

HOTBEDS OF INFECTION

How ICE Detention Contributed to
the Spread of COVID-19 in the United States



DETENTION
WATCH NETWORK



Accnowledgements

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About Detention Watch Network

Detention Watch Network is a national coalition of organizations and individuals building power through collective advocacy, grassroots organizing, and strategic communications to abolish immigration detention in the United States. Founded in 1997 by immigrant rights groups, DWN brings together advocates to unify

strategy and build partnerships on a local and national level.

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Introduction

Since the World Health Organization (WHO) declared COVID-19 a global pandemic on March 11, 2020, the virus has devastated communities around the world. The United States has seen more than twelve million confirmed cases at the time of writing this report, the highest in the world.

The U.S. response to the deadly virus continues to be an example of what not to do, largely ignoring the advice of public health professionals and other experts, doing little to stop the spread of infection, and displaying a callous disregard for the safety and health of its residents. The results have been both tragic and predictable. Federal and state policies have been inconsistent and ineffective, and medical supplies (from personal protective equipment [PPE] to testing supplies) have been unavailable.¹ In short, the U.S. has failed — and continues to fail — spectacularly. With roughly five percent of the world's population, the U.S. accounts for 20 percent of COVID-19 cases and deaths worldwide.²

The response of Immigration and Customs Enforcement (ICE) to the pandemic also played a role in the spread of COVID-19. The U.S.

immigration detention system, operated by ICE, has a well-documented history of medically negligent and abhorrent conditions.³ Experts have long condemned the agency for violating international norms and placing the health and welfare of detained people at risk. Despite the overwhelming evidence, the restrictive and punitive detention system has continued to grow over the last several decades. While these defects and steady growth of the system predate 2016, the Trump administration further expanded the detention system, promoted punitiveness, and degraded health and safety conditions.⁴

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people from detention
during the pandemic
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to the total U.S. caseload.*

Recommendations

The immigration detention system is cruel and unnecessary. Its defects are only heightened during a global health crisis. People navigating their immigration cases should be able to do so with their loved ones and in community, not behind bars.

The only just and long-term solution is to free all people from detention.

In the meantime,

1. ICE must immediately heed the advice of public health experts by significantly and quickly reducing the number of people in detention.⁵
2. ICE must halt enforcement activities.
3. ICE must halt all transfers within the immigration detention system as well as all transfers from state and local jails and prisons.
4. ICE must adopt a moratorium on deportations in conjunction with the above recommendations.

In this context, it is not surprising that ICE detention facilities have been uniquely vulnerable to the novel coronavirus, with an infection rate that far outweighs the infection rate among the population.

Immigration advocates and public health officials warned of these risks in March and made clear the only way forward was to immediately release people from detention so that they could safely socially distance. People in detention fearing for their lives have spoken out and protested, asking to be released in one of the few ways that they can: refusing meals. From March to July 2020, nearly 2,500 people joined in COVID-19-related hunger strikes in detention centers nationwide.⁶

ICE refused to heed the warnings and even evaded court orders requiring them to reduce numbers.⁷ As expected, the virus swept through the ICE detention system, impacting detained people and those working in detention facilities at disproportionate rates, as well as their families.⁸

The impact of ICE's failure to adequately respond to the pandemic



was far reaching and multilayered. People working at detention centers travel to and from their homes and communities, potentially introducing the virus both to people detained and to their communities. Multiple reports revealed that those working in ICE detention centers were not regularly wearing PPE. In addition, detained people were not given adequate access to soap or PPE.⁹ Further, ICE's continued and irresponsible transfer of people throughout the detention system also facilitated the spread of the virus.¹⁰ As community transmission surged out of control in the spring and summer of 2020, counties with detention facilities and surrounding counties endured higher rates of infection. Even as COVID-19 cases have surged across the country, ICE has ramped up enforcement activities,¹¹ creating a recipe for disaster for those in detention and surrounding communities.

This report adds to the body of research that points to ICE's abuse and medical neglect of people in detention, and its failure to adequately respond to the ongoing COVID-19 pandemic. ICE's failure to release people led to higher numbers of COVID-19 cases in counties where detention centers are located and the economic areas that surround them.

Based on the findings of this report, ICE's failure to release people from detention during the pandemic added over 245,000 cases to the total U.S. caseload.

ICE's deadly detention system

ICE operates a sprawling network of 221 dedicated and non-dedicated detention facilities throughout the U.S.¹² This system has proven deadly to those it detains. More than 200 people have died in ICE custody since the creation of the Department of Homeland Security (DHS) in 2004. In Fiscal Year (FY) 2020, 21 people died in ICE detention.¹³ Even excluding deaths due to COVID-19, FY 2020 was the deadliest year for people detained by ICE since 2005.¹⁴

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Detention Watch Network has previously documented the egregious conditions that typify immigration detention, including lack of access to basic hygienic products, inadequate food, abuse, and medical neglect.¹⁵ Public health officials have long warned infectious disease spreads rapidly through the system. In 2019, ICE had to place 5,200 people in quarantine — or about one in every 10 detained people at the time — for exposure to mumps and chicken pox. Advocates attributed the outbreaks to inadequate medical care in a lawsuit against the agency.¹⁶

ICE has repeatedly failed to appropriately respond to outbreaks of contagious diseases. In October 2018, the Texas Department of State Health Services reported five confirmed cases of mumps among immigrants transferred between two ICE detention centers. By August 2019, there were 898 reports of mumps cases in 57 facilities. According to the Center for Disease Control and Prevention (CDC), 84 percent of patients were exposed while in custody.¹⁷



ADELANTO DETENTION CENTER | PHOTO CREDIT: ALONSO YÁÑEZ, LA OPINION



COVID-19 in ICE detention facilities

Against this backdrop, it is no surprise that COVID-19 spread rapidly in the ICE detention system. Throughout the pandemic, ICE failed to provide adequate supplies of soap and PPE to people in detention and to detention center staff. Testing was inadequate and irregular. As of November 19, 2020, ICE has reported 7,339 positive cases among detained people out of a total of 62,080 individuals who had been tested. To date, eight people in ICE detention have died of complications from COVID-19.¹⁸ The number of those who have died due to COVID-19 contracted at ICE facilities may, in fact, be higher. It is possible that a number of people contracted the virus in detention, were not tested, and then passed away after being released from detention or deported.

