-19. A room had been prepared with space for the three of us (myself, Ms. Brubaker, and Dr. Murray) to leave belongings, change PPE, and ask questions before touring the facility. I was the only one who interviewed the leadership; based on what I witnessed, Dr. Murray had only one question for the staff during the entire inspection. Dr. Murray did not participate in the detainee interviews, which were conducted confidentially.

22. At this visitor's entrance, I posed questions that were answered by Chief Deputy Hazel, Lieutenant Chambers, HSA Patrick and/or PA Applebey. As indicated below, some of the information they provided was contradicted by detainee reports or documents I reviewed:

    a. Facility leadership stated that all newly-admitted people in the facility underwent a 14-day quarantine, which could have people detained by ICE placed either together with or separate from people under local jurisdiction, depending on the number of people and security classification of the newly-admitted people. At the time of the inspection, they asserted that there were no housing areas reported to be under quarantine other than the new admission areas, and that four patients with COVID-19 were being housed in K unit. The four people with active COVID-19 were reportedly identified during new admission testing, three of whom came under ICE jurisdiction from Baldwin Northlake Correctional Facility (a Bureau of Prisons facility run by GEO Group that houses noncitizen federal prisoners).

    b. None of the four people with COVID-19 had been tested at their sending facilities before transfer into Calhoun. As detailed below, I later interviewed the three positive ICE detainees and learned that at least two

of them were not even notified that they had tested positive for COVID-19 and were unsure of their COVID-19 status. Fortunately, none of them had risk factors for serious COVID-19, but there were issues with their monitoring that reflect systemic issues. In addition, it became apparent through staff interviews that a wide variety of practices exist with regard to pre-release COVID-19 assessments for people arriving at Calhoun from other correctional settings, including some that do not routinely test people before transfer.

c. Facility leadership (the Deputy Chief and HSA) stated that their current protocol was to conduct new admission testing on day one and again on day 14, using PCR tests. Staff reported in interviews after the inspection that the facility has moved almost exclusively to this PCR testing, with little use of rapid antigen testing due to accuracy concerns. *As I explain below, the testing records show that this protocol of testing new admissions on day one and on day 14 before release into other housing units is not consistently followed.*

d. Close contact investigations were reportedly conducted by a combination of the HSA and security leadership. According to facility leadership, no changes to the close contact investigation process had occurred since the CDC redefined close contacts in October 2020 to include anyone who was within six feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period, including individual exposures added together over a 24-hour period (e.g., three 5-minute exposures for a total of 15 minutes).[3] When asked how much exposure they consider to be sufficient to be considered a "close contact," Chief Deputy Hazel stated they were "conservative" but did not provide any specific information about consecutive versus cumulative accounting, although they did note that they would not differentiate between someone who had 14.5 minutes from 15 minutes of contact.

e. Corizon was reported as the primary health services vendor although a second vendor was identified as the mental health provider.

[3] Centers for Disease Control and Prevention, *Contact Tracing for COVID-19* (updated Dec. 16, 2020), https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/contact-tracing.html.

f. Security staff were unsure how many of their staff had been fit-tested for N95 masks, stating that "some" had undergone fit-testing. Health leadership stated that all of the health staff were fit-tested. A shortage of fit-testing solution and supplies was reported by security leadership as the primary reason that their officers were not fit-tested. Security staff identified that there were several scenarios in which security staff would be required to wear full PPE, including N95 masks, but that there was no system in place to verify whether the people doing these tasks were in fact fit-tested.

g. Facility leadership explained that in instances when detained people were identified as potentially having COVID-19, there was a cleaning protocol in place to have specially trained security staff clean the living spaces where those people had been housed, and that specially trained detainee cleaning crews may also engage in this work. *Detainees reported to the contrary about the cleaning protocols, as detailed below.*

h. Security leadership stated that work crews for laundry, kitchen and other aspects of the facility were comprised of people who were housed together, all of whom were under local jurisdiction. These detainee-workers, according to security leadership, were screened every day with temperature check and symptom screening before they reported to their work area, and also underwent bi-weekly testing. *Again, detainee-workers reported to the contrary, as detailed below, that they had never been screened for COVID-19 symptoms, elevated temperature, or pulse oximetry.* Staff who are responsible for this screening later reported that this is a verbal, informal process, without records or standard questions. *The consequences of not seeking out or responding to COVID-19 symptoms is detailed in my account of the recent outbreak among ICE detainees in H unit, with the early infection of men working as tray runners.*

i. The facility staff also stated that they had recently implemented routine COVID-19 testing every two weeks for people who were high risk for serious illness or death from COVID-19 based on CDC criteria. *But the testing logs show that this biweekly testing had not been implemented consistently: although testing started October 27, the next round did not occur until December 9.*

j. Facility leadership reported that the daily screening of people in new admission quarantine for COVID-19 symptoms and elevated temperature had recently been discontinued. The rationale was unclear, although the leadership stated that was not because of the newly implemented testing protocols (which provide for testing at the outset and conclusion of the 14-day quarantine period), but rather because the cases that have been detected in the new admission unit to date have been asymptomatic.

k. The HSA and PA stated that high-risk individuals are identified using the ICE criteria but were unsure how or whether those criteria differed from the criteria utilized for people under local jurisdiction. They were also unclear whether any specific changes in frequency or type of health encounters had been implemented for high-risk individuals. The HSA stated that there were about 138 people total in the facility (i.e. around a third of the population) who fell into the "high risk" category. *My experience in conducting COVID-19 assessments, and correctional health generally, is that approximately one half of detained men and a greater percentage of women meet these criteria for being high-risk.*

l. People who were identified as having COVID-19 were reportedly transferred to a medical isolation unit where they would be assessed twice daily with a vital sign check and questions about current symptoms. *The COVID-positive detainees I interviewed reported, however, that while they were given a twice-daily vital sign check, they were not asked about symptoms.*

m. Every person reportedly receives three surgical masks and two cloth masks upon entry to the facility and laundry is done twice per week according to the facility leadership. The facility has acquired biodegradable laundry bags and developed a workflow to conduct laundry without any interruption to frequency for quarantine and medical isolation units by batching the laundry in these new bags and running them after the rest of the laundry on any given day. *Detainees separately confirmed the twice-weekly laundering of their cloth masks but reported that surgical masks were not offered on a daily basis.*

23. Facility leadership and health staff elaborated on the following protocols for those who test positive for COVID-19:

    a. Patients in medical isolation with any symptoms are supposed to be tracked on a new COVID-19 acuity tool utilized by nursing staff. *I reviewed this tool and noted that it only included one static risk factor (age), as well as dynamic risk factors relating to vital signs to create a point or score-based guidance for staff on elevating the level of assessment and care for patients. Significantly, I noted that the tool did not include questions about underlying conditions that put a patient at higher risk of a severe outcome from a COVID-19 infection, nor did the tool assign any points based on risk factors other than age. In other words, the screening tool does not consider high risk factors, other than age, in identifying which COVID-19 positive patients should receive elevated care or monitoring.*

    b. The staff explained that they primarily relied on this tool to determine whether to transfer an individual into one of the three medical cells, two of which are negative pressure (meaning rooms that are ideal for medical isolation as they prevent airborne diseases like COVID-19 from spreading outside the room), and whether higher levels of care were needed for COVID-19 patients with symptoms. *Thus, it appeared that the ability to communicate and elicit symptoms from the patient (as opposed to simply measurement of vital signs) is integral to fully evaluating a patient and properly utilizing this tool/protocol in the first place*.

    c. Health leadership explained that once a person exhibits COVID-19 symptoms or abnormal vital signs, then this tool is utilized, and also that this is the point where a physical examination is conducted, including assessment of the lungs and heart with a stethoscope. When I asked whether people with COVID-19 who are considered asymptomatic have their lungs and heart auscultated on a daily basis, the response was no. *Hence, this tool and physical examination generally is utilized only after the health services determines that a person has some symptoms of COVID-19, which may be missed if staff are not proactively asking about symptoms.*

    d. Health staff indicated that standardized changes to chronic care encounters have been implemented to provide COVID-19 education, or

ask about vaccine engagement and history of serious allergic reactions, or track ongoing/prolonged symptoms of COVID-19.

e. Health staff stated that anyone who was identified with COVID-19 would receive a health encounter seven to 10 days after release from medical isolation to check on their status and recovery. *None of the detainees that I interviewed who had COVID-19, including those who are high risk, had received such a follow-up health encounter.*

f. Health staff stated that no mental health rounds or other mental health services occurred routinely for people in medical isolation, per facility leadership. Staff reported that people in medical isolation or quarantine could request mental health services as they normally would.

g. Health leadership stated that sick call access/monitoring was provided seven days per week so that any new medical problems reported via sick call (written or electronic) would result in a face-to-face encounter within one day. The HSA stated that a recent review of the sick call timeliness showed 100% compliance, and similarly that review of chronic care encounters occurring within the prescribed timeframes was also 100% compliant. *A review of the sick calls reflects, however, that responses were only superficial and did not involve face-to-face encounters, contrary to the health leadership's assertion. The clinical standard of care in correctional health is that a sick call request for a new medical problem will result in a face-to-face encounter within 24 hours, not an email reply that the request was received. As I discuss below, under Section G Findings, nearly half of all responses were not substantive and there was no documentation of any face-to-face encounter with a nurse or doctor. Many simply involved a pro forma response that the individual's request was forwarded to a nurse. Detainees similarly reported significant delays in accessing care.*

24. As we walked to the medical clinic, facility leadership showed a face temperature scanner that is supposed to be utilized by all staff as they enter and leave the building. It appeared to me that staff could enter and pass by this scanner without stopping, and I did not observe any check point or officer posting to ensure that every person conducts a facial scan. Facility leadership stated that staff with elevated temperatures are directed to self-quarantine and

the facility leadership report that when staff have close contact with a COVID-19 case, they self-quarantine at home for 14 days.

25. The next area inspected was the medical clinic. The waiting area has seats marked for social distancing. The staff reported that they called one housing area at a time so that people from different housing areas do not wait together. For any housing area under quarantine or medical isolation, staff went to those areas to provide care. Patients under quarantine or isolation were not brought to the clinic unless they were being assessed for emergencies or being placed in one of the isolation cells. Staff stated that these three cells were utilized for anyone requiring medical observation. Two of the three were negative pressure rooms. Two of the cells had beds and one had a mattress on the floor, without a bed. A cart with PPE was present outside the cells and a phone was present in one of the cells. I asked about how the facility did or would respond if more than three people required medical isolation and observation. The response was that a housing area would need to be utilized in this scenario, but the staffing and logistics of this response, including how medical observation would be conducted, were not established.

26. At the medical clinic, health staff related the following:

    a. Health staff reported that no COVID-19 patients had required hospitalization thus far and that if needed, health staff could provide oxygen and IV fluids, but could not conduct their own monitoring of blood tests for D-dimer (blood clots), complete blood count, metabolic panel, and other standard metrics of infection and dehydration.

    b. Health staff reported that no COVID-19 patients had thus far required IV fluids or oxygen therapy during the outbreak.

    c. Health staff confirmed that daily screenings of COVID-19 symptoms and elevated temperature had stopped in the past two weeks for all people in quarantine units with the exception of people who are known to be high risk.

    d. Daily screenings are still being done for COVID-positive individuals who are in medical isolation and for people who have been identified as high-risk, wherever they are located. Health staff reported that these screenings always include asking about symptoms of COVID-19, but

detained people consistently reported that they are never asked any questions about symptoms of COVID-19 during these encounters.

e. The HSA reported that "a couple hundred" sick call encounters were conducted each week. However, far fewer sick call requests were provided than would be reflected in this rate. (As discussed below, Calhoun produced about 650 sick call encounters for an eight-week period, which should have resulted in about 1,800 to 2,000 encounters at the rate reported by the HSA.)

f. The HSA reported that a separate contract existed for mental health services that included social work and psychiatry staff for 40 and 8 hours per week respectively.

g. Chief Deputy Hazel indicated that there was no current rapid COVID-19 testing of staff during close contact investigations.

h. Health staff indicated that there was only very limited medication that detained people could keep on their person throughout the day (i.e., the "keep on" program was very limited, even for over-the-counter skin creams), that most medications required daily contact between patients and staff, and that nursing staff distributed these medications through carts, traveling from housing area to housing area.

27. Several examination rooms were present with standard equipment, and the PA stated that he was in the facility Monday-Friday full time and the Medical Director was present for 8 hours per week and that nursing staff were present in the facility 24/7, and that there have not been any shifts during the past several months where no health staff are present in the facility. My understanding is that nursing staff are physically present at all times in the facility and that when PA or MD staff are not present, they have a system of coverage via phone contact.

28. I asked whether the health and security leadership track the weekly or monthly occurrence of COVID-19 cases at the facility and whether there had been any recent spikes or increases. Both health and security leadership stated that to their recollection the cases in the facility had been fairly steady, without any recent spikes or increases. This is clearly contradicted by the outbreaks among the male and female housing units in late October to early November 2020.

29. The next area inspected was L unit, which was observed from the outside on the way to the intake area. We did not have enough time to go into the unit itself; we only had time to visit a subset of housing units. Facility leadership explained that in units like L, which are not direct observation—meaning that no staff are stationed on the unit itself—an officer would enter the unit periodically to make checks and conduct a count of the people housed there and then spend the rest of the shift elsewhere in the facility, either in break areas or other duty assignments. Chief Deputy Hazel also reported that in housing areas of this design, supervisors also intermittently enter and move from one unit to another. Staff indicated that L unit (or ones of similar design) may be utilized as a medical isolation unit in the event that more than three people have COVID, exceeding the capacity of the medical clinic cells. One of the concerns with using units of this design for medical isolation of COVID-positive individuals is that these individuals could start deteriorating away from the eyes of both health and security staff.

30. The next area of the inspection was the facility intake, a horseshoe-shaped collection of cells and pens utilized for men and women. A facial scanner similar to the previously-described unit was present in the passage from the outside sally port to the intake itself. This passage was described as the place where all incoming detained people (except self-surrender and weekend detainees, which occur only among the local/non-ICE population) enter the facility and are asked a series of screening questions about COVID-19, have their temperature checked, and receive masks.

31. The next area of the inspection was unit C, which was comprised of 29 cells for men on two levels, most of which were double bunk cell except two, which were single and utilized for detainee workers. Hand sanitizer was present at the entry to the unit and the dispenser was filled. The unit was clear of debris and trash on the floor and cleaning supplies were present near the entry-way. Bathroom areas were clean and had paper towels nearby. At the time of the inspection, most detained people were wearing masks and all officers were wearing masks. *However, I spoke to several detainees whose experiences raise issues with COVID-19 protocols, as I relay below.*

32. The next area I inspected was G unit, a two-level cell area for women that had a separate segregation annex on the top level. Hand sanitizer was present at the entry to the unit and the dispenser was filled. The unit was clear of debris and trash on the floor and cleaning supplies were present near the entry-way.

Bathroom areas were clean and had paper towels nearby. Facility leadership stated that these segregation cells had never been utilized as medical isolation for women with suspected or known COVID-19. This was separately contradicted by several detainees who reported being medically isolated in those segregation cells. Facility leadership reported that several women had been identified as COVID-19 positive based on mass testing of the unit and that they had been transferred to another unit while those without COVID-19 remained in G. It was not made clear which of the cases occurring in this unit prompted the testing of the entire unit or when that case was identified. I later spoke with some detainees in the G unit, who relayed their experience with the outbreak that took place after a symptomatic arose in the unit.

33. The next area I inspected was the men's H unit. H unit is another indirect supervision unit, meaning that instead of having officers assigned inside the housing area, staff enter periodically to conduct their checks and then exit to go to other parts of the jail. The layout of the unit consists of two levels, with open bunks and a common area on the lower level. Multiple bunks were unused but there was no apparent spacing between bunks and all of the bunks were arranged in the same head-to-toe orientation. The layout of the bunks appeared to result in approximately 4-5 feet between people, with the head of each person aligned with the next person. The space between the top bunk and bottom bunk appeared to be approximately three feet. Individuals sleeping in those bunks cannot socially distance from the person in the next bunk, or the bunk above them. The unit was clear of debris and trash on the floor and cleaning supplies were present near the entry way. Bathroom areas were clean and had paper towels nearby. Most detained people were wearing masks and all officers were wearing masks. Facility leadership reported that several men had been identified as COVID-19 positive based on mass testing of the unit and that they had been transferred to another unit while those without COVID-19 remained in H. It was not made clear which of the cases occurring in this unit prompted the testing of the entire unit or when that case was identified. I also spoke with several ICE detainees from H, as relayed below, one of whom identified one of the early cases among detainees who were symptomatic but were deported without being tested.

34. The next area I inspected was N unit, the segregation unit. This area was described by facility leadership as being utilized for both punitive and administrative segregation, but never for COVID-19 medical isolation. The unit was a two-tier cell housing area with a group of three cells on the top tier

separated from the others by a secure passageway. These cells were referred to as "supermax." I spoke with one person on the bottom floor who was in ICE custody and another in the "supermax" area who was in local custody. The unit was generally clean and the staff reported that people receive one hour per day out of cell time and that phone, showers and recreation were provided on a daily basis. The cells in these units were described as having two-way intercom capability, which would be initiated by noise activation from within the cell. Facility leadership reported that food was brought into this unit by security staff with the 'rover' duty during mealtimes. The person I spoke with in ICE custody stated that he had daily access to shower and that since his arrival two weeks earlier, he observed officers consistently wearing masks. He stated that his first COVID-19 test was negative and he was transferred to this unit before he was given his second test, which was also negative. He was unaware of the reason he was placed in segregation but stated that it may have been because he came from a prison setting. As elaborated below, this individual's transfer out of quarantine before undergoing two rounds of testing is not unique and instead one of many violations of the new admissions protocols that Calhoun has reportedly in place.

35. The next unit I inspected was M unit, one of two housing areas specifically designated for high-risk people, the other being F unit. However, the housing reports reflect that high-risk individuals are held in multiple other units including A, B, F and L, which resulted in the mixing of high-risk and non-high-risk, in addition to ICE and non-ICE detainees. This two-tier cell unit was comprised of double bunk cells on the top and bottom tiers with a common space and tables on the bottom level. Only one person was housed in each cell at the time of the inspection. People in this unit reported that a number of other detained people had been transferred out of the unit in the days or week prior to the inspection and that before the inspection many cells had two or even three people in each cell, with the third person utilizing a mattress on the floor. The housing reports show as many as double the number of people in the unit in late November. More details from individuals in Pod M are reported below. Most detained people were wearing masks and all officers were wearing masks. In M unit, detained people were also wearing gloves, which both staff and detained people reported as having been started in the day or two before the inspection. The unit was clear of debris and trash on the floor and cleaning supplies were present near the entry-way.

36. The next unit I inspected was a new admission quarantine unit, A. This was a two-tier unit with cells and a common area on the lower level. This unit had telephones placed approximately 18 inches (1.5 feet) apart with people using all available phones, meaning they were not socially distant from one another. The unit was clear of debris and trash on the floor and cleaning supplies were present near the entry-way. Most detained people were wearing masks and all officers were wearing masks.

37. The next stage of my inspection was to have additional interviews with several people in an office in the intake area.

38. While these interviews were being coordinated, I asked the HSA whether either the October/November 2020 outbreaks among detainees in G or H units had prompted any reviews of sick call or case-finding protocols. The HSA replied no. I asked whether any changes to how people access health services came out of reviews of those two recent sets of spikes in cases and the HSA again stated no, and asserted that the original protocols for detecting new cases of COVID-19 were adequate.

39. After about 1.5 hours of interviews, the next unit I inspected was K unit, where four people with active COVID-19 were housed. This unit had signage outside the unit reflecting the level of PPE required and I put on a face shield and gown to enter the unit. An officer also donned PPE to enter the unit with me, which was a small six-cell unit that had two tiers of cells, with a total of three cells occupied, one cell housing two people. A small common area was located on the bottom tier. This unit did not have any officers stationed inside the unit, but was reported to be supervised similar to the other units in which officers would enter periodically to check on the status of detained people. People in these cells had a combination of surgical and cloth masks as well as N95 masks When we conducted our interviews, all three were asked to wear their N95 mask and it was clear to me that they had never been educated on the basics of how or when to utilize these various masks. Although alarm buttons were present in these and all other cells to alert security staff in the case of emergencies, as noted above with respect to L unit, a concern with housing COVID-positive individuals in an indirect supervision unit, especially absent adequate symptom checks, is that their condition will deteriorate out of view of security or health staff, particularly with people who are unfamiliar with these types of correctional intercoms and/or who have language barriers.

