UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

O.M.G. et al., *Petitioners*, v. WOLF et al., *Respondents*.	**DECLARATION OF GREGORY P. COPELAND** Case No. 1:20-cv-00786

I, Gregory P. Copeland, being duly sworn, do hereby declare and state as follows:

1. I make this declaration under penalty of perjury pursuant to 28 U.S.C. §1746 in support Petitioners' Emergency Verified Petition for a Writ of Mandamus ("Petition"). I am a Legal Director with Rapid Defense Network (RDN). RDN together with ALDEA-The People's Justice Center and the Refugee and Immigrant Center for Immigrant Center for Education and Legal Services (RAICES) are counsel for Petitioners.
2. Petitioners are seeking emergent relief from this Court because they are non-citizen parents and their children detained in purported civil immigration family detention and are in conscious shocking risk of exposure to contracting the deadly COVID-19 virus in the midst of a global pandemic by failing to take the mostly minimally precautions to prepare for the all too foreseeable catastrophe in crowded family detention.
3. The following Exhibits are submitted in support of the Petition.
4. Attached hereto as Exhibit 2 is a true and correct copy of the Declaration of Bridget Cambria.
5. Attached hereto as Exhibit 3 is a true and correct copy of the Declaration of M.B.G.
6. Attached hereto as Exhibit 4 is a true and correct copy of the Declaration of Shalyn Fluharty.
7. Attached hereto as Exhibit 5 is a true and correct copy of the Declaration of Allison Herre.

8. Attached hereto as Exhibit 6 is a true and correct copy of the Declaration of Stephanie Alvarez-Jones.
9. Attached hereto as Exhibit 7 is a true and correct copy of the Declaration of Andrea Meza.
10. Attached hereto as Exhibit 8 is a true and correct copy of the Declaration of Julia Valero.
11. Attached hereto as Exhibit 9 is a true and correct copy of the Declaration of Laila Ayub.
12. Attached hereto as Exhibit 10 is a true and correct copy of the Declaration of R.P.
13. Attached hereto as Exhibit 11 is a true and correct copy of the Declaration of T.F.
14. Attached hereto as Exhibit 12 is a true and correct copy of the Declaration of Dr. Ronald Waldman.
15. Attached hereto as Exhibit 13 is a true and correct copy of the Declaration of Dr. Julia DeAun Graves.
16. Attached hereto as Exhibit 14 is a true and correct copy of the Letter to Congress Profs. Allen and Rich.
17. Attached hereto as Exhibit 15 is a true and correct copy of the Declaration of Dr. Jaimie Meyer.
18. Attached hereto as Exhibit 16 is a true and correct copy of the Declaration of O.M.G.
19. Attached hereto as Exhibit 17 is a true and correct copy of the Declaration of C.L.
20. Attached hereto as Exhibit 18 is a true and correct copy of the Flores Settlement Agreement ("FSA")
21. Attached hereto as Exhibit 19 is a true and correct copy of the Declaration of Dr. Rachel Pearson.

22. Attached hereto as Exhibit 20 is a true and correct copy of the Declaration of Amy Maldonado, Esq.

I declare, under penalty of perjury, that the foregoing is true and correct.

Dated: March 21, 2020
Brooklyn, New York

/s/ Gregory P. Copeland
Gregory P. Copeland (D.D.C. Bar # NY0311)

DECLARATION OF BRIDGET CAMBRIA, ESQ.

I, Bridget Cambria, declare and say as follows:

1. My name is Bridget Cambria, Esq. and I am an attorney licensed to practice in the State of Pennsylvania since May of 2007. This declaration describes my experiences and observations working with clients detained in an ICE family residential center, including detention practices and conditions and, in particular, issues concerning the detention of parents and children in the Berks Family Residential Center during the COVID-19 pandemic, their concerns about contracting a life-threatening illness in detention and the conditions of detention which threaten the lives of the families in immigration family detention in Pennsylvania.

2. For more than 12 years, I have exclusively practiced immigration law, working with children, families and adults, both in the detained and non-detained settings. In my practice, I have represented immigrants, children and families before Immigration Courts nationwide, the Board of Immigration Appeals, Federal District Courts and the Third Circuit Court of Appeals. I am a graduate of the Roger Williams School of Law, where my studies focused on immigration and public interest law. Prior to law school, on or about 2002, I was employed by the County of Berks as a staff member at the Berks County Residential Center (hereinafter "BCRC," previously and alternatively known as the "Berks County Youth Center", "Berks Family Shelter", or the "Berks Family Detention Center").

3. Currently, I am an attorney with, and the Executive Director of, Aldea – The People's Justice Center ("Aldea"), a non-profit located in Reading, Pennsylvania in the County of Berks. Our organization, Aldea, offers universal representation to families detained at the Berks County Residential Center in Leesport, Pennsylvania. In the last five years, we have represented more than one thousand parents and children who have been detained in family detention in the BCRC.

4. In the course of employment, I have regular occasion to observe, and therefore am familiar with, the policies and practices of United States Immigration and Customs Enforcement ("ICE") toward the detention, release, and treatment of children and parents in family detention generally and the Berks County Residential Center. I have also had the opportunity to observe detention practices and detention conditions for families detained by ICE in Pennsylvania.

5. Aldea maintains a near daily presence on the ground at the BCRC providing pro bono legal services to detained families at no cost to ensure that all detained families and children have access to legal services in immigration matters, which often times is a matter of life and death. Families detained at the BCRC are seeking protection from persecution and torture and are actively pursuing asylum, withholding of removal and protection under the United Nations Convention Against Torture. Although the majority of families detained in Berks are from Mexico, Guatemala, Honduras and El Salvador, families in the BCRC come from all over the world. Other countries currently represented in the detained population at Berks include also families from Haiti and India.

6. Prior to arriving at Berks, the vast majority of families are first detained in a "*hielera*" ("icebox") prior to arriving at Berks. Our clients frequently report they were crammed into a large, cold cell for multiple days without access to hot meals, showers, toiletries, medical care, and beds while in CBP custody. Following this time in unsanitary conditions in CBP the families are transported to airports and flown to the BCRC. Often we observe families and children arriving to the facility ill due to the poor conditions in CBP custody, and often children and families fall ill shortly after arriving at the detention center as a result of the same.

Detention Practices at the Berks County Residential Center

7. I have provided legal services to the BCRC for more than five years and am a Flores Consultant, meaning that I participate in discussions concerning the legal rights of detained

minors pursuant to the Flores Settlement Agreement (FSA). It is undoubtable that the current pandemic prevents appropriate care of minors in ICE custody as required under the FSA which requires that custody determinations must be made while taking into account the particular vulnerability of children as well as to protect the minor's *well being and that of others*. See Paragraph 11. The FSA requires *safe* and sanitary conditions for children and that they be processed expeditiously. The FSA requires a detention determination *without unnecessary delay* and that the determination be made to not only ensure appearance in court, but to *ensure the safety of minors or others*. See Paragraph 12 and 14. Further, if for some reason, such as danger, the DHS desires to continue to detain the child, they are obligated to immediately provide a bond hearing before an immigration judge, *in every case*. Paragraph 24A. Further, in the case of detained children, in consideration of bond, simultaneous release of the detained parent pursuant to 8 C.F.R. 1236.3(2) *must* be considered.

8. I have also had an opportunity to tour the BCRC facility in my capacity as a Flores monitor. Our staff continue to provide services during the COVID-19 outbreak as we are obligated by the EOIR to provide legal representation in Immigration Courts that remain open. Detained Immigration Courts have not shuttered during the pandemic, therefore our clients, detention centers, and our employees remain at risk.

9. The BCRC detains mothers, fathers and children. The BCRC detains children of all ages, as young as an 11-day-old newborn through children aged 17 years of age. The current population of Berks consists of children as young as 6 months old to children who are teenagers. The BCRC can detain up to 96 persons at one time. As of this writing, we can estimate that about 50 mothers, fathers and children are detained at the BCRC, a facility that consists of one building where the detainees are in close quarters. The placement determination of families in the BCRC, rather than placement in liberty, is made by ICE. The majority of families apprehended by the Department of Homeland Security ("DHS") are

not subject to confinement. By and large, families subject to removal from the United States are subject to alternatives to detention. Those in family detention are the exception and not the rule.

10. Family detention by the DHS occurs only in the BCRC in Leesport, Pennsylvania, the South Texas Family Residential Center in Dilley, Texas and the Karnes County Residential Center, in Karnes, Texas. A family cannot be detained in any other facility in the United States. For that reason, families are transported from every part of the United States into the family detention centers in Texas and Pennsylvania. We receive families from the Southern Border, from interior apprehensions by ICE throughout the United States and apprehensions at the Northern Border.

11. Not a single family in the Berks County Residential Center has a criminal record. Every family in the BCRC is an asylum seeker, with a pending proceeding with the Asylum Office or the Executive Office for Immigration Review. Every family is considered a “civil detainee.” Every detained family would be subject to the same civil immigration proceeding whether in detention or outside of detention.

12. Routinely, detained families are released from the BCRC by ICE and placed with their families, friends and sponsors who reside in the United States without necessary intervention by a Judge or the requirement of payment of a monetary bond given the particular vulnerability of children, to ensure proper care of children outside of a detention environment, and because asylum-seeking detainees can provide a fixed address wherein the family will reside while abiding by alternatives to detention, including electronic monitoring, phone monitoring, in person ICE supervision appointments and/or participation in an intensive supervision appearance program.

13. Family detention is the secure detention of parents and children. The BCRC is a secure care facility. It is a secure facility in several ways, however, most simply, no parent or child is free to leave the facility.

14. The BCRC is a facility that consists of a single building. It is owned and operated by the County of Berks. The facility is staffed with more than 60 employees. Further, the facility has a medical clinic, which is staffed with medical personnel of an unknown number. The building is also occupied by ICE who operates a Field Office from within the same building as the family detention center. The ICE offices are fully staffed with ICE personnel of an unknown number. It includes the Enforcement and Removal Officers assigned to the BCRC itself, as well as ICE personnel who operate in the field throughout the surrounding region, administrative personnel for the family detention center as well as the ICE office itself. The ICE offices also possess holding areas for local ICE arrests, including those persons arrested by ICE in the Berks County area as well as those ICE detainees released from local jails pursuant to ICE detainers. An unknown number of detainees are processed at the BCRC over and above the families detained at the center. There is a constant ebb and flow of officers, personnel, families, children and detainees that come and go from the BCRC.

15. Families in the BCRC are held in very close spaces with lots of other detainees, employees of the facility and ICE personnel. The detainees sleep in rooms with six beds to a room. Each of the currently detained families are in overcrowded bedroom spaces. The detainees state that less than one half, of one meter of space divides the beds in their room. Detained families are advised of this in their Resident Handbook. *See attached excerpts from the Resident Handbook.* "At the Center, you will be living in close proximity with other families, so personal hygiene is essential. You are expected to bathe regularly and keep your hair clean." *[See Handbook page 13]* Further, "due to the communal nature of the Center … children from different families may room together, and non-related adults room together." *[See Handbook Page 9]* Detained families often are required to use the same items, spaces,

and toys which are located throughout the detention center. "Residents are expected to share common equipment such as telephones, televisions, tables, recreational games and other equipment." *[See Handbook Page 9].* The more than 50 current detainees are limited to two floors of a single building, where they share limited common areas, shared sleeping quarters, shared bathrooms, and a very cramped dining area.

16. Throughout the day, detained parents and children are mandated to congregate together, including three census periods, three lunch periods and times when free movement is prohibited. At no point is a family permitted to leave the building into the recreation area, except where given permission and at no point may a family leave the facility of their own choosing without being under the threat of federal criminal arrest.

17. Census requires detainees to report to the bedroom floor courtesy desk as a family to check in from 6:30am TO 7:30am 3:00pm TO 4:00pm 7:30pm TO 8:00pm. Failure to comply results in discipline. *[See Handbook page 15].*

18. Meals are provided in a single dining room three times a day, for both detained families and employees of the Berks facility. The families currently report more than 60 people are in the dining room during meal periods. Detained families, including small children, are required to be present in the dining room from: 7:30am to 8:00am 12:00pm to 1:00pm 5:30pm to 6:30pm. *[See Handbook Page 17.]*

19. The BCRC has a medical unit which is operated by Immigration Health Services Corps. There is no pediatrician nor gynecologist. A doctor is not present in the facility at all times, but comes and goes from the facility. All medical decisions for parents and children are made by the medical unit, including diagnosis, treatment, over-the-counter medication, and whether a parent or child should receive a test or visit a hospital.

20. Detained families are not allowed free movement throughout the BCRC or in recreation at various times, including after 8PM, and during all eating periods. Estimated times when detained families are permitted in outside recreation areas are 8:30AM to 11:30AM, 1:30PM to 4:30PM, and 6:30PM until the sun begins to set, however, they are not permitted outside without a guard escort or observation. At 8:00PM each day, all detained families are restricted to the second floor and no longer permitted even supervised free movement.

21. Children are to be in the company of their parents at all times.

22. In Family Residential Centers, parents are not responsible for determinations as to the care of their children. Parents cannot determine when their children wake up, what they eat or if they need to go to a hospital. Parental decisions are made for children, by the facility procedures, the guards within the facility and by ICE themselves. Children are told when they can and cannot play, when they can or cannot be outside, when they can eat and what they eat, and what happens when they misbehave – by the facility and not their parents. Medical decisions are not made by parents, either. Those decisions are made by ICE medical personnel or County facility staff.