In at least one detention facility — the Mesa Verde ICE Processing Center in Bakersfield, California — ICE purposefully rejected universal testing because it would be too difficult to quarantine all detained people who may test positive.¹⁹ ICE has even been blamed for spreading the virus internationally by deporting people who

were detained in facilities with active COVID-19 cases without testing them. People deported to countries including India, Haiti, Guatemala, and El Salvador tested positive shortly after their deportations.²⁰

At the Stewart Detention Center in Columbus, Georgia, three detained people have died and at least 379 have tested positive for the virus. Santiago Baten-Oxlaj, a 34-year-old Guatemalan immigrant, died in May. Mr. Baten-Oxlaj was detained for six weeks at Stewart and was infected with the virus during his detention.²¹ Weeks before his death, people detained at Stewart went on hunger strike demanding the most basic health precautions and advocacy groups demanded their release.²²

In May, officials in Pearsall, Texas raised the alarm after every local case of COVID-19 could be traced back to ICE's negligence at the South Texas ICE Processing Center. Local officials expressed concern that GEO Group, the company that operates the facility, failed to respond to emails or properly keep the community apprised as the virus quickly spread in the facility.²³

In August, a federal judge ordered ICE to stop transferring people to the detention center in Farmville, Virginia



after 339 detained people tested positive for COVID-19. The judge commented that social distancing was not enforced and that many staff at the facility did not wear proper protective equipment, including masks.²⁴

In October, the conditions devolved so badly at the nearly 2,000-bed Adelanto Detention Center in California that a federal judge ordered the administration to immediately begin releasing people from detention. More than 160 people in detention and 30 staff members were infected at the facility, even as ICE and GEO Group attempted to expand the facility.²⁵

ICE's failed response contributed to the spread of COVID-19 throughout the country

Our analysis explores how ICE's failures contributed to the spread of COVID-19 across the country, adding to the body of research documenting ICE's mismanagement, grievous medical negligence, and lack of transparency.

Key findings of the report include:

1. Counties with ICE detention centers were more likely to report COVID-19 cases earlier in the pandemic than counties without a detention center. Not only were counties with ICE facilities more likely to see an initial case in the spring of 2020, these counties were also more likely to confront a serious outbreak (at least 15 cases), a major outbreak (more than 250 cases) and a health care emergency (more than 2,500 confirmed cases).
2. The heightened risk was not limited to the county where an ICE detention facility was located. Nearby counties were also more likely to confront a serious COVID-19 outbreak in the spring of 2020.
3. As the pandemic raged in the summer of 2020 (May – August), COVID-19 spread more rapidly in economic areas with ICE detention facilities.
4. Larger ICE detention facilities contributed to accelerated growth in COVID-19 cases in nearby counties. Counties in economic areas with the largest immigrant detention centers added an estimated 150 COVID-19 cases per 100,000 residents to baseline estimates.



5. Taken as a whole, the spread of COVID-19 due to ICE's negligence was dramatic. Across the United States, the COVID-19 caseload surged over the summer of 2020. ICE exacerbated the pandemic. Between May and August, our analyses reveal that ICE detention facilities were responsible for over 245,000 COVID-19 cases throughout the country. These cases were concentrated in multicounty economic areas where ICE facilities are located.
6. If a country had reported 245,000 cases on August 1st to the World Health Organization, that country would have ranked 16th in the world, meaning that the number of COVID-19 cases attributed to spread caused by ICE detention in the United States would have outranked countries including Germany, France, and Canada.
7. California, Texas, and Arizona had the most net COVID-19 cases due to the presence of ICE detention facilities. Arizona had by far the most net additional COVID-19 cases per 100,000 residents.

Studying community transmission of COVID-19: Counties and multicounty economic areas

Because people commute, shop, and socialize across counties, for this study we examined the impacts of ICE detention for the county in which an ICE facility was located. Those who work in one county but live in another county are exposed to COVID-19 in more than one county. And, if they become infected, they can infect people in more than one county. For this reason, we also examined community transmission of COVID-19 to nearby counties, specifically counties co-located in Bureau of Economic Analysis economic areas.²⁶

Consider the Farmville Detention Center (FDC), located in Farmville, Virginia (Prince Edward County), approximately 65 miles from Richmond. Including Prince Edward County, 39 counties are in the Richmond economic area. FDC experienced a severe outbreak during the summer of 2020, with more than 75 percent of people detained there testing positive for COVID-19.²⁷ In addition to raising concerns about the management of the facility, this high rate of infection



– Table 1 –

Number of people detained by county and economic area

	LITTLE OR NO ICE DETENTION	HIGHER RATE OF ICE DETENTION
COUNTY	2,983 counties With 0 or 1 person detained	157 counties with 2 or more people detained Median number of people detained among these counties: 60 people
MULTI-COUNTY BEA ECONOMIC AREA (179 AREAS)		1,345 counties in BEA area with more than 25 people in ICE detention. Median number of immigrants detained in the BEA economic area among these counties: 245 people



at FDC elevated the risk to residents of Farmville, residents of Prince Edward County, and those residing in nearby counties. In the following analyses, we include a measure to assess exposure to the county in which the facility is located, and we include a second measure that taps into exposure to counties in the larger economic area.