40. The tour component of the inspection ended shortly after I went through K unit.

E. Detainee Interviews

41. As referenced above, I spoke to a total of about 27 detained people (about 80% of whom were ICE detainees) at Calhoun regarding the facility's COVID-19 response. Below, I highlight the experiences of certain individuals that were particularly egregious or reflective of issues with Calhoun's COVID-19 response.

    a. The outbreak in the women's G unit, comprised of people in both ICE and local custody, included several consistent reports of delays in access to assessment and care for COVID-19. In total, I spoke with five women from unit G during the inspection.

        i. One woman reported that she felt ill on October 26, 2020, and reported to health staff that she had headache and fatigue. Health staff told her in person that she likely had a cold, and she continued in her duties as a food service worker. Another woman reported similar symptoms and was nevertheless also returned to the unit without any further precautions after being told that she likely did not have COVID-19. Neither of these women were tested at the time they reported symptoms.

        ii. Two other women reported submitting two or three sick call requests in the week before the unit was tested, including symptoms of headache, weakness and loss of smell and that they went two to four days before being seen by health staff. These two women reported that, after reporting COVID-19 symptoms, they were placed into the segregation cells in G unit with a third woman and that after two or three days in those cells, they were tested along with the rest of the unit. During their time in the segregation cells (two days for two women and three days for one woman), health staff conducted a daily symptoms screening. Two of these three women reported that none of the questions asked of them were in Spanish, and that they were therefore unable to relay their symptoms.

iii. All the women I spoke with reported that on the overnight shift of October 31, 2020, 11 women were removed from G unit and transferred to B unit, apparently because their COVID-19 tests were positive. After three or four days in B unit, women reported being transferred to K unit for the remainder of their medical isolation. Several of the women reported not having access to phones while in medical isolation, and that their vital signs were not checked on a daily basis during this time.

iv. One woman who is under treatment by health staff for hypertension stated that she never had her blood pressure checked during medical isolation. Another woman reported that she submitted three requests for mental health services while in medical isolation because of the stress of being locked in a cell all day, and that she never received any mental health services or encounter.

b. The outbreak in the men's H unit, comprised of people in ICE custody, included, like for the women in the G unit, several consistent reports of delays in access to assessment and care for COVID-19. H unit is an indirect supervision unit, meaning that instead of having officers assigned inside the housing area, staff would enter periodically to conduct their checks and then exit to go to other parts of the jail.

i. One person reported that in mid-October, he submitted an electronic medical request stating that seven people around him were ill with COVID-19 symptoms and needed care. He stated that he received an electronic reply that someone would come to the unit, but no health staff came to the unit; he was called to the medical unit three days later after submitting a total of three requests, where he again stated that the problem was with others in H. He stated that he was then returned to the unit but that others who were ill were not seen and that the entire unit was not tested until nearly two weeks after his initial message.

ii. I was able to see the electronic kiosk and view the requests submitted by this person and verify his report: he submitted a request on October 15, 2020, which read "Subject virus; Please check the people in this unit, many are sick fever, cough,

headache, thank you." A response was sent the same day electronically, stating "This request has been forwarded to the day clinic nurse. Thank you."

iii. I spoke with several other people in H unit who similarly reported that they had reported being ill in mid-October with no or very delayed responses by health staff. None were tested immediately. One person reported submitting medical requests because he felt ill starting on October 12, 2020, and was repeatedly put off by health staff. Review of his actual medical requests revealed the following exchanges with health staff:

10/12/20

Medical Request: "I don't feel good I'm sick, 2 days no sleep."

Response: "Try to drink some water and take it easy, we do not treat sleep issues."

Medical Request: "It's not sleep issue my throat hurts, I have fever and I don't feel good."

Response: "OK we can give you Tylenol for your fever. It may take a few days. Unfortunately there's nothing we can do about the sore throat. Thank you."

10/15/20

Medical Request: "I feel not good, my all body pain."

Response: "This has been forwarded to the day nurse."

This patient was not seen and tested until October 20, 2020 – eight days after his initial sick call request – when he was found to be COVID-19 positive and transferred with the other positive people to L unit for medical isolation. I spoke with another person on the same unit who reported fever, throat pain, chest pain and other symptoms from October 11 through October 17, 2020, but who was given Tylenol two days after his first report

and ultimately tested on October 20, 2020, with a positive result.

iv. Another person I encountered in one of the high-risk units (M) reported that, while he was housed in the H unit, he told multiple medication nurses and also submitted medical requests that he was ill and had body aches, fever, loss of the ability to smell, and that he was never seen over the following four or five days except to receive Tylenol from a medication nurse who did not take his vital signs. He reports that four or five days later, health staff came to H unit to conduct COVID-19 testing on everyone. At the time, he was too weak to stand or walk to the common area when testing occurred and he needed help to leave his bed and cell. He reports then being taken to the medical unit where he was placed on a mattress on the floor for six hours before being taken to L unit; while in the medical cell, he never had his lungs listened to with a stethoscope, and did not receive IV fluids or oxygen. He recalls that his oxygen level was 92% when checked initially upon entering the cell, and that his vital signs were not rechecked before leaving the cell. Such an abnormally low oxygen level, especially with shortness of breath, should have resulted in immediate evaluation by a physician or physician assistant and also supplementary oxygen.

c. None of the people I spoke with during my inspection reported any efforts to create social distancing in medication lines, when people line up twice daily for their medication in housing areas. None of the people interviewed had ever seen a security or health staff person make any comments to encourage or implement social distancing in these lines. Reports of social distancing during meals and during phone calls were mixed.

d. I spoke with the three ICE detainees in the current medical isolation unit, K. All three of them were Spanish-speaking. I was told that the person in medical isolation under local jurisdiction did not wish to speak with me. These three ICE detainees described a twice-daily encounter with nursing staff that included having their vital signs checked and not being asked any questions about their symptoms in Spanish. It was unclear from these

conversations whether the health staff had asked questions about symptoms in English and these questions were not understood, or whether no such questions had ever been asked. This concern about not being asked questions regarding COVID-19 symptoms in Spanish or other non-English languages was also reported by other people I spoke with who were in G and H units.

e. People that I interviewed throughout the facility who had experienced COVID-19 screening reported that it often did not occur every day and that when it did occur in their unit, it did not involve asking questions about COVID-19 symptoms, only temperature and pulse oximetry checks.

f. None of the people I spoke with who had been in medical isolation for COVID-19 reported receiving a health encounter in the weeks after they left, during which (according to Calhoun and recommendations by the CDC) they are supposed to be asked about ongoing COVID-19 symptoms or problems. Ongoing symptoms of COVID-19 were reported to me by several people, including difficulty sleeping, loss of taste or smell, and shortness of breath.

g. Most detained people I spoke with reported that mask wearing by officers had improved in recent weeks or months and was now routine. Most detained people I spoke with reported that access to paper towels and soap had improved in recent weeks or months and was now routine. Several people in H unit stated that paper towels had been made available in the past two weeks. Several people reported that the hand sanitizer stations were recently installed, had quickly run out of hand sanitizer, were empty for at least two weeks, and were refilled just a day or two before the inspection. One detainee reported asking security staff about the refilling of these dispensers and reported being told that it would be refilled "for Christmas."

h. None of the people whom I interviewed who had work assignments outside their housing areas (including those in the food service and laundry details) reported any daily COVID-19 screenings occurring, either temperature checks or daily questions about symptoms, contradicting the representation of facility staff that such screenings are done.

i. People who tested negative for COVID-19 and remained in G and H units (after those who tested positive for COVID-19 were moved to other units during the outbreaks) stated that the personal areas of those with COVID-19 were never cleaned by anyone. Instead, the detainees who remained in those units had to advise the newly arriving people who occupied those spaces to make sure to clean them. I spoke with some of the newly-arrived people in these units who confirmed being told by other detainees that their new areas had never been cleaned and that they needed to do so. According to both the newly arrived and prior H unit inhabitants, no staff members told them that there had been no cleaning of the areas where people with COVID-19 had been housed or that the newly arrived-detainees were moving into it. I asked about special cleaning of areas where COVID-19 positive detainees had been sleeping, and nobody had ever seen correctional staff or any work details of detained people clean these areas after someone left for medical isolation.

j. Several people with serious health problems reported not receiving their medications or treatment. Two detained people I spoke with reported that they had not received their asthma medications while in Calhoun. Both were in ICE custody and had been prescribed two inhalers at previous facilities, one rescue inhaler to use when symptoms worsened, and one daily inhaler to prevent worsening of symptoms. Both reported that they arrived at Calhoun with their two inhalers and records of their asthma severity but that health staff at Calhoun only prescribed them the rescue inhaler, which both reported using on a daily basis (a sign of poorly controlled asthma). One of these people reported asking health staff multiple times about the need for his other inhaler and was told that he did not need it, despite submitting a medical request for shortness of breath and stating that he was having nighttime symptoms including cough, a cardinal sign of uncontrolled asthma. One person I spoke with in the new admission unit reported a history of two strokes, hypertension, having stents placed in his carotid arteries, and being on numerous medications. He reported arriving in the facility on December 4, 2020, that he went at least five days before receiving many of his medications. and that he had not yet seen a physician or physician assistant. Another person with a chronic anal fissure reported that his rectal bleeding had been well controlled at another detention facility with high fruit/vegetable diet. Despite reporting this problem to health staff and being told that they agree that such a diet would control his bleeding, he

was unable to access a high fiber or high fruit/vegetable diet and was experiencing daily and ongoing rectal bleeding.

k. All but one person I spoke with about the fingertip pulse oximetry devices (used to measure blood oxygen saturation levels) reported that they were not cleaned or disinfected between uses by different patients. A person I spoke with had been in a quarantine setting when COVID-19 screenings were occurring and reported that he had filed multiple grievances with the health staff concerning their failure to wipe down or otherwise clean or disinfect the pulse oximetry devices between uses. He reported being told by health staff that they did not have adequate supplies to clean or disinfect the pulse oximetry device between uses and that it was his responsibility to wash his hands after COVID-19 screenings. Another person who was housed in a separate unit also reported being told that the detained people need to wash their hands in between uses. Several other people confirmed this practice by health staff, including two people in K unit who had active COVID-19 and stated that they observed the nurse before and after their vital signs were checked and never saw the device being wiped down or cleaned between uses. When I asked the HSA about this issue, she stated that the devices are wiped down between every use and that this is the policy of the health service.

l. Several people reported that the shower and common bathroom areas were rarely cleaned before the inspection and had been cleaned just prior to the inspection. One person reported that because the security staff may limit the number of times a person can flush their own toilet (two flushes per hour), many people rely on the common toilets, even in cell areas. He reported that these toilets (which lacked lids) were often uncleaned and covered in feces.

m. Three people reported that they have been threatened with disciplinary tickets for 'over–kiting,' referring to submitting more medical requests than health staff deem appropriate. One of them was a woman with chronic medical problems who reported that, because she believed that disciplinary tickets could impact her immigration case, she was reluctant to seek treatment for infections or pain.

42. I was struck by the extreme discrepancies between what Calhoun staff and detainees reported. I was also struck by the consistency of the reports among the detainees and inmates whom I interviewed. In my experience, consistent reports by multiple detainees is a good indicator of the actual practices in a facility, and is a more accurate reflection of day-to-day practices than the "cleaned-up" version of a facility that is typically presented during a tour itself. Following the inspection, I conducted several more interviews with detainees and staff to probe these discrepancies and follow up on other subjects.

F. Follow-Up Interviews

43. Due to the unavailability of Calhoun staff during the holidays, phone interviews took place on January 4, 2021. During these interviews, staff[4] relayed the following additional information:

    a. Security staff indicated that inmate workers receive a verbal, informal COVID-19 screening that amounts to the supervisor speaking with them and that there is no standard set of questions they are asked or written record of these screenings.

    b. Security staff confirmed that many staff have not been fit-tested for N95 masks and that there are many circumstances under which staff are required to wear N95 masks.

    c. Security and health staff stated that all newly-arrived detained people are assessed concerning their risk for COVID-19, and that the classification staff are informed by health staff of all newly-admitted people who meet the high-risk criteria. This notification occurs within one or two days and allows the classification team to determine whether the high-risk person should be placed into M or F units. The assessment done by nursing staff is insufficient to establish the high-risk status of newly detained people. This correctional standard of deferring physician or mid-level health assessments of newly arrived patients for days to weeks is a common practice in jail settings, but it creates a barrier to quickly establishing a

[4] I spoke with Lieutenant Kevin Hirakis, Deputy Ray Manson, Deputy Mandi Zimmerman, RN Brandy Chapman, Lieutenant Tracey Chambers, and Captain Holly Thomas. I was scheduled to speak with Dr. Paul Troost, but he did not call at the scheduled time, and we were unable to successfully reschedule.

person's high-risk status. No assessment of newly-arriving detainees' risk level is done by a physician or physician assistant.

d. Security staff indicated that when a person is identified as possibly having COVID-19, the housing area deputy would clean or disinfect their living area. As noted above, detainees reported the contrary.

e. Security staff indicated that if more than three people were symptomatic with COVID-19, they would utilize one of the housing units as medical isolation, likely L unit, which is near medical.

f. Health staff stated that they do ask questions about COVID-19 symptoms during their screenings, which are now occurring twice daily with all high-risk people. As noted above, detainees reported the contrary.

g. Health staff stated that they utilize the language line service for all people who require assistance, including during activities in the housing areas. As noted above, detainees reported the contrary.

h. Health staff stated that pulse oximeters are wiped down with alcohol pads between every use and that there is no shortage of alcohol pads. As noted above, detainees reported the contrary.

i. Health staff stated that the compliance with sick call timeliness is 100% and also that all patients who report medical problems are seen within one day, and that sick call is conducted 7 days per week. Detainees reported to the contrary. A review of sick call requests shows that 47% of sick call requests simply receive a perfunctory response, such as that the request has been forwarded for review or that the person would be scheduled to see a nurse.

j. Health and security staff were unaware of any changes that were made in response to the outbreaks in H and G units and were also not aware of people reporting symptoms of COVID-19 to health or security staff in the days or weeks before testing occurred.

44. Following the inspection, I spoke to four more detainees. Some were still detained at Calhoun while a few had since been released:

    a. I spoke with a person who was in the H unit in October 2020 and currently, who reported the following: he worked as a tray runner along with other workers. As a tray runner, going to multiple parts of the facility, the detainee had never been screened for elevated temperature or symptoms of COVID-19 as part of his work duties and he had never seen or heard about this occurring. While going from one unit to another, he did not have access to new gloves, and he was forced to reuse the same set of disposable gloves throughout a shift unless a security officer gave him some of their personal gloves. In early October, two other people were transferred into H unit from B unit and placed into bunks near his. One of them, who was also a tray runner, became ill with COVID-19 symptoms shortly after arriving, and then the detainee whom I interviewed also started to feel ill by around October 6. He told the administrator in charge of the work details that he felt ill on October 13 and was seen by a physician that day. The detainee was worried he had COVID-19 because he had a runny nose, sore throat and body aches. He also told the physician about the other tray runner (transferred in from B pod) who was ill in his housing area and stated that health staff needed to go check him out. The physician assessed him as being dehydrated and needing to drink more water, but told him that he should return to his normal duties as tray runner that day, without any COVID-19 testing. The detainee felt progressively ill over the following three days and reported this to the facility staff, but he was told to work regardless. He was not tested or checked for COVID-19 signs or symptoms until Saturday evening, October 17, after his shift ended and he was finally taken back to the medical clinic to be tested for COVID-19. He stayed in the medical clinic until the following Thursday. Once his first COVID-19 test came back positive, the rest of H unit was tested on October 20 or 21. However, the man who became ill first (another tray runner) was deported to Guatemala without being tested or transferred to medical isolation.

    b. A second person I spoke with by phone reported that she was in G unit when she became ill with COVID-19 and that health staff came to conduct checks of her temperature and pulse oximetry during a 14-day period but that no health staff ever spoke to her with a Mandarin

interpreter, which she requires. She also reported that no health staff ever listened to her lungs with a stethoscope. She still has problems with cough and shortness of breath, but has not been seen for these problems since her clearance from medical isolation or been asked about ongoing COVID-19 symptoms.

c. A third person I spoke with by phone reported that he has hypertension and is prescribed medication for his hypertension and PTDS, but that he is not considered by the facility to be high risk. He has been detained at Calhoun for eight months. He stated that he had numerous blood pressure readings in the 160s/90s range and that the physician told him several times to relax and that his anxiety was likely the cause of his high blood pressure. He was never asked about his family history, which includes coronary artery disease and high blood pressure in his father. This person works as a pod cleaner (or trustee) and reports that in the day or two before the inspection, his housing area went from having just one rag to clean common surfaces to receiving eight newly purchased rags. These rags were then removed in the days after the inspection. He also stated that other inmates who are not regular cleaners were hired by security staff to work for three days before the inspection and that they stopped doing that work after the inspection. He also stated that there is no effort by staff to promote social distancing during medication or meal lines or during TV watching. He reported that recently, two cell mates were locked into their cells for four or five days while they waited for COVID-19 tests, and that they were not removed from the unit while waiting. One of these men was sick, reported his symptoms, and then he and his cellmate, who was not feeling ill, were both locked into their shared cell, coming out one hour per day on C unit. This person reported that others on the unit now speak about not reporting their symptoms if they become ill because of witnessing this response. This person also reports that he has never witnessed any special cleaning process for areas where people with COVID-19 were housed. The practice he and others reported was that while some COVID-19 positive people may take their own property with them, when their property was left behind, or when it came to cleaning the living space where a person had been, cleaning was left to other detained people.

d. I spoke with another person who reported that nurses never utilize interpreters or language services in the housing areas and that he

routinely sees people not understanding their interactions with health staff in the housing areas. This person, who is high risk, also reported that he has never been asked questions about COVID-19 symptoms during his twice-daily screenings, and that he only has his temperature and pulse oxygen checked. He also stated that he has never seen a nurse wipe down or clean the pulse oximeter device between uses.

G. Findings

45. My findings from Calhoun's COVID-19 response are presented below, first summarizing the strengths and then explaining the deficiencies.

46. I incorporate by reference the previous discussion about the nature of COVID-19 and congregate settings from my last declaration, submitted November 6, 2020, specifically on: the higher risk that COVID-19 poses to older adults and those with certain underlying medical conditions, our growing understanding of who is at higher risk, the long-term side effects from COVID-19, the possibility of reinfection, and role that airborne transmission plays in spreading COVID-19 (*see* ECF No. 400-4, ¶¶ 7–17).

47. Strengths of Calhoun's COVID-19 response include the following:

    a. The on-paper policy of twice COVID-19 testing during the new admission period for all detainees, as well as biweekly testing for high-risk individuals is an important step to monitor the facility for new cases. Based on the testing logs, however, testing appears to be inconsistently implemented.

    b. The facility security staff were clearly aware of which units house people with COVID-19 concerns and those units and their level of infection control are clearly identified with signage, and PPE is well-positioned.

    c. The facility was clean and both paper towels and cleaning supplies were available throughout the facility at the time of my inspection. This appears to reflect a recent improvement and is not necessarily indicative of any consistent practice. My experience is that significant preparations may occur before an inspection that do not reflect the day-to-day facility operations and the reports regarding conditions of bathrooms and availability of hand sanitizer are consistent with this. I am concerned by the report of a person who works as a pod cleaner that special efforts

were made to clean before the inspection, and that those were discontinued after the inspection. Hygiene practices should remain, at minimum, at the level I witnessed during the inspection, rather than that reported by detainees as being the case prior to and after the inspection.

d. Detained people I spoke with reported significantly improved mask wearing by security staff in recent weeks. This is an important development because is displays the capacity of the security staff to implement new approaches when motivated to do so.

e. The reported workflow in the intake area for COVID-19 screening, giving newly-detained people masks and maintaining separation of those with COVID-19 symptoms, appeared consistent with CDC guidelines.

f. The COVID-19 acuity tool presented by the health staff represents a good tool for monitoring the clinical status of patients who are symptomatic with COVID-19 but needs modification to include risk factors.

g. The staff screening process, if the same as what I underwent, appears effective and consistent with CDC guidelines. The use of the temperature monitoring devices at two entry points is also a helpful tool if consistently used.

48. Below I discuss the deficiencies of Calhoun's COVID-19 response. I have organized these into categories and attempt to highlight the most pertinent issues.