23. Finally, at the BCRC, few employees speak Spanish. If a detainee has a problem, they must make a language service request, a guard must take them to a telephone to connect with an interpreter by phone, and an interpreter must be available. This arrangement does not permit adequate care of children, especially during emergencies. In a pandemic, the lack of in person interpreters in facilities that detain immigrants threatens the lives of the parents and children they detain. There is no way to communicate an emergency to a staff member quickly if neither the detainee nor the staff understands what is being said. This is unacceptable in an environment with children during the COVID-19 outbreak.

Detention Conditions at the BCRC During the COVID-19 Pandemic

24. I have had the opportunity to interview the detainees about their concerns and worries with the outbreak of the COVID-19 pandemic. The families are scared.

25. It is impossible for detained parents and children at the BCRC to practice social distancing—remaining 6 feet from others— as has been recommended to combat the COVID-19 pandemic. Based upon my observations at Berks, it would be impossible for detained individuals to create the distance between themselves and other detainees necessary to protect themselves. Detainees are forced to sleep in close quarters with others, share crowded bathrooms, and are forced to congregate in small communal areas. There are no more than two floors of permitted movement space for every single detainee limited to a handful of small rooms.

26. Clients of Aldea are very concerned that they will be exposed to COVID-19 and that they lack access to appropriate testing or medical treatment services while in detention. This is exacerbated by the fact that they cannot make medical decisions for themselves or their children. Without exception, each family interviewed by Aldea has reported that their children are currently ill, or were recently ill. Without exception, the families advised knowing about the outbreak only through news reports and are upset that the facility has not advised them the reality of what is happening on the outside of detention.

27. Detainees report that children and parents were not educated about the COVID-19 outbreak. They were not advised of different processes or procedures employed by the facility to prevent spread. They report a sign was posted saying "Wash your hands" in Spanish, but that other posters were in the English language and they are unable to read them. One detained family reported they were told to "cough in their elbow" and that was all.

28. Many families report having inadequate access to soap and hand sanitizer at the facility. Families report that hand sanitizer is available only for the staff and not for the detainees. I can report that there is hand sanitizer in the lobby of the facility, which is inaccessible to the detainees, as well as the legal visit room. I have instructed the detainees to use the hand sanitizer within the legal area. The families report it is not available elsewhere for them to use freely. The families report at times a lack of access to hand and body soap. In some instances, they reported no soap in bathrooms and broken dispensers which have not been fixed.

29. Detainees do not have gloves or masks. Upon observation, staff was not wearing masks. Residents reported that the staff did use gloves when treating the detained families. Detainees only have access to gloves when they clean. They are paid $1 dollar a day to participate in a voluntary work program which, in part, cleans the facility. Upon observation there is no outside cleaning service. Cleaning is conducted by the families and the shelter care counselors of the BCRC.

30. Families expressed great concern about the health of their children. They express that they see staff of the facility spray cleaning product throughout a room, but do not wipe anything. They state they see the staff spray cleaning product directly on top of the children’s toys, that both ill and well children play with toys, and parents fear that children often touch many things and put toys in their mouth, spreading germs.

31. The detained families reported that children, parents and staff within the facility have shown signs of illness. Residents have noticed that some staff have disappeared from work, and the families are concerned that the staff is exhibiting symptoms. The detained families are exceptionally worried about new families being introduced into the BCRC without adequate screening, since they report that families are arriving sick into the center.

32. Families report that children who show symptoms like constant cough, fever, sore throat, lethargy, congestion, difficulty breathing or sleeping, lack of appetite often go untreated. When treated, they are only provided Tylenol and it takes much time to receive actual medicine. Often, families report they are told the problem is allergies and that is all. This is true even in the time of the COVID-19 pandemic. Two days prior to this writing, Aldea staff requested "cough syrup" for a two-year-old boy who has a persistent cough and upon appearance was visibly ill. We requested the medicine when asked to inquire by client, as is often the case when children are ill for a prolonged time without treatment. Upon request to we were asked "What is cough syrup?" Then upon speaking with a caseworker to continue to ask for cough medicine, we were advised that we could not ask him that it was medical's decision, and when we asked to fill out a resident request form for cough medicine, were told that that such a request didn't exist, despite such requests being available pursuant to the detainee handbook. *[See Handbook Page 8]*

33. Families often face an impossible wall to receiving medical care in detention, which rings the alarm to legal service providers as to what will happen when the pandemic hits the detained population. It will result in a threat to the lives of men, women, parents and children.

34. As of this writing, we are unaware of any parent, child or employee at the BCRC who has been tested for COVID-19, this is despite the fact that the families and children do have cold and flu-like illnesses.

35. The facility can, and has, isolated families at different times. During medical isolation in detention, a parent is isolated with their children. They are isolated together even when only one of the members of the family unit is ill. There is no physical capability to medically quarantine everyone.

36. The facility does not have 24/7 doctors on site and cannot treat emergencies. A hospital is closely located to the detention facility, however, an outbreak of COVID-19 with parents and children at Berks will overwhelm the small local hospital that is currently dealing with the population of Berks County and the city of Reading, PA. Further, and undoubtedly, should one person at the BCRC contract the COVID-19 virus, every person in the BCRC may be affected given the communal nature of family detention.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct pursuant to 28 U,S,C,. ¶ 1746.

Executed this 20th of March, 2020 in Reading, Pennsylvania.

Bridget Cambria, Esq.

Berks Family Residential Center

Resident Handbook

1040 Berks Road
Leesport, PA 19533
610.396.0310

- For students- follow classroom rules that are established by the teachers and the Center staff;
- Promptly report broken items or damaged property to staff;
- Alert staff immediately of any problems or concerns;
- Ask staff if you do not understand or remember Center rules;
- Abide by the room visitation policy. See the section concerning bedrooms for more information;
- Do not borrow or trade clothing, hygiene products, jewelry or make-up;
- Do not deface or otherwise damage Center property;
- Comply with the dress code found in this handbook;
- Do not use tobacco products, alcohol or gum;
- Do not waste food;
- Do not use profanity.

Failure to follow the above rules may result in the initiation of disciplinary proceedings. Serious and/or continuous infractions may lead to a review of your continued suitability for placement in this residential setting. See the section on disciplinary procedures for more information. Residents who act in an aggressive manner and/or attempt to cause harm to themselves or others, may be passively restrained under the Center restrictive procedure policy to protect themselves and others.

RESIDENT REQUESTS

Generally, residents can have questions answered and obtain services merely by speaking to staff. For those who would rather request information formally, the official method is by completing a Resident Request form. These forms are available at the Resident Information Center. Please complete all the information requested on the forms. You may obtain assistance from another resident or staff member in preparing your request form. Completed forms are to be placed in the mailbox labeled "Requests" located at the Resident Information Center. These forms are collected each business day and routed to a caseworker for resolution. This procedure is not to be used for submitting formal grievances. See the section on grievance procedures for more information.

CONTACTING IMMIGRATION

ICE staff are assigned to your immigration case and conduct announced and unannounced (not scheduled) visits to the Center. The purpose of these visits is to speak to residents about their immigration concerns and observe living conditions. You may visit with ICE during their announced visits and also submit written questions, requests or concerns to them by completing an ICE communication form. These forms are available at the Resident Information Center. Completed forms are to be placed in the mailbox labeled "ICE. These forms are collected each business day and routed to ICE without

being read or altered. You may obtain assistance from another resident or staff member in preparing your request form. The ICE staff receiving your request form will respond to you. ICE officers are the only staff who can answer immigration related questions. See the posted ICE visit schedule at the Resident Information Center. The county staff, in blue shirts and tan pants/shorts you interact with at the Center cannot answer any immigration related questions.

CASEWORKERS

Each family admitted to the Center is assigned a specific caseworker, although questions may be directed to any of the caseworkers as needed. These caseworkers assist residents with questions regarding rights, rules, responsibilities, programing and services, housing and education, property issues, access phone numbers and addresses of family and friends, treatment referrals and other issues that arise while living at the Center. Residents may contact the caseworkers in their office on the activity floor during free movement and through the use of a Resident Request form. These forms are located at the Resident Information Center. Completed forms are to be placed in the mailbox labeled "Requests". Signup sheets for hair care services, legal aid assistance and phone calling cards among other items are located outside of the caseworkers' office.

LIVING ARRANGEMENTS

Residents are expected to share common equipment such as telephones, televisions, tables, recreational games and other equipment. Quiet hours are from 10:30am to 6:30am on weekdays (Sunday night through Thursday night) and at 12:00 midnight to 6:30am on weekends (Friday and Saturday night) and holidays. During quiet hours residents are expected to refrain from activities which would disturb the sleep of others.

BEDROOMS

Children 12 years and under will be assigned a bedroom with their parent. Children 13 years and over will be assigned a bedroom with other children of the same gender and like age. Each resident is provided with their own bed. Residents should make their beds and straighten up their immediate area each morning. When not in use, beds should remain made. Beds are not to be moved. Due to the communal nature of the Center, where children from different families may room together, and non-related adults room together, residents must abide by the following room visitation policies to ensure the privacy and safety of all residents: Anytime an unrelated child is present in a bedroom, adult residents must have staff supervision while in that bedroom. Children may enter their parent's bedroom only in the company of their parents. As there are many areas in the Center to relax with other residents for conversation, adults are not allowed to congregate in bedrooms. Residents are permitted to decorate their rooms with personal items, so long as the decorations do not present a health or safety hazard, do not peel paint off the walls or otherwise deface Center property. No items are allowed to cover

the light fixture, doors or windows. Items are not to be hung from vents or beds. Due to the communal nature of the Center, residents are encouraged to only change their clothes in the shower rooms or in their bathroom. Approved property will be stored inside assigned bedroom closets. See the section on allowed personal property for more information. Closets shall be kept organized. No open food or drinks are allowed to be stored in bedrooms. Unopened commissary purchases may be stored in bedrooms provided they are kept in a closed bin to discourage pests. All hygiene items must be stored hygiene boxes and kept in assigned bedroom closets. Toys are allowed in bedrooms during free movement hours. After free movement, all toys must be taken back to the common areas so that they can be sanitized for the following day. See the section on free movement for more information.

CHILDREN'S BEDTIMES

Children's bedtimes were set to promote a routine for the Center children and to allow for their restful attendance in class. The general bedtime for children 4 years and younger is 8:30pm Sunday through Thursday. The general bedtime for children 5 years to 18 years is 9:00pm Sunday through Thursday. Lights are turned out 15 minutes after these bedtimes. There are no general bedtimes set for children on Friday and Saturdays. Parents are encouraged to continue (or develop) their children's bedtime routines while at the Center.

OVERNIGHT CHECKS

State regulations require staff to conduct room checks at a minimum of every fifteen minutes during each overnight to ensure resident safety. During these checks staff is required to shine a flashlight into your room; the checks will be done with as little disruption as possible.

FREE MOVEMENT

Barring temporary restrictions due to medical or security reasons, free movement hours are from 8:00am to 8:00pm each day. During this time adult residents are allowed to move freely throughout all programing areas of the Center without first asking staff permission or notifying staff where they are going. Children age 10 and older may participate in free movement, when issued a pass by their parent. See the section on free movement passes for more information. Children over 10 who do not currently have a pass and all children under 10 years old are expected to be under the direct supervision of their parent at all times when not in school or participating in an organized activity. Outside of free movement hours, residents are expected to remain on the bedroom floor. This floor has resident bedrooms, dayroom, law library, telephone room, medical department, bathrooms and shower rooms; all of which may be accessed freely 24 hours a day.

These linens will be exchanged for clean linens once a week, or more frequently as needed. Speak with staff should an occasion arise when you need clean linens outside the normal exchange day.

LAUNDRY

Laundry services are available 7 days a week. Each family is scheduled to wash their laundry on an assigned day. The laundry schedule is posted near the laundry room door on the bedroom floor. In the event clothing become soiled between scheduled laundry times, ask staff for additional clothing and/or to be given additional time to wash laundry. See staff at the bedroom floor courtesy desk for machine soap and machine use instructions. Report any machine issues to staff at the bedroom floor courtesy desk.

PERSONAL HYGIENE

At the Center, you will be living in close proximity with other families, so personal hygiene is essential. You are expected to bathe regularly and keep your hair clean. Upon arrival to the Center each resident was issued hygiene products. These items may be replaced as needed by submitting a Resident Request form. These forms are located at the Resident Information Center. Completed forms are to be placed in the mailbox labeled "Requests". You are also allowed to purchase hygiene items from the Center commissary. Feminine hygiene items are available in the female shower room on the bedroom floor. Residents have free access to showers during free movement hours, 7 days a week. Should you need to shower at other than free movement times, speak to staff. The shower rooms are labeled according to gender (male and female). Children 9 years and older will shower according to their gender. Should your child need assistance and is older than 9, see staff for accommodations. Children 8 years and younger will shower only under the direct supervision of their parent so as to not disturb other residents using the shower room. Adults may wear their own make-up. All make-up must fit in a hygiene box or it will need to be placed in storage. Razors are available at any time by speaking with staff at the bedroom floor courtesy desk. Residents will exchange their Center identification for a razor and return it to the courtesy desk staff immediately after use. Nail clippers and tweezers are available through the Center commissary.