In analyses focused on the arrival of COVID-19 in the spring of 2020 (Figures

1 and 2 below), a simple contrast is presented – counties in the United States with one or zero immigrants in ICE detention versus counties with at least two people in ICE detention. Parallel to the county-specific measure, the multicounty measure contrasts counties in economic areas with 25 or fewer people in ICE detention to those in multicounty economic areas with more than 25 people in ICE detention.²⁸



ADELANTO DETENTION CENTER | PHOTO CREDIT: ALONSO YÁÑEZ, LA OPINION



In 2020, active ICE detention facilities were located in a minority of counties across the country. Among the 3,143 counties included in these analyses, the vast majority (2,983 counties – 95 percent) have no detention facility (0 or 1 person detained). In the remaining 157 counties (about 5 percent of all counties) ICE detained at least two people in Fiscal Year 2020. Among these 157 counties, the median number of people detained was 60. In other words, half of these 157 counties had fewer than 60 people in detention; the other half had more than 60 people in detention.

However, when we zoomed out to consider economic areas, rather than individual counties alone, we found that more than two-thirds of counties in the U.S. (2,211 counties or 70 percent) are located in an economic area where ICE detention centers are present. Only 30 percent of counties (929) are in economic areas with zero people in ICE detention. A significant number of counties are in economic areas in which ICE detention is more prominent. Forty-three percent of counties (or 1,345) had more than 25 people in ICE detention in their economic area. The median for these counties is 245 people in ICE detention across the economic area.

Counties and multicounty economic areas with ICE facilities were more likely to confront serious COVID-19 outbreaks

When considering the role that ICE played in the spread of COVID-19, it is not enough to simply look at the presence of ICE facilities. A myriad of factors (other than ICE facilities) impacted the timing and severity of COVID-19 outbreaks.²⁹ Our analyses consider the presence of an ICE facility in a county and in a multicounty economic area (25 or more people detained in the larger economic area).³⁰

Using this approach, it is possible to hold constant a host of factors that might influence the timing of COVID-19 arriving in a county and zero in on factors of concern. Logistic regression³¹ was employed to evaluate the possibility that counties (Figure 1, next page) were at heightened risk of (a) COVID-19 being present in the county by April 1st (at least one case), (b) COVID-19 being present in the county by May 1st (more than 2 cases), (c) significant outbreak (15



- Figure 1 -

Impact of ICE Detention Facility in the County on Confirmed Cases of COVID-19 (various measures)

Between March 1 and May 1, 2020 (3,071 counties)

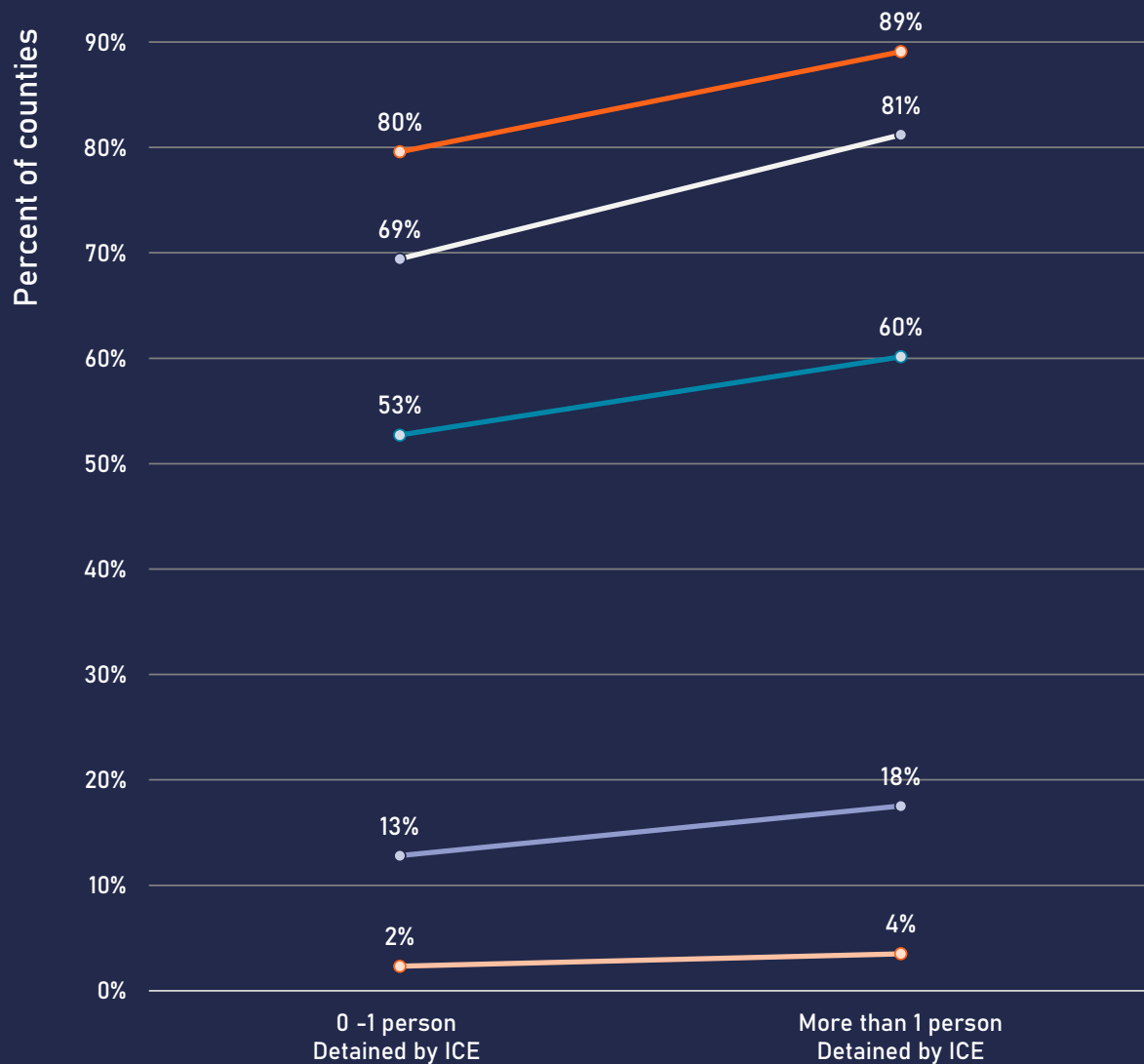


Figure 1 is focused on five unwanted COVID-19 milestones:

- Presence: More than 2 cases (May 1)
- Presence: At least one case (April 1)
- Significant outbreak: More than 15 cases (May 1)
- Serious outbreak: More than 250 cases (May 1)
- Major outbreak: More than 2,500 cases (May 1)



cases) by May 1st, (d) serious outbreak (more than 250 cases by May 1st), and (e) a major outbreak (more than 2,500 cases by May 1st).