49. **Deficiencies Related to Detecting and Responding to New Cases of COVID-19.**

a. Testing and Quarantine: The facility claims to be testing all new admissions twice while in a quarantine unit before releasing them into the general population after a 14-day quarantine. However, housing and testing records starting from September 18, 2020 through December 30, 2020 show the following violations of the quarantine protocols, as detailed in the Declaration of Aaron Haier, Exhibit A. Notably, because the housing records only show weekly, as opposed to daily, data, these estimates are likely very conservative and would not capture any

violations that occurred from transfers done between the weekly reports. *Id.* at ¶ 12.

i. Since September 18, 2020, at least 15 ICE detainees were transferred out of their quarantine unit prior to the two-week quarantine period being completed. *Id.* at ¶ 11.

ii. Calhoun stated during the inspection that units A, B, and J were used for new admission quarantine. But in previous documents, Calhoun stated that they also used units M, P, and K as quarantine areas. Even considering those units as "quarantine" units, at least 50 ICE detainees who arrived after September 18, 2020, were not immediately placed into any of these quarantine units after being initially booked in. *Id.* at ¶ 13.

iii. For at least three ICE detainees who arrived after September 18, 2020, there is no record of an initial COVID-9 test after admission. Another nine ICE detainees did not receive a test at the end of their quarantine period before being released from admission quarantine and moved into another housing unit. *Id.* at ¶ 17.

b. The facility staff stated that they have stopped implementing daily symptom checks and temperature checks in quarantine units, which dramatically impedes their ability to detect new cases and control the spread of COVID-19. This change in practice was also apparently made without changing the policy on paper, which still states that all detainees in quarantine units must be screened for symptoms twice daily.

i. The discontinuation of daily screening for new admissions is extremely concerning, as detainees who test negative on day one can easily develop symptoms thereafter, and any such cases of COVID-19 would remain undetected either until symptoms become dire or until the person's second COVID-19 test, meaning that the infected individual does not receive prompt treatment and can also spread the virus to others.

ii. The policy also states that high-risk individuals must get twice-daily screenings no matter where they are, including in new admission quarantine. When these checks are done, the checks do not involve

asking about symptoms, but instead only rely on temperature and pulse oximetry, delaying identification of new cases.

c. Testing After New Admissions: Following the outbreak, Chief Deputy Hazel submitted a declaration in late October 2020 stating that high-risk ICE detainees would be tested on a biweekly basis. However, the testing logs appear to show that this testing started on October 27 and was not implemented again until December 9, 2020.

d. In general, testing seems very incomplete. Once a facility reaches the point of multiple outbreaks occurring, it is important to implement a broad and ongoing approach to detecting new cases, including testing. As a practical matter, as the CDC recognized, the movement of staff and detained people in certain congregate settings is so complex as to render testing of all staff and detained people far more reliable than attempting to track subsets of testing cohorts based on location and risk status.[5] For Calhoun, I would recommend testing of all staff and detained people every two weeks until at least 14 days have passed without a new positive test. At a minimum, there should be regular testing of not only high-risk individuals but all other people in their housing areas, and regular testing of all facility staff and inmate workers.

e. Monitoring of COVID-19 Symptoms: The facility appears to disregard or respond slowly to reports of COVID-19 symptoms among detained people, which is likely to worsen their individual clinical course and also increase the spread of the virus. This represents a particular danger for high-risk detained people, as it dramatically increases the likelihood that people with active COVID-19 symptoms will deteriorate and spread their infection to others out of the view and care of the health service.

f. The records of responses to sick call requests show that responses are far slower than correctional standards (24 hours between submission and

[5] Centers for Disease Control & Prevention, *Interim Considerations for SARS-CoV-2 Testing in Correctional and Detention Facilities* (updated Dec. 3, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/testing.html (noting that "facility management should consider **a broader testing strategy, beyond testing only close contacts within the facility, to reduce the chances of a large outbreak**").

face-to-face encounter), and far slower than represented by health care staff.[6] People I spoke with reported up to over a week in substantive sick call response times, even though sick call is the stated avenue by which the facility plans to detect future cases of COVID-19 outside quarantine units. My review of the sick call records in the electronic kiosk also indicated the same.

g. At my request the Plaintiffs' data team at Paul, Weiss logged all of the sick call requests and responses that were provided by Defendants. *See* Exhibit B, Declaration of Sarah Maneval. As noted above, facility staff indicated a volume of a "couple hundred" sick call requests a week, which should have produced approximately 1,800 to 2,000 sick call requests and responses for the relevant time periods. However only approximately 650 sick call requests/responses were provided. *Id.* at ¶ 7. Analysis of those sick call requests that were provided showed that:

   i. For 306 out of 651 sick call requests, or approximately 47 % of the requests, there was no substantive response documented within 24 hours. Of those, there was no documented response at all in 59 cases or the comment sections of the responses were blank (representing 9 % of all sick call requests produced). For the remaining 247 sick call requests, the responses indicated that the request had been forwarded or the person would be scheduled to be seen, but there was no indication on the sick call request of any further action. *Id.* at ¶ 10. In 11 instances, an individual submitted a sick call request, stating that they had previously requested medical treatment and had yet to receive a response or see a medical provider. *Id*. at ¶ 11.

   ii. At least 54 sick call requests included references to symptoms consistent with a possible COVID-19 diagnosis. *Id*. at ¶ 12. Of these, there is no documented substantive response for 28, or nearly 52% of those requests. *Id*. In at least two cases, the response to the COVID-19 symptoms were simply to tell the individual to

[6] National Commission on Correctional Health Care, *Screening, Sick Call and Triage* (2010), https://www.ncchc.org/cnp-screening-sickcall-triage.

drink water and get rest; the responses did not indicate that they were seen by medical staff or tested. *Id.*

iii. There were multiple instances identified of detainees who reported COVID-19 symptoms, but were not tested immediately. At least 30 detainees (who submitted 35 sick call requests) were not tested for COVID-19 within five days of reporting symptoms consistent with COVID-19 in their sick call requests. *Id*. at ¶ 12. And of the 54 sick call requests with COVID-19 symptoms and requesting treatment for it, six detainees (who submitted seven of those sick call requests) had eventually tested positive for COVID-19. *Id*.

iv. The sick call requests also reflect a disturbing trend in which individuals state that they were not informed of their test results, even if they have tested positive for COVID-19. *Id.* at ¶ 14.

v. Other issues identified from the records review are outlined further below under ¶ 53 (Other Issues).

h. The outbreaks in G and H units are especially concerning because they are recent, and because repeated reports of obvious COVID-19 symptoms were brushed off by health staff. The lack of awareness by facility health leadership that these recent responses were deficient raises the clear likelihood that subsequent outbreaks will also occur and responses to those will likewise be deficient.

i. The placement of women reporting symptoms of COVID-19 into the solitary cells in G unit, despite the clear report of the security leadership that these cells were never utilized for medical isolation, may also reflect the slow and inconsistent response of health service to reports of COVID-19 symptoms. Cells that are separated from the rest of the unit in an annex may be appropriate for medical isolation, but if the security staff are not aware of this practice or of the COVID-19 status of the people in those cells, then there is significant risk of staff not utilizing proper PPE and movement of those patients into and out of the adjacent areas in a manner that increases facility transmission.

j. The delays in responding to patients who report symptoms of COVID-19 also undercut the new acuity tool presented by health staff, since patients

and their records indicate that people were falling ill with COVID-19 and were simply not being seen by health staff.

k. The lack of Spanish-speaking health staff in the facility, and the failure to utilize translation services for other languages, is especially deficient and negatively impacts all aspects of COVID-19 detection where the facility is supposed to be asking about COVID-19 symptoms, including at intake, during close contact investigations, and in medical isolation where patients with COVID-19 are being monitored for development of symptoms.

l. Detainees also reported instances of retaliation for "abuse" of sick calls or "over-kiting." Such behavior discourages detainees from timely and accurately reporting COVID-19 symptoms and other issues with COVID-19 protocols.

m. All of the above contributes to a health system that is poorly equipped to identify new cases of COVID-19 in a timely manner, especially among people in ICE custody. The combination of delayed or absent response to people reporting COVID-19 symptoms, with the systematic lack of language services when detecting, testing, or caring for people with COVID-19, creates an environment in which ICE detainees are in jeopardy of contracting COVID-19 without having access to adequate care.

n. Response to Outbreaks: Calhoun appears to rely heavily on their quarantine/testing process during the new admission phase and appears poorly suited to detect and respond to new symptoms of COVID-19 after the new admission period. This practice is based on the misperception that screening and testing of newly-admitted people eliminates the possibility that COVID-19 will be introduced into the facility, and that therefore little monitoring is necessary once individuals have cleared the new admission process. However, as demonstrated by the outbreaks in H and G units, COVID-19 can enter and spread through Calhoun in multiple ways, not least of all through staff and vendors, as well as gaps in the implementation of the quarantine process itself (as discussed above). In addition, the reports of people working as tray runners and going days without assessment or care despite reporting COVID-19

symptoms indicates that much more transmission is occurring without being detected in Calhoun's contact investigation.

o. Calhoun staff were unclear, despite repeated questioning during the inspection and in follow-up interviews, about their contact tracing protocol. They stated they were "conservative" about counting any contact, but did not state whether they had updated their practices to account for the CDC's revisions to contact tracing protocols to include cumulative (and not just continuous) contact. I have not seen any documents regarding Calhoun's contact tracing protocols for staff and detained people and remain unsure whether they utilize the updated CDC definition, or how they implement actual contact tracing. Either Calhoun does not have written protocols on contact tracing, or these were not provided to me. The report by a tray runner, who had multiple contacts in numerous housing areas while ill with COVID-19, is a good example of a case that should have been detected earlier on; instead, even though he reported symptoms on October 13 and was finally tested on October 17, it was not until October 28 when Calhoun determined that it could determine the scope of the outbreak and had to conduct widespread testing. This reflects how Calhoun is relying on tracing secondary or tertiary cases because of delay in responding to initial ones.

p. Calhoun is also not testing all close contacts. Identifying a close contact during an investigation only leads to daily symptom monitoring, which as noted above, detainees report only includes a vitals check. The CDC recommends, however, that all close contacts be tested and monitored for symptoms for 10-14 days.[7]

q. Calhoun has yet to identify the source of either of the outbreaks in H and G units. Worse, the medical staff stated that they took no steps to review their records in the October period preceding the outbreak to see what they could learn from those experiences. I was particularly surprised to hear the medical leadership state that they would not change anything despite what happened with the outbreaks in these units. This raises the very real prospect that, as more cases develop in the facility, the

[7] Centers for Disease Control and Prevention, *Contact Tracing for COVID-19* (last updated Dec. 16, 2020), https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/contact-tracing.html#anchor_15900119.

identification of those ill with COVID-19 will continue to be delayed and the transmission will be far more widespread than necessary. This is also a real concern because the newly-identified COVID-19 strain is characterized as being more transmissible than the currently dominant strain.[8] As this strain enters the local community of Calhoun County, delays in identification of COVID-19 cases will become even more consequential.

50. **Deficiencies in Controlling the Spread of COVID-19.**

a. Lack of Social Distancing: As has been previously described in detainees' prior declarations, it is very difficult to practice the strict social distancing necessary to prevent transmission of COVID-19 in a congregate setting like Calhoun. This was particularly evident in spaces like G and H units, where detainees were sharing cells or in bunk-style housing. Even basic steps to increase safety, like having detainees alternate sleeping head-to-toe, appear not to have been taken. Some detainees have continued to report difficulty staying six feet apart from others not just in cells/bunk-style sleeping areas, but also in common areas while eating or recreating. In particular, it appears that telephone areas, like in unit A, were spaced only 1.5 feet apart. This is additionally problematic because detainees have limited out-of-cell time, and are thus forced to use phones with others in their unit during a compressed time period. Moreover, detainees have very little control over how close other detainees or staff come to them. During the inspection, I did not observe staff at any time inform detainees that they should stand further apart.

b. The six-feet social distancing rule is also not perfect. We now understand the role that airborne transmission plays in spreading COVID-19, which is why the gathering of multiple people in indoor spaces with poor

[8] The new strain (UK VOC 202012/01) has been identified in the United States already in multiple states. *See* Centers for Disease Control and Prevention, *Emerging SARS-CoV-2 Variants* (last updated Dec. 30, 2020), https://www.cdc.gov/coronavirus/2019-ncov/more/science-and-research/scientific-brief-emerging-variants.html; *see also* Jonathan Wolfe, *Coronavirus Briefing: What Happened Today*,The New York Times, (Jan. 6, 2021), https://www.nytimes.com/2021/01/06/us/coronavirus-today.html.

ventilation is so dangerous.[9] Because aerosols containing the virus can remain suspended in the air for extended periods of time and travel long distances—greater than six feet—extra precautions should be taken for congregate settings like Calhoun.

c. The lack of social distancing during medication lines represents an important lapse in the COVID-19 response. According to the staff, there is a limited "keep on person" program, meaning that detainees are not allowed to hold their medication and instead virtually every person receiving a medication must queue in medication lines on a daily or twice-daily basis. Having close contact among people in these lines creates a disproportionate risk of COVID-19 transmission among people with health problems, exactly the opposite of a risk mitigation strategy. In addition, the housing of high-risk people throughout the facility makes it improbable that improvement to these practices can be focused on those most impacted by them, even if there is an effort to address these deficiencies in the dedicated high-risk housing areas.

d. During the inspection, while I was visiting housing units, most detainees were in their cells. It appeared that detainees were left to monitor social distancing on their own, and that staff were not engaging in promoting social distancing in meal times or other routine activities in housing areas.

e. Moreover, there are still roving staff and detainees who move between different housing units. For instance, Calhoun stated that officers move in and out of the unsupervised housing units and that supervisors also intermittently move from one unit to another. Medical staff also necessarily move between units when delivering medication. And, as elaborated on below, detainees on cleaning duties move between units, including going into those housing high-risk individuals.

f. Insufficient Cleaning and Hygiene Protocols: Calhoun stated that it had a policy to clean areas where COVID-19 patients had been living, but it appears this critical task is not taking place. As mentioned above,

[9] Centers for Disease Control and Prevention, *Scientific Brief: SARS-CoV-2 and Potential Airborne Transmission* (last updated Oct. 5, 2020), https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-sars-cov-2.html.

detainees in H unit reported that after positive individuals were removed, no staff or other crew returned to the unit to clean the areas where these individuals had been sleeping. Instead, detainees who were newly transferred into the unit were advised—by other detainees, and not even the facility itself—to clean those areas themselves.

g. Calhoun also claimed to be conducting daily screenings of detained people who are on work crews. But interviewed detainees on work crews denied having daily symptom screening or vitals checks. These deficiencies represent significant gaps in adherence to CDC guidelines.

h. The lack of basic infection control in cleaning and disinfecting the pulse oximeters is especially concerning because it was reported among people with active COVID-19. While an individual person may be protected by washing their hands if they can and immediately do so, it is unacceptable (and contrary to the policy stated by the HSA) for these devices not to be cleaned/disinfected in between uses, since that failure promotes spread of the COVID-19 virus.

i. Although cleaning and PPE supplies seemed to be sufficient during the inspection, multiple detainees reported gaps in availability of hand sanitizer, paper towels, and surgical masks in the weeks prior to and following the inspection.

j. Insufficient Monitoring: As I mentioned above, it appears that Calhoun medical staff are conducting COVID-19 screening checks without proactively asking about symptoms, especially in Spanish or other non-English languages. Thus, for those with COVID-19, like the individuals in K unit, staff is conducting checks without actual communication. A person could get quite ill, but it may not be caught because all staff are doing is taking the patient's vitals. The three ICE detainees in K unit were in their 20s and did not seem to have underlying health issues, so the inadequate screenings will not likely lead to deaths. However, this reflects that the system is set up to only catch cases and address serious consequences when it is too late.

k. The fact that almost all of the COVID-19 screening forms indicate no symptoms being present stands in stark contrast both to the reports of

detained people who say they are not even being asked about symptoms and to the actual occurrence of outbreaks.

i. For instance, as detailed in the Maneval Declaration, there were several detainees who had tested positive for COVID-19 and submitted declarations that I reviewed attesting to their COVID-19 symptoms. Many of these symptoms were also corroborated in sick call requests around the same time. Yet, these individuals' COVID-19 screening records reflected none of the symptoms reported elsewhere, with "No" checked indiscriminately across the sheet.

ii. It also appeared that these screening forms were not even consistently filled out, with no screenings conducted on similar dates across multiple individuals, in the middle of the individuals' quarantine period.

l. One of the core problems in finding and caring for new cases of COVID-19 is lack of language services, especially in housing areas where many critical health services occur. Despite the health staff stating that all health services that occur in housing areas, including COVID-19 screenings utilize the language line, no detainees had seen or experienced this and many of the detainees I spoke with personally reported a lack of language line access during encounters with health staff, especially when they occurred in housing areas.

51. **Deficiencies in Protecting High-Risk Patients.**

a. Failure to Release: No further light has been shed on the process for custody review of those who are at higher risk of serious consequences from COVID-19, which largely reflects the fact that the inspection and interviews were with Calhoun staff, while release decisions are made by ICE. The most information was provided in Officer Ronald Whalen's declaration, dated October 30, 2020, whose issues I previously identified: ICE is not considering release of *all* high-risk individuals, only those whose detention is not "mandatory"; ICE has not identified anyone it has released through this process or explained how long it takes from identification of an individual to the custody decision; ICE's view of "high risk" is too limited and does not include all CDC-recognized

factors; and it is unclear who conducts the reviews (*see* ECF No. 400-4, ¶ 19(d)). It does not appear that the Defendants have been proactively releasing such individuals from detention despite the universal acceptance among the medical community that those facing higher risk should be prioritized for release, both for the health and safety of those detainees as well as the medical resources of the facility and surrounding community. As I have previously underscored, there is no substitute for consideration for release.

b. Failure to Timely and Adequately Identify: There are two distinct, if interrelated, problems with Calhoun's identification of high-risk detainees. First, Calhoun's definition of who is high-risk does not include many individuals who are high-risk. The HSA stated that they were using the same criteria as in the *Fraihat* litigation in determining whether an ICE detainee is high-risk. However, ICE appears to have contested the medical vulnerability of multiple individuals who should be covered under *Fraihat* because of their mental health illnesses and/or other factors recognized by the CDC, including body mass index of 25-30 and smoking history. As I explained in my previous declarations, ICE also does not recognize risk factors of increased age (50-55) or other factors on the margins.

c. Second, Calhoun lacks adequate procedures for identifying those who are high-risk, even for those whose conditions Defendants concede make a person high-risk. One person I spoke with in his eighth month of detention was being treated for hypertension in the facility but was not identified as high-risk. Another person I spoke with met criteria for being high-risk due to his BMI but was not identified as high-risk for many months. When asked about their process for identifying risk factors, Calhoun staff said they relied primarily on their chronic care reports and assert they are relying on records when individuals are transferred from other facilities. However, Calhoun has not explained why certain individuals on ICE's chronic care reports are not considered to be high-risk. Chronic care reports are also under-inclusive because individuals may have risk factors, such as a high BMI, that do not necessarily require chronic care, but nevertheless put them at high-risk for a severe outcome if infected with COVID-19. The separate declaration submitted with this report documents additional cases in which people who meet the high-risk criteria were not identified until Plaintiffs intervened.

d. I have reviewed the chronic care registry and am also concerned that people may enter with health problems that do not result in a chronic encounter for many weeks. For example, one patient with hypertension and two other chronic health issues entered with very elevated blood pressure, 160/100, stating that he had not taken any of his medications for three days. The physician restarted his medications but ordered the next chronic care encounter for 90 days, when he should have been seen in the following week to see whether his medications were having the desired effect.

e. The process of identifying high-risk people also appears to take an unreasonably lengthy amount of time as some detainees—even those transferred from BOP facilities—have not been identified as high risk until several weeks or over a month after being at Calhoun. According to Plaintiffs' records, as of January 6, 2021, they had identified 30 detainees that Defendants failed to identify but conceded to be medically vulnerable or the Court determined are medically vulnerable. *See* Exhibit C, Gardner Declaration.

f. Issues with Housing and Accommodations: Calhoun is housing ICE and criminal detainees together in nearly all of the housing units. Moreover, Calhoun is housing those identified as high-risk with other detainees. The mixed housing assignments raises confusion as to who should be provided certain accommodations. Moreover, it makes little sense to provide accommodations to a subset of a housing unit when the risk of transmission is relatively the same within a unit. In other words, only testing or providing symptom monitoring for some people in a unit means that the facility will likely miss cases among the non-high-risk individuals in the unit until it is too late and reaches the high-risk individuals. It would be much simpler and more effective to test and monitor the whole housing unit or facility than simply the high-risk individuals.

g. As discussed above, it is also unclear to what extent Calhoun has been able to implement its protocols for high-risk individuals. High-risk detainees were tested on October 27, 2020, but then not again until December 9, 2020. And even then, a few individuals were not tested on December 9, including two who had previously tested positive for COVID-19. As explained before, however, reinfection is possible so a

prior infection does not mean that those individuals have no need for current protection.

h. Inadequate Medical Treatment: The facility also appears to have an inadequate chronic care and medication system that likely causes chronic health problems to be poorly controlled, which directly increases the risk of serious illness or death from COVID-19 infection.

i. The delays and lack of delivery of medications to people with chronic health problems is very concerning because it increases the risk of poor outcomes if and when people are infected with COVID-19. Combined with the overall slow and deficient responses to the two recent outbreaks in G and H units, the facility is an extremely dangerous place for anyone who is high-risk for serious illness or death from COVID-19.

52. Defendants recently submitted a memorandum on December 23, 2020, arguing that they have a much lower rate of positive cases—1% for the period from May 8, 2020 through December 17, 2020—compared to general rates in counties and even among other employment settings. There are several issues with Calhoun's representation of the numbers. *See generally*, Haier Declaration, Exhibit A, ¶¶ 20–24.

a. First, compared to non-detained populations, the population at Calhoun experiences far higher turnover rates: detainees, particularly those who are not under ICE custody, can cycle in and out of the facility after several days or hours, as opposed to ICE detainees who are more likely to experience at least several weeks if not many months or more of detention. Because length of detention correlates to possibility of infection, it is simply erroneous to lump all the positive cases and divide by every single individual who has gone through Calhoun, no matter the length of time they face in custody. This represents a misunderstanding of the risk that congregate settings pose, and the outbreaks of October/November reflect the reality. Thus, Calhoun is not comparing like to like because its positivity rate is based on dividing the number of positive cases (minus those who tested positive at intake) by the *entire* population of detainees who passed through Calhoun regardless of how long they were detained at Calhoun.

b. Second, ICE detainees have a higher positivity rate than criminal detainees, which may well reflect the fact that they tend to be detained longer at Calhoun. Of the 3876 individuals who passed through the jail, only 678 were ICE detainees. Yet 47 of the 72 positive cases were ICE detainees. Thus, the positivity rate for ICE detainees was 6.93% (47 out of 678). *Id.* at ¶ 22.

c. However, this positivity rate still understates the risk, because it does not account for the fact that some ICE detainees are also only held briefly at Calhoun, and that detainees who are held longer are more likely to become infected. In order to assess the positivity rate of ICE detainees held for longer periods, I asked Plaintiffs' litigation team to cross reference the testing logs with the housing logs and exclude individuals who were detained for less than three weeks. The positivity rate for ICE detainees held longer than three weeks is 13.4% (39 cases out of 291 detainees). *Id.* at ¶ 23.

d. Third, it appears that Calhoun is once again downplaying the spike in cases that resulted from the outbreaks in October/November, attempting to smooth over the rate of transmission over a period of many months instead of the two-week period in which Calhoun experienced over 40 new cases. Defendants' list of positive ICE detainees shows 22 positives (of which only one was at intake) during the period from October 17 to October 29 when the outbreaks were occurring. ECF No. 477, Exh. A. Defendants' testing log shows that during that same period, 127 ICE detainees were tested, for a positivity rate of 17%. (If one uses Defendants' method and excludes those tested at intake, the numbers are even higher: there were 21 positives out of 84, or a positivity rate of 25%.) *Id.* at ¶ 24. These numbers reflect the reality that once an index case occurs inside Calhoun, it is likely to quickly result in numerous other cases.

e. In addition, where people are detained matters. Once the outbreak occurred, the positivity rates for individuals in units H was 53%. This was established by cross-referencing the positives cases from October 17-29 with ICE detainees who were tested and who were shown on the October 7, October 14, or October 21, 2020 housing lists as in Pod H, where the main outbreak occurred. 18 detainees out of 34 tested positive. *Id.*

f. Fourth, Calhoun has excluded those who came into the facility with a positive test. But when calculating rates among populations in various counties and geographic areas, health departments do not distinguish between those who had traveled elsewhere and then tested positive in that region and those who had become infected while in the region. So, Calhoun is not comparing like to like. Moreover, in terms of infection transmission, a detainee who enters the facility as a positive case is still capable of spreading the virus so it makes little sense to discount them from the overall statistic.

g. Fifth, in its calculation, Calhoun also overlooks the fact that it did not begin regular testing until several months into the pandemic, around mid-June 2020, and even then, the facility only regularly tests among new admissions and not the general population or staff. Thus, the reported positivity rate only reflects cases that were covered under these protocols and not those that escaped undetected as asymptomatic or untested cases. In order to include the entire population in the denominator of this calculation, Calhoun health staff would need to ask people about COVID-19 symptoms and/or conduct antibody testing to determine how many people are likely to have contracted COVID-19 before testing was expanded.

h. Finally, the positivity rate among staff at Calhoun is 15% (18 staff members out of 120 total staff members). *Id.* at ¶ 25.