ALLOWABLE PERSONAL PROPERTY

While at the Center, you are permitted to retain in your bedroom:

- 10 sets of clothes per resident as described above;
- Personal hygiene items;
- Legal documents, legal papers and legal Information;
- Photos;
- Medical prostheses, (i.e. eyeglasses, dentures, etc.);

Case 4:20-cv-00786 Document 21-2 Filed 03/20/20 Page 171 of 182

The outdoor evacuation location is next to the resident soccer field. Please familiarize yourself with the diagram posted at the recreation door which shows the location of the outdoor evacuation location. There are exit diagrams posted around the Center which show the location of all emergency exits. Study these diagrams carefully and become familiar with their locations. Should an emergency occur and you are near a fire exit, do not wait for staff – go down the fire exit to the outdoor evacuation location and wait for staff to arrive. Per local, state and federal laws, the Center is required to perform evacuation drills. The Center performs several drills each month, at varied times of the day and night. These drills are not designed to inconvenience residents, but rather to comply with regulations and ensure resident and staff safety in the case of an actual emergency. Parents should advise and discuss these drills with their children.

RESIDENT CENSUS

At this Center, resident accountability is done through residents reporting for censuses 3 times during each 24 hour period. Census times are:

6:30am TO 7:30am
3:00pm TO 4:00pm
7:30pm TO 8:00pm

Residents will report to the bedroom floor courtesy desk as family units during the times listed above. If residents are at an appointment near the close of the census time, the staff supervising the appointment will report the resident's location. Residents who do not check in properly during census will be counseled regarding the requirement.

THE CENTER LAYOUT

The Center is comprised of two floors and an outdoor campus. The first floor, where you first entered the Center is the activity (A) floor and the second floor is the bedroom (B) floor. The outdoor campus is outlined by a post and rail fence.

Activity Floor (A Floor):

- Center Administration
- Visitation
- Court
- Library
- Internet Café
- Children Education
- Chapel
- Caseworkers' Office
- Supervisors' Office
- Adult Education
- Phone Room
- Indoor Recreation Room
- Resident Fitness Room
- Toddler Room
- Art and Activity Rooms
- Movie Room
- Additional Laundry (use with supervisor approval)
- Additional Showers (use with supervisor approval)
- Day Room
- Game Closet

Bedroom Floor (B Floor):

- Bedrooms
- Phone Room (open 24/7)
- Law Library (open 24/7)
- Day Room
- Game Closet
- Table Games
- Dining Room
- Medical Clinic
- Showers
- Laundry
- Kitchenette

MEALS

All menus are designed to be nutritionally balanced and are approved by a certified dietician. Residents are provided 3 meals each day in the dining room, located on the bedroom floor:

Breakfast 6:30am -8:00am
Lunch 12:00pm -1:00pm
Dinner 5:30 pm – 6:30 pm

Seating in the dining room is not assigned. Residents may sit wherever they desire for each meal. High chairs and booster seats are available in the dining room. Small children are expected to be seated during meals to encourage sound eating habits. Residents are required to be present in the dining room from:

7:30am to 8:00am
12:00pm to 1:00pm
5:30pm to 6:30pm

Utensils and trays used in the dining room are not disposable. At the end of each meal, residents are required to clear their family's immediate area and return all utensils and trays to be cleaned. Residents are allowed unlimited trips to the self-service bars in the dining room, and it is your responsibly to eat what you take, to reduce food waste. All food or drink must be consumed during the meal – no food or drink may be taken from the dining room.

KITCHENETTES

Fruit, snacks and drinks are available 24 hours a day at the activity and bedroom floor kitchenettes. Residents are not allowed to take more food or drinks from the kitchenettes than they will consume at one sitting. This food is replenished several times a day so there is no need to hoard kitchenette food.

SPECIAL DIETS

Therapeutic/medical diets shall be prepared and provided according to the orders of the Center medical department physician. Religious diets shall be prepared and provided for residents whose religious beliefs require the adherence to religious dietary laws. Residents are required to meet with the Center Chaplain for religious diet approval. See the section on the Chaplain for more information.

SWORN STATEMENT OF M.B.G.

I, M.B.G., hereby swear and attest, under the penalties of perjury, that the following is true and correct to the best of my knowledge:

1. My name is M.B.G.. I arrived at the Berks County Detention Center on March 14, 2020 with my wife M.E.F. and my child A.B.E..

2. When we arrived, we were briefly checked in the medical center. They only took our temperatures to see if we had a fever. We had bloodwork done to see if we had any sickness. I did not fully understand what they were doing to us because I do not understand English. Two days later my arm was inflamed and they took me to the hospital for.

3. The next day after we arrived, they told us that we have to wash our hands and to cough and sneeze into the inside of our elbow.

4. I was separated from my family and we are placed in different housing. I am in a room with three other men. One of them has shown signs that he might be sick. He started coughing and I am afraid that I may get sick as well. We are in a small room and in close proximity of each other. There is nowhere in the center where we can keep a reasonable amount of distance from each other.

5. From what I have seen the Berks detention center is not a sanitary place. The workers do not clean anything. The only thing they do is spray a liquid on surfaces. They do not wipe down tables, door knobs or any sort of surface. They quickly and lightly spray the top of things and then go away.

6. What worries me the most is that the workers do not clean the toys the children play with. Their immune system is still not fully developed and are most at risk. I worry when I see my son play with the toys because I see other children who are obviously sick play with them. I am afraid that the children will spread any illnesses they may have.

7. There are only three places where soap is available. There is one soap dispenser in the cafeteria, one outside the TV room, and one outside the teen playroom. We do not have soap in the room or in our bathrooms. I tried to request soap to a staff member but they did not do anything. I do not know if they do not understand me or they do not want to replace the soap. There has not been any soap in the bathrooms since I arrived to Berks on Saturday March 14, 2020. When we use the bathrooms we are only able to rinse or hands with water.

8. Many of us detained at Berks are afraid because they are not telling us anything about the Corona Virus, they only told us to wash our hands and cough on our elbows. I am frightened because we heard about the virus in Mexico before we were brought to

Berks. The only information we have gotten is from the News on TV and that is in English. We try to read the subtitles but we do not fully understand was is being said.

9. I have noticed that the staff members are keeping their distance from us. They stand as far as they can when they are supervising us. When someone is coughing or looks sick, the staff members just tell them to couch in their elbow and to wash their hands.

10. They have not put any notices or flyers letting us know about the Corona Virus. If they did, we do not know because everything is in English and we do not understand what they posters say.

11. I am afraid that we will catch this Virus because Berks keeps bringing in new people all the time. Every new person has been through the airports and I think they may be infected. Since I do not know anything about the Virus and they have not explained anything to us, I fear that we could get sick at any time.

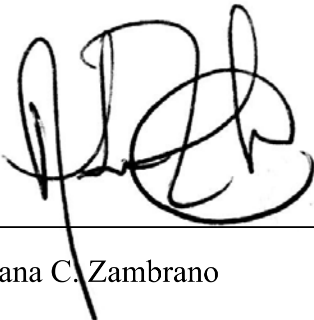
12. None of the Berks staff speak Spanish and we cannot communicate with anyone. I believe that they should have someone who speaks Spanish explain to us what is going on.

This statement was prepared with me in my native language of Spanish. I understood and agreed with the contents of this statement before signing.

M.B.G. Signature ____________________ 3/19/20

M.B.G.

I, __Adriana C. Zambrano___, swear and affirm that I am fluent in both English and Spanish and that the above statement from Mardoqueo Bonilla Garcia is a true and correct translation to the best of my ability.



____________________________________ 03/19/2020

Adriana C. Zambrano

DECLARATION OF SHALYN FLUHARTY

I, Shalyn Fluharty, hereby declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. I am an attorney licensed and admitted in the State of California. I am the Director of the Dilley Pro Bono Project ("DPBP"), a volunteer-based project that provides free legal services to asylum-seeking families who are detained at the South Texas Family Residential Center ("STFRC") in Dilley, Texas. I have served in this role since December 2016.

2. Immigration and Customs Enforcement ("ICE") has capacity to detain up to 2,400 women and children at STFRC at any given time. The facility is operated by CoreCivic, a private prison company contracted by ICE. Medical services at STFRC are provided by the ICE Health Service Corps.

3. DPBP has maintained a daily on-site presence at STFRC since December 2014, when the facility opened. On March 18, 2020, DPBP ceased in-person visitation with clients in response to the COVID-19 pandemic.

4. Families detained at STFRC seek protection from persecution in the form of asylum. Although the majority of families detained in Dilley are from El Salvador, Guatemala, and Honduras, families detained in Dilley come from all over the world and transit numerous countries in route to the United States. For example, in March 2020, DPBP provided legal services to families from Uzbekistan, India, Romania, Turkey, Haiti, and Brazil, to name a few.

5. Most families are detained at a Customs and Border Patrol ("CBP") processing center before being transported to Dilley in a bus with many other families. Our clients frequently report they were crammed into a large, cold cell for multiple days without access to hot meals, showers, toiletries, medical care, and beds while in CBP custody.

6. Social distancing—keeping a distance of 6 feet from others—is impossible for families who wish to protect themselves from COVID-19 while detained at STFRC. The facility is comprised of numerous trailers which are enclosed by a perimeter that keeps families from leaving. Detainees are surrounded by hundreds of other detainees at any given time and required to share bedrooms, the bathroom, and numerous communal spaces.

7. ICE and CoreCivic limit the movement of DPBP staff and volunteers at STFRC to four specific locations. The legal visitation trailer is a large trailer just beyond STFRC's security entrance. It has capacity to hold 135 people at any given time. The trailer has one large common room where approximately 90 people receive Know Your Rights presentations and wait for an appointment with a lawyer at any given time. The legal visitation trailer also houses 14 individual rooms that are used for legal and social visitation with detained families. In order to seek legal services – whether through in-person visitation or telephonically – a detainee must

go to the legal visitation trailer where there are numerous other detainees waiting to speak with counsel most, if not all, of the time. Although there are telephones located in each housing unit, these phones are not free and phone calls are recorded and not confidential.

8. The "court" building is a large trailer with numerous rooms, including five courtrooms that are used for immigration court proceedings and meetings hosted by ICE. The court trailer also contains smaller rooms used for consular visitation and asylum interviews, and two large waiting rooms where 20 or more families are required to wait side by side for their appointments, interviews, and court hearings. Meetings and appointments that occur in the court building are mandatory, not optional. Although perhaps an individual could choose to not go to their asylum interview of court hearing, this would ultimately indicate they were abandoning their request for asylum, and place them at risk of removal. When a court docket or asylum interviews are scheduled, the Executive Office of Immigration Review and asylum office schedule numerous families at the same time. In other words, in order to attend a court hearing or interview, a family is required to be close to a high volume of other families who are simultaneously scheduled to appear.

9. The "asylum" building is a trailer with numerous individual meeting rooms and a lobby that holds approximately 20 people at a time. Families who are scheduled for credible fear interviews with the asylum office are scheduled in groups, and wait in the lobby together, before being called to their interview.

10. "Building 100" is a trailer used by ICE for meetings with large groups of families, and by DPBP for group legal presentations. Building 100 has capacity to hold approximately 45 people at a time. The space is not large, and families who attend meetings in building 100 are typically required to sit approximately six inches away from other individuals who attend the meeting.

11. Although DPBP movement is limited to the four locations detailed above, I was provided a tour of STFRC by ICE in 2017. During the tour I asked questions, and ICE provided a general explanation of facility operations. The tour began in the "intake" trailer. During intake at STFRC, the personal possessions of arriving families are inventoried and stored. Families are provided with uniforms, processed by ICE officials, and given a brief medical screening. During intake – which can last for hours – families wait their turn in line surrounded by numerous other families.

12. Families are assigned to a "neighborhood" and room at intake, where they are housed. A neighborhood is comprised of multiple trailers that are connected by walkways and car ports. Most dormitories contain six bunkbeds (12 beds) that are separated from one another by a few feet. The dormitories do not have a bathroom. Rather, families share a bathroom with many others who sleep in different rooms within their neighborhood. Neighborhoods also have a community room, where detainees gather and have meetings required by CoreCivic.

13. STFRC maintains numerous common spaces, including: (1) a dining hall that holds hundreds of people, (2) a school, divided by multiple classrooms that hold approximately 20 children each, (3) a large gymnasium that is used for group exercise classes and as a waiting room for medical appointments, (4) outdoor playgrounds and spaces where groups of children and families congregate, (5) a large auditorium that holds approximately 200 people, (6) a library, and (7) a small building used to dispense medication to detainees who wait in line at designated times each day.

14. Mothers currently report that detainees are crowded in lines in the dining room, and that there are no efforts to keep individuals from touching or breathing on the food. These reports are consistent with what I personally observed during my tour of STFRC. Mothers have also informed DPBP staff that as of March 20, 2020, the school and daycare at the detention facility continue to operate.

15. During my tour of STFRC I was not permitted to see the medical units. DPBP is generally prohibited from having direct contact with medical staff at the facility.

16. Based upon my observations at STFRC, it would be impossible for detained individuals to create distance between themselves and other detainees. Detainees are required to share rooms and the bathroom and must wait in large communal areas in order to receive access to legal services, medical care, education, and to participate in their legal proceedings.

17. Many DPBP clients are concerned they will be exposed to COVID-19 and not have access to adequate testing or treatment at STFRC. Detained families have access to television at STFRC, and have learned about the outbreak - and its risks and symptoms - by watching the news. To date, DPBP staff is not aware of any formal education provided to families detained at STFRC regarding COVID-19 and precautions for limiting its transmission.