After holding all other variables constant (i.e., all other variables in the logistic regression model held at their respective means), presence of an ICE facility (more than one person detained) significantly increased a county's risk of a COVID-19 event. Whereas 69% of counties were dealing with at least one case of COVID-19 by April 1st, an ICE detention facility made this 11% more likely (80%). A month later (May 1st), more than 2 cases had been confirmed in 80% of counties without an ICE facility and in 89% of counties with a facility. Similarly, whereas slightly more than half (53%) of counties without an ICE facility had

confirmed more than 15 cases, counties with a facility were 7 points more likely to have done so (60%).

ICE facilities also heightened the risk of more serious outbreaks:

- More than 250 cases (May 1): 13% of counties with 0 or 1 person detained, compared to 18% of counties with 2 or more people detained.
- More than 2,500 cases (May 1): Few counties were dealing with an outbreak of this magnitude. But counties with ICE facilities (3.5%) were at significantly greater risk than counties without an ICE facility (2.3%).

Figure 1 reveals that the novel coronavirus does not respect the walls and fences surrounding ICE detention facilities. ICE employees, vendors, contractors, and visitors bring the virus with them as they travel to and from the facility where it can spread rapidly in congregate settings. Especially in the initial spread of the virus, residents of counties in which ICE facilities were located were more likely to report COVID-19 cases early in the pandemic and were at heightened risk of a serious outbreak. Nor does the virus respect county boundaries. As reported in Figure 2 (on page 16), the heightened

The presence of an ICE facility significantly increased a county's risk of a COVID-19 event.



risk attributable to ICE facilities extended to counties across multicounty economic areas. Figure 2 is also focused on unwanted COVID-19 events. Notably, our analyses provide evidence that the presence of an ICE facility did not make it more likely that a multicounty economic area reported COVID-19 cases early in the pandemic, only that the presence of an ICE facility made it more likely that the multicounty economic area faced a serious outbreak:

- Presence:
More than 15 cases (May 1)
- Significant outbreak:
More than 100 cases (May 1)
- Serious outbreak:
More than 250 cases (May 1)
- Major outbreak:
More than 2,500 cases (May 1)

The contribution of ICE detention in multicounty economic areas to several COVID-19 events are displayed in Figure 2 (next page).

Figure 2 shifts the focus from the impact of ICE detention facilities in a county (Figure 1) to the impact of ICE detention facilities in nearby counties: more than 25 people detained across the multicounty BEA economic area. The focus continues to be on unwanted COVID-19 milestones:

Presence (as of May 1st):

- More than 15 cases: The risk of having 15 or more cases increases by 5% -- 51% of counties with 25 or fewer persons detained in the entire BEA area compared to 56% of counties in BEA area in which more people are detained.

Larger outbreaks (as of May 1st):

- More than 100 cases: 21% of counties in BEA areas with fewer people detained reported 100 cases, compared to one-fourth (25%) of counties in a BEA area with more than 25 persons detained.
- More than 250 cases: For counties in a BEA area with more than 25 persons detained, the risk of a major outbreak was over 14%. The risk was approximately 2% lower in BEA areas with fewer persons detained by ICE.
- More than 2,500 cases: Few counties were dealing with an outbreak of this magnitude. But counties in a BEA area with more than 25 persons detained were twice as likely to confront a major outbreak (3.0%) when compared to counties few persons detained by ICE (1.5%).

When compared to Figure 2, the increased risk is higher for each

- Figure 2 -

Impact of ICE Detention Facility across the Multicounty BEA Economic Area
on Confirmed Cases of COVID-19 (various measures)
Between March 1 and May 1, 2020 (3,071 counties)