53. **Other issues**

a. As I noted above, an analysis of the sick call requests produced by Defendants show that—despite Calhoun's guarantee of a face-to-face encounter within 24 hours—there were no substantive responses documented in nearly half of all requests in the record, including no response at all or a response with a blank comment section in 59 cases. Maneval Declaration, Exhibit B, ¶ 10(a). A significant number (54) of sick call requests included references to symptoms consistent with COVID-19, but there is no documented substantive response for over half (28) of these requests, as well as gaps in time it takes to get a test. *See* Maneval Declaration, Exhibit B, ¶ 12.

b. Comparing detainees' reports to sick call requests and COVID-19 screening forms, there were several discrepancies that alarmed me. Notably, many detainees who tested positive for COVID-19 during the October/November 2020 outbreaks had attested to having COVID-19 symptoms in declarations and sick call requests. Yet, those symptoms were not documented in Calhoun's COVID-19 screening forms. A few examples are highlighted below:

    i. One detainee testified that he started to feel symptoms on October 14, including headaches, muscle soreness, nausea and night sweats. Maneval Declaration, Exhibit B, ¶ 19(a). He submitted a sick call request on October 20, as documented by Calhoun, in which he sought treatment because he had been throwing up for the past three days. He tested positive on October 21 and his COVID-19 screening form was filled out for October 19 through 29 (skipping October 22). Yet at no point in his COVID-19 screening form were any of his symptoms indicated. *Id.*

    ii. Another detainee who tested positive on October 20 had submitted multiple sick call requests from October 12 through November 3, documenting COVID-19 symptoms like stomach pain and headaches. Yet, there are no symptoms documented on his COVID-19 screening form. *Id.* at ¶ 19.

    iii. A third individual reported severe COVID-19 symptoms beginning around October 19 or 20, and was so ill that he had to be taken to the medical unit for part of the day on October 20. Yet, there is no indication of any of his symptoms (such as headaches, dry cough, loss of taste and smell) on his COVID-19 screening form, and Calhoun produced no records of this individual's admission into the medical unit despite Defendants confirming, in an email to the Court, that he had been housed in the medical unit. *Id.* at ¶ 19.

    iv. These records confirm how I suspect the outbreaks to have arisen at Calhoun. During the inspection, the HSA verified that individuals had reported upper respiratory symptoms in housing unit H, but suggested that there was no decision to test because nobody had a fever. Yet it was precisely this failure to respond to clear COVID-19 symptoms that allowed the disease to spread as

quickly as it did within the unit. Calhoun's inattention to COVID-19 symptoms is reflected in their own screening forms, which by and large do record vitals like temperature and oxygen saturation level—with noticeable gaps discussed below—but the specific questions for COVID-19 symptoms appear either not to be asked or the box "No" is checked for every symptom on every date for which there is an entry, even where detainees are reporting symptoms in their sick call requests. *Id.* at ¶ 18 – 19.

v. This is consistent not only with what detainees have reported—that there is no proactive questioning about symptoms—but also with Calhoun's own reports. During the inspection, medical staff estimated that it could take about 10 to 15 minutes to conduct screenings in a unit; specifically, for the four people isolated in K unit for COVID-19, they estimated needing 15 minutes to conducting a daily screening. However, in order to measure respiratory rate, heart rate, temperature, and oxygen saturation level, and ask eight questions about COVID-19 symptoms, it would take at minimum five minutes per person—and double that time if using a language line with a non-English speaker. It would require closer to 30-35 minutes for Calhoun to adequately screen four individuals in unit K (with three Spanish speakers), not the reported 15.

c. Gaps in Records: Calhoun was responsible for producing certain documents prior to the inspection. However, there were several gaps in the records that either reflect issues with the facility's record process or their record organization and storage.

i. Although some sick call requests were provided, it does not appear that all the requests were provided. Calhoun provided approximately 650 sick call requests. But based on the volume of sick call requests I was told Calhoun handles per week (a couple hundred), there should have been many more sick call requests for the eight-week period of October 1-November 13 and December 3-16, closer to 1,800 to 2,000. I was, of course, unable to review the documents that were not provided.

ii. A review of Calhoun's COVID-19 symptom screening forms also had some gaps, as elaborated on in the Maneval Declaration. For instance, inexplicably, for multiple detainees, screenings appeared to be skipped on a certain date during the period when they were in quarantine—for many, across the same date on multiple forms. Maneval Declaration, Exhibit B, ¶ 18. For at least 60 of these individuals, the screening form was not filled out for multiple days in their quarantine (two to five days), without any explanation. *Id*.

iii. Calhoun provided records for two detainees who were housed in the medical unit, but evidence indicates that a few others had been admitted into the medical unit, including one that Defendants confirmed by email and another discussed during the facility inspection. Without these records, I am unable to review the extent of these individuals' illness or Calhoun's treatment of them.

iv. Lastly, Calhoun indicated that it used the same screening tool for COVID-19 positive individuals who have no symptoms or mild symptoms. But it is unclear how or to what extent Calhoun documents information about COVID-19 positive individuals who show more severe symptoms (like for those individuals who had been in the medical unit).

d. The HSA reported that Corizon has a 100% on its quality assurance on their chronic care and sick calls. However, as discussed above, there were many issues with Calhoun's response to sick call requests, including not providing face-to-face encounters within 24 hours, or dismissing complaints without an adequate response. Moreover, the HSA clarified that the compliance rate was based on a review of last year's data. Obviously, COVID-19 represents a seismic shift in health care and treatment in congregate settings, and Calhoun should be undertaking a more recent and active assessment of their health care provision systems.

H. Recommendations

54. Although Calhoun has seen some improvement since the beginning of the COVID-19 pandemic and has adopted some changes since the recent outbreaks, it is my expert opinion that the COVID-19 response protocols and practices remain inadequate to prevent and manage the spread of COVID-19 within the facility, especially within the responses of the facility health

service. There are three types of concern. First, there are structural issues, including the inherent dangers of congregate settings, the facility design, and the inadequacy of the health services infrastructure, that are either very expensive or effectively impossible for Defendants to address, but that create a significant risk of COVID-19 infection and of poor outcomes from infection. Second, while Calhoun has adopted precautions on paper that can be an important step to mitigate risk, not all of these precautions are being implemented consistently, as reflected in detainee accounts and Calhoun's own housing and testing records. The problem here is not with the protocols themselves, but with ensuring that they are followed. Third, the current precautions are inadequate and incomplete to address fundamental gaps in Calhoun's response. Additional precautions needed to be adopted, and then consistently implemented. In order to assist the Court in distinguishing between recommendations that require consistent implementation of existing protocols and recommendations that require adoption of additional measures, a chart showing which recommendations fall into which category can be found above at Section B.

55. Throughout my inspection, and in documents I reviewed, Calhoun staff repeatedly stated that their response has been entirely appropriate and that they do not need any additional resources to properly manage the COVID-19 outbreak in the facility. I disagree with this characterization for the following reasons:

    a. With two recent outbreaks revealing a lack of timely health assessment and care for people repeatedly reporting symptoms of COVID-19, the facility is an extremely dangerous setting for anyone who meets CDC criteria for serious illness or death from COVID-19. The lack of awareness of these ongoing problems by health leadership leaves me concerned that these deficiencies will not be quickly or easily remedied. There are deep structural issues that Calhoun has not and likely will not be able to address, including the inherent inability to social distance at all times in a congregate setting where detainees are inevitably exposed to other detainees and staff, and the endemic failure to address detainees' healthcare needs in a timely fashion, which can lead to rapid spread of COVID-19, especially when someone outside the admission units is infected.

b. Ongoing COVID-19 cases are likely to occur at Calhoun as long as there is significant spread of COVID-19 in the community around the facility and an influx of staff and detained people on a daily basis—including detainees being transferred from other facilities in which COVID-19 is spreading. The new strain of COVID-19, which is more transmissible, further increases the likelihood of more outbreaks.

c. The facility leadership stated that rates of COVID-19 cases had been fairly steady for many months, and when pressed, the health leadership expressed confidence in the adequacy of their response to recent outbreaks in G and H units. These responses were woefully inadequate in my opinion, based on the clear pattern of multiple people reporting clear COVID-19 symptoms over many days, only to be brushed off by health staff instead of taken seriously, and quickly assessed, tested and cared for.

56. The following are recommendations, based on my inspection and record review, to mitigate morbidity, mortality and severe health outcomes from COVID-19 among people in ICE custody at Calhoun.

57. **Recommendation 1. High-risk people should not be detained at Calhoun unless there is no safe way for them to be supervised in the community.** People who are at high risk of severe outcomes from COVID-19 are in danger if detained at Calhoun, both because of the significant risk that they will become infected and because of the likelihood that if infected, they will not be promptly treated.

a. A transparent and expedited process for considering high-risk individuals for release is critical to ensuring that those individuals who can be safely supervised in the community are not unnecessarily detained.

b. While infection may not be entirely preventable for most detainees, it is entirely preventable and warranted for those who are at higher risk of serious illness or death from COVID-19 if and when the facility were to undergo another outbreak.

58. **<u>Recommendation 2.</u> Implement a system that timely and adequately identifies all high-risk people at Calhoun.**

    a. Expand the risk factors used to identify individuals as high risk to explicitly include all risk factors listed by the CDC, including smoking history and BMI 25+, as well as consider individuals to be medically vulnerable if they have multiple threshold risk factors.

    b. Upon admission, comprehensively screen all incoming detainees for all risk factors listed by the CDC, including for blood pressure, BMI, and smoking history. Ensure that all intake health assessments are reviewed by the MD or PA within 24 hours of arrival for any potential high-risk criteria, including a review of the individual's current medications to determine if they indicate a high-risk condition and a prompt face-to-face encounter if additional information is needed to determine whether the person is high risk.

    c. The MD and PA should further review all new prescriptions, medical orders, and additions to the chronic care list at least weekly to determine whether any people who did not meet the high-risk criteria at intake now do.

    d. Maintain a roster of all high-risk individuals in the facility that is used to identify people for consideration for release and for additional precautions pending release decisions or if release is denied.

    e. For all high-risk individuals, conduct a dedicated encounter with a physician or physician assistant to discuss whether they have been infected with COVID-19 and have any persisting symptoms, their potential complications from COVID-19 should they become infected, as well as their willingness to receive vaccination and their allergy history.

59. **<u>Recommendation 3.</u> Adopt adequate precautions to reduce risk for all detainees and to protect high-risk detainees while releases are considered.**

    a. **Social Distancing Precautions:** Social distancing is a critical element of COVID-19 prevention, but is not currently possible for detainees at Calhoun.

i. Keep population levels low by limiting the number of new intakes and transfers into Calhoun.

ii. Implement single-celled housing for all detainees in a non-punitive manner. This would require limiting the population to approximately one half of cell areas where double bunks are present.

iii. At a minimum, continue to ensure that all high-risk detainees are single celled in a non-punitive manner.

iv. Staff should be involved in maintaining social distancing in common spaces and settings, including recreation, medication lines, meals and general usage of common spaces.

b. **Precautions to Promptly Identify Infected Individuals**

i. Ensure that all detainees who report COVID-19 symptoms are promptly seen by medical staff and promptly tested (within 24 hours). They should also be placed in medical isolation, in separate units from people not in medical isolation and in a manner consistent with CDC guidelines that prevents the potential spread of COVID-19.

ii. Administratively track and monitor all cases where detainees report COVID-19 symptoms in order to quickly identify situations where COVID-19 is spreading in the facility.

iii. Restart and properly implement daily screening for COVID-19 signs and symptoms in quarantine and new admission areas.

iv. Ensure that all high-risk individuals are provided twice-daily screenings of temperature and vitals, and proactive questioning regarding COVID-19 symptoms with adequate provisions for translation during these encounters.

v. Provide daily COVID-19 screenings for individuals in work crews.

vi. Develop protocols for contact tracing to identify all individuals with close contact to a detainee, inmate or staff member who tests positive. Define close contact based on CDC definitions to include anyone with 15 minutes *cumulative* contact over a 24-hour period. Ensure that all detainees who have close contacts are promptly seen by medical staff and promptly tested (within 24 hours).

vii. Ensure that health services, including COVID-19 screenings and medical isolation rounds, occur with Spanish-speaking staff and rely on language line access for people requiring other languages.

c. **Testing and Quarantine Precautions:**

i. Provide for regular biweekly testing of *all* detainees, inmates and staff. Comprehensive, regular testing is necessary to promptly identify all cases and prevent spread.

ii. Ensure that all incoming detainees and inmates are not placed into the general population until they have cleared two rounds of COVID-19 testing and 10-14 days of quarantine. When possible, Calhoun should insist on COVID-19 testing among people being transferred from other facilities.

iii. Ensure that close contacts and individuals reporting COVID-19 symptoms (staff and detainees) are immediately tested and fully quarantined while awaiting test results.

iv. Ensure all individuals who test positive for COVID-19 are cared for in medical isolation in a manner that is consistent with CDC standards, based on days without symptoms or follow-up testing.[10] Medical isolation should include at least daily health assessments that include vital signs, lung and heart auscultation and asking about COVID-19 symptoms. The symptom acuity tool utilized by

[10] Centers for Disease Control and Prevention, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* (last updated Dec. 31, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#Medicalisolation.

health staff should be reviewed for addition of pre-existing risk factors, but the physical examination of COVID-19 patients' lungs and heart should occur for every person on every day of their medical isolation, whether or not they are considered 'symptomatic'.

v. Ensure that detainees are promptly (within 24 hours) informed of test results.

d. **Hygiene Precautions:**

i. Design and implement a cleaning/disinfecting protocol for responding to new cases of COVID-19 that meets CDC criteria and does not rely on untrained and unequipped detained people to do this work.

ii. Ensure that detainees have regular access to soap, paper towels, and hand sanitizer.

iii. Provide all detainees with two cloth masks that are regularly laundered (twice a week), as well as the offer of one new surgical mask each day.

iv. Clean and disinfect pulse oximeters and other medical equipment utilized in daily screenings and other health services in between uses. Given the repeated reports from detainees that this is not done, the director of nursing and HSA should document that this occurs.

e. **Precautions to Reduce Risk that Staff Will Be a Source of Transmission:**

i. Ensure that all health and security staff are fit tested for N95 masks. Until universal fit testing can be completed for all staff, the facility must ensure that only staff who have been fit tested (and who are wearing the make and size of N95 mask they are fit tested for, along with other necessary PPE), responds to any situations that involve direct close contact.

60. **Recommendation 5. Address flaws in current health provision system.** Inadequacies in Calhoun's health care system affect morbidity and mortality risk from COVID-19 in multiple ways including (1) failure to properly identify high-risk individuals; and (2) failure to properly identify individuals with COVID-19 due to inadequate screening protocols and inadequate response to sick call, creating conditions for rapid disease spread. In addition to the recommendations above, the following improvements are needed:

    a. Employ additional infection control staff to do COVID-19 screenings and respond timely to sick call requests. The facility should track every sick call request that includes a potential COVID-19 symptom and ensure that a) each person reporting these symptoms is assessed in 24 hours or less and b) that the symptoms, housing areas and timeliness of response to those symptoms is tracked in an aggregate database that allows staff to see the daily emergence of symptoms and the timeliness of clinical responses.

    b. Develop a plan to ensure that health care encounters, including COVID-19 screenings in housing units and medical isolation rounds, are conducted in detainee's primary language, either with Spanish-speaking staff or through use of language line. The lack of Spanish-speaking health staff to ask basic screening and treatment questions relating to COVID-19 in a facility that has a contract to detain many Spanish-speaking people in ICE custody is unacceptable and represents a human resource issue. The HSA and security leadership should maintain a list in every housing area of people who require language assistance and ensure that all health services are provided with this assistance.

    c. Ensure that people who arrive with medication from other facilities, or who report taking medications for chronic health problems are seen upon arrival by a physician or physician assistant and that their medications are not interrupted during their new admission process absent a review and documentation of the reason for changes or discontinuation of medications.

    d. All people in medical isolation, whether with suspected or confirmed COVID-19 and whether symptomatic or asymptomatic, should have at least a daily health assessment that includes vital signs, questions about COVID-19 symptoms, and a physical examination of heart and lungs.

The clinical acuity tool being utilized in the facility is a good improvement, but it is utilized only for people who are found to be symptomatic, which leaves a gap in the people who are thought to be asymptomatic, but may simply be unable to report their symptoms because of language barriers and who are not being physically examined.

e. Implement a post-COVID-19 encounter so that all individuals who have tested positive for COVID-19 have a dedicated encounter with a physician or physician assistant one to two weeks after a patient leaves medical isolation. The purpose of this encounter is to ask about the symptoms each patient experienced during the acute phase of COVID-19 infection and detect any lingering or ongoing symptoms and potential need for ongoing care physical therapy or specialty referral.

f. Ensure that detainees are not retaliated against for "over-kiting" or requesting COVID-19 protection, testing and/or medical treatment.

61. **<u>Recommendation 6.</u> Investigate recent outbreaks and review practices for improvements.**

a. Review recent outbreaks to identify how the health service can deploy to a housing area where an outbreak is being reported and conduct clinical assessment and testing in a period of hours, as opposed to the one to two weeks reported in G and H units.

b. Retain an infection control nurse to review these outbreaks and make recommendations to the facility on improving current practices.

c. Review the transfers of people around the time of the two recent outbreaks in G and H units to determine whether people with COVID-19 were transferred without being tested, and how much potential exposure among other detainees and staff may have occurred. Special attention should be given to any transfers/removals of people from G or H units in the 10 days before those units were tested. One specific example reported by people I spoke with was the removal of 2 people to Ecuador who were housed in H unit around the time that the unit was tested, and at least one of whom had been reported to health staff as being ill with COVID-19 symptoms.

I. Conclusion

62. The current situation puts all detainees at Calhoun at risk. However, for individuals who face a higher risk of serious illness or death from COVID-19, this setting presents a serious danger because Calhoun is unlikely to prevent the entry of new infections and, more importantly, does not have the systems in place to adequately catch and prevent transmission of new infections, particularly those outside the new admissions quarantine units.

Executed this 7th day of January, 2021 in Port Washington, NY.

Signed,

Homer Venters MD, MS

APPENDIX A

Dr. Homer D. Venters

hventers@gmail.com,

HEALTH ADMINISTRATOR PHYSICIAN EPIDEMIOLOGIST

Professional Profile

- International leader in provision and improvement of health services to patients with criminal justice involvement.
- Innovator in linking care of the incarcerated to Medicaid, health homes, DSRIPs.
- Successful implementer of nations' first electronic health record, performance dashboards and health information exchange among pre-trial patients.
- Award winning epidemiologist focused on the intersection of health, criminal justice and human rights in the United States and developing nations.
- Human rights leader with experience using forensic science, epidemiology and public health methods to prevent and document human rights abuses.

Professional Experience

Medical/Forensic Expert, 3/2016-present

- Appointed to Connecticut State Prison COVID monitoring panel.
- Review COVID-19 policies and procedures in detention settings including in-person inspections of;
    - MDC Brooklyn (BOP), NY
    - MCC Manhattan (BOP), NY
    - FCI Danbury (BOP), CT
    - Cook County Jail, IL
    - Broome County Jail, IL
    - Sullivan County Jail, NY
    - Shelby County Jail, TN
    - Farmville Detention Center (ICE), VA
    - Lompoc Prison (BOP), CA
    - Southern Mississippi Correctional Facility, MS
    - Central Mississippi Correctional Facility, MS
    - FDC Philadelphia (BOP), PA
    - Osborn Correctional Institution, CT
    - Robinson Correctional Institution, CT
    - Hartford Correctional Center, CT
    - Dallas County Jail, TX
    - Cheshire Correctional Institution, CT
    - Calhoun County Jail, MI
    - York Correctional Institution, CT

- Independent correctional health monitor (Santa Barbara County Jail, CA & Fluvanna Women's Correctional Center, VA)
- Conduct analysis of health services and outcomes in detention settings.
- Conduct site inspections and evaluations in detention settings.