18. Many families report having inadequate access to soap and hand sanitizer at the facility. On March 17, 2020, one mother noted that she had not been able to find soap all morning, and that that there was no soap available to her until at least 1:30 in the afternoon. Another mother informed DPBP staff that the soap dispenser in her room had been broken for three weeks, despite repeatedly notifying staff at the detention center. Several mothers also reported that they have not been provided with additional soap or hand sanitizer to account for the heightened need for hand washing. One child noted on March 19, 2020 that there was no hand sanitizer available in the dining hall.

19. Several mothers report they have not been provided with adequate cleaning supplies to clean their rooms, which they are required to do. On March 18, 2020, twenty-three mothers stated that they were not provided with disinfectant wipes, and that their requests for disinfectant wipes were denied. One mother reported that she was only given paper towels to clean her room. Another mother stated that she asked CoreCivic staff for cleaning supplies, and was informed cleaning supplies were being rationed because the facility has a short supply.

20. Several mothers reported to DPBP staff that there have been no heightened efforts to clean or disinfect common areas in the detention center. Several families state the bathrooms are extremely dirty. One mother noted that she has only observed detention center staff disinfect areas once per day. Another mother noted that she has never seen the communal computer in the library cleaned or disinfected.

21. Facemasks are generally not available to families at STFRC, not even to individuals who are sick. Families report that although some medical staff at the facility wears gloves, many do not wear masks. Mothers have observed facility staff coughing, and staff who appear to be sick with a fever, who are not wearing a mask. One child reported that she had an appointment with a dentist who coughed throughout their appointment.

22. On March 18, 2020, DPBP conducted a survey with 27 detained families to learn more about STFRC's COVID-19 response plan and implementation. Survey results revealed the following:

- 18.5% of families surveyed stated the mother or child had a high fever within the last 24 hours;
- 63% of families stated the mother or child had a new or continuous cough;
- 40.7% of families stated that someone else in their dormitory presented with a new or uncontrollable cough or high fever;
- 16.7% of families stated they had encountered a facility employee or visitor who had an uncontrollable cough or apparent fever who returned to the facility after the first day they observed their symptoms;
- 46.2% of families stated they had not been advised to wash their hands for 20 seconds;
- 40.7% of families stated they had not been provided with tissues or advised to cough or sneeze into a tissue;
- 88.9% of families stated they had not been provided with masks, gloves, or cleaning supplies to perform cleaning tasks in their housing unit;
- 70.4% of families stated they had not been provided with additional soap or hand sanitizer to make it easier to wash their hands;
- 51.8% of families stated they have not seen facility staff frequently clean and disinfect objects and surfaces that are regularly touched;
- 81.5% of families stated that individuals who show signs of illness are not provided with a facemask;
- 81.5% of families stated that individuals who show signs of new or uncontrollable cough, or a high fever, are not transferred to an outside facility or the hospital, and are not placed in isolation; and
- 85.2% of families stated that potentially infected persons are not grouped together in the same room or housing unit.

23. Families have repeatedly reported inadequate access to medical care at STFRC. Detainees are frequently required to wait two to three hours in a crowded waiting

room in order to speak with a medical provider, and there have been times when DPBP clients have reported waiting eight hours to see a doctor. DPBP clients regularly report they are denied access to medical assessment, follow-up, and treatment. Mothers often tell DPBP staff they fear their child will die in detention due to illness and a lack of medical care. This fear became a reality for one of DPBP's former clients, Yazmin Jaurez, whose 18 month old daughter Mariee died shortly after release from STFRC due to an untreated infection.

24. As of March 20, 2020, DPBP staff was unaware of any mother or child who had been tested for COVID-19, despite the fact that many individuals currently detained at STFRC have flu-like symptoms. This is consistent with our ongoing observation at STFRC over the last four years that detainees are regularly deprived of timely and appropriate medical evaluation and treatment, even in the most egregious of circumstances.

25. Our clients report that sick individuals are intermingled with the rest of the population at STFRC, despite exhibiting a cough, fever, and other COVID-19 symptoms. Seventeen mothers informed DPBP staff on March 18, 2020 that either they or their child had a cough or a high fever, and yet none of them had been tested for COVID-19 or placed in isolation. The same day, eleven mothers reported that there was at least one other person in their dormitory that was presenting with a new or uncontrollable cough or a high fever.

26. On March 19, 2020, two families detained at STFRC reported that eight new families had arrived at the facility that day. Both families reported that one of the newly arrived mothers is exhibiting COVID-19 symptoms and has been provided a facemask. Her child, however, was not provided with a facemask.

27. Failure to test individuals who display COVID-19 symptoms is of particular concern to many DPBP clients. One mother informed DPBP that her five-year-old daughter has experienced fatigue and a severe cough for a week. When the mother sought medical care at STFRC, she was told to give her daughter water, and that there is no cough medicine available for children. The family was not given advisals regarding COVID-19 or tested for it.

28. DPBP represents many mothers and children with pre-existing medical conditions who are particularly vulnerable to COVID-19. Although these individuals are uniquely susceptible to the harms of COVID-19 under any circumstance, many state their condition has deteriorated due to inadequate access to medical care while detained, placing them even at greater risk.

29. DPBP is aware of at least five children with asthma who are currently detained at STFRC. One mother informed DPBP staff that her eight-year-old asthmatic child was transported to a hospital after he was struggling to breathe. Since the child's release from the hospital, however, he has not been provided with an inhaler or necessary follow-up care. DPBP staff spoke to another mother whose seven-year-

old son was diagnosed with asthma while detained. The child's condition has deteriorated significantly during his five months in detention. In early February 2020 the mother sought medical care for her son because he was struggling to breathe. STFRC medical staff refused to provide the child with treatment until the next morning, when his lips turned blue and he required emergency transportation to the hospital and more than 24 hours on an oxygen tank.

30. DPBP represents several pregnant women, including women with complicating factors. For example, O.M.G., a named plaintiff, is six months pregnant. O.M.G. miscarried during a prior pregnancy and has been diagnosed with a vaginal infection while detained at STFRC. Medical staff at the facility has informed O.M.G. that her condition may lead to another miscarriage or birth defects. On March 21, 2020 I spoke with O.M.G. by telephone. During the telephone call I translated the entirety of the "Declaration of O.M.G." into Spanish. I am fluent in the Spanish and English language and swear under the penalty of perjury that O.M.G. confirmed that the information contained in the declaration is true and correct.

31. DPBP represents numerous clients with heart-related problems, including a five-year-old child with a heart murmur that has experienced chronic fatigue, loss of appetite, excessive sweating and lethargy, and a fifteen-year-old child that was hospitalized while in CBP custody for heart palpitations. Another fifteen-year-old child represented by DPBP has suffered cardiac attacks for approximately four of the almost seven months that she has been in detention. The child's mother reports that on numerous occasions her daughter has suffered episodes where she develops heart palpitations, a prickling sensation in her limbs, trouble breathing, dizziness, nausea, sweating, and sudden fatigue. On one occasion in February 2020, while suffering another cardiac attack, the child had trouble breathing and became dizzy. Upon seeking medical attention at STFRC, a medical staff member told the child to "calm down" and only checked her blood pressure after her mother insisted.

32. DPBP also represents numerous children with anemia, including one mother and a son who are both anemic. That mother informed DPBP staff that she sought supplements for her son shortly after they arrived at the detention facility in September 2019 but was turned away from the medical unit. After her son was determined by medical staff to be underweight, he was prescribed Pediasure. The child has not received additional treatment.

33. The above examples are few of many. An additional non-exhaustive list of medical conditions currently experienced by individuals detained at STFRC includes: diabetes, thyroiditis, hyper-throidism, tooth infections, vitiligo, epilepsy, gastric liver damage, tachycardia, eye infection, chronic gastritis, and seizure disorder. Medical conditions reported by our clients that are currently untreated and not sufficiently evaluated, or evaluated at all, include: heart palpitations, heart

murmurs, deteriorating vision, undiagnosed lumps with accompanying pain and swelling, kidney inflammation and complications, continued vomiting, severe migraines, numbness in limbs, tumors and ovarian cysts. In addition, there is a child who recently survived a severe skull fracture, a child who is a cancer survivor, and a mother who recently required surgery while detained.

34. Although there are medical providers on site at STFRC, specialists are not available to detainees and the facility is not able to respond to medical emergencies. The facility is 20 minutes away from the Frio Hospital, a very small hospital located in Pearsall, Texas. The Frio Hospital is not equipped to respond to medical emergencies, and the overwhelming majority of individuals who required heightened medical care are transported to a hospital in San Antonio, which is approximately one and half hours away from STFRC.

35. Should emergency medical care be needed to provide care to someone impacted by COVID-19, it is likely they would need to be transported to a hospital in San Antonio. Unfortunately, if one person is infected in Dilley, it is likely the entire population will quickly become infected. If 2,400 individuals required hospitalization at once in San Antonio, the system would become flooded and neither the families detained at STFRC, or individuals who required hospitalization from the community, would have the access and medical care they require.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed March 20, 2020 in San Antonio, Texas.

_/s/___________________
Shalyn Fluharty

DECLARATION OF ALLISON HERRE

I, Allison Herre, hereby declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. The facts set forth below are based on my personal knowledge. I can testify competently to them if called upon to do so.

2. I am an attorney licensed in the State of Ohio. I am the Managing Attorney of the Dilley Pro Bono Project ("DPBP"), and have worked for direct the Dilley Pro Bono Project since July 2019. In this capacity, I supervise a team of attorneys, paralegals and volunteers, and provide direct representation to detained immigrant families before the Executive Office of Immigration Review and the Department of Homeland Security.

3. Based upon this experience, I am familiar with the population of asylum seekers that pass through the South Texas Family Residential Center ("STFRC") and the policies—and changes to those policies—that are implemented by Immigration and Customs Enforcement ("ICE") and CoreCivic at STFRC.

4. On Monday, March 16, 2020 at 2:00 p.m., Tami Goodlette, Deputy Director of our Project, and I met with ICE Assistant Field Office Director ("AFOD") Richard Hunt and the ICE Office of Chief Counsel, Deputy Chief Counsel, Emmanuel Garcia. The purpose of the meeting was to learn more about ICE's COVID-19 response plan, and address access to counsel concerns inherent in our project's decision to end in-person visitation with clients at the facility.

5. During the meeting I expressed concern regarding the potential spread of COVID-19 at STFRC, and asked AFOD Hunt whether families would be tested for COVID-19. AFOD Hunt explained medical intake procedures would not change, and that medical personnel would continue to briefly screen incoming families during the intake process. AFOD Hunt further

explained that that medical staff would look for worrying symptoms during intake, and if worrying symptoms were identified, families would be "flagged in the system" and sent to the medical residential housing unit for monitoring. If symptoms persist or a person were to test positive for COVID-19 (or any other communicable disease), the family would be moved into a negative pressure room.

6. I asked AFOD Hunt whether COVID-19 testing would be implemented, facility wide. AFOD Hunt stated everyone would not be tested, and that there was no plan for large-scale testing of any sort. AFOD Hunt did not confirm whether COVID-19 tests were indeed available at STFRC, or if any detainees have actually been tested for it.

7. Based upon ongoing conversations with hundreds of families at STFRC, and targeted surveys of clients to learn more about ICE's response to COVID-19 in practice, we have not identified a single individual who has been tested for COVID-19 or who was placed in a negative pressure room for a suspected of actual COVID-19 infection.

8. When asked what precautions ICE is taking to prevent the spread of COVID-19 in the facility, AFOD Hunt responded that ICE may consider releasing a family with a positive COVID-19 test, but did not commit to release occurring. AFOD Hunt explained that the facility would continue to clean the facility in accordance with its prior practice, which includes wiping down toys in the play area three times per day.

9. AFOD Hunt also stated that self-serve stations in the dining hall would be staffed by contracted personnel, who wear gloves and dish out food to detainees. This is the only change AFOD Hunt indicated was being implemented at STFRC in response to COVID-19.

10. I have reason to believe that the three things identified by AFOD Hunt as part of STFRC's COVID-19 response plan (medical screening on the bus with further observation of

individuals who present COVID-19 symptoms, cleaning of toys three times a day, and contracted personnel taking over the self-serve food lines in the dining hall), have not been consistently implemented, if at all. Based upon detailed conversations with DPBP clients, it does not appear self-serve lines have been staffed by a contractor. Numerous clients have informed DPBP that the self-serve lines in the dining hall are still in operation. We have also received reports of CoreCivic staff refusing to wipe down toys and withholding sanitizing wipes from residents upon request. Additionally, we have heard from mothers who have taken children to medical with worrying symptoms, including new and uncontrollable coughing and a high fever, that they have not been seen by a doctor, tested, or provided with any medical treatment and that individuals who arrive to STFRC with a cough – which is very common – are not placed in isolation.

11. During our conversation about ICE's COVID-19 response plan, AFOD Hunt failed to detail any plans for staff or detainee education about the COVID-19 virus, changes to staffing plans for STFRC medical or custody staff, and changes to staffing for cleaning the facility. AFOD Hunt also did not mention any steps in increase detainee hygiene and hand washing, coordination with hospital or outside medical providers in case of an outbreak, screening for COVID-19 exposure (rather than just symptoms), changes to sleeping arrangements at the facility, additional precautions for vulnerable populations, procedures to implement social distancing amongst detainees, or the provision of masks, new cleaning supplies, or gloves to staff or detainees.