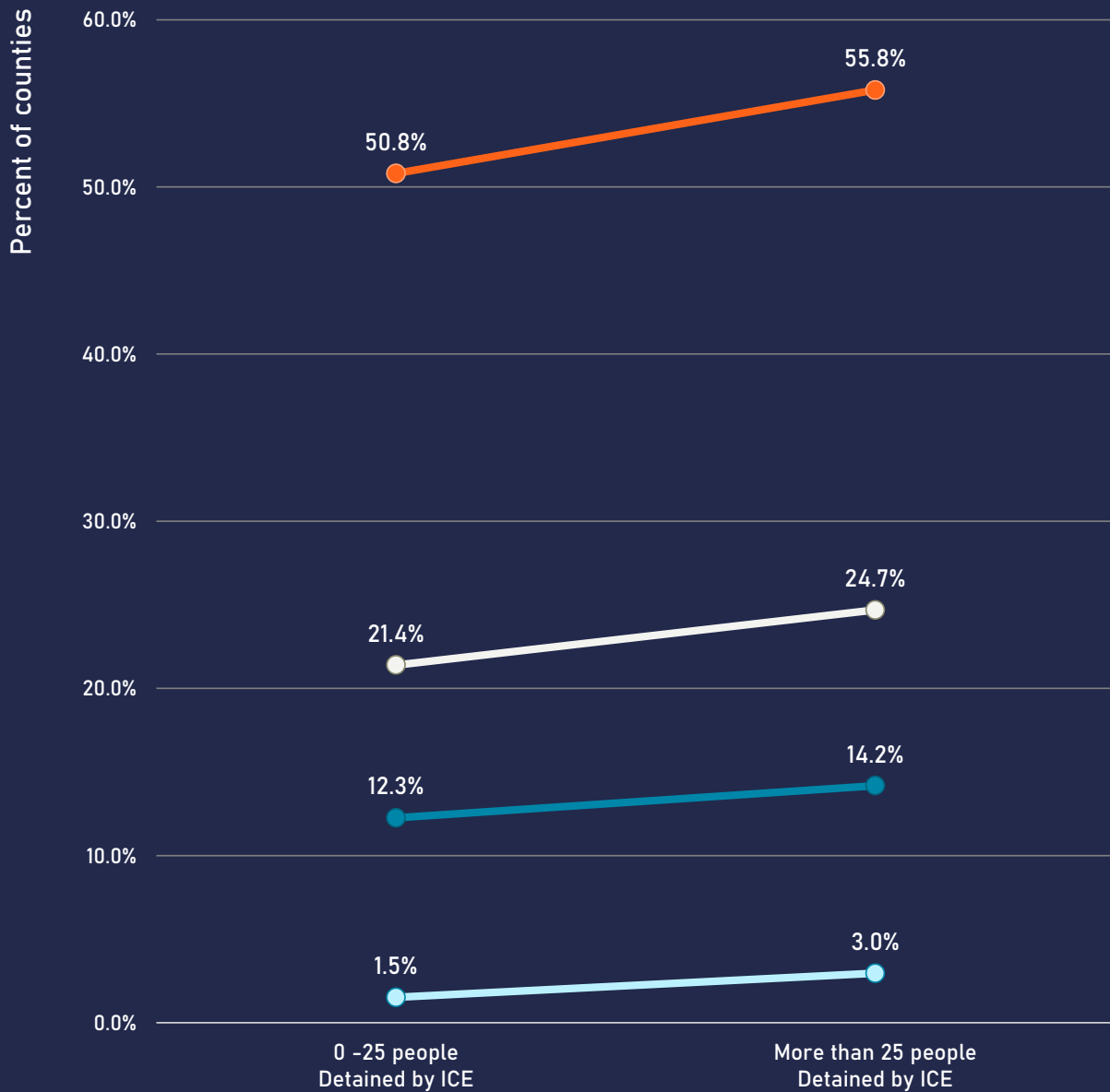


Figure 2 is focused on four unwanted COVID-19 milestones as of May 1st:

—●— Presence:
More than 15 case

—●— Significant Outbreak:
More than 100 cases

—●— Serious Outbreak:
More than 250 cases

—●— Mayor Outbreak:
More than 2,500 cases



COVID-19 event in Figure 1. This should not be surprising. Figure 1 is comparing the 157 counties in which ICE detains 2 or more people to nearly 3,000 counties in which 0 or 1 person has been detained in 2020. In Figure 2, however, the comparison is between 1,345 counties in multicounty economic areas with more than 25 people detained by ICE and counties in multicounty economic areas with lower levels of ICE detention. The increased prevalence of COVID-19 displayed in Figure 2 highlights the risks posed by ICE detention facilities across many more counties.

Figure 1 provides evidence that counties with ICE facilities were more likely to report cases of the novel coronavirus early on – and heightened risk of serious outbreaks as well. Figure 2 highlights the increased risk of serious outbreaks for counties near those with ICE facilities.

Building on these analyses, the emphasis now shifts to the impact of ICE facilities as the COVID-19 pandemic spiraled out of control over the summer of 2020.

COVID-19 spread more rapidly in multicounty economic areas with ICE facilities

Building on the preceding analyses, we next considered the magnitude of the impact, i.e. the number of additional cases that could be attributed to the presence of an ICE facility. As is common in health research, the dependent variable is not the absolute number of cases. Instead, it is the number of COVID-19 cases per 100,000 residents. Poisson regression was employed to estimate impacts on COVID-19 caseloads per 100,000 residents.³²

We used the average daily population in ICE detention in a county and in the surrounding economic area to estimate the number of cases (per 100,000 residents) that could be attributed to the presence of an ICE detention center in a county and the surrounding economic area. In order to focus on the relationship between the number of

Counties near ICE facilities experienced an increased risk of a serious outbreak.



- Table 2 -

Impact of ICE Detention Facilities across BEA Economic Areas
Additional Cases of COVID-19 per 100,000 Residents
between May 1 and August 1, 2020 (3,114 counties)

PERCENTILE RANKING (Persons detained by ICE in BEA Economic Area)	CONFIRMED CASES (per 100,000 residents)	INCREASE OVER BASELINE
BASELINE: 0 People Detained	791	-
50TH PERCENTILE: 5 People Detained	791	0.0%
75TH PERCENTILE: 131 People Detained	798	0.8%
90TH PERCENTILE: 785 People Detained	830	5.0%
95TH PERCENTILE: 1,376 People Detained	861	8.9%
99TH PERCENTILE: 2,959 People Detained	950	20.2%



people detained by ICE and the spread of COVID-19, we included a range of control variables.³³

The Poisson regression estimates did not provide evidence that ICE facilities contributed to growing caseloads of COVID-19 in the county in which they were located. However, providing additional evidence that the callous mismanagement of ICE facilities contributed to community spread, these analyses did provide evidence that as the size of ICE detention in the multicounty economic area increased, so did the incidence of COVID-19 (see Table 2).