- Produce expert reports, testimony regarding detention settings.

President, Community Oriented Correctional Health Services (COCHS), 1/1/2020-4/30/20.
- Lead COCHS efforts to provide technical assistance, policy guidance and research regarding correctional health and justice reform.
- Oversee operations and programmatic development of COCHS
- Serve as primary liaison between COCHS board, funders, staff and partners.

Senior Health and Justice Fellow, Community Oriented Correctional Health Services (COCHS), 12/1/18-12/31/2018
- Lead COCHS efforts to expand Medicaid waivers for funding of care for detained persons relating to Substance Use and Hepatitis C.
- Develop and implement COCHS strategy for promoting non-profit models of diversion and correctional health care.

Director of Programs, Physicians for Human Rights, 3/16-11/18.
- Lead medical forensic documentation efforts of mass crimes against Rohingya and Yazidi people.
- Initiate vicarious trauma program.
- Expand forensic documentation of mass killings and war crimes.
- Develop and support sexual violence capacity development with physicians, nurses and judges.
- Expand documentation of attacks against health staff and facilities in Syria and Yemen.

Chief Medical Officer/Assistant Vice President, Correctional Health Services, NYC Health and Hospitals Corporation 8/15-3/17.
- Transitioned entire clinical service (1,400 staff) from a for-profit staffing company model to a new division within NYC H + H.
- Developed new models of mental health and substance abuse care that significantly lowered morbidity and other adverse events.
- Connected patients to local health systems, DSRIP and health homes using approximately $5 million in external funding (grants available on request).
- Reduced overall mortality in the nation's second largest jail system.
- Increased operating budget from $140 million to $160 million.
- Implemented nation's first patient experience, provider engagement and racial disparities programs for correctional health.

Assistant Commissioner, Correctional Health Services, New York Department of Health and Mental Hygiene, 6/11-8/15.
- Implemented nation's first electronic medical record and health information exchange for 1,400 staff and 75,000 patients in a jail.
- Developed bilateral agreements and programs with local health homes to identify incarcerated patients and coordinate care.
- Increased operating budget of health service from $115 million to $140 million.
- Established surveillance systems for injuries, sexual assault and mental health that

drove new program development and received American Public Health Association Paper of the Year 2014.
- Personally care for and reported on over 100 patients injured during violent encounters with jail security staff.

Medical Director, Correctional Health Services, New York Department of Health and Mental Hygiene, 1/10-6/11.
- Directed all aspects of medical care for 75,000 patients annually in 12 jails, including specialty, dental, primary care and emergency response.
- Direct all aspects of response to infectious outbreaks of H1N1, Legionella, Clostridium Difficile.
- Developed new protocols to identify and report on injuries and sexual assault among patients.

Deputy Medical Director, Correctional Health Services, New York Department of Health and Mental Hygiene, 11/08-12/09.
- Developed training program with Montefiore Social internal medicine residency program.
- Directed and delivered health services in 2 jails.

Clinical Attending Physician, Bellevue/NYU Clinic for Survivors of Torture, 10/07-12/11.

Clinical Attending Physician, Montefiore Medical Center Bronx NY, Adult Medicine, 1/08-11/09.

Education and Training

Fellow, Public Health Research, New York University 2007-2009. MS 6/2009
Projects: Health care for detained immigrants, Health Status of African immigrants in NYC.
Resident, Social Internal Medicine, Montefiore Medical Center/Albert Einstein University7/2004- 5/2007.
M.D., University of Illinois, Urbana, 12/2003.
M.S. Biology, University of Illinois, Urbana, 6/03.
B.A. International Relations, Tufts University, Medford, MA, 1989**.**

Academic Appointments, Licensure

Clinical Associate Professor, New York University College of Global Public Health, 5/18-present.

Clinical Instructor, New York University Langone School of Medicine, 2007-2018.

M.D. New York (2007-present).

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Testimony: U.S. House of Representatives, House Judiciary Committee's Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law: Hearing on Problems with Immigration Detainee Medical Care, June 4, 2008.

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MacDonald R, Parsons A, **Venters H.** The Triple Aims of Correctional Health: Patient safety, Population Health and Human Rights. *Journal of Health Care for the Poor and Underserved*. 2013. 24(3).

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Venters H, Foote M, Keller AS. *Journal of Immigrant and Minority Health.* (2010) Medical Advocacy on Behalf of Detained Immigrants. 13(3): 625-8.

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Kjome JR, Swenson KA, Johnson MN, Bordayo EZ, Anderson LE, Klevan LC, Fraticelli AI, Aldrich SL, Fawcett JR, **Venters HD**, Ala TA, Frey WH 2nd (1997) Inhibition of antagonist and agonist binding to the human brain muscarinic receptor by arachidonic acid. *J. Mol. Neurosci.* 10, 209-217.

Honors and Presentations (past 10 years)

Invited presentation, Screening and treatment for sexually transmitted infecitons in justice. National Academy of Sciences Committee on Law and Justice, remote,

September14th, 2020.

Invited presentation, Vaccination for COVID-19 in correctional settings. National Academy of Sciences Committee on Law and Justice, remote, August 20th, 2020.

Invited Presentation, Documenting Deaths in Custody, National Association for Civilian Oversight of Law Enforcement (NACOLE), remote, August 3rd, 2020.

Invited presentation, COVID-19 in correctional settings. Briefing for U.S. Senate Staff, sponsored by The Sentencing Project, remote, May 29, 2020

Invited presentation, COVID-19 in correctional settings. Briefing for Long Island Voluntary Organizations Active in Disaster , sponsored by The Health & Welfare Council of Long Island, remote, May 29, 2020.

Invited presentation, COVID-19 in correctional settings. National Academy of Sciences Committee on Law and Justice, remote, May 12, 2020.

Invited presentation, COVID-19 in correctional settings. National Association of Counties, Justice and Public Safety Committee, remote, April 1, 2020.

Keynote Address, Academic Correctional Health Conference, April 2020, Chapel Hill, North Carolina, postponed.

TedMed Presentation, Correctional Health, Boston MA, March 15, 2020.

Finalist, Prose Award for Literature, Social Sciences category for *Life and Death in Rikers Island*, February, 2020.

Keynote Address, John Howard Association Annual Benefit, November 2019, Chicago IL.

Keynote Address, Kentucky Data Forum, Foundation for a Healthy Kentucky, November 2019, Cincinnati Ohio.

Oral Presentation, Dual loyalty and other human rights concerns for physicians in jails an prisons. Association of Correctional Physicians, Annual meeting. 10/16, Las Vegas.

Oral Presentation, Clinical Alternatives to Punitive Segregation: Reducing self-harm for incarcerated patients with mental illness. American Public Health Association Annual Meeting, November 2015, Chicago IL.

Oral Presentation, Analysis of Deaths in ICE Custody over 10 Years . American Public Health Association Annual Meeting, November 2015, Chicago IL.

Oral Presentation, Medication Assisted Therapies for Opioid Dependence in the New York City Jail System. American Public Health Association Annual Meeting, November 2015, Chicago IL.

Oral Presentation, Pathologizing Normal Human Behavior: Violence and Solitary Confinement in an Urban Jail. American Public Health Association Annual Meeting, November 2014, New

Orleans, LA.

Training, International Committee of the Red Cross and Red Crescent, Medical Director meeting 10/15, Presentation on Human Rights and dual loyalty in correctional health.

Paper of the Year, American Public Health Association. 2014. (Kaba F, Lewis A, Glowa-Kollisch S, Hadler J, Lee D, Alper H, Selling D, MacDonald R, Solimo A, Parsons A, Venters H. Solitary Confinement and Risk of Self-Harm Among Jail Inmates. *Amer J Public Health*. 2014. Vol 104(3):442-7.)

Oral Presentation, Pathologizing Normal Human Behavior: Violence and Solitary Confinement in an Urban Jail. *American Public Health Association* Annual Meeting, New Orleans LA, 2014.

Oral Presentation, Human rights at Rikers: Dual loyalty among jail health staff. American Public Health Association Annual Meeting, New Orleans LA, 2014.

Poster Presentation, Mental Health Training for Immigration Judges. American Public Health Association Annual Meeting, New Orleans LA, 2014.

Distinguished Service Award; Managerial Excellence. Division of Health Care Access and Improvement, NYC DOHMH. 2013.

Oral Presentation, Solitary confinement in the ICE detention system. American Public Health Association Annual Meeting, Boston MA, 2013.

Oral Presentation, Self-harm and solitary confinement in the NYC jail system. American Public Health Association Annual Meeting, Boston MA, 2013.

Oral Presentation, Implementing a human rights practice of medicine inside New York City jails. American Public Health Association Annual Meeting, Boston MA, 2013.

Poster Presentation, Human Rights on Rikers: integrating a human rights-based framework for healthcare into NYC's jail system. *American Public Health Association* Annual Meeting, Boston MA, 2013.

Poster Presentation, Improving correctional health care: health information exchange and the affordable care act. *American Public Health Association* Annual Meeting, Boston MA, 2013.

Oral Presentation, Management of Infectious Disease Outbreaks in a Large Jail System. American Public Health Association Annual Meeting, Washington DC, 2011.

Oral Presentation, Diversion of Patients from Court Ordered Mental Health Treatment to Immigration Detention. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Initiation of Antiretroviral Therapy for Newly Diagnosed HIV Patients in the NYC Jail System. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Medical Case Management in Jail Mental Health Units. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Injury Surveillance in New York City Jails. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Ensuring Adequate Medical Care for Detained Immigrants. Venters H, Keller A, American Public Health Association Annual Meeting, Denver, CO, 2010.

Oral Presentation, HIV Testing in NYC Correctional Facilities. Venters H and Jaffer M, *American Public Health Association,* Annual Meeting, Denver, CO, 2010.

Oral Presentation, Medical Concerns for Detained Immigrants. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Oral Presentation, Growth of Immigration Detention Around the Globe. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Oral Presentation, Role of Hospital Ethics Boards in the Care of Immigration Detainees. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Oral Presentation, Health Law and Immigration Detainees. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Bro Bono Advocacy Award, Advocacy on behalf of detained immigrants. Legal Aid Society of New York, October 2009.

Oral Presentation, Deaths of immigrants detained by Immigration and Customs Enforcement. Venters H, Rasmussen A, Keller A, *American Public Health Association* Annual Meeting, San Diego CA, October 2008.

Poster Presentation, Death of a detained immigrant with AIDS after withholding of prophylactic Dapsone. Venters H, Rasmussen A, Keller A, *Society of General Internal Medicine* Annual Meeting, Pittsburgh PA, April 2008.

Poster Presentation, Tuberculosis screening among immigrants in New York City reveals higher rates of positive tuberculosis tests and less health insurance among African immigrants. *Society of General Internal Medicine* Annual Meeting, Pittsburgh PA, April 2008.

Daniel Leicht Award for Achievement in Social Medicine, Montefiore Medical Center, Department of Family and Social Medicine, 2007.

Poster Presentation, Case Findings of Recent Arestees. Venters H, Deluca J, Drucker E. *Society of General Internal Medicine* Annual Meeting, Toronto Canada, April 2007.

Poster Presentation, Bringing Primary Care to Legal Aid in the Bronx. Venters H, Deluca J, Drucker E. *Society of General Internal Medicine* Annual Meeting, Los Angeles CA, April 2006.

Poster Presentation, A Missed Opportunity, Diagnosing Multiple Myeloma in the Elderly Hospital Patient. Venters H, Green E., *Society of General Internal Medicine* Annual Meeting, New Orleans LA, April 2005.

Grants: Program

San Diego County: Review of jail best practices (COCHS), 1/2020, $90,000.

Ryan White Part A - Prison Release Services (PRS). From HHS/HRSA to Correctional Health Services (NYC DOHMH), 3/1/16-2/28/17 (Renewed since 2007). Annual budget $ 2.7 million.

Ryan White Part A - Early Intervention Services- Priority Population Testing. From HHS/HRSA to Correctional Health Services (NYC DOHMH), 3/1/16-2/28/18 (Renewed since 2013). Annual budget $250,000.

Comprehensive HIV Prevention. From HHS to Correctional Health Services (NYC DOHMH), 1/1/16-12/31/16. Annual budget $500,000.

HIV/AIDS Initiative for Minority Men. From HHS Office of Minority Health to Correctional Health Services (NYC DOHMH), 9/30/14-8/31/17. Annual budget $375,000.

SPNS Workforce Initiative, From HRSA SPNS to Correctional Health Services (NYC DOHMH), 8/1/14-7/31/18. Annual budget $280,000.

SPNS Culturally Appropriate Interventions. From HRSA SPNS to Correctional Health Services (NYC DOHMH), 9/1/13-8/31/18. Annual budget $290,000.

Residential substance abuse treatment. From New York State Division of Criminal Justice Services to Correctional Health Services (NYC DOHMH), 1/1/11-12/31/17. Annual budget $175,000.

Community Action for Pre-Natal Care (CAPC). From NY State Department of Health AIDS Institute to Correctional Health Services (NYC DOHMH), 1/1/05-12/31/10. Annual budget $290,000.

Point of Service Testing. From MAC/AIDS, Elton John and Robin Hood Foundations to Correctional Health Services (NYC DOHMH), 11/1/09-10/31/12. Annual budget $100,000.

Mental Health Collaboration Grant. From USDOJ to Correctional Health Services (NYC DOHMH), 1/1/11-9/30/13. Annual budget $250,000.

Teaching

Instructor, Health in Prisons Course, Bloomberg School of Public Health, Johns Hopkins University, June 2015, June 2014, April 2019.

Instructor, Albert Einstein College of Medicine/Montefiore Social Medicine Program Yearly lectures on Data-driven human rights, 2007-present.

Other Health & Human Rights Activities

DIGNITY Danish Institute Against Torture, Symposium with Egyptian correctional health staff regarding dual loyalty and data-driven human rights. Cairo Egypt, September 20-23, 2014.

Doctors of the World, Physician evaluating survivors of torture, writing affidavits for asylum hearings, with testimony as needed, 7/05-11/18.

United States Peace Corps, Guinea Worm Educator, Togo West Africa, June 1990- December 1991.

-*Primary Project;* Draconculiasis Eradication. Activities included assessing levels of infection in 8 rural villages and giving prevention presentations to mothers in Ewe and French
-*Secondary Project;* Malaria Prevention.

Books

Venters H. *Life and Death in Rikers Island*. Johns Hopkins University Press. 2/19.

Chapters in Books

Venters H. Mythbusting Solitary Confinement in Jail. In Solitary Confinement Effects, Practices, and Pathways toward Reform. Oxford University Press, 2020.

MacDonald R. and **Venters H.** Correctional Health and Decarceration. In Decarceration. Ernest Drucker, New Press, 2017.

Membership in Professional Organizations

American Public Health Association

Foreign Language Proficiency

French	Proficient
Ewe	Conversant

Prior Testimony and Deposition

Benjamin v. Horn, 75 Civ. 3073 (HB) (S.D.N.Y.) as expert for defendants, 2015

Rodgers v. Martin 2:16-cv-00216 (U.S.D.C. N.D.Tx) as expert for plaintiffs, 10/19/17

Fikes v. Abernathy, 2017 7:16-cv-00843-LSC (U.S.D.C. N.D.AL) as expert for plaintiffs 10/30/17.

Fernandez v. City of New York, 17-CV-02431 (GHW)(SN) (S.D.NY) as defendant in role as City Employee 4/10/18.

Charleston v. Corizon Health INC, 17-3039 (U.S.D.C. E.D. PA) as expert for plaintiffs 4/20/18.

Gambler v. Santa Fe County, 1:17-cv-00617 (WJ/KK) as expert for plaintiffs 7/23/18.

Hammonds v. Dekalb County AL, CASE NO.: 4:16-cv-01558-KOB as expert for plaintiffs 11/30/2018.

Mathiason v. Rio Arriba County NM, No. D-117-CV-2007-00054, as expert for plaintiff 2/7/19.

Hutchinson v. Bates et. al. AL, No. 2:17-CV-00185-WKW- GMB, as expert for plaintiff 3/27/19.

Lewis v. East Baton Rouge Parish Prison LA, No. 3:16-CV-352-JWD-RLB, as expert for plaintiff 6/24/19.

Belcher v. Lopinto, No. 2:2018cv07368 - Document 36 (E.D. La. 2019) as expert for plaintiffs 12/5/2019.

Imoerati v. Semple, U.S. District Court, CT. No 3:18cv01847 (RNC), as expert for plaintiffs, 3/11/20.

USA v. Pratt. Western Dist of PA. Criminal No. 19-213, as expert for plaintiffs (Video Hearing 4/28/20).

USA v. NELSON Western Dist. Of PA. No: 1:19-cr-00021-DSC, as expert for plaintiffs (Video Hearing 5/4/20).

Chunn v. Edge, No: 1:20-CV-01590-RPK-RLM, as expert for plaintiffs (Video Hearing 5/12/20, Video Deposition 4/30/20).

Dianthe Martinez-Brooks et al v. D. Easter, Warden No. 3:20-cv-569 (MPS), as expert for plaintiffs (Video deposition 6/8/20. Video Hearing 6/11/20).

Busby v. Booner, Western District of Tennessee, No. 3:20-cv-2359-SHL, as expert for plaintiffs (Video hearing 7/10/20).

Fee Schedule

Case review, reports, testimony $500/hour.
Site visits and other travel, $2,500 per day (not including travel costs).

APPENDIX B

TAB	DATE	DESCRIPTION	BATES #
INSP-00001 – INSP-00648			
1.	03/12/2020	Email from R. Hazel to B. Edmonds, C. Swarthout, et al. re COVID 19	INSP-00001 – INSP-00003
2.	04/22/2020	Email from H. Thomas to Jail Supervisors, A. Good, et al. re FW: STAFF PLEASE READ: Change in COVID19 Procedures	INSP-00004 – INSP-00006
3.	08/18/2020	Email from R. Hazel to Jail Supervisors re Updates	INSP-00007 – INSP-00008
4.	03/19/2020	Email from R. Hazel to A. Good, A. Grodavent, et al. re COVID Update	INSP-00009 – INSP-00011
5.	10/02/2020	Email from R. Hazel to Jail Supervisors cc J. Patrick re COVID Directive changes Attachment: COVID-19 Directive REV 9-08-20	INSP-00012 – INSP-00016
6.	10/09/2020	Email from R. Hazel to Jail Supervisors c J. Patrick re Mask Procedure	INSP-00017
7.	10/15/2020	Email from R. Hazel to Jail Supervisors re COVID Tests	INSP-00018
8.	10/27/2020	Email from R. Hazel to A. Good, A. Grodavent, et al. cc Jail Supervisors re Covid Update	INSP-00019 – INSP-00020

TAB	DATE	DESCRIPTION	BATES #
9.	11/23/2020	Email from K. Hirakis to Jail – Corrections, Jail – CROs, and Jail Supervisors re COVID Compliance checklists and Cloth Masks	INSP-00021
10.	12/08/2020	Email from R. Hazel to A. Good, A. Grodavent, et al. cc Jail Supervisors re COVID Testing-Staff	INSP-00022 – INSP-00023
11.	12/08/2020	Chronic Care Roster	INSP-00024 – INSP-00043
12.	12/08/2020	Chronic Care Roster	INSP-00044 – INSP-00088
13.	12/09/2020	Condensed Health Services Encounters	INSP-00089 – INSP-00123
14.	N/A	CCDC Emergency Response Plan to Corona Virus (COVID-19) Manual for Health Services	INSP-00124 – INSP-00133
15.	12/08/2020	Corizon Health @ Calhoun – Position Control Document	INSP-00134
16.	12/03/2020	COVID-19 Non-symptomatic Forms 11/20/2020 – 12/03/2020	INSP-00135 – INSP-00203
17.	N/A	Non-Positive COVID-19 / Asymptomatic / Non-Exposed Patient Screening Forms	INSP-00204 – INSP-00360
18.	12/09/2020	Detainee Medications for 11/01/2020 – 12/09/2020	INSP-00361 – INSP-00378

TAB	DATE	DESCRIPTION	BATES #
19.	08/07/2020	ICE Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19): Detainee Care	INSP-00379 – INSP-00393
20.	11/03/2020	ICE Grievance from Dijana Kilic	INSP-00394 – INSP-00395
21.	11/13/2020	Calhoun Detention Center Health Service Requests for 10/01/2020 – 11/13/2020	INSP-00396 – INSP-00588
22.	12/03/2020	Calhoun Detention Center Health Service Requests for 11/20/2020 – 12/03/2020	INSP-00589 – INSP-00626
23.	Nov 2020	Calhoun County ICE Emergency Room Visits for October and November 2020	INSP-00627 – INSP-00628
24.	12/03/2020	Order for In-Person Facility Inspection by Plaintiffs' Expert	INSP-00629 – INSP-00638
25.	10/21/2020	Calhoun County Board of Commissioners Policy Statement – COVID-19 Response – Temporary Health Emergency Response Leave	INSP-00639 – INSP-00641
26.	10/21/2020	Calhoun County Policy Statement – COVID-19 Response – Temporary Requirements for Protective Safety Measures	INSP-00642 – INSP-00648
INSP-00660 – INSP-01117			
27.	08/31/2020	Second Amended Stipulated Protective Order	INSP-00649 – INSP-00660
28.	12/02/2020	Calhoun Population Report	INSP-00661