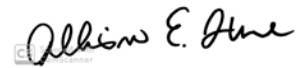
12. I expressed significant concern for detained families with pre-existing medical conditions who are uniquely vulnerable and at risk of death if infected by COVID-19. Specifically, I noted the possibility that infected individuals who are asymptomatic may come

into contact with other detainees with pre-existing conditions. AFOD Hunt informed me ICE has no plans to release medically fragile detainees, and that ICE planned, to instead, isolate infected (or potentially infected) individuals to prevent the spread of the virus to medically vulnerable individuals.

13. On March 20, 2020 I received a phone call from AFOD Hunt informing me that ICE has, or will, release medically vulnerable families who are detained at STFRC. DPBP maintains a non-exhaustive list of clients who we have identified as medically vulnerable. Our current list includes approximately 100 individuals. As of March 21, 2020 I am not aware that any of these individuals have been released from STFRC.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed March 20, 2020 in San Antonio, Texas.



Allison Herre

Declaration of Stephanie Alvarez-Jones

I, Stephanie Alvarez-Jones, hereby declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. I am a staff attorney and Justice Catalyst Fellow with the Dilley Pro Bono Project ("DPBP"), where I have worked since September 2019. I am an attorney licensed to practice in the State of New Jersey.

2. Part of my regular duties involve meeting with and speaking with families detained at the South Texas Family Residential Center ("STFRC") in Dilley, Texas. I meet with clients at STFRC at least once a week.

3. Ever since I started working with the Dilley Pro Bono Project in September 2019, the process to enter the detention facility has largely been the same. For example, in February 2020, when I entered the security trailer at STFRC, I was required to place my belongings in a bin which was then passed through an x-ray machine. I then had to walk through a metal detector. After collecting my belongings, I was required to sign into the visitor's sign-in sheet. I am required to list my name, the organization with which I am affiliated, my driver's license number, and the time of my entry. I then exit the security trailer, walk through a covered walkway into the legal visitation trailer.

4. There was nothing different about the entry procedure when I entered STFRC on Tuesday, March 17, 2020. When I signed in, I was not asked to provide any additional information. I was not asked whether I had a cough or fever; whether I had traveled outside of the United States in the last fourteen days; whether I had traveled to an affected area in the last fourteen days; whether I had come into close contact with someone who had COVID-19 in the last fourteen days; or if I had any contact with someone who had travelled outside of the United States. At no point was my temperature taken during my 11-hour visit at STFRC that day. At no point was I offered or asked to wear a face mask or gloves. At no point was I asked to wash my hands.

5. The only difference I noticed on Tuesday, March 17, 2020, was a laminated notice on the door to the legal visitation trailer. This notice was from the Federal Bureau of Prisons regarding the COVID-19. It recommends that individuals with cough or fever not enter the facility.

6. Upon entering the legal visitation trailer, I walked to a table at the far end of the visitation trailer. I observed four Core Civic guards in the legal trailer. None of them were wearing face masks and none of them were wearing gloves.

7. I met both individually with clients and with large groups of clients on Tuesday, March 17, 2020. At no point did I see anyone – other DPBP staff, detention facility staff, ICE

officers, or women and children – wearing face masks. The cleaning crew did wear gloves, as they usually do.

8. On March 21, 2020, I spoke with C.L. by telephone. During the telephone call I read the entirety of the "Declaration of C.L." in English to a certified Haitian Creole interpreter, who translated from English into Haitian Creole. I swear under the penalty of perjury that C.L. confirmed that the information contained in the declaration is true and correct.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed March 21, 2020 in Dallas, Texas.

Stephanie Alvarez Jones

DECLARATION OF ANDREA MEZA

I, Andrea Meza, swearing under penalties of perjury, make the following declaration:

1. My name is Andrea Meza and I am an attorney and the Director of the Family Detention Services Program at the Refugee and Immigrant Center for Education and Legal Services ("RAICES"). I have been the program Director since March 2019. Prior to my position as Director I served as the Associate Director from October 2018-March 2019. From September 2015 to July 2017 I was an Equal Justice Works Fellow and provided direct legal services to families at Karnes. I have been licensed in the state of Texas since November 6, 2015.

2. RAICES, with volunteers and pro bono attorneys, has provided free legal services at Karnes County Family Residential Center in Karnes City, Texas ("Karnes family detention center" or "Karnes") since its opening as a family detention center in August 2014. In 2018, RAICES provided legal services to over 8,000 people detained at Karnes. RAICES' Family Detention Services program strives to provide free, universal representation through all phases of the immigration process during detention at Karnes.

3. RAICES is the primary non-profit legal services provider at Karnes, the only pro bono legal services organization operating on the ground at Karnes, and the primary source of free legal representation for Karnes detained persons. RAICES estimates that it provides free legal services to between 80-95% of the population at Karnes.

4. The Karnes family detention center is located in Karnes City, Texas, which is a small town about an hour southeast of San Antonio. The town of Kenedy, Texas is the slightly larger town about a ten-minute drive away from Karnes City. The hospital closest to the Karnes family detention center is the Otto Kaiser Memorial Hospital in Kenedy, which has about 25 staffed beds. I have heard of several cases when individuals detained at Karnes were first taken to Otto Kaiser, then transferred to a larger more intensive hospital in San Antonio, Texas.

5. I have visited the Karnes family detention center hundreds of times to meet with clients since 2015. I have heard complaints about medical services at Karnes for years. The

population at Karnes generally is released from detention within 4-6 weeks, but at various periods of time, the population has been detained for months at a time. No matter the circumstance, the complaints I have heard about the inadequacy of medical services at Karnes remain the same. There is no pediatrician or OB-GYN on staff at Karnes. Families report being attended to by nurses who pay their complaints little heed.

6. I have had a stakeholder relationship with ICE Assistant Field Office Directors at Karnes throughout my work with RAICES. In January of 2020, Anthony Hofbauer became the Assistant Field Office Director at Karnes. Assistant Field Office Director Anthony Hofbauer ("AFOD Hofbauer") and I have maintained regular communication about changes at Karnes. Since he began his position at Karnes, AFOD Hofbauer has attempted to make changes to improve conditions at Karnes. However, these attempted improvements have often been thwarted by the culture of indifference and fear that permeates the GEO and ICE staff at Karnes, and also by restraints inherent to the facilities and design of the Karnes family detention center.

7. Karnes was originally built to detain single adult men. It is a secure, prison-like setting, though through the years of its existence as a family detention center, cosmetic changes have been made, such as painting murals and hanging colorful art on the walls. The doors are heavy metal doors that require pushing a button to request entry or exit. Many have only very small windows. I have never been permitted entry into the space where detained families are held beyond the main visitation room. From what I can see through a window in the visitation room, and from what I have heard from clients, GEO, and ICE, Karnes is set up in square units surrounding courtyards. Playgrounds were added to the courtyards when the detention center began to imprison families. Cells where families sleep have bunk beds, a TV, and a small table inside, and my understanding is that multiple families share a single bathroom, and often share a room. The cells are organized into "patios", and there are a few shared recreation rooms. There is one cafeteria, one library, and one medical unit for the entire detention center. An additional wing of cells and a courtyard were added to Karnes after it became a family detention center, but I am not aware that any additional cafeterias, libraries, or medical units were

constructed. I regularly hear clients, GEO, and ICE refer to these spaces in the singular, such as saying that a client is "in medical" or "needs to go to medical."

8. The visitation space at Karnes consists of a main room a bit larger than a typical school classroom, surrounded by five private rooms. Three of those rooms are equipped with a telephone. In order to enter the visitation area from within Karnes, detained persons must pass through a "sally port" type hallway that connects the outdoor courtyard to the main visitation room. Where the door from the sally port meets the main visitation room, there is a desk set up where one to three GEO staff sit and monitor visitation. Detained persons are not permitted entry into the main visitation room without permission from GEO staff. There are several tables and chairs set up in the main visitation room, but meetings at these tables are not confidential because GEO staff is present at their desk in the main visitation room. Additionally, many GEO and ICE employees use the visitation space as a means for their ingress and egress between the main part of the detention center where families are held and the lobby and main entry hallway of Karnes that connects to ICE and GEO administrative offices. There is frequently regular foot traffic throughout the day in the main visitation room.

9. In my years providing legal services to families at Karnes, I have heard consistent complaints about the medical services provided by GEO. Detained persons regularly complain that their needs are not addressed in the medical unit. Over the years, when I have brought up complaints about medical services to ICE, supervisors regularly state that medical services are available 24 hours on a walk-in basis. They indicate that therefore, complaints about the availability and quality of medical care are unfounded. However, clients specifically state that there are prohibitively long waits at the medical unit. For years clients have told me that they have waited hours at medical without being attended to. They additionally state that often, medical staff ignore their needs. Detained persons regularly report that medical staff dismiss their concerns or say that there is nothing that can be done for the reported ailment at Karnes. The most commonly reported recommendations from medical staff include the following: ibuprofen, cough syrup, water, and eating more food. RAICES has represented clients with cancer, brain

damage, diabetes, HIV, and many women who recently suffered rape or miscarriage, who have reported deficient or no medical care at Karnes.

10. On March 13th, I spoke with AFOD Hofbauer over the phone about changes in visitation at Karnes given concerns about the COVID-19 virus. This was the first of several times that I spoke with the AFOD about COVID-19 and its impact on Karnes. AFOD Hofbauer informed me that he had just received word through "executive order" which prohibited community visitors. AFOD Hofbauer informed me that legal visitation would continue at Karnes.

11. AFOD Hofbauer stated that the changes to legal visitation would consist of the following: legal visitors would be subjected to a temperature check and a short questionnaire on a daily basis.

12. AFOD Hofbauer told me that he would offer skype and facetime options for legal visitation beginning on Monday March 16th. He said that GEO did not yet have the iPads for these video visits, so legal visitation could be conducted by phone over the weekend.

13. I asked AFOD Hofbauer how many rooms would be available for legal video calls and he told me that there wouldn't be many, given the space constraints at Karnes. He said that if we needed more iPads, he would ask the GEO Warden if the request could be accommodated.

14. AFOD Hofbauer told me that there was a "possibility [ICE] might not be going to work either, we might be teleworking."

15. On Sunday March 15th, I emailed AFOD Hofbauer to see if he had an update in protocol regarding COVID-19. He stated:

> Morning, we have identified more tablets if you all prefer that method. I'm waiting to hear back from the Warden to see if the thermometer has arrived but all else is the same.....We have about eight tablets available and we can utilize all the offices in visitation, if needed. We will make every attempt available to ensure the meetings are confidential. I have attached the [legal visitation] screening questionnaire, as requested.

16. On Tuesday March 17th, I had a meeting with AFOD Hofbauer over the phone for a little more than an hour. He informed me that there were two iPads available for FaceTime calls and six other iPads that were not yet functional. He said that detained persons would be able to use iPads in visitation, he suggested they might be able to use them in their dormitory cells, and said that they likely could not use them in private courtroom areas because of staffing needs to monitor that space.

17. I asked AFOD Hofbauer about plans to address COVID-19. He stated that he was in "close communication" with Karnes County officials, the CDC, and the ICE Health Services Corps. He said that there were "no concerns, no cases for COVID-19." When I asked him if he had a plan for what would happen if someone were to test positive he said he had some guidance, but that it would be a new situation for all involved if someone were to have COVID-19.

18. I asked AFOD Hofbauer how they were testing for COVID-19. He told me that they were taking temperatures of detained families while they were in the carport before they even entered the detention center, and asking a few questions. He indicated that he did not have access to tests for COVID-19.

19. AFOD Hofbauer has thus far proven to be helpful and accommodating to us, and I expressed appreciation for that. I asked him frankly if he was concerned about his staff given the President's warning not to congregate in groups of more than ten people, and I asked him if there were plans to "shut down" Karnes. AFOD Hofbauer expressed that he and others at ICE were concerned about spread of the virus and had raised those concerns through their channels, but that he and his superiors were waiting on guidance from ICE Headquarters as to how to respond.

20. I received the AFOD's response as sincere and concerned. AFOD Hofbauer has demonstrated that he is very reasonable and understanding, unlike many other ICE officials I've encountered, even officials with whom I considered myself to have a decent working relationship. My impression is that the AFOD is, quite reasonably, concerned about the safety of all who are in Karnes, but that he has not been given the authority to address the issue as he would like to see it addressed.

21. I directly asked the AFOD if he had considered releasing people from Karnes given concerns about large groups and COVID-19. I told him that in the past, RAICES has helped ICE facilitate release of families, and that we were willing to work with ICE to do so in the event that release is ordered. I mentioned that in December of 2016, there was a mass release that was poorly coordinated and that we were interested in working with ICE to avoid a similar situation. When I pressed AFOD Hofbauer regarding whether he had considered releasing all families at Karnes he said: "Unfortunately I can't comment on that, I wish I had the ability to do that but I can't comment on that."