Table 2 displays additional cases attributable to ICE facilities in the BEA economic area. The chart focuses on an “average” county, i.e., the mean was assumed for all variables in the Poisson regression model, except people detained by ICE in the BEA area. The “baseline” assumes no one (0) is detained by ICE in the BEA area: it is estimated that this “average” county confirmed 791 COVID-19 cases (per 100,000 residents) between May 1st and August 1st. Table 2 reports additional cases on top of this baseline as the number of people detained by ICE increases. Counties in economic areas with relatively few people in ICE

detention do not diverge significantly from the baseline estimate. In fact, at the 50th percentile (5 persons detained in the BEA area), a county might expect a negligible increase (less than 1 additional case per 100,000 on top of the baseline estimate). However, as the detained population increases so does the severity of the COVID-19 outbreak. Counties in a BEA economic areas at the 75th percentile (131 people detained) were expected to confirm approximately 7 additional cases per 100,000, and the caseload increased by 39 per 100,000 residents for counties at the 90th percentile (5% increase). The situation was worse still for counties in BEA areas at the 95th percentile (1,376 people detained): 70 additional cases per 100,000 residents. At the extreme (99th percentile, 2,959 or more people detained in the economic area), it is estimated that the number of additional cases was more than 150 cases (per 100,000 residents) higher – i.e., a 20% increase in the COVID-19 caseload.

Whereas Table 2 is concerned with cases per 100,000 residents, these results can also be used to estimate the net additional cases attributable to ICE detention for each county.³⁴ Table 3 (next page) summarizes impacts across the 25 states where ICE exerted

– Table 3 –

Impact of ICE Detention Facilities on 25 States Experiencing Highest Impact Net Additional Cases of COVID-19 Confirmed (May 1 - August 1)

RANK	STATE	NET ADDITIONAL CASES	TOTAL POPULATION	NET ADDITIONAL CASES PER 100,000 RESIDENTS
1	California	111,415.9	39,148,760	284.6
2	Texas	35,564.4	27,885,196	127.5
3	Arizona	28,793.7	6,946,685	414.5
4	Florida	19,906.5	20,598,140	96.6
5	New York	11,429.9	19,618,452	58.3
6	Illinois	10,840.3	12,821,497	84.5
7	New Jersey	5,305.8	8,881,845	59.7
8	Louisiana	4,866.7	4,663,616	104.4
9	Mississippi	3,006.8	2,988,762	100.6
10	Washington	1,673.5	7,294,336	22.9
11	Massachusetts	1,601.1	6,830,193	23.4
12	Connecticut	1,501.3	3,581,504	41.9
13	Georgia	1,232.3	10,297,484	12.0
14	Colorado	1,129.4	5,531,141	20.4
15	Minnesota	990.9	5,527,358	17.9
16	Virginia	983.2	8,413,774	11.7
17	Pennsylvania	793.4	12,791,181	6.2
18	Alabama	792.0	4,864,680	16.3
19	New Mexico	442.9	2,092,434	21.1
20	Tennessee	406.7	6,651,089	6.1
21	Indiana	370.4	6,637,426	5.6
22	Michigan	333.6	9,957,488	3.3
23	Maryland	326.2	6,003,435	5.4
24	Nevada	290.0	2,922,849	9.9
25	Rhode Island	268.9	1,056,611	25.4



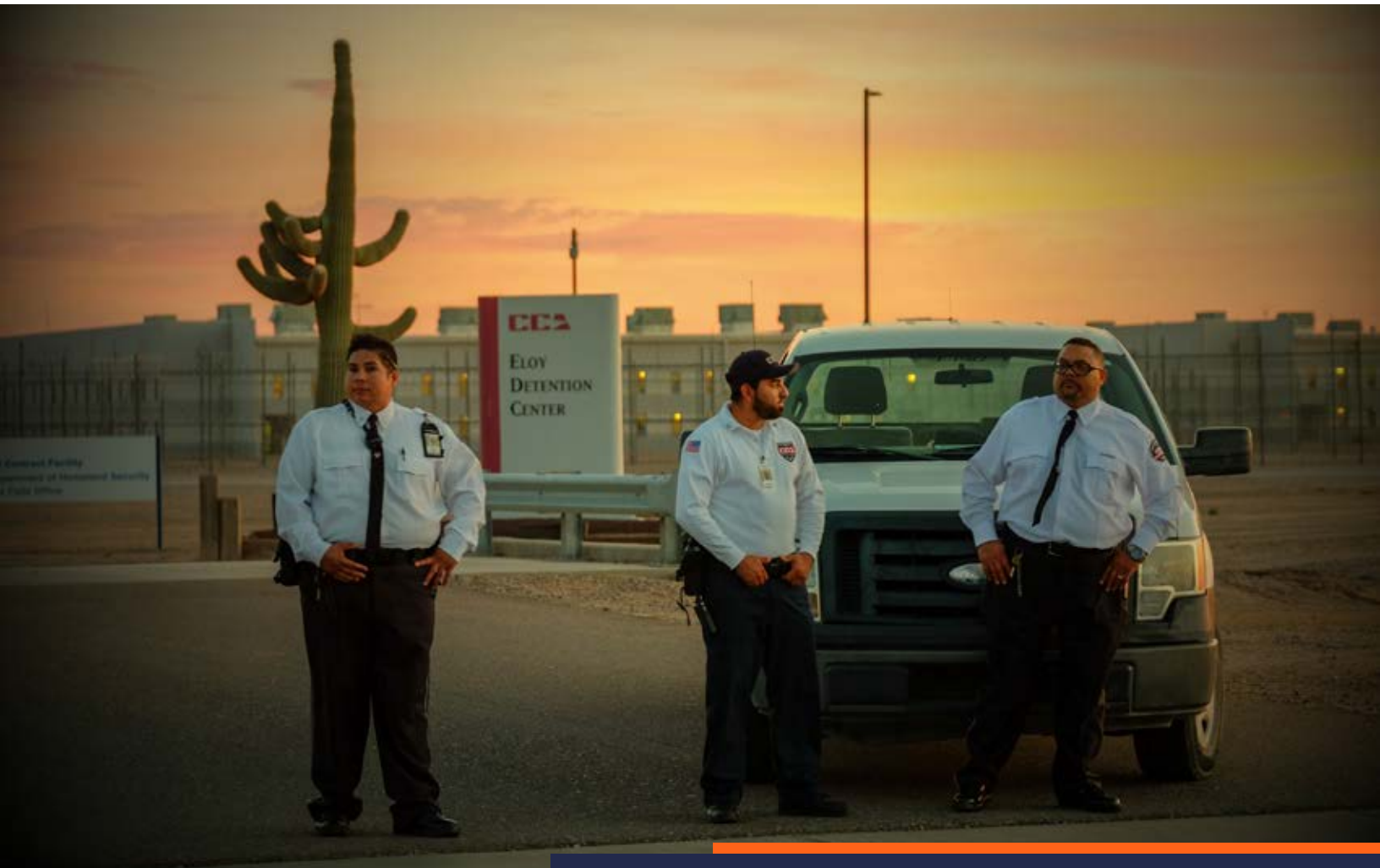
the strongest impact in the spread of COVID-19.