TAB	DATE	DESCRIPTION	BATES #
29.	12/02/2020	Chronic Care Report	INSP-00662 – INSP-00664
30.	12/02/2020	CCSO ICE Housed Inmate Report by Location	INSP-00665 – INSP-00668
31.	12/02/2020	ICE COVID Testing Log	INSP-00669 – INSP-00678
32.	12/09/2020	Audit Tool Calhoun County – CDC COVID Guidelines	INSP-00679 – INSP-00691
33.	N/A	COVID Compliance Checklist	INSP-00692
34.	10/27/2020	Declaration of Randy A. Hazel	INSP-00693 – INSP-00694
35.	10/27/2020	Declaration of Randy A. Hazel	INSP-00695 – INSP-00697
36.	10/27/2020	ICE Enforcement and Removal Operations COVID-19 Pandemic Response Requirements	INSP-00698 – INSP-00733
37.	08/07/2020	ICE Health Service Corps Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19): Detainee Care	INSP-00734 – INSP-00746
38.	08/17/2020	Deposition of Chief Deputy Randy A. Hazel Volume 1	INSP-00747 – INSP-00920
39.	08/20/2020	Deposition of Chief Deputy Randy A. Hazel Volume 2	INSP-00921 – INSP-01080
40.	N/A	Bilingual Notice: Masks Must Be Worn	INSP-01081

TAB	DATE	DESCRIPTION	BATES #
41.	05/26/2020	Calhoun County Board of Commissioners Policy Statement: Temporary Health Emergency Response Leave	INSP-01082 – INSP-01083
42.	N/A	Bilingual Notice: CAUTION Maintain Social Distancing AT LEAST 6 ft. Distance from Others	INSP-01084
43.	05/21/2020	Calhoun County Policy Statement COVID-19 Response: Temporary Requirements for Protective Safety Measures	INSP-01085 – INSP-01091
44.	05/21/2020	Calhoun County Policy Statement COVID-19 Response: Temporary Telecommuting Policy	INSP-01092 – INSP-01093
45.	11/06/2020	Second Supplemental Declaration of Homer Venters, MD in Support of Plaintiffs' Motion for Emergency Relief to Respond to COVID-19 Outbreak	INSP-01094 – INSP-01104
46.	10/28/2020	Supplemental Declaration of Homer Venters, MD in Support of Plaintiffs' Motion for Emergency Relief to Respond to COVID-19 Outbreak	INSP-01105 – INSP-01116
47.	N/A	Bilingual Notice: Wear masks correctly	INSP-01117
INSP-01118 – INSP-01156			
48.	12/02/2020	ICE COVID Testing Log	INSP-01118 – INSP-01127
49.	11/11/2020	Pod Photos	INSP-01128 – INSP-01133

TAB	DATE	DESCRIPTION	BATES #
50.	11/20/2020	Email from J. Newby to C. Thomson, M. Aukerman, W. Barkholz, M. Ngo, and S. Maneval cc B. Darling, K. Gadsden, et al. re 20-10829 Malam v Rebecca Adducci et al	INSP-01134
51.	11/24/2020	Third Declaration of Randy A. Hazel	INSP-01135 – INSP-01143
52.	11/24/2020	Exhibit H: Email from J. Newby to C. Thomson, M. Aukerman, W. Barkholz, M. Ngo, and S. Maneval cc B. Darling, K. Gadsden, et al. re 20-10829 Malam v Rebecca Adducci et al	INSP-01144 – INSP-01145
53.	11/30/2020	Exhibit B: Email from J. Newby to C. Thomson, M. Aukerman, W. Barkholz, M. Ngo, and S. Maneval cc B. Darling, K. Gadsden, et al. re 20-10829 Malam v Rebecca Adducci et al	INSP-01146 – INSP-01147
54.	11/30/2020	Declaration of Lt. Kevin Hirakis	INSP-01148 – INSP-01150
55.	11/23/2020	Pod Photos	INSP-01151 – INSP-01154
56.	12/04/2020	Exhibit E: Email from J. Newby to C. Thomson, M. Aukerman, W. Barkholz, M. Ngo, and S. Maneval cc B. Darling, K. Gadsden, et al. re 20-10829 Malam v Rebecca Adducci et al	INSP-01155 – INSP-01156
INSP-01157 - 01176			
57.	12/16/2020	Calhoun Population Report	INSP-01157

TAB	DATE	DESCRIPTION	BATES #
58.	12/16/2020	Chronic Care Report	INSP-01158 – INSP-01160
59.	12/16/2020	ICE Detainee Testing Log	INSP-01161 – INSP-01171
60.	12/16/2020	Calhoun County Sheriff's Office ICE Housed Inmate Report by Location	INSP-01172 – INSP-01175
61.	12/16/2020	Calhoun ACLU Bail Survey Distribution List for 12/11/2020	INSP-01176
INSP-1177-2077			
62.	10/1/2020	Medical Grievance Reports	INSP-01177 – INSP-01193
63.	N/A	Calhoun County Detention Center: Ice High Risk Unit Process	INSP-01194
64.	12/18/2020	Medical Sick Call Requests	INSP-01197 – INSP-01372
65.	N/A	Corizon Clinical Services/Nursing Services Coronavirus (COVID-19) Screening Form – 2020	INSP-01373
66.	N/A	Office of the Sheriff Calhoun County Michigan Correctional Facility Initial Medical and TB Screening Form	INSP-01374
67.	10/21/2020	Calhoun County Police Statement: COVID-19 Response Attachments: COVID-19 Employee Screening Questionnaire, COVID-19 Employee Return to Work Requirements, COVID-19 Visitor Screening Questionnaire	INSP-01375-01381

TAB	DATE	DESCRIPTION	BATES #
68.	N/A	Nurse Rounding Tool: COVID-19 Risk Scoring	INSP-01382
69.	10/27/2020	ERO: U.S. Immigration and Customs Enforcement, Enforcement and Removal Operations: COVID-19 Pandemic Response Requirements	INSP-01383 – INSP-01418
70.	12/18/2020	Medical Sick Call Requests	INSP-01419 – INSP-01558
71.	12/18/2020	Medical Sick Call Requests	INSP-01559 – INSP-01695
72.	12/4/2020 12/6/2020 12/8/2020	Daily Housing Sanitation Task Log (Pt. 3)	INSP-01697 – INSP-01711
73.	N/A	Daily Housing Sanitation Task Log (Pt. 4)	INSP-01712 – INSP-01740
74.	12/7/2020	Daily Housing Sanitation Task Log (Pt. 5)	INSP-01741 – INSP-01771
75.	12/16/2020	Daily Housing Sanitation Task Log (Pt. 6)	INSP-01772 – INSP-01784
76.	12/13/2020	Daily Housing Sanitation Task Log (Pt. 9)	INSP-01785 – INSP-01806
77.	N/A	Daily Housing Sanitation Task Log (Pt. 10)	INSP-01807 – INSP-01831

TAB	DATE	DESCRIPTION	BATES #
78.	12/8/2020 12/9/2020 12/10/2020	Daily Housing Sanitation Task Log (Pt. 11)	INSP-01832 – INSP-01864
79.	12/6/2020 12/7/2020 12/8/2020	Daily Housing Sanitation Task Log (Pt. 12)	INSP-01865 – INSP-01889
80.	11/29/2020 11/30/2020 12/1/2020 12/2/2020 12/3/2020	Daily Housing Sanitation Task Log (Pt. 14)	INSP-01890 – INSP-01920
81.	12/3/2020 12/4/2020 12/5/2020 12/6/2020 12/7/2020	Daily Housing Sanitation Task Log (Pt. 13)	INSP-01921 – INSP-01954
82.	11/29/2020 12/12/2020 12/16/2020	Daily Housing Sanitation Task Log (Pt. 1)	INSP-01955 – INSP-01964

TAB	DATE	DESCRIPTION	BATES #
83.	12/6/2020	Daily Housing Sanitation Task Log (Pt. 2)	INSP-01965 – INSP-01980
84.	N/A	Daily Housing Sanitation Task Log (Pt. 7)	INSP-01981 – INSP-01989
85.	12/14/2020 12/15/2020	Daily Housing Sanitation Task Log (Pt. 8)	INSP-01990 – INSP-02013
86.	11/24/2020 11/27/2020 11/28/2020 11/29/2020	Daily Housing Sanitation Task Log (Pt. 15)	INSP-02014 – INSP-02031
87.	11/25/2020 11/26/2020 11/27/2020 11/28/2020	Daily Housing Sanitation Task Log (Pt. 16)	INSP-02032 -- INSP-02058
88.	11/23/2020	Housing Unit Weekly COVID Protocol Check Sheets	INSP-02059 – INSP-02077
INSP-2078-2297			
89.	10/3/2020 – 11/11/2020, 12/3/2020 – 12/16/2020	Paper Corizon Health Service Request Forms and Inmate Request Forms	INSP-02078 – INSP-02266

TAB	DATE	DESCRIPTION	BATES #
90.	12/4/2020 - 12/16/2020	Electronic Medical Sick Call Requests	INSP-02267 – INSP-02297
INSP-2298-2405			
91.	N/A	Non-Positive COVID-19 / Asymptomatic / Non-Exposed Patient Screening Forms	INSP-02298 – INSP-02405
INSP-2406-2424			
92.	N/A	Non-Positive COVID-19 / Asymptomatic / Non-Exposed Patient Screening Forms	INSP-02406 – INSP-02424

DECLARATION OF DARREN GARDNER

I, Darren Gardner, certify under penalty of perjury pursuant to 28 U.S.C. § 1746 that the following statement is true and correct.

1. My name is Darren Gardner. I make these statements based upon my personal knowledge.

2. I am an Associate with the law firm Paul, Weiss, Rifkind, Wharton & Garrison LLP ("Paul, Weiss"). Paul, Weiss is co-counsel for Plaintiffs, along with the American Civil Liberties Union ("ACLU") Fund of Michigan, the ACLU Foundation National Prison Project, and the ACLU Foundation Immigrants' Rights Project.

3. As part of our representation of detainees, I work with a team of Paul, Weiss lawyers to identify detainees at Calhoun County Correctional Facility ("Calhoun") who may have medical vulnerabilities that put them at high risk of a severe outcome if they contract COVID-19. In order to identify medically vulnerable individuals, we collect and analyze questionnaires we receive by mail from detainees, and we run an intake line to allow detainees and family members to call in and report medical conditions. We also track information about individuals whom the government concedes are high risk.

4. When we identify someone whose medical conditions put them at high risk but whom the Defendants have not identified through their screening process, we reach out to Defendants to ask whether they agree that the individual is indeed high risk. If Defendants agree that this individual is at high risk, we typically move forward with filing a bail application on behalf of that individual. If Defendants do not agree, we may instead choose to file a motion for inclusion to allow the Court to decide the question of medical vulnerability.

5. The attached chart shows 30 detainees whom Defendants failed to identify as medically vulnerable through their screening process. After learning of their medical vulnerabilities, Class Counsel brought these individuals to Defendant's attention. In all but three cases, Defendants conceded that each of these individuals is high risk. In one case, Defendants originally did not concede, but changed their position shortly after Class Counsel filed a medical expert declaration. In the other two cases, Defendants did not concede. Class Counsel thereafter brought motions to include these individuals in the Habeas Litigation Group, which were opposed by Defendants and granted by the Court.

/s/ Darren S. Gardner
Darren S. Gardner
Associate
Paul, Weiss, Rifkind, Wharton & Garrison LLP
2001 K Street, NW
Washington, DC 20006-1047

Dated: January 7, 2021

Sublass Members Identified by Class Counsel

	A-Number	Family Name	Given Name	Condition	Date Conceded	Dkt Number for Notice of Conceded Habeas Litigation Group Members
1				Hypertension; smoker; age	8/31/2020	227
2				Cough; BMI; respiratory infection; asthma; smoker; history of bronchitis/pneumonia	8/20/2020	203-5
3				Hypertension; BMI	10/16/2020	374
4				BMI; breathing problems; past respiratory infections	8/20/2020	203-5
5				Type II Diabetes	12/11/2020	Forthcoming
6				Hypertension	9/21/2020	310-4
7				Hypertension; smoker	11/18/2020	442
8				Bronchitis/pneumonia; hospitalized for breathing issues;	8/18/2020	203-3
9				Hypertension; BMI	8/20/2020	203-5
10				Diabetes; BMI; smoker	9/21/2020	310-4
11				BMI; age; possible liver disease	Inclusion Motion Granted 11/18/2020	Forthcoming
12				Hypertension; smoker	9/29/2020	310-5
13				Hypertension; BMI; pre-diabetes	8/18/2020	203-3
14				BMI; smoker	11/18/2020	442
15				BMI	8/20/2020	203-5
16				BMI	8/30/2020	310-2
17				BMI; breathing problems	9/14/2020	310-3
18				BMI	8/18/2020	203-3
19				BMI; smoker	8/30/2020	310-2
20				Asthma; hypertension	8/20/2020	203-5
21				Hypertension; BMI	9/14/2020	310-3
22				Hypertension; awating cancer test results	8/18/2020	203-3
23				BMI	8/20/2020	203-5
24				BMI	10/16/2020	374
25				Diabetes; bronchitis	8/18/2020	203-3
26				Asthma	10/8/2020	374
27				Age; schizophrenia	9/14/2020	310-3
28				Heart Condition treated with blood thinners; Chronic fatigue; breathing problems; coronary artery disease; stenosis with 30% blockage; high blood pressure	Inclusion Motion Granted 12/3/2020	Forthcoming
29				Asthma; fibroadenoma of breast	8/25/2020	215; 310

Sublass Members Identified by Class Counsel

	A-Number	Family Name	Given Name	Condition	Date Conceded	Dkt Number for Notice of Conceded Habeas Litigation Group Members
30	[redacted]		[redacted]	Hypertension; anxiety	9/14/2020	398

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

JANET MALAM,

Petitioner-Plaintiff,

- against -

REBECCA ADDUCCI, *et al.*,

Respondent-Defendants.

No. 5:20-cv-10829-JEL-APP

DECLARATION OF AARON E. HAIER

I, Aaron E. Haier, certify under penalty of perjury that the following statement is true and correct pursuant to 28 U.S.C. § 1746.

1. My name is Aaron E. Haier. I am over the age of 18 and I am competent to make this declaration.

2. I am an associate at Paul, Weiss, Rifkind, Wharton & Garrison LLP ("Paul, Weiss"), one of class counsel in this case.

3. I was asked to prepare this Declaration for reference by Plaintiffs' expert, Dr. Homer Venters, for his report on the inspection of Calhoun County Correctional Facility ("Calhoun"). In preparation for this Declaration, I reviewed the following documents produced by Defendants regarding detainees held by Immigration and Customs Enforcement ("ICE") at Calhoun:

a. Calhoun County Sheriff's Office ICE Housed Inmate Report by Location, from September 18, 2020 through December 30, 2020 ("ICE Detainee Housing Logs");

b. Calhoun's ICE Testing Log, from November 2 through December 30, 2020 ("ICE COVID-19 Testing Logs");

c. Defendants' Memorandum Submitting Documents Requested in the Eleventh Bail Order (ECF No. 477); and,

d. Defendants' Supplemental Sealed Exhibit to Memorandum Submitting Documents Requested in Eleventh Bail Order (ECF No. 482).

4. The purpose of this Declaration is to explain the analysis I undertook of the ICE Detainee Housing Logs and ICE COVID-19 Testing Logs, most of which were produced by Defendants to Plaintiffs as part of their weekly report from September 18, 2020 through December 30, 2020. This Declaration also explains the analysis I undertook of the positivity rate at Calhoun in response to Defendants' memorandum about testing rates.

METHODOLOGY

5. The ICE Detainee Housing Logs include columns showing the full name of each detainee housed at Calhoun, their citizenship, ICE alien identification number ("A-number"), race/sex, date of birth, booking date, the number of days they have spent in jail, and the pod in which they were housed each week.

6. The ICE COVID-19 Testing Logs include columns showing the full name of every detainee that was tested, their Calhoun identification number (different from the A-number), date of birth, test date, result, and reason for testing for all tests conducted at Calhoun to date of the log. The log dated November 2, 2020 shows entries for all tests conducted at Calhoun for

both ICE detainees and individuals not held under ICE jurisdiction ("inmates") up to that date. The test logs for all other dates only show results for ICE detainees.

7. The testing data reported in Defendants' Memorandum at Dkt. 477 pertain to ICE detainees, inmates and certain staff at Calhoun up to December 23, 2020. Defendants' Supplemental Memorandum at Dkt. 482 lists all Calhoun staff, including contractors, who have tested positive for COVID-19 up to January 6, 2020.

8. To analyze the ICE Detainees Housing Logs, I first transferred the data from the documents Defendants produced to an Excel workbook.

9. Once the data was entered into an Excel spreadsheet, I organized it by week in keeping with the manner in which Defendants produced it.

10. Using Excel, I was able to generate a pivot table that shows in which pods the detainees were housed and when they were housed in each particular pod.

FINDINGS

11. I used the pivot table to analyze how long newly admitted detainees remained in quarantine. Defendants have represented that the policy at Calhoun is to quarantine detainees upon arrival and house them in the same pod for 14 days before transferring them. (Respondents' First Supplement to

its Responses and Objections to Petitioners' First Set of Expedited Interrogatories at 2.) From viewing the pivot table, it is possible to see that at least 15 detainees who arrived at Calhoun for the first time after September 18, 2020 did not remain quarantined in the same pod for 14 days before being transferred to another pod. Exhibit 1 lists those detainees and their circumstances.

12. It is important to note that Defendants' housing logs provide only one day's worth of data for each week. If Defendants were to provide daily logs, we might be able to ascertain if there were multiple transfers within a given week. I have previously submitted a declaration in this case, analyzing daily housing reports covering a one-month period (April 15 to May 15, 2020) and found 18 instances where individuals did not properly remain in a single quarantine area for a full 14 days. *See* ECF No. 91-3, PageID.3012–3017. But the weekly logs we currently have for the September to December 2020 period do not account for this possibility, making the above estimate very conservative.

13. I also analyzed where in the facility new detainees were initially reported as being housed. I was also able to ascertain that 50 detainees who arrived at Calhoun for the first time after September 18, 2020 were not initially reported as being housed in Pod A, B, M, P, J, or K, the pods Defendants

previously represented were the pods being used as quarantine areas for new detainees. (Respondents' First Supplement to its Responses and Objections to Petitioners' First Set of Expedited Interrogatories at 2.) Exhibit 2 lists those detainees and their circumstances.

14. During the facility inspection, Calhoun staff reported that they only used Pods A, B and J as quarantine areas for newly admitted detainees. This is a more limited list of quarantine units as reported by Calhoun earlier in the year, so if their quarantine policy has changed, then the above estimate is a conservative number as well.

15. Based on the available information, it is unclear whether these individuals were not quarantined, or whether Calhoun has been using additional housing units for quarantine beyond those it has reported. As these findings show, Pod S, Pod L, and Pod N frequently appear as a detainee's first reported pod, despite none of those pods ever having been noted as a quarantine area (save for the exception described in Chief Deputy Hazel's Declaration, ECF No. 423, Ex. A).

16. I also examined Calhoun's testing protocols for releasing detainees from their quarantine by cross-referencing the pivot table I created against the ICE COVID-19 Testing Logs. According to Defendants, the facility's policy for releasing detainees from quarantine is such that an

individual is tested upon intake and then again at the end of their quarantine. *See* Bostock Decl., ECF No. 119-1, ¶ 4; Hazel Decl., ECF No. 382, ¶ 11.

17. Based on a review of housing and testing data, I first identified 11 detainees who have had no record of ever being tested. Three of these individuals were admitted to the facility for the first time after the start of the relevant time period for this analysis (after September 18, 2020). There is no explanation as to why these three individuals did not at least receive an initial test upon admission. Exhibit 3 lists those three detainees and their circumstances.

18. I was also able to determine that there were nine individuals who were released from quarantine without receiving a test at the end of their quarantine period. Exhibit 3 lists those nine detainees and their circumstances.

19. Notably, because we do not have comprehensive housing data or testing logs for inmates, the above estimates do not capture any issues with testing among inmates, who are also subject to the 14-day quarantine and testing policy.

20. Lastly, I analyzed the data set forth in Defendants' Memorandum Submitting Documents Requested in the Eleventh Bail Order (ECF No. 477). In their memorandum, Defendants represented that approximately 1% of the

detained population at Calhoun contracted COVID-19 while detained. To achieve this percentage, Defendants counted the number of positive cases between May 2020 and December 23, 2020 (72 total, of whom 47 were ICE detainees and 25 local inmates), excluded those who tested positive at intake (28 total, of whom were 22 ICE detainees and six local inmates) and divided the remaining 44 cases by the entire detained population in that time (3,876 total, including both ICE detainees and local inmates).

21. Defendants' calculation does not account for the fact that, as shown by Defendants' weekly testing logs, quarantine clearance testing did not begin until June 11, 2020, testing at intake did not begin until July 31, 2020, and that Calhoun has never conducted regular comprehensive testing of its general population. This means that the actual rate of infection is unknown.

22. Defendant's calculation also does not account for the fact that, as shown in their memorandum, the vast majority of detainees are local inmates. Of the 3,876 individuals who passed through the jail, only 678 were ICE detainees. If one divides the total number of ICE detainees who tested positive in that period of time (47) by *the total number of ICE detainees in that period* (678), the positivity rate for ICE detainees is approximately 7% (6.93%). This positivity rate is higher than the national positive test rate (5.5%) and the

Calhoun County positive test rate (5%) that Defendants cite in their memorandum. ECF No. 477 at 2.