22. I then asked AFOD Hofbauer a series of questions related to the COVID-19 response:

    a. First I asked whether the facility had a written exposure control plan approved by a physician. AFOD Hofbauer responded that he did not have a plan, but he said that GEO had a written plan in the event of an exposure. I asked when the plan was last reviewed and updated and he stated that he would have to ask GEO.

    b. I asked if there were any updates in protocols for medical, dental, and laboratory equipment and instruments to be appropriately cleaned, decontaminated, and sterilized per applicable recommendations and/or regulations. AFOD Hofbauer responded that GEO goes above and beyond in cleaning and that Karnes is one of the nicest facilities he had ever seen. The AFOD told me that there are full cleanings two to three times daily. He stated that detained families do additional cleaning in their rooms themselves. AFOD Hofbauer said that because of the alcohol level in hand sanitizer, he could not provide hand sanitizer to the families because of the Family Residential Standards, but he said that there was "plenty" of hand soap.

    c. I then specifically asked who cleans the rooms. AFOD Hofbauer told me that GEO staff and detained persons clean the rooms, and that detained persons help clean the facility generally. I asked if there had been any changes to the cleaning solutions used and he said that the solutions were formulated according to standards that are uniform across the country. He stated that the standards allow for a certain percentage dilution with water.

d. I asked if there were protocols for biohazardous waste disposal and the AFOD did not have that specific information available.

e. I asked AFOD Hofbauer if he was aware of anyone currently in medical isolation. He said that there were some cases of people in observation based on CDC guidance based on countries through which they had traveled. I asked what "observation" meant, and he told me it meant that they cannot leave the medical unit. He said that they would be on a 14 day observation period. I asked him if entire family units were in observation together, he said yes.

f. I asked AFOD Hofbauer if there is there a functional negative pressure room for patients requiring respiratory isolation. AFOD Hofbauer said that there are "more than five" negative pressure rooms. He indicated that there are two medical areas, but I did not follow up and ask whether that meant that there are actually two medical unit clinics where detained persons may receive services. As mentioned above, I am only aware of the existence of one medical unit clinic where detained persons may receive services.

g. I asked what procedures are used to disinfect bedding and clothing. AFOD Hofbauer indicated that was a question for GEO, but that he did know that when a family leaves and a new family is going to come in, that the room is "deep cleaned" before the new family enters, and that sometimes this even causes a delay at intake as there is a wait time to go to the room while it's thoroughly cleaned.

h. I asked AFOD Hofbauer what considerations are taken for pregnant women and children in terms of treatment. He implied that release of families including those with pregnant women, children, and those with health concerns was being evaluated on a case by case basis, but that there was currently no guidance to generally release pregnant women.

i. I asked AFOD Hofbauer how often environmental health inspections are conducted. He said that there is a yearly safety inspection, that GEO does a daily

inspection of all rooms as part of their shift, and that there are monthly inspections and other regular inspections by outside authorities.

j. I asked AFOD Hofbauer if there were any changes in the protocols for cleaning food, utensils, and dishes. He said that the same standard for sanitizing dishes that is specific to family residential centers remains in use.

k. I asked AFOD Hobauer if there were specific screenings for people with respiratory illnesses such as asthma. He said that there are regular medical screenings at intake, and that the medical unit is open 24/7. I mentioned that clients often tell us about long wait times at medical, and he said that receiving services should be "automatic."

l. I asked whether there are facemasks, gloves, and cleaning supplies available. He said that these items are available for officers, and that GEO has them as well, but that they will be available in case of an emergency situation. AFOD Hofbauer indicated that if our staff were present and someone were to have COVID-19, that ICE would make surgical masks available temporarily to our team.

m. I asked what precautions are taken in terms of aerosolized treatments that may adversely affect persons with chronic respiratory diseases. AFOD Hofbauer indicated he was not aware of any specific precautions. He said that medical had higher grade cleaners than what is used sleeping areas.

n. AFOD Hofbauer asked the supervisory deportation officers, who report directly to him, if there were other precautions in place. He said that besides the tests (temperature tests and questionnaire), it appeared that most things were going on as usual.

o. AFOD Hofbauer indicated that the biggest change at the detention center was education, meaning giving the families detained information about the virus and the need for more frequent hand washing.

p. I asked if there were handwashing stations set up for people before entering the cafeteria, and AFOD Hofbauer said that the only stations available were in their rooms and in any restroom.

q. My colleague, Javier Hidalgo, our team's supervising attorney, asked AFOD Hofbauer if there had been any scale back on staff. The AFOD said that school is up and running and that there haven't been any issues with employees not showing up for work.

r. I asked if sick leave was available for staff, and AFOD Hofbauer stated that it is.

23. From Monday March 16th to Thursday March 19th, the staff that I supervise reported a number of concerning deficiencies, and that they observed very few precautions being taken by GEO or ICE at Karnes. They observed GEO and ICE employees shaking hands with each other, and even joking about their colleagues who were working at Karnes while exhibiting flu-like symptoms. Our staff also reported that upon entry to Karnes, their temperature is taken and they must complete a survey about their recent travel, however no Karnes staff members are wearing gloves or masks when they are reviewing identification or personal items, and that counters and commonly touched surfaces in the entrance do not appear to be wiped down or disinfected apart from regular cleaning. Detained persons used phones in visitation and there were no cleaning supplies available to wipe down phones, tables, or chairs between use. Toys in the visitation area were not cleaned between use, and the GEO staff in visitation handle detained persons' identification cards but did not use gloves or take any additional sanitary measures.

24. During this time, staff reported that detained persons repeatedly raised serious concerns about their and their families' health at Karnes. Nearly everyone that our staff spoke to expressed concern that many children were suffering from diarrhea and vomiting, that pregnant women were not receiving appropriate care, and that everyone – though in particular, children – were losing alarming amounts of weight. Detained families expressed fear about the threat posed by COVID-19 and the lack of appropriate precautions taken at Karnes. They report that cafeteria staff do not wear masks, that

requests for masks or gloves by detainees to Karnes staff are denied, and that detainees are not provided soap and must purchase it from the commissary.

25. On March 20, 2020 around 6:00 PM, AFOD Hofbauer called me to give me further updates about the COVID-19 response at Karnes. He clarified that masks and personal protective equipment would only be available in the event of an emergency. He said that he does not have a lot of resources because of the demand for masks around the country.

26. AFOD Hofbauer told me that there would be additional changes at Karnes due to an order from the Governor prohibiting gatherings of more than ten people. He said that legal visitation would continue, but that there would be no person to person contact. AFOD Hofbauer indicated that in order for us to conduct in-person visitation at Karnes, we would have to wear gloves, masks, and protective eyewear.

27. AFOD Hofbauer indicated that at some detention centers, legal visitation could function with one attorney in a visitation room then "the other across the hall" but that such an arrangement was not possible at Karnes because of the limited space for legal visitation at the detention center.

28. In this conversation AFOD Hofbauer stated "We're [employees and legal visitors] the ones on the outside; we're a risk to them [detained families], not them to us."

29. AFOD Hofbauer stated that with the governor's new restriction, we could meet with no more than ten people in visitation at any given time.

30. I asked AFOD Hofbauer what would happen at meal times. He said, "That is a good question. Yeah we're gonna have to figure something out… feeding times will take forever. We're going to be eating all day. I'd have to check with the warden because that's more of a facilities issue." He opined that grouping detained families together in settings of more than ten people might not be problematic because they are people who have already been in contact with each other, as opposed to outsiders coming into the detention center. It is evident to me that while AFOD Hofbauer may be doing his best to address the COVID-19 threat within his authority, that he has received very little practical guidance as to how precautions for families and staff at Karnes may be

implemented in a detained prison setting. His responses to me indicate the impossibility of full compliance with the most protective measures as recommended by the CDC and local authorities.

31. Staff who visited Karnes on Friday March 20, 2020, when GEO began to implement the 10-person rule in visitation, reported that deficiencies in application of precautions for COVID-19 continued. Their observations demonstrate that it is impossible for necessary precautions to be effectuated in a detention center environment, especially with a family population.

32. Although it is my understanding that schools have been ordered closed in the State of Texas, as of March 20, 2020 children at Karnes continued to attend the school inside the detention center, making social distancing impossible.

33. Additionally, staff who visited Karnes on March 20th observed that GEO interpreted the 10 person rule to mean that no more than ten clients could be present in the main visitation room at a given time. It did not appear that GEO staff or RAICES staff were counted in that ten person limit. Because of requirements that family units remain together during the day, most families arrive together for a legal visitation appointment. However, because of the 10 person rule, only one representative of the family can enter the large visitation room at a time. The rest of the family was forced to wait in the small "sally port" room. This meant that more than ten people from multiple families were cramped into a small space while they waited for one person from each of their families to meet with legal representatives.

34. Our staff observed that a play carpet in the main visitation room was removed, so babies were forced to play on the hard floor. Staff observed adult clients suffering from constant cough during their legal visit. They observed the near impossibility of avoiding touching one's face, especially for those with babies and small children, who often sit in their parents' laps. They saw, during a GEO shift change, that many GEO employees were crowded shoulder to shoulder in the main entry hallway waiting to clock out and leave.

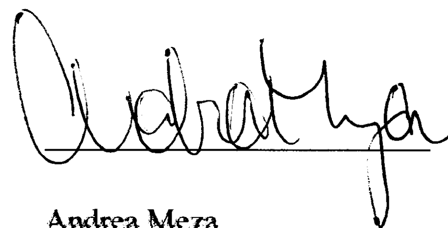
35. My experience over the years at Karnes and our RAICES staff's experience this week indicate that it is inherently impossible to effectively implement adequate safety precautions for COVID-19 at the Karnes detention center. The medical care has been deficient for years, as Karnes has never invested in building a culture of care, given the fact that typically, most families are not detained long enough for GEO to be held accountable for their inattention to detained persons' medical needs. The medical staff at Karnes is not equipped to respond to a pandemic situation. The remote location of Karnes means that an outbreak of COVID-19 will decimate the detained population and will immensely impact care available to the local community. The physical construction of Karnes as a prison makes it impossible for social distancing measures to be implemented. Families are constantly in close contact with each other and with staff who come in and out of the detention center daily. Even if the extreme measure of a quarantine of family units to individual rooms were taken, bathrooms are shared, and children, babies, and pregnant women would be forced into effective solitary confinement, which would amount to torture.

36. The detention setting of Karnes is a serious public health concern not only for the families detained there, but also for ICE and GEO staff who are not equipped to take necessary precautionary measures at Karnes. It is impossible to keep staff and detained families in Karnes safe from the threat of a serious COVID-19 outbreak as long as the detention center remains open.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: March 21, 2020

San Antonio, Texas



Andrea Meza

DECLARATION OF JULIA MARCELLA VALERO

I, Julia Marcella Valero, swearing under penalties of perjury, make the following declaration.

1. My name is Julia Marcella Valero and I am the Karnes Pro Bono Volunteer Manager for the Karnes Pro Bono Project, under the auspices of RAICES. Prior to becoming the Karnes Pro Bono Volunteer Manager in October 2019, I provided legal assistance as a Legal Assistant under the auspices of RAICES to the migrants detained at the Karnes County Family Residential Center, previously named Karnes County Residential Center, ("Karnes") since June, 2018. I have been coming to Karnes to provide legal services since June, 2017, when I provided legal services as a legal assistant undergraduate intern with RAICES.
2. I have extensive experience working with migrants in immigrant detention. I have met with and provided legal services to more than a thousand individuals detained in Karnes as they fought their deportations and detention, including mothers with minor children, fathers with minor children, single adult women, and nuclear family units consisting of mother, father, and minor children.
3. Almost every family I have met with in Karnes this week has expressed concern about the possible spread of COVID-19.
4. Not a single family I have met with this week in Karnes has been healthy.
5. Multiple families have expressed fear that they may die if COVID-19 comes to Karnes due to the lack of adequate medical care.
6. Multiple families have expressed that Karnes' medical care is not adequate for basic medical needs such as headaches and the common cold, and so families express that they are even further worried about Karnes' capacity or desire to provide families with medical treatment for the virus if infected.
7. Not a single family I have spoken to has had access to hand sanitizer, a protective mask, or gloves.
8. Multiple families have expressed frustration with their lack of access to basic cleaning materials such as soap.
9. Multiple families have expressed concerns about how GEO staff disturbs families' sleep. Many families say that GEO aggressively checks on the families at night, and families expressed that these disturbances affect their health negatively. On the night of March 18, 2020, multiple families stated that GEO was especially aggressive in checking on families following the suicide of a father in Karnes. Despite concerns about COVID-19, GEO staff went in and checked families' pulses with their bare hands, with no gloves used for protection, no 6 foot rule observed, and no consent from the families.
10. Multiple families have also expressed fear of the virus spreading quickly in Karnes because families are housed in shared rooms and cannot remain 6 feet apart for social distancing within the constraints of detention. Multiple families have expressed that they are forced to remain in close contact with each other when eating together in the shared cafeteria, when in line for the cafeteria and the medical center, and when in their shared bedrooms. Multiple families have expressed that the cafeteria is crowded. One family estimated that

approximately 120 people fit into the cafeteria during mealtime, and the cafeteria fills to capacity as people wait outside in line to be able to eat.