Recall that the dependent measure in our estimation (as summarized in Table 2) is the number of additional cases per 100,000 residents (rightmost column in Table 3). Calculating net additional cases is based on the state's total population and additional cases per 100,000. For each of the three top ranked states (California, Texas and Florida), net additional cases per 100,000 residents exceeded 100. However, if

the rank in Table 3 was based on net additional cases per 100,000, Arizona would be first – and by a wide margin: its estimated 414.5 additional cases per 100,000 is approximately 130 additional cases higher than the second highest (California with 284.6 additional cases per 100,000 residents).

Adopting a similar approach, we also ranked economic areas (Table 4).

Comparable to states, calculating net additional cases in a BEA area is based



– Table 4 –

Impact of ICE Detention Facilities on 25 Economic Area Experiencing Highest Impact Net Additional Cases of COVID-19 Confirmed (May 1 - August 1)

RANK	BEA ECONOMIC AREA	NET ADDITIONAL CASES	TOTAL POPULATION	ADDITIONAL CASES PER 100,000 RESIDENTS
1	Los Angeles-Long Beach-Riverside, CA	112,563	20,678,296	544
2	Phoenix-Mesa-Scottsdale, AZ	27,549	5,260,048	523
3	New York-Newark-Bridgeport, NY-NJ-CT-PA	18,524	23,602,788	78
4	Miami-Fort Lauderdale-Miami Beach, FL	18,165	6,855,487	265
5	Houston-Baytown-Huntsville, TX	13,187	7,809,735	168
6	Chicago-Naperville-Mich. City, IL-IN-WI	11,137	10,457,692	106
7	San Antonio, TX	8,871	2,736,961	324
8	Dallas-Fort Worth, TX	6,931	8,892,231	78
9	McAllen-Edinburg-Pharr, TX	4,391	1,356,787	323
10	Lafayette-Acadiana, LA	3,503	867,513	403
11	Jackson-Yazoo City, MS	3,055	1,661,397	183
12	Boston-Worcester-Manchester, MA-NH	1,969	8,594,883	22
13	Jacksonville, FL	1,871	1,884,231	99
14	Seattle-Tacoma-Olympia, WA	1,671	5,168,694	32
15	El Paso, TX	1,257	1,208,018	104
16	Denver-Aurora-Boulder, CO	1,155	4,558,349	25
17	Minneapolis-St. Paul-St. Cloud, MN-WI	1,047	5,533,996	18
18	Richmond, VA	825	1,745,675	47
19	Shreveport-Bossier City-Minden, LA	814	557,323	146
20	Columbus-Auburn-Opelika, GA-AL	771	494,720	156
21	Washington-Baltimore-Northern Virginia, DC-MD-VA-WV	575	10,040,033	5
22	Austin-Round Rock, TX	543	2,181,797	24
23	Albany, GA	523	607,225	86
24	Memphis, TN-MS-AR	518	2,047,494	25
25	Monroe-Bastrop, LA	427	337,021	126



on the total population and additional cases per 100,000. The Los Angeles area is both a major population center and experienced the highest impact from ICE detention activities (544 additional cases per 100,000 residents). Consequently, the number of additional cases in the Los Angeles area exceeds 100,000 while the second highest impact (Phoenix) had an additional 27,549 cases due to ICE detention facilities. Each of the top six areas had an increased caseload that exceeded 10,000 cases, and the 17 highest ranked areas had more than 1,000 additional cases by August 1st.

Shifting the focus to additional cases per 100,000 residents (rightmost column in Table 4), only Los Angeles and Phoenix areas were hit by more than 500 additional cases. However, the comparable measure for Lafayette (Louisiana) exceeded 400 cases, and Miami, San Antonio, and McAllen (Texas) were left to cope with more than 250 additional cases per 100,000 residents. Most of the areas listed in Table 4 had to come to terms with more than 100 additional cases per 100,000 residents.

A national tragedy

Adopting the same approach that was used to estimate net additional cases

in states (Table 3) and multicounty BEA economic areas (Table 4), we calculated the net effect of ICE detention for the entire United States. We estimate that ICE detention activities were linked to an additional 245,581 cases from May 1st to August 1st. Because the United States' management of COVID-19 is and has been a spectacular failure, this additional caseload may seem modest in comparison to the overall number of COVID-19 cases in the U.S. After all, by August 1st, the United States had confirmed nearly 4.5 million cases (and this is likely an undercount given the ongoing problems with testing). However, if ICE's contribution to the COVID-19 pandemic is compared to national caseloads around the world, the impact of ICE's poor management of the pandemic becomes readily apparent.