23. That 7% positivity rate does not account for the fact that some ICE detainees, like some local inmates, are only briefly at Calhoun. To assess the percentage of infections for ICE detainees who are detained at Calhoun for three weeks or more, I cross-referenced the data in ECF No. 477 with the data contained in ICE Detainee Housing Logs and excluded individuals who do not appear on at least two weekly reports between September 18, 2020 and December 30, 2020 (meaning they were at Calhoun 20 days or less). That analysis leaves 291 detainees, of whom 39 were infected, for a positivity rate of 13.4% for that time period.

24. I also calculated positivity rates based on when and where a person is at Calhoun. Defendants' list of positive ICE detainees shows 22 positives (of which only one was at intake) during the period from October 17, 2020 to October 29, 2020 when outbreaks were occurring. ECF No. 477, Ex. 1. Defendants' testing log shows that during that same period, 127 ICE detainees were tested, for a positivity rate of 17%. Using Defendants' method and excluding those tested at intake, I identified 21 positives out of 84 detainees tested, or a positivity rate of 25%. By cross-referencing the positive cases during that period with ICE detainees who were tested and who were

shown on the October 7, 2020, October 14, 2020, or October 21, 2020 housing logs as in Pod H, where the main outbreak among male detainees occurred, I identified that 18 detainees out of 34 tested positive, for a positivity rate of 53%.

25. Finally, based on Defendants' Supplemental Memorandum (ECF No. 482), I determined that the positivity rate among all staff who worked at Calhoun is 15% (18 staff members tested positive out of 120 total staff members).

26. Should the Court desire, Plaintiffs can provide an Excel document containing all of the relevant data in connection with my analysis.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge and belief.

Executed on this 7th of January 2021 in Jersey City, New Jersey.

/s/ Aaron E. Haier
Aaron E. Haier
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EXHIBIT 1

Length of Quarantine[1]

The following is a list of 15 detainees who arrived at Calhoun for the first time after September 18, 2020 and who *did not* remain quarantined in the same pod for 14 days before being transferred for the first time.

1. [redacted]
   - First reported in Pod S on 11/11 after three days in the facility, then moved to Pod K the following week (11/18 report), then moved to Pod M during the week after that (11/25 report; appears on no subsequent reports).

2. [redacted]
   - First housed in Pod P on 10/21 (first day in facility), then moved to Pod A during the following week (10/28 report), then moved to Pod H (11/4 report) where he remained through the 12/30 report.

3. [redacted]
   - First reported in Pod A on 10/28 after two days in the facility, then moved to Pod H the following week (11/4 report) and remained through the 12/30 report.

4. [redacted]
   - First housed in Pod P on 10/21 (first day in facility), then moved to Pod A during the following week (10/28 report), then relocated to Pod H the week after that (11/4 report), where he remained through the 12/30 report.

5. [redacted]
   - First reported in Pod B on 10/7 report after five days in the facility, then relocated to Pod N the next week (10/14 report), then relocated to Pod E the week after that (10/21 report), where he remained through the 12/3 report.

[1] All conceded high-risk individuals are identified with an asterisk (*) following their respective names.

6. [redacted]
   - First reported in Pod S on 11/11 report after three days in facility, then moved to Pod K during the following week (11/18 report), then relocated during the following week to Pod M (11/25 report; appears on no subsequent reports).

7. [redacted]
   - First reported in Pod P on 11/25 report, then moved to Pod L during the following week (12/2 report), where he remained through the 12/16 report.

8. [redacted]
   - First reported in Pod P on 11/4 report after six days in the facility, then moved to Pod B during the following week (11/11 report), then relocated to Pod C during the week after that (11/18 report; appears on no subsequent reports).

9. [redacted]
   - First reported in Pod P on 11/4 report after three days in the facility, then moved to Pod B during the following week (11/11 report), then relocated to Pod H during the week after that (11/18 report; appears on no subsequent reports).

10. [redacted]
    - First housed in Pod R on 10/21 (first day in facility), then moved to Pod B during the following week (10/28 report), then moved to Pod A during week after that (11/4 report), then moved to Pod E the following week (11/11 report), where he remained through the 12/30 report.

11. [redacted]
    - First reported in Pod M on 10/21 after four days in the facility, then moved to Pod S during the following week (10/28 report), then moved back to Pod M approximately two weeks later (11/11 report), where he remained through the 12/9 report.

12. [redacted]
    - First reported in Pod S on 11/11 report after three days in the facility, then moved to Pod K during the following week (11/18

report), then moved to Pod D during the week after that (11/25 report), where he remained through the 12/30 report.

13. [redacted]

- First reported in Pod S on 11/11 report after five days in the facility, then moved to Pod K during the following week (11/18 report; appears on no subsequent reports).

14. [redacted]

- First reported in Pod A on 12/2 report after spending two days in the facility, then moved to Pod N during the following week (12/9 report) where he remained through the 12/30 report.

15. [redacted]

- First reported in Pod A on 12/2 report after spending five days in the facility, then moved to Pod N during the following week (12/9 report), then back to Pod A during the week after that (12/16 report), and then to Pod C the subsequent week (12/23 report), where he remained through the 12/30 report.

EXHIBIT 2

Initial Reported Pod[2]

The following is a list of 50 individuals who arrived at Calhoun for the first time after September 18, 2020 and who *were not* immediately reported to be housed in a pod that Defendants previously represented as being a quarantine pod, *i.e.* Pod A, B, M, P, J, or K.

1. [redacted]
   - **Initial Report:** Pod S on 11/4 (after six days in facility).
2. [redacted]
   - **Initial Report:** Pod S on 10/28 (after six days in facility).
3. [redacted]
   - **Initial Report:** Pod N on 12/2 (after seven days in facility).
4. [redacted]
   - **Initial Report:** Pod S on 10/28 (after nine days in facility).
5. [redacted]
   - **Initial Report:** Pod S on 11/11 (after three days in facility).
6. [redacted]
   - **Initial Report:** Pod S on 11/11 (after three days in facility).
7. [redacted]
   - **Initial Report:** Pod S on 10/28 (after six days in facility).
8. [redacted]
   - **Initial Report:** Pod L on 12/2 (after seven days in facility).
9. [redacted]
   - **Initial Report:** Pod L on 12/9 (after five days in facility).

[2] All conceded high-risk individuals are identified with an asterisk (*) following their respective names.

10. [redacted]
    - **Initial Report:** Pod N on 9/30 (after seven days in facility).
11. [redacted]
    - **Initial Report:** Pod L on 12/9 (after five days in facility).
12. [redacted]
    - **Initial Report:** Pod S on 11/11 (after five days in facility).
13. [redacted]
    - **Initial Report:** Pod L on 12/2 (after seven days in facility).
14. [redacted]
    - **Initial Report:** Pod L on 12/9 (after five days in facility).
15. [redacted]
    - **Initial Report:** Pod S on 10/28 (after six days in facility).
16. [redacted]
    - **Initial Report:** Pod L on 12/2 (after six days in facility).
17. [redacted]
    - **Initial Report:** Pod S on 11/11 (after three days in facility).
18. [redacted]
    - **Initial Report:** Pod S on 11/11 (after eight days in facility).
19. [redacted]
    - **Initial Report:** Pod S on 10/28 (after seven days in facility).
20. [redacted]
    - **Initial Report:** Pod S on 11/11 (after eight days in facility).
21. [redacted]
    - **Initial Report:** Pod S on 11/11 (after eight days in facility).
22. [redacted]
    - **Initial Report:** Pod L on 12/9 (after five days in facility).

23. [redacted]
    - **Initial Report:** Pod L on 12/9 (after five days in facility).

24. [redacted]
    - **Initial Report:** Pod L on 12/9 (after five days in facility).

25. [redacted]
    - **Initial Report:** Pod L on 12/2 (after seven days in facility).

26. [redacted]
    - **Initial Report:** Pod L on 12/2 (after six days in facility).

27. [redacted]
    - **Initial Report:** Pod L on 12/9 (after five days in facility).

28. [redacted]
    - **Initial Report:** Pod L on 12/2 (after eight days in facility).

29. [redacted]
    - **Initial Report:** Pod R on 10/21 (first day in facility).

30. [redacted]
    - **Initial Report:** Pod K on 12/23 (after three days in facility).

31. [redacted]
    - **Initial Report:** Pod S on 11/11 (after eight days in facility).

32. [redacted]
    - **Initial Report:** Pod L on 12/2 (after six days in facility).

33. [redacted]
    - **Initial Report:** Pod L on 12/9 (after five days in facility).

34. [redacted]
    - **Initial Report:** Pod N on 10/7 (after one day in facility).

35. [redacted]
    - **Initial Report:** Pod L on 12/9 (after two days in facility).

36. [redacted]
    - **Initial Report:** Pod L on 12/9 (after five days in facility).

37. [redacted]
    - **Initial Report:** Pod S on 11/11 (after three days in facility).

38. [redacted]
    - **Initial Report:** Pod S on 10/28 (after nine days in facility).

39. [redacted]
    - **Initial Report:** Pod S on 11/11 (after five days in facility).

40. [redacted]
    - **Initial Report:** Pod S on 11/4 (after six days in facility).

41. [redacted]
    - **Initial Report:** Pod S on 10/28 (after six days in facility).

42. [redacted]
    - **Initial Report:** Pod N on 11/4 (after six days in facility).

43. [redacted]
    - **Initial Report:** Pod S on 11/11 (after eight days in facility).

44. [redacted]
    - **Initial Report:** Pod L on 12/9 (after five days in facility).

45. [redacted]
    - **Initial Report:** Pod L on 12/2 (after six days in facility).

46. [redacted]
    - **Initial Report:** Pod L on 12/9 (after five days in facility).

47. [redacted]
    - **Initial Report:** Pod S on 10/28 (after six days in facility).

48. [redacted]
    - **Initial Report:** Pod S on 10/28 (after eight days in facility).

49. [redacted]
    - **Initial Report:** Pod L on 12/2 (after six days in facility).

50. [redacted]
    - **Initial Report:** Pod L on 12/2 (after six days in facility).

EXHIBIT 3[3]

Testing Protocols for New Admissions

The following is a list of three detainees who arrived at Calhoun after September 18 and were not recorded as *ever* receiving a COVID-19 test at the facility.

1. [redacted]
   - Reported in Pod B on 12/23 report and 12/30 report.
   - Not listed on testing log.

2. [redacted]
   - Reported in Pod S on 11/4 report. Appeared on no other weekly reports.
   - Not listed on testing log.

3. [redacted]
   - Reported in Pod N on 11/4 report. Appeared on no other weekly reports.
   - Not listed on testing log.

The following is a list of nine detainees who were released from quarantine without receiving a test at the end of their quarantine period.

1. [redacted]
   - Reported in three different pods across three different reports: Pod S on 11/11, Pod K on 11/18, and Pod M on 11/25. Did not appear on any other housing reports. Only received one initial test on 11/9 (Day 2 at Calhoun).

2. [redacted]
   - First reported in Pod B on 10/7 report, then moved to Pod N during the following week (10/14 report), and then moved to Pod E during the week after that (10/21 report).

[3] All conceded high-risk individuals are identified with an asterisk (*) following their respective names.

- Initially tested on 10/1. Did not receive a second test until 10/22, after he already moved to Pod N and then to Pod E.
- Received tests on 10/22, 11/20, and 12/2 following close contact.

3. [redacted]
   - Tested positive while in Pod G (first test on 10/26, retest confirmed positive status on 10/29).
   - Reported as still in Pod G on 10/28 report. Reported in Pod B on 11/4, Pod K on 11/11, and back in Pod G on 11/18.
   - No additional tests were recorded.

4. [redacted]
   - Tested positive during initial test on 12/1/2020 (Day 1 at Calhoun).
   - First housed in Pod A (as of 12/2), then moved to Pod K the following week (as of 12/9), then moved to Pod H during the week after that (12/16 report). Apparently left the facility during the week after 12/16 report.
   - No additional tests were recorded despite movement between pods described above.

5. [redacted]
   - First reported in Pod S on 11/11 report, then moved to Pod K during the following week (11/18 report; appears on no subsequent reports).
   - Only received one initial test on 11/5 (Day 2 at Calhoun).

6. [redacted]
   - First reported in Pod N on 10/7 report and again on 10/14, then moved to Pod D during the following week (10/21 report), where he remained for several subsequent weeks.
   - Received initial test on 10/5 (Day 1 at Calhoun). Was not tested again until 10/28 (following close contact), despite moving to Pod D in the interim.

7. [redacted]
   - First reported in Pod S on 11/11, then moved to Pod K during the following week (11/18 report), then moved to Pod D during

the week after that (11/25 report), where he remained several weeks thereafter.
- Received initial test on 11/9 (Day 1 at Calhoun). Was not tested again until 12/9 for bi-weekly high-risk testing, despite moving to Pod K and Pod D in the interim.

8. [redacted]
   - First reported in Pod S on 11/11 report, then moved to Pod K during following week (11/18 report), then moved to Pod D the week after that (11/25 report), where he remained several weeks thereafter.
   - Received initial test on 11/4 (Day 1 at Calhoun). Was not tested again until 12/9 for bi-weekly high-risk testing, despite moving to Pod K and Pod D in the interim.

9. [redacted]
   - First reported in Pod M on 9/30 reported, moved to Pod S during week leading up to 10/28 report, then moved to Pod C during week leading up to 11/18 report, and then moved back to Pod M during following week (12/2 report), where he remained for several weeks thereafter.
   - Received initial test on 9/25 (Day 1 at Calhoun). Was not tested again until 12/9 for bi-weekly high-risk testing, despite moving to Pod S, Pod C, and then back to Pod M in the interim.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

JANET MALAM, Petitioner-Plaintiff, and QAID ALHALMI *et al.*, Plaintiff-Intervenors, - against - REBECCA ADDUCCI, *et al.*, Respondent-Defendants.	No. 5:20-cv-10829-JEL-APP

DECLARATION OF SARAH MANEVAL

I, Sarah Maneval, certify under penalty of perjury that the following statement is true and correct pursuant to 28 U.S.C. § 1746.

1. My name is Sarah Maneval. I am over the age of 18 and I am competent to make this declaration.

2. I am an associate at Paul, Weiss, Rifkind, Wharton & Garrison LLP ("Paul, Weiss"), one of the class counsel in this case.

3. I respectfully submit this Declaration for reference by Plaintiffs' expert, Dr. Homer Venters, for his report on the inspection of Calhoun County Correctional Facility ("Calhoun"). In preparation for this Declaration, I reviewed the following documents, most of which were produced by Defendants in connection with the facility inspection of Calhoun, pursuant to this Court's order, ECF No. 439:

a. Non-Positive COVID-19 / Asymptomatic / Non-Exposed Patient Screening Forms (INSP-00135 – INSP-00360, INSP-02298 – INSP-02424) ("COVID-19 screening forms");

b. Calhoun Detention Center Health Service Requests (INSP-00396 – INSP-00626, INSP-01195 – INSP-01372, INSP-02078 – INSP-02297) ("sick call requests");

c. Condensed Health Services Encounters for [redacted] and [redacted] (INSP-00089 – INSP-00123) ("medical unit records");

d. Calhoun Immigration and Customs Enforcement ("ICE") Testing Logs dated November 2, 2020 and December 30, 2020 ("testing log");

e. Calhoun County Sheriff's Office ICE Housed Inmate Report by Location, dated October 21, 2020 and October 28, 2020 ("housing log"); and,

f. Emails from J. Newby, dated January 5 and January 6, 2021 (Exhibit 1).

4. The purpose of this Declaration is to explain the analysis I undertook of the medical records produced by Defendants.

SICK CALL REQUESTS

5. Pursuant to this Court's order, ECF No. 439, Defendants were required to provide the sick call requests for the period of October 1, 2020 through November 13, 2020, and for the two-week period preceding the inspection. Defendants provided sick call requests covering October 1, 2020 to December 16, 2020. The sick call requests include the message from the detainee or inmate and the response from the medical provider. The requests

also include the full name of each detainee or inmate, their housing unit at Calhoun, and additional information about the request, including the reference number and the status of the request.

6. My colleagues at Paul, Weiss and I logged all of the sick call requests and responses that were provided in an excel chart.

7. During the facility inspection, facility staff indicated they could encounter a volume of a "couple hundred" sick call requests a week and that they usually have "3,000 nursing encounters" in a month. Assuming no fluctuations (and no increases around the time of the outbreaks), this volume should have produced approximately 1,800 to 2,000 sick call requests for the relevant eight-week time period ordered by the Court. However, only 651 sick call requests were provided. This number of calls over the given time period would result in an average of around 80 sick call requests a week, as opposed to the couple hundred cited by Calhoun staff during the inspection.

8. Pursuant to this Court's order, ECF No. 439, Defendants were required to provide all relevant documents ordered by the Court "[a]t least five days in advance of the facility inspection." However, the initial document production provided on December 11, 2020 was incomplete. Plaintiffs' counsel repeatedly followed up with Defendants' counsel about missing records on December 17, December 22, December 28, December 29, January

4, and January 5. As of January 6, Defendants assert that they have produced all relevant records ordered by the Court. Due to the incomplete document production, Plaintiffs had to delay providing the expert report until January 7, 2021.

9. Thus, this Declaration is limited to the sick call requests and other records that Defendants actually produced. In separate sections below, I discuss discrepancies between what Defendants' produced records show (or do not show) and what detainees at Calhoun have reported in declarations previously filed with the Court.

10. Analysis of the sick call requests that were provided showed that for 306 sick call requests, or approximately 47% of the requests, there was no substantive response documented within 24 hours.

a. Of these, there was no documented response at all in 59 cases (9% of total sick call requests).

b. In the other 247 sick call requests, the responses indicated that the request had been forwarded to a nurse or that the detainee or inmate would be scheduled to be seen, but there was no indication on the sick call request of any further action, and Defendants produced no

documentation showing whether or when the detainee or inmate was seen by medical staff.

11. Analysis of the sick call requests also shows 11 instances where the detainee or inmate submitted a sick call request, stating that they had previously requested medical treatment and had yet to receive a response or see a medical provider.

12. Analysis also shows that at least 54 sick call requests among the total produced included references to symptoms consistent with a possible COVID-19 diagnosis, including the specific COVID-19 symptoms identified by the Centers for Disease Control and Prevention ("CDC")[1] and general symptoms that might stem from COVID-19, such as feeling weak or dizzy.

a. Of these, there is no documented substantive response for 28 sick call requests. For example, two detainees who reported COVID-19 symptoms in sick calls were told to drink water and get rest. We have no record that they were

[1] *See* Centers for Disease Control and Prevention, *Symptoms of Coronavirus* (last updated Dec. 22, 2020), https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html (listing fever, chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea).

seen by medical staff or that they were not tested for COVID-19.

b. Further, at least 30 detainees, who submitted 35 sick call requests, were not tested for COVID-19 within five days after reporting COVID-19 symptoms in a sick call request.

c. Additionally, of these 54 sick call requests, six detainees, who submitted seven sick call requests, had tested positive for COVID-19 and were requesting treatment for COVID-19 symptoms.

13. From reviewing the sick call requests and the testing log, I have determined that some of the detainees or inmates who reported COVID-19 symptoms do get tested. However, they may not be tested immediately.

a. For example, [redacted], who tested positive for COVID-19 on October 20, first reported symptoms in a sick call request on October 12. (INSP-01657.) Despite reporting symptoms on October 12 and October 15, and being seen by medical staff on October 13 and 16, (INSP-00506 – 00508), he was not tested until October 20.

b. Similarly, [redacted], who tested positive for COVID-19, submitted a sick call request on

October 16 saying that he had been in the medical unit suffering from "chill, [cough], sore [throat]" and that the doctor did not give him anything. (INSP-00532). Despite seeing a medical provider earlier in the week, around October 13, for COVID-19 symptoms,[2] he was not tested until October 17, after he submitted a sick call request requesting additional treatment.

14. The sick call requests, which include requests by several detainees and inmates for information about the results of their COVID-19 tests, also support accounts by detainees who say that they were not informed of test results, even if they test positive for the virus.

a. For example, testing logs show that [redacted] was tested for COVID-19 on October 20, and housing logs indicate that he was in Pod H. He appears to have then been transferred to Pod L with detainees who had tested positive for COVID-19. He submitted a sick call request

[2] [redacted] has consistently reported that he notified a staff member of his symptoms on October 13 while reporting to work as a tray runner, and was escorted to be seen in the medical unit. [redacted] Decl., ECF No. 479-6, ¶ 11; [redacted] Decl., ECF No. 373-2, ¶¶ 3(c)–(e). Defendants' records do not show any indication of his examination, either because it was not classified as a sick call request or "admission" into the medical unit.

on October 24, 2020, asking whether he had COVID-19 and why he was transferred to a unit with detainees who had tested positive for COVID-19. The medical professional's response was "You can talk to medical when seen."

b. Records similarly show that [redacted] asked for COVID-19 test results. The medical provider responded "[y]our result was negative. If it would have been positive, we would of [sic] re-located you. That goes for anyone. Pass the word please and thank you."

c. Similarly, [redacted] submitted a sick call request on October 27, 2020 asking if he could get the results of his COVID-19 test. The medical provider responded that he was negative.

COVID-19 SCREENING FORMS

15. Defendants provided COVID-19 screening forms falling in the period from October 1, 2020 to December 16, 2020. The screening forms have separate pages to be filled out for each individual, listing certain vitals (respiratory rate, heart rate, temperature, oxygen saturation level) and responses to questions about COVID-19 symptoms for up to 14 days. There

is an area for the examiner to initial and sign at the bottom of the form for each screening date. Attached as Exhibit 2 is a sample blank form.