11. I have seen multiple GEO guards shake hands, not abide by 6 feet of social distancing in line to clock in or clock out. I have not seen a single GEO guard wearing gloves or a protective mask this week. I overheard GEO medical personnel saying this week "we never know anything until the very last."
12. I witnessed my colleague Dinorah Galeana be denied entry into Karnes on March 19, 2020 because she has traveled out of the U.S. in the last 14 days. When Dinorah raised that she had been allowed entry into Karnes on March 17, 2020 and had met with families after disclosing that she was outside of the U.S. in the last 14 days, Officer Cisneros admitted that Dinorah should not have been allowed entry on March 17, 2020. Officer Cisneros called this a "mistake."
13. I have met with many families who are unable to stomach the food in Karnes. Many families express that the food has caused them vomit, diarrhea, and nausea.
14. I have recently met with at least three families with children under two who are not eating and are very ill. Their families have tried to access medical care for them but they are not receiving care in Karnes.
15. I have recently met with multiple women with severe pregnancy complications that are not being treated in Karnes. The women I have spoken to have all tried to get help at the medical center in Karnes but they are not receiving care.
16. I have met multiple families in Karnes who express that there is an attitude of "stay silent and sign" in terms of GEO group complying with its obligations for care of the families. Multiple families have expressed that there is an attitude from the prison guards that they must sign the forms (the forms acknowledging they have eaten in the cafeteria, the forms acknowledging they have seen a mental health provider, etc.) but that the GEO officers (including medical officers) do not care if the families are actually being cared for. Multiple families have independently told me that they believe this is GEO group abiding by its obligations without care for how families are actually doing.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: March 21, 2020

San Antonio, TX

Julia Marcella Valero

DECLARATION OF LAILA AYUB

I, Laila Ayub, swearing under penalties of perjury, make the following declaration.

1. I am a staff attorney at RAICES. I regularly make legal visits with families detained at the Karnes County Residential Center in Karnes City, Texas. Typically, I spend about 10 hours there, two to three times a week. The following are my firsthand observations and recollections from conversations with families and staff at Karnes.
2. On March 9 and 11, 2020, I made legal visits to Karnes. Between those two days, approximately six families organically shared with me that their children have stopped eating within preceding two weeks. Three fathers specifically expressed concern that their children, two three years old and one six years old, have been losing weight as a result of not eating.
3. One father described his three-year-old son as "skin and bones." He told me that he took his son to the medical center because of the weight loss. He told me that the medical staff just weighed his son and told him that it is normal for a young child to not eat a lot of food, and that it is okay for a young child to not be gaining weight.
4. Other fathers told me similar stories. They took their children to the medical center because they were not eating, and the GEO medical staff weighed their children, and said that the children were doing fine.
5. One father told me that his son has lost seven pounds since being detained.
6. Each of the fathers I spoke with told me that their children never had problems eating prior to detention. They also had not experienced weight loss like this prior to detention and were growing normally before their detention.

7. I visited Karnes on March 18, 2020, for the first time since ICE announced changes to visitation procedures at Karnes.

8. When I entered the building that day, I was allowed to go through security to the front desk as I normally would. I placed my belongings on the conveyer belt and walked through to the front desk to check in.

9. GEO staff took my temperature with a no-contact thermometer and had me fill out a questionnaire. GEO staff did not explain anything to me. They did not ask me to wash my hands. They were not wearing gloves. I handed them my license as I normally would, and they handed me a visitor badge. They placed my license in a binder along with those of all other staff and visitors in the building. They told me I could enter the visitation area to begin meeting with clients.

10. When I walked into the visitation room, at approximately 9:40 am, a group of detained fathers were cleaning the restrooms and high traffic tables, doors, and windows. The only protective gear they had was gloves. GEO staff were telling them what to clean.

11. Throughout the day, GEO staff were touching all of the surfaces on tables and the front desk and standing within close proximity to one another. They lined up within inches of one another on the hour to clock in and out from their shifts. They use a touch screen to do this. I have never seen someone clean the touch screen.

12. I noticed that I could not avoid touching certain surfaces with my hands throughout the day. For example, I have to open two doors to get into the visitation room. The second door requires me to press a button so that someone can unlock the door remotely. The trash can in

the visitation room requires me to use my hands to close it. The doors to the rooms where I meet with clients cannot be opened without using my hands.

13. I have not seen any of the children's toys in visitation get cleaned, nor phones or tablets that are used for family visits. As far as I know, there is no protocol in place for cleaning these surfaces before or after client meetings. Clients had to use phones and tablets to be able to speak to RAICES staff for remote legal visits. I took it upon myself to wipe these down between clients.

14. GEO guards handled families' identification cards with their bare hands. I did not see them getting up to wash their hands frequently.

15. ICE staff came very close to me to speak with me, multiple times throughout the day. They were within a three feet distance from me. The only apparent precaution they took was to tell me they could not shake my hand.

16. The waiting room to get into visitation was full of families sitting in chairs immediately next to each other.

17. The rooms in visitation require that we sit across the table from the person with whom we are meeting. I would estimate that we are about a foot or two apart from one another, sitting face to face.

18. GEO staff required families to line up to head into the cafeteria as usual, in two parallel single file lines, with no more than an arms distance between each other. The fact that families line up at meal times indicates that they are required to all eat at once. I would therefore assume that the cafeteria is full of people at meal times.

19. Children were still attending school throughout the day as usual, and going to the daycare.

20. Clients told me that they were being called one by one to meet with officers to sign forms about coronavirus. They said that these forms seemed like a way for staff to put on a facade of having explained coronavirus and taken the necessary precautions, but they did not actually explain it to them.

21. In the afternoon, a large group of families tried to enter visitation at once to speak with RAICES attorneys. GEO staff did not let them speak to me. GEO did not ask the group to disperse, even though they were very crowded in a small room and standing close to each other. In fact, GEO staff also got very close to the group of families.

22. Every family I met with during the day organically told me that children are sick, many are vomiting and have diarrhea. They told me there have been several children and fathers with fevers but that they do not get removed from housing units, most people are still living in their rooms with other families.

23. In the evening, a toddler came up to me and touched me, so as to try and play with me. The child was clearly too young to be able to grasp the concept of taking precautions against a virus. Because it was the evening, the daycare was closed, which means that the child had to accompany his parents while they spoke with RAICES attorneys. Because of the size of the room, there was no appropriate space for the child to be able to distance himself from me or vice versa. It also seems inhumane to have to think about communicating to a toddler that he needs to move away from me in order to keep an appropriate social distance. The same child

approached a GEO staff member. The GEO staff member did not take any care to avoid touching the child or create space between himself and the child.

24. I cannot imagine how this situation would be avoided within the setting of Karnes. I believe that the only appropriate preventative measure for that toddler and other children at Karnes would be for him to live outside of detention, in a setting where his parents would be able to exercise the power to make decisions to protect their child's health and safety.

25. I am afraid that I could unknowingly carry the virus to the families I meet with at Karnes because of the above stated observations.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on March 21, 2020 in San Antonio, Texas.

Laila Ayub

Declaration of R.P. , A2 1-613

I, R.P. , declare under penalty of perjury that the following is true and correct to the best of my knowledge and recollection.

1. My name is R.P. . I was born in Port Au Prince, Haiti on April 6, 1986. I am 33 years old and currently detained in ICE custody at the Karnes County Residential Center with my pregnant wife, R.M. , A#213-211-614, born on November 4, 1997 in Ouanaminthe, Haiti and my one year old son, V.P. , A# 1-615, born on April 10, 2018 in Port Au Prince, Haiti.
2. I am not too comfortable here. Most of the people here are women and children, many of whom are already sick or not eating well. We are all worried that if the virus reaches this detention center, many people could die. The GEO officials have not said anything to us or shared important information about safety. Everything that we know has come from the news that we watch. The officials have been silent.
3. I believe that if my family was able to be released and continue my case outside of detention, we would have a better chance of staying healthy. The doctors here are already not able to protect us. The doctors say they are already busy and they are frequently unable to take care of our current needs. My wife, for example, is sick and has ovarian cysts. She is in lots of pain and has gone to the doctors here many times but has been told treatment is not available. She has not had her period in over 5 months. If this is how this center handles routine medical care, I fear for our lives if the virus reaches us and we are stuck here.

A#: 1-613

I, R.P., swear under penalties of perjury that the above declaration is true and accurate to the best of my abilities. This declaration was read back to me in Haitian Creole, a language in which I am fluent.

R.P.
Signature

3/16/20
Date

CERTIFICATE OF INTERPRETATION

I, Matthew Bratek, certify that I speak English and I read the foregoing in the English language to Ruth, a certified telephonic interpreter in the English and Haitian Creole languages. The interpreter read the foregoing in the Haitian Creole language to R.P. before the declarant signed it.

Signature

Date 3/16/20

2511 Texas 1604 Loop, #201
San Antonio, TX 78258
Interpreter Address

(855) 571-8342
Interpreter Telephone

Declaration of T.F. A#213-211-563

I, Tanie Francois, declare under penalty of perjury that the following is true and correct to the best of my knowledge and recollection.

1. My name is T.F., A#213-211-563. I was born on May 17, 1983 in Haiti. I am 37 years old and currently detained in ICE custody at the Karnes County Residential Center ("Karnes") with my husband, A.R., and our two children, B.F. R., 4 years old, and D.F.R., 19 months old.

MY BABY'S HEALTH HAS DETERIOTED SINCE BEING DETAINED AT KARNES

2. Since we arrived at Karnes, my baby's health has deteriorated. I first noticed she was struggling to breathe at night while she slept. She becomes easily congested and begins wheezing. As a result of her difficulty breathing, she wakes up in the middle of the night crying and cannot fall asleep. Her lack of sleep is also concerning because it puts her at an increased risk of becoming ill from coronavirus ("COVID-19"). I feel like she is in pain.

3. I visit the medical center at Karnes every day, so the medical staff can care for her. However, I do not trust that they care. The doctor at Karnes, whose name I do not know, told me that D.F.R. has secretion in her lungs that's causing her breathing complications but that it was normal. They also tell me that her weight is normal when in reality, she's lost about 7 pounds since we arrived at Karnes. She used to weigh about 33 pounds (15 kilograms) but now weighs about 26 pounds (12 kilograms). This kind of weight loss is not normal for a baby. If I cannot trust the medical staff to tell me the truth about her weight loss, I cannot trust that they care about our health.

4. When she first began to exhibit breathing problems, the medical staff used a machine to get the congestion out of her lungs. After telling me the machine was no longer necessary, they took her a hospital off-site for some additional testing. I do not know the results of the tests they performed, however, because they never shared them with me. They also said they will need to repeat the test but they have not done it yet.

5. Currently, my baby is not eating. She was not always like this. Before we were detained, she was a healthy baby and ate often. She no longer wants to eat. I breast-feed her because she does not want to eat anything.

GEO AND ICE ARE FAILING TO PROTECT US FROM COVID-19

6. On top of her health complications we worry that our baby is at an increased risk of contracting COVID-19. Because her health has deteriorated in detention, and she's not sleeping or eating, she could very easily get sick. On top of her existing health problems, COVID-19 could really harm her.

7. On top of that, neither GEO or ICE are taking the measures necessary to protect us. In fact, they are exposing us to more risk. My husband, for example, helps clean common areas at Karnes but GEO only provides him with gloves, no masks or hand sanitizer. There is also no hand sanitizer in our rooms or in common areas. When we go eat, hundreds of people, about 200, eat at a time in addition to standing in line much closer than 6 feet away from one another. This is in direct violation of recommended protocols set forth by the US government to fight the spread of COVID-19.

8. GEO guards themselves also expose us to harm. Most do no wear any gloves or masks when in close contact with us. We are afraid that a GEO or ICE officer will bring COVID-19 in with them and we all get sick. They put our health in danger every day.

9. In addition to exposing us to increased risk, there are not poster or notices on the walls in Haitian Creole for us to know how to protect ourselves. The lack of education and information regarding the virus suggest to me that they do not care about our health.

10. We want to be released from detention as soon as possible. Our baby's health continues to deteriorate and doctors have left us in the dark regarding her care. In addition, we are afraid that her poor health puts her in danger of contracting COVID-19. On top of GEO and ICE's failures in protecting our health, we believe that our lives and our children's lives remain in danger the longer we stay here.

Declaration of Ronald Jay Waldman, MD

1. I, Ronald Jay Waldman, MD am currently Professor of Global Health at the Milken Institute School of Public Health at George Washington University, Washington, DC. In addition, I serve as President and Chairman of the Board of Directors of Doctors of the World – USA, a 501(c)(3) not-for-profit entity incorporated in the State of New York.

2. I received my medical degree from the University of Geneva, Switzerland in 1975 and a Master of Public Health degree from the Johns Hopkins University, Baltimore, MD in 1979. Subsequently, I United States Public Health Service as a Commissioned Officer and was assigned as a Medical Epidemiologist to the US Centers for Disease Control and Prevention from 1979-200? I was honorably discharged and retired with the rank of Captain (O6). In addition, I have served as a Medical Officer with the World Health Organization, working in the Division of Child and Adolescent Health. I am the founding Director of the Program on Forced Migration and Health at the Mailman School of Public Health of Columbia University, New York, NY.

3. Finally, I have been employed or partially employed by the United States Agency for International Development since 2007 and have worked to provide them and their partner organizations with assistance in the area of pandemic preparedness.

4. COVID-19 is an acute disease of the respiratory tract caused by a novel corona virus designated SARS-CoV-2 that is transmitted from person-to-person via the respiratory route. It was first reported from Hubei Province China in December 2019 and has subsequently encircled the globe, causing severe illness and death in many countries, including the United States of America, where, as of this writing cases have been confirmed in all fifty states. The exact number of cases and deaths is undeterminable, as serological confirmatory testing has been unavailable for surveillance purposes. Most public health authorities are of the opinion that the actual number of cases is far greater.

5. While case counts change daily, and even hourly, as of this writing (March 21) there have been more than 200 cases reported from the State of Texas, prompting the declaration of the first public health emergency in that State in more than 100 years and resulting in the closing of schools, restaurants, bars, and other places of public gathering.

6. While every demographic within the population is susceptible to becoming infecting the with virus that causes COVID-19, certain groups appear to be at higher risk, and thereby more vulnerable, than others. These include the elderly, especially those with underlying chronic conditions, and others with compromised immune systems, including children.