*ICE detention activities
were linked to an
additional 245,581 cases
from May 1st to August 1st.*

– Table 5 –

Net Additional Cases of COVID-19 Due to ICE Detention (May 1- August 1)
Compared to Countries with 100,000 or More Confirmed Cases
 (as of August 1, 2020)³⁷

RANK	COUNTRY	CONFIRMED CASES	CASES PER 100,000 RESIDENTS
1	USA	4,456,389	1,588
2	Brazil	2,610,102	1,541
3	India	1,695,988	187
4	Russia	845,443	632
5	South Africa	493,183	984
6	Mexico	416,179	396
7	Peru	407,492	1,565
8	Chile	355,667	2,008
9	Iran	304,204	406
10	United Kingdom	303,185	466
11	Spain	288,522	733
12	Colombia	286,020	874
13	Pakistan	278,305	130
14	Saudi Arabia	275,905	854
15	Italy	247,537	419
16	Additional cases attributable to ICE facilities	245,581	
17	Bangladesh	237,661	166
18	Turkey	230,873	294
19	Germany	209,653	266
20	Argentina	185,373	624
21	France	175,920	419
22	Iraq	124,609	429
23	Canada	115,799	322
24	Qatar	110,695	3,985
25	Indonesia	108,376	50



Table 5 (previous page) lists all countries with at least 100,000 confirmed cases as of August 1st – and inserts the cases attributable to ICE in this ranking. If the cases linked to ICE were the reported caseload of a country, that country would have ranked 16th in the world – nearly tied with Italy (the site of an early and severe outbreak). Equally disturbing is the monthly case rate among people detained by ICE. In a research letter published by the Journal of the American Medical Association (JAMA), Erfani, Uppal, and Lee³⁵ calculated a monthly case rate of 6,683 as of August 2020. The rate of infection among people detained

by ICE was more than 13 times higher than that of the general population. If a nation reported an infection rate of this magnitude to WHO, it would have the highest rate of infection in the world – and by a wide margin.

The broader mismanagement of the pandemic helps explain the large number of cases linked to ICE facilities. Table 5 reports the cases per 100,000 as of August 2020 (rightmost column). With nearly 1,588.7 cases per 100,000, the United States had one of the highest infection rates in the world (only Qatar [3,985] and Chile [2,008] were higher).



FREE THEM ALL ACTION | PHOTO CREDIT: MARCELA HERNANDEZ



Among high-income countries, the infection rate in Spain is roughly half of the US rate; for the United Kingdom and Italy, the infection rate was less than a third. For Canada and Germany, it was lower still. If the infection rate was comparable to Germany or Canada (roughly 20% of that found in the United States), it is quite possible that cases linked to ICE detention facilities would have been below 50,000. Neither Korea nor Japan are listed in Table 4 because their total caseloads were well below 100,000 as of August (roughly

15,000 and 55,000 respectively). This translates into fewer than 50 cases per 100,000 residents. Had the United States managed the pandemic comparably to these countries, there might have been fewer than 10,000 COVID-19 cases linked to ICE detention facilities. Instead, as of August 1st, due to the perverse synergy between these two policy failures, over 245,000 cases can be traced back to ICE detention.

While ICE detention contributed to over 245,000 COVID-19 cases in the US, and the presence of an ICE facility made a serious outbreak more likely, it is important to note that the people being detained by ICE bear no responsibility for this result. These 245,000 cases are the result of (uncontrolled) community transmission of COVID-19 – beyond the walls and fences of ICE facilities. Outside of the risk factors posed by their detention, people who are detained are no more or less likely to get sick than other people in the U.S. Rather detention centers, like other congregate settings, provide the perfect storm for the spread of a virus. ICE knew this and was warned about the consequences. Their failure to release people resulted in a spike in the infection rate in ICE facilities and in surrounding communities.

A research letter published by the Journal of the American Medical Association found that the rate of infection among people detained by ICE was more than 13 times higher than that of the general population.



Conclusion and Recommendations

For years, the United States has ignored the advice of experts on immigration detention and has displayed a disregard for the dignity, safety, and health of people in detention. Time and again these chronic failures have been exemplified by a culture of abuse and medical neglect. These failures are endemic in the current system, but they are avoidable. Human rights abuses and medical neglect could be avoided if those navigating immigration cases were able to do so at home with their families and in their communities, not behind bars. Now during the ongoing global pandemic, these failures have created conditions for infection rates to soar.

Medical professionals, advocates, and, most notably, detained immigrants themselves called on ICE to release people from detention as the COVID-19 pandemic grew in early spring 2020, noting the unique vulnerability people face in detention. Meanwhile ICE continued enforcement operations and transfers between facilities, while people working in detention centers went back and forth from work and home in nearby communities, creating conditions for exposing the virus to people in detention, where it could

spread quickly due to congregate settings. ICE refused to listen to these warnings. The failure to release people from custody in the spring and summer of 2020 – despite recommendations advanced by advocates and public health experts – proved to be catastrophic for people detained, for those working in detention centers, and for those living in surrounding communities.

The failure to release people from custody proved to be catastrophic for people detained, for those working in detention centers, and for those living in surrounding communities.



Our analysis demonstrates that counties with ICE facilities were more likely to report cases of COVID-19 early on. The impact then rippled into the surrounding communities. Counties with ICE facilities and their surrounding multicounty economic areas were more likely to face a serious outbreak than those without ICE facilities. The spectacular mismanagement of COVID-19 resulted in spiraling community transmission of the disease. Once introduced into ICE detention, COVID-19 transmitted quickly within facilities and the surrounding communities and counties (Table 2). The consequences of this transmission were magnified many times over by the uncontrolled spread of COVID-19 in communities across the country.³⁶

As COVID-19 cases are rising sharply and will continue to climb in the coming months, now is the time for immediate action to mitigate the spread of COVID-19 inside and outside the detention system.

The immigration detention system is cruel and unnecessary. Its defects are only heightened during a global health crisis. People navigating their immigration cases should be able to do so with their loved ones and in community, not behind bars.

The only just and long-term solution is to free all people from detention.

In the meantime,

1. ICE must immediately heed the advice of public health experts by significantly and quickly reducing the number of people in detention.³⁸
2. ICE must halt enforcement activities.
3. ICE must halt all transfers within the immigration detention system as well as all transfers from state and local jails and prisons.
4. ICE must adopt a moratorium on deportations in conjunction with above recommendations.



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DETENTION
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