16. Analysis of the screening forms shows 13 instances where detainees had a fever above 100 degrees or reported symptoms consistent with a possible COVID-19 diagnosis, such as a cough, muscle pain, or headache.[3]

17. Defendants provided screening forms clearly labeled for use for non-positive, non-exposed, or *asymptomatic* individuals. In an email on January 5, 2021, in response to Plaintiffs' request for forms related to *symptomatic* individuals in the relevant time period covered by the inspection order, ECF No. 439, Defendants asserted that "[t]here were no symptomatic cases" and, thus, they did not provide symptomatic screening forms. However, as noted above, the screening forms show 13 instances where detainees have possible COVID-19 symptoms. Similarly, there were 54 sick calls requests from detainees or inmates with potential COVID-19 symptoms among the documents produced by Defendants. And, as discussed below, Calhoun produced records for two detainees who were admitted to the medical unit because of their COVID-19 symptoms. On January 6, 2021, Defendants clarified that the Calhoun health provider, Corizon, uses the same screening

[3] *See* INSP-00180, INSP-00292, INSP-00338, INSP-00340, INSP-002406, INSP-002409, INSP-002419, INSP-002420, INSP-002421, INSP-002422.

tool for COVID-19 positive individuals who have no symptoms or mild symptoms that do not require them to be housed in the medical unit. It is still unclear how or to what extent Calhoun screens or documents information about COVID-19 positive individuals who show more severe symptoms.

18. A review of these records also demonstrates some gaps in Calhoun's screening. For instance, for multiple detainees, there were dates on which either the questions' section of the form was not filled out[4], or vitals were not filled in.[5] For at least 63 individuals, screenings appeared to be skipped on a certain date during the period they were in quarantine—many across the same date (like October 22, November 5, and December 8[6]). For

[4] *See* INSP-00210, INSP-00221, INSP-00223, INSP-00236, INSP-00245, INSP-00247, INSP-00249, INSP-00251, INSP-00252, INSP-00258, INSP-00266, INSP-00273, INSP-00284, INSP-00292, INSP-00342, INSP-00360, INSP-02313, INSP-02406, INSP-02408, INSP-02409, INSP-02412, INSP-02413, INSP-02416, INSP-02417, INSP-02420, INSP-02421, INSP-02422, INSP-02423, INSP-02424.

[5] *See* INSP-00292, INSP-00293, INSP-00302, INSP-00312, INSP-00313, INSP-00334, INSP-02406, INSP-02407, INSP-02408, INSP-02409, INSP-02412, INSP-02413, INSP-02416, INSP-02417, INSP-02420, INSP-02421, INSP-02422, INSP-02423.

[6] *See* INSP-00224, INSP-00234, INSP-00239, INSP-00255, INSP-00256, INSP-00268, INSP-00294, INSP-00295, INSP-00309, INSP-00323, INSP-00326, INSP-00332, INSP-00336, INSP-00338, INSP-00340, INSP-00343, INSP-00344, INSP-00346, INSP-00348, INSP-00352, INSP-00359, INSP-02298, INSP-02299, INSP-02307, INSP-02308, INSP-02312, INSP-02314, INSP-02315, INSP-02318, INSP-02319, INSP-02321, INSP-02322, INSP-02325, INSP-02329, INSP-02330, INSP-02332, INSP-02333, INSP-02337, INSP-02339, INSP-02340, INSP-02343, INSP-02346, INSP-02348, INSP-02362, INSP-02363, INSP-02365, INSP-02368, INSP-02372 – INSP-02376,

at least another 15 individuals, the screening form was not filled out for multiple days in their quarantine, from two to five days[7], without any explanation.

19. I also noted that there were several detainees who had tested positive for COVID-19 and submitted declarations attesting to their COVID-19 symptoms, including difficulty breathing, loss of taste and smell, and fatigue, but whose symptoms were not recorded in their screening forms. These include: [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], and [redacted]. For some of these individuals, their COVID-19 screening forms were missing answers or had markings scratched out on certain dates. But for most, the box "no" was checked across the board for all questions regarding COVID-19 symptoms.

a. The case of [redacted] is illustrative. In his declaration, he explained that he started feeling symptoms on October 14, including headaches, muscle soreness, nausea and night sweats. ECF No. 354-4, ¶ 3. In an

INSP-02378, INSP-02381, INSP-02383 – INSP-02385, INSP-02388 – INSP-02393, INSP-02395, INSP-02405.

[7] *See* INSP-00255, INSP-00257, INSP-00267, INSP-00296, INSP-00297, INSP-00298, INSP-00299, INSP-00300, INSP-00301, INSP-00303, INSP-00304, INSP-00328, INSP-00350, INSP-00354, INSP-02358.

October 20 sick call request produced by Calhoun, he noted that he had been throwing up for the past three days. (INSP-00541.) He then tested positive on October 21. On his COVID-19 screening form, however, all boxes are checked "no" under the symptoms category for every date that is filled in (October 19 through 29, with exception of October 22, which is left blank). (INSP-00342 – 00343.)

b. Similarly, [redacted] reported COVID-19 symptoms in multiple sick call requests produced by Calhoun spanning October 12 through November 3, including saying "I'm in so much pain .stomac.head.and [sic] my eyes too" on October 22, and "my eys stiil pan [sic] and haad pan [sic]" on October 24. (INSP-01474; INSP-00512.) Yet on both those days, and all the others filled out on his COVID-19 screening form, there is no indication of any COVID-19 symptoms. (INSP-00352 – 00353).

c. Further, [redacted] reported severe COVID-19 symptoms beginning around October 19 and 20, including headaches, dry cough, loss of taste and smell, and

worsened hearing. ECF No. 400-8, ¶¶ 4(b)–(c). He was so ill that he was taken to the medical unit for part of a day, around October 20. ECF No. 447-2, ¶ 3. During the height of the outbreak, Defendants reported to the Court that [redacted] was one of the detainees housed in the medical unit. Email from J. Newby, ECF No. 374, Ex. 26, at 10. Yet, on his COVID-19 screening forms, there are no symptoms indicated at all for October 19 through November 3 (with vitals crossed out and no questions answered on October 22). (INSP-00340 – 00341). And, as discussed below, Calhoun produced no records of [redacted] time in the medical unit.

MEDICAL UNIT FORMS

20. Calhoun produced medical records for two individuals who had tested positive for COVID-19 in late October 2020 and were housed in the medical unit. On January 5, 2021, Defendants stated that these individuals were isolated in the medical unit not because they were symptomatic, but because "the practice is to isolate in the medical unit where space allows."

21. However, the records themselves demonstrate that both detainees had displayed COVID-19 symptoms: [redacted]

records from October 23 through November 1 reflect that he had a high fever, difficulty breathing, and body aches. (INSP-00089 – 00105.) Likewise, the records from October 22 through November 1 describe [redacted] as having shortness of breath, a cough and body aches. (INSP-00106 – 00123.)

22. Further, at least three other detainees had reported detainees being housed temporarily in the medical unit: [redacted] reported being housed in the medical unit from October 17 until around October 22, *see* [redacted] Decl., ECF No. 479-6, ¶¶ 14–15; Defendants confirmed that [redacted] was housed in the medical unit in late October, *see* ECF No. 374, Ex. 26, at 10; and, Defendants confirmed during the inspection that a woman had been housed in the medical unit while the housing unit she lived in went on quarantine. Yet Defendants produced no medical unit records for these individuals.

CONCERNS ABOUT ADEQUACY OF DEFENDANTS' PRODUCTIONS

23. Based on the above analysis, it appears that Calhoun has underproduced certain documents. There are much fewer sick call requests compared to the numbers estimated by Calhoun's own staff during the inspection. It is unclear how or to what extent Calhoun documents information about COVID-19 positive individuals who show more severe

symptoms, since the forms provided were for allegedly asymptomatic individuals and those with mild symptoms. We also received no medical unit records for certain detainees who had been housed or treated in that unit. Lastly, Calhoun staff stated during the inspection that they had discontinued the daily COVID-19 screenings for individuals in the new admission quarantine, but continued to monitor individuals who were in medical isolation after testing positive for COVID-19. However, as of January 7, 2021, Calhoun has still not produced screening forms for two individuals who had tested positive in the relevant period.

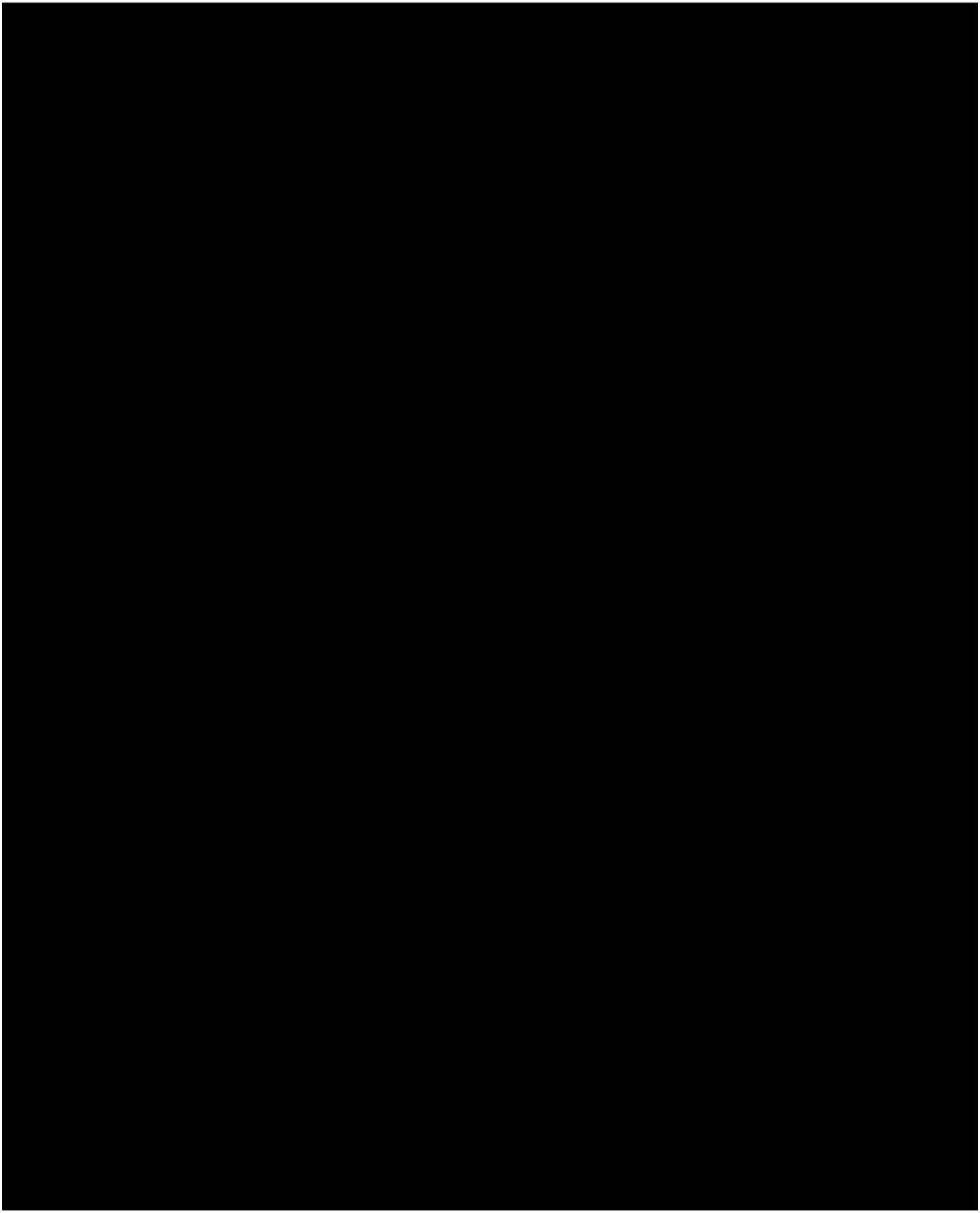
24. Should the Court desire, Plaintiffs can provide an excel document containing all of the relevant information reviewed in connection with my analysis.

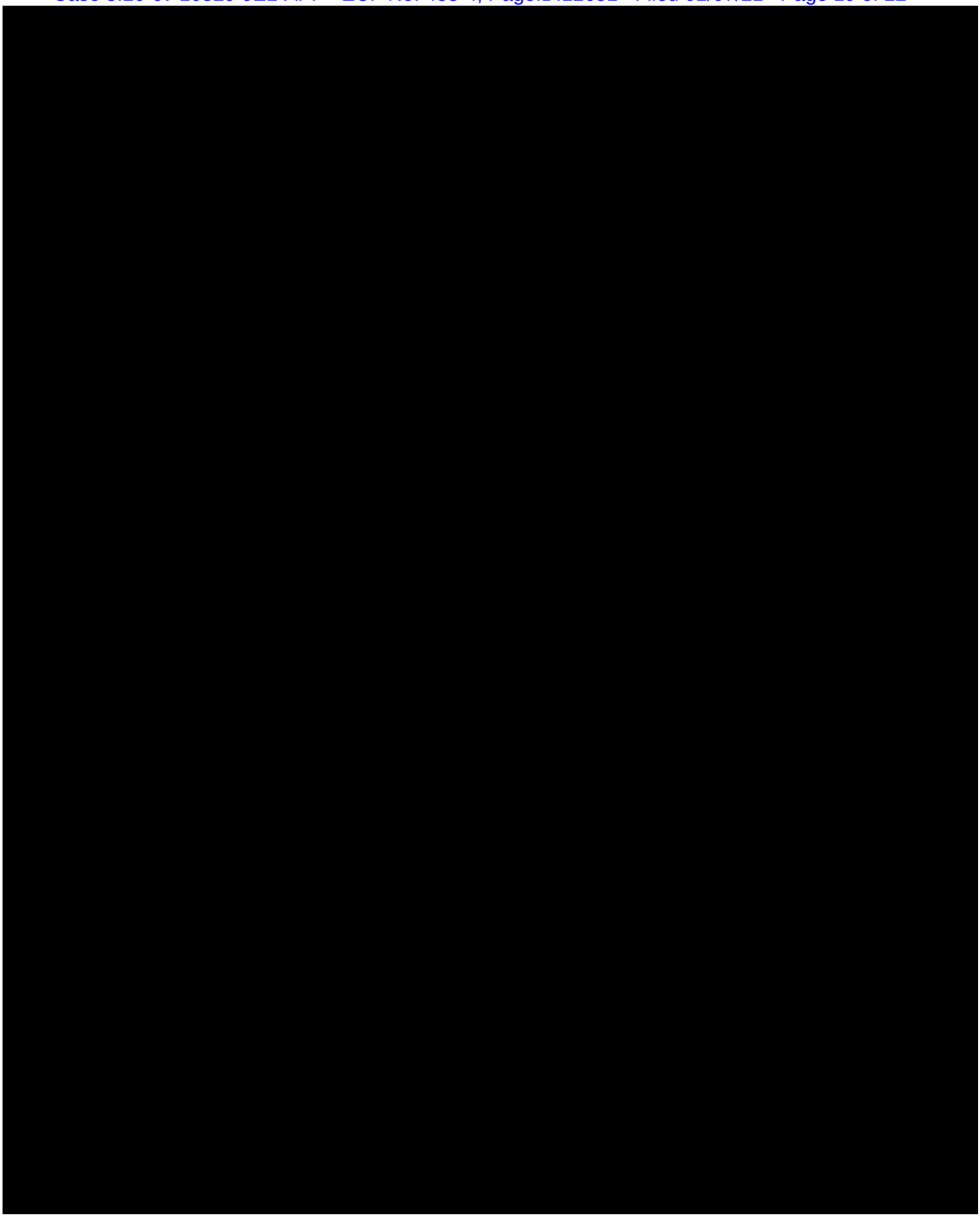
I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge and belief.

Executed on this 7th day of January 2021 in New York, New York.

/s/ Sarah Maneval
Sarah Maneval
Paul, Weiss, Rifkind, Wharton
& Garrison LLP
1285 Ave. of the Americas
New York, NY 10019
Tel: (212) 373-3900
Fax: (212)757-3990

Exhibit 1





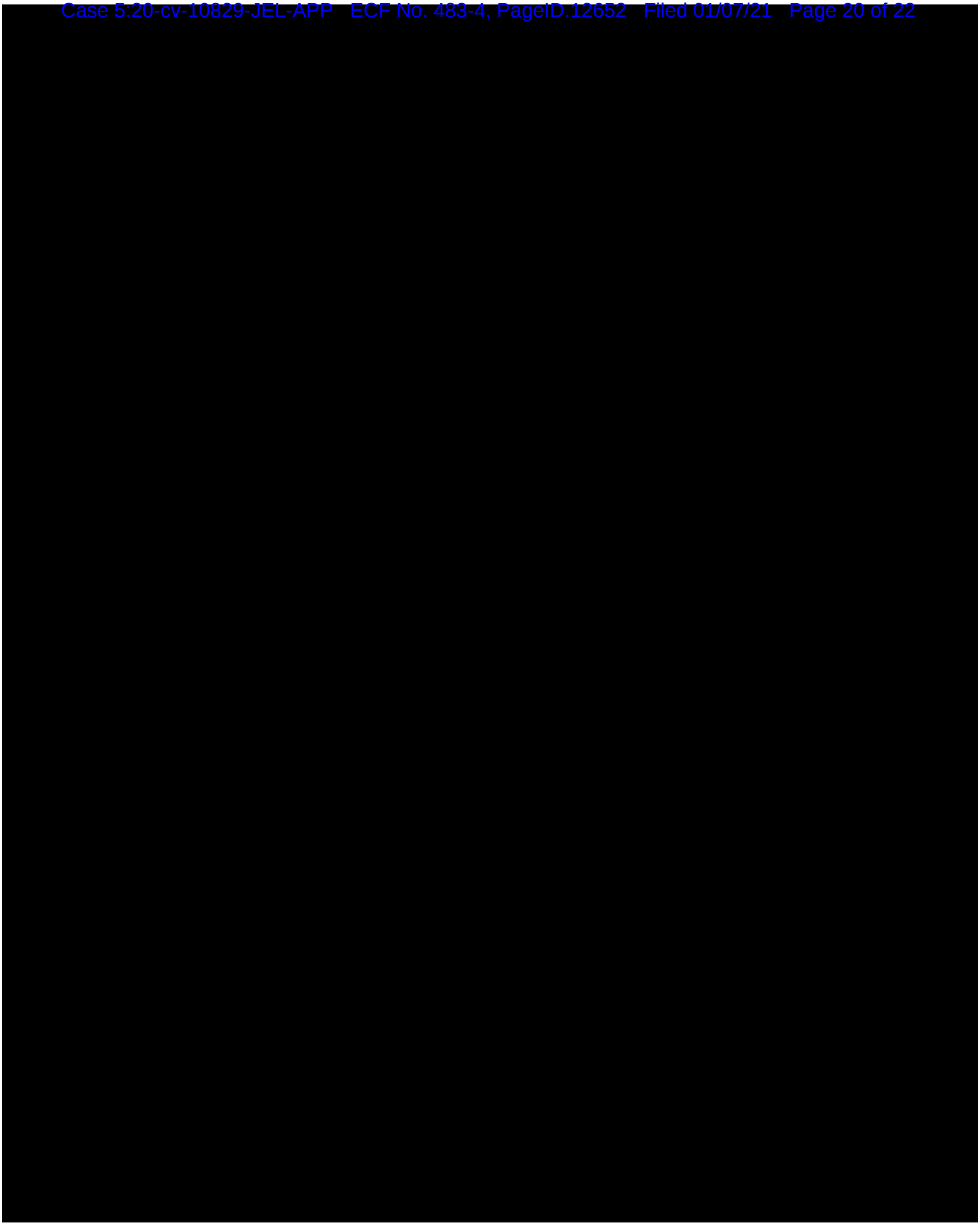


Exhibit 2

CORIZON HEALTH

Non-Positive COVID-19/Asymptomatic/ Non-Exposed Patient Screening Log

Calhoun County Detention Ctr
161 East Michigan Avenue
Battle Creek, MI 49014
(269) 969-6315 phone
(269) 965-2103 fax

Name Last, First, MI	ID#	DOB:	Facility

Nursing Assessments BID	First Assessment Date/Time:	Second Assessment Date/Time:	First Assessment Date/Time	Second Assessment Date/Time:	First Assessment Date/Time:	Second Assessment Date/Time:	First Assessment Date/Time:	Second Assessment Date/Time:	First Assessment Date/Time:	Second Assessment Date/Time:	First Assessment Date/Time:	Second Assessment Date/Time:	First Assessment Date/Time	Second Assessment Date/Time
Resp. Rate														
Heart Rate														
Temp (oral-F)														
Oxygen Saturation														
Group A Questions														
Cough	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Group B Questions														
Chills/ Repeated Shaking with chills	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Muscle Pain	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Headache	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sore Throat	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Nausea/ vomiting	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
New loss of taste or smell	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Nursing Initials														

If the patient has one or both symptoms from Group A and/or at least two symptoms from Group B: contact the provider for orders

Per the CDC:

- Healthcare Providers should immediately notify their local or state health department in the event of a person under investigation (PUI) for COVID-19, to be advised necessary interventions and treatment
- Suspected patients should be given a surgical/procedural mask to wear during transport
- Suspected patients should be placed in Airborne Infection Isolation Room (AIIR) or negative pressure room with proper precautions, if available
- Treating staff should wear N95 and PPE and perform hand hygiene before and after all patient contact

Nursing Signature		