7. There is no specific cure or medical countermeasure for COVID-19. Only non-pharmaceutical interventions are available to slow its spread and to mitigate the serious consequences that result from it. The most important of these is commonly termed "social distancing". As the term implies, effective social distancing requires individuals (or family units) to keep a certain distance between themselves; the usual recommendation is 6 feet. In order to reduce/eliminate transmission from an infected to an uninfected individual, individuals having more proximate contact with an actual or potentially infected individual should wear appropriate personal protective equipment.

8. In addition, the virus, if excreted from the respiratory tract of an infected individual, can survive on various surfaces for a time varying from hours to days, depending upon the nature of the surface and the viral load.

9. With the preceding in mind, I have reviewed the ICE Guidelines o COVID-19 (https://www.ice.gov/covid19, accessed March 21, 2019). While the guidelines appear to have been prepared with reasonable attention to current scientific knowledge, and with a reasonable degree of respect for current US Government policies, they are deficient in a number of areas, and are not necessarily protective of ICE personnel nor of those in their charge, as witness the confirmation of COVID-19 in an ICE officer in Elizabeth, New Jersey, reported on March 19.

10. The Guidelines are inadequate in the following respects:

    a. No provisions are made for SARS-CoV-2 serologic testing in either ICE personnel or detainees. Without this, no definitive statements can be made about the existence of virus, disease, or disease transmission in ICE facilities.
    b. Provisions for personal protective equipment to be used in some circumstances call for the use of surgical masks. These are insufficient and the use of N-95 particulate filtering facepiece respirators should be specified. To be sure, these are in short supply throughout the US, but they represent the "gold standard" and any deviation from this standard should be specified as an inadequate measure for the prevention of transmission.
    c. The guidance contains no provisions for the appropriate, hygienic, cleaning of potentially contaminated surfaces. Lack of discussion of this potentially important means of transmission in the guidelines is a serious shortcoming.
    d. The guidelines call for the detention of individuals determined to be I particularly vulnerable in groups, rather than as individuals or in family groups. This places an excess number of people at risk of infection and is poor public health practice.
    e. Although international air travel has been discouraged in most parts of the world during the pandemic, ICE continues to discuss international air travel for detainees as standard policy. The only concession made to the possibility that the US Government might be responsible for exporting SARS-CoV-2 virus to other countries through this practice is that any detainee with a temperature of 100.4 degrees or higher will be immediately referred to a medical provider. The

means by which body temperature would be determined is not specified, and there is no provision made for the follow-up of any contact of a detainee, whether ICE staff of another detainee, determined to have a high temperature, to be confined and/or tested for COVID-19.

11. It is my expert opinion that the policies expressed in the ICE Guidelines for COVID-19 are inadequate and contrary to accepted public health practice being adopted during the current pandemic. Rather than focusing on how to prevent transmission among ICE officers in detention facilities, policies should be developed to transfer detainees to places where proper social distancing can be practiced. In addition, removal of detainees to foreign countries by air travel should be immediately suspended.

Pursuant to U.S.C. 1746, I declare under penalty of perjury that the foregoing is true and correct.

Prepared in Washington, DC, on March 21, 2019,
Ronald J. Waldman, MD
Ronald Jay Waldman, MD, MPH

Ronald J. Waldman, M.D., M.P.H.

Department of Global Health
Milken Institute School of Public Health
The George Washington University
Telephone: 202-374-2364 (cell)
ronwaldman@gwu.edu

Date of Birth: March 4, 1946

Place of Birth: New York, New York, USA

EDUCATION

MPH, Johns Hopkins University School of Hygiene and Public Health, 1979
MD, University of Geneva, Switzerland, 1975
BA, University of Rochester, New York, 1967

PROFESSIONAL EXPERIENCE

Professor of Global Health, Department of Global Health, George Washington University School of Public Health and Health Services, July 2012 – present. Co-director, Humanitarian Health Program. Member, Branch Consortium on impact of armed conflict on reproductive, maternal, neonatal, infant and child health and nutrition.

Advisor, Emerging Pandemic Threats Program, United States Agency for International Development, 2012-present. Provide technical input to the Community Pandemic Preparedness Project (CP3), working with the. International Federation of Red Cross and Red Crescent Societies to strengthen the ability of eight low-income countries to prevent, detect, and respond to epidemics and outbreaks of diseases of pandemic potential. Provide technical advice to the Predict Project, one of a suite of USAID-funded projects aiming at strengthening countries' abilities in the areas of viral discovery, identification, surveillance, and response.

President, Doctors of the World – USA, 2014-present. Provide leadership and direction to a growing member of a 16 chapter international non-governmental organization working in the areas of emergency response and health sector development.

Global Health Fellows Program, Public Health Institute, Oakland, California, 2007-2012.

Assigned to the Global Health Bureau, Avian and Human Influenza Unit, of the United States Agency for International Development. Led the development and implementation of the Humanitarian Pandemic Preparedness (H2P) initiative, a $100 million effort to prepare up to 30 countries for an influenza pandemic. Put together a broad partnership (Humanitarian Pandemic Preparedness) consisting of the International Red Cross and Red Crescent Societies, five United Nations Agencies (UNOCHA, WHO, UNHCR, IOM,

and WFP), the US Department of Defense (AFRICOM and PACOM) and a number of non-governmental organizations. The partners worked with host countries toward the development of detailed pandemic preparedness plans intended to mitigate the consequences of a severe pandemic. From May, 2009, the partnership concentrated primarily on response to the H1N1(2009) pandemic.

Subsequently, directed and coordinated an initiative called "Towards a Safer World", an effort to capture the practical lessons learned from the "whole of society" approach taken for pandemic preparedness. This effort looks across 10 sectors at the current state of global disaster preparedness. Principal partners include the UN Secretariat for Influenza Coordination, World Health Organization, World Food Programme, World Tourism Organization, and the Academy for Educational Development (now FHI360).

Haiti Earthquake Relief: In January-February 2010, led the US Government health sector response to the Haiti earthquake, responsible for coordinating the efforts of USAID, the Department of Health and Human Services including the Centers for Disease Control and Prevention, and the Department of Defense.

Pakistan Flood Relief: From September through November 2010 I was assigned to the World Health Organization and the UN Office for the Coordination of Humanitarian Assistance to advise in the management of the emergency response to the floods in Pakistan and served as Senior Health Advisor to the UN Humanitarian Coordinator.

Professor of Clinical Population and Family Health and Professor of Clinical Epidemiology, 2005-2012. See below.

Deputy Director, Center for Global Health and Economic Development, Mailman School of Public Health of Columbia University, 2003-2005.

Responsibilities included the day-to-day management of this joint venture with the Earth Institute of Columbia University. The Center housed the Forced Migration Program (see below), as well as the Access Project, devoted to helping countries apply for and manage grants from the Global Fund for HIV/AIDS, Tuberculosis and Malaria; the MacroHealth Project, an attempt to devolve to national level the processes that were initiated by WHO's Commission on Macroeconomics and Health; and an NGO, FilmAid, that seeks to use the power of film for health education in refugee camps.

A large proportion of my time at the Center was devoted to co-coordinating The Task Force on Child Health and Maternal Health of the UN Millennium Project and serving as a lead author on its report, Who's Got the Power: Transforming Health Systems for Women and Children.

Professor of Clinical Population and Family Health and Director of the Program on Forced Migration and Health, Heilbrunn Center for Population and Family Health, and the Department of Epidemiology, Mailman School of Public Health of Columbia University, New York, NY 1998-2003.

Founded and directed the Program on Forced Migration and Health. Activities included post-graduate education, short-term training, and research. Responsible for establishing a Master of Public Health program with a concentration in public health in conflict-affected

societies, refugee health, health aspects of humanitarian assistance, and post-conflict rehabilitation of health systems.

Tsunami Relief: served as Emergency Coordinator for WHO in Aceh, Indonesia, December 2004-February 2005.

Technical Director, BASICS, Arlington, VA, 1993-1998.

Responsible for the coordination of all technical aspects of the largest international child health project of the United States Agency for International Development. Responsibilities included supervision of about twenty professional personnel working in immunization, diarrheal disease control, malaria control, control of acute respiratory infections, integrated management of the sick child, health care policy formulation and implementation, childhood nutrition, and long-term behavior change of caretakers and health care professionals. BASICS was active in more than twenty countries in Latin America, Africa, and Asia.

Democratic Republic of Congo: Seconded by CDC to serve as infectious diseases advisor for UNHCR, serving Rwandan refugees in N. and S. Kivu Provinces, July-August, 1994.

Coordinator, WHO Global Task Force on Cholera Control, World Health Organization, Division of Diarrheal and Acute Respiratory Disease Control, Geneva, Switzerland, 1991-1993.

Collaborated with WHO Regional Offices and with Member States in activities involving the planning, implementation, and evaluation of cholera control policies. Also responsible for coordination with other United Nations agencies, bilateral donors, and non-governmental organizations. In conjunction with the Division Director, responsible for policy formation, development of activities, procurement of extra-budgetary funding, and implementation of country and regional programs for the control of cholera, dysentery, and other epidemic diarrheal diseases. Coordinated the writing, publication, and distribution of Guidelines for cholera control (World Health Organization, 1993) and Guidelines for the control of epidemics due to *Shigella dysenteriae* type 1 (WHO/CDR/95.4).

Medical Officer, World Health Organization, Division of Epidemiological Surveillance and Health Situation and Trend Analysis, Geneva, Switzerland, 1991-1992.

Responsible for country-oriented activities of the Programme of Intensified Action for Strengthening Epidemiological Capacities of Member States. In conjunction with other WHO programs, including the Expanded Program on Immunization and the Program for the Control of Diarrheal Diseases, served as facilitator in a number of inter-country workshops to improve the ability to use data derived from surveillance systems for improving health policy formulation and program management. At the request of the Emergency Relief Organization (now Health Action in Crises), developed an emergency health monitoring system for highly vulnerable populations of ex-Yugoslavia. Also served as Co-Secretary of the Task Force for Strengthening Epidemiological Capacities of the Children's Vaccine Initiative and as acting coordinator of the WHO Global Task Force on Cholera Control.

Director, Division of Technical Support, and Assistant Director for Project Development, International Health Program Office, Centers for Disease Control and Prevention, Atlanta, Georgia, 1987-1991.

Responsible for supervising approximately twenty biomedical and social science professionals in international child survival activities including immunization, diarrheal disease control, malaria control, and the control of acute respiratory infections. Disciplines represented in the Division included epidemiology, health education, evaluation research, training, anthropology, and health economics. The Division provided technical assistance in these areas to other parts of CDC, other US government agencies, the World Health Organization, Ministries of Health of foreign governments, and private voluntary organizations. Most of the work by the Division was in support of the USAID-funded Combating Childhood Communicable Diseases project (CCCD).

N. Iraq, displacement of Kurdish population: In 1991, in conjunction the military activity Operation Provide Comfort, coordinated public health services on behalf of USAID.

Coordinator of Diarrheal Disease Control Activities, Centers for Disease Control, International Health Program Office, Atlanta, Georgia, 1985-1987.

Field Epidemiologist, Centers for Disease Control, International Health Program Office, Atlanta, GA, 1983-1985.

Served as consultant (based in Abidjan, Cote d'Ivoire) in sixteen West African countries on health information systems, operational research, and EPI and CDD program planning, implementation and evaluation. Conducted surveys on various aspects of EPI, CDD, and malaria control programs, including childhood mortality and morbidity, use of health service, and prevailing health practices.

Staff Epidemiologist, Centers for Disease Control, International Health Program Office, GA, 1983-1985.

Made multiple visits to African countries to review aspects of public health interventions aimed at reducing infant and child mortality. Worked closely with officials of USAID to develop bilateral health care projects and to negotiate projects in Togo, Liberia, Guinea, and Cote d'Ivoire.

Assisted with the formation of, and was subsequently assigned to, the Refugee Health Unit, Ministry of Health, Somali Democratic Republic as epidemiology consultant (resident, and multiple visits, 1980-1985). Conducted baseline mortality, morbidity and nutrition surveys aimed at establishing priorities for intervention; provided technical support and direction to a large (1,000,000 population) refugee health program, including design and implementation of the surveillance system, training or professional health staff and community health workers, and advising on control of communicable diseases.

Epidemic Intelligence Service (EIS Officer), Centers for Disease Control, Epidemiology Program Office, Atlanta, GA, (assigned to the Michigan Department of Public Health), 1979-1980.

Major projects included two case-control studies that identified aspirin as a major risk factor for the development of Reye Syndrome; investigation and control of outbreaks of acute disseminated histoplasmosis, eastern equine encephalitis, and multiple food-borne outbreaks of various etiologies.

Somalia, refugee relief: was instrumental in describing epidemiological situation of Somali-ethnic Ethiopian refugees throughout Somalia and for designing and implementing appropriate public health interventions. Worked with Ministry of Health and National Refugee Commission to establish Refugee Health Unit and served as senior advisor to it, first in-residence (1979-81) and then periodically (1981-85).

Internship and one year of residency in internal medicine (Board eligible), Highland Hospital, Rochester, NY, 1976-1978.

Medical Epidemiologist, World Health Organization, Smallpox Eradication Program, Geneva, Switzerland, 1975-1976.

Assigned to two rural areas, later to four urban areas, of Bangladesh. Responsibilities included surveillance, detection of cases of smallpox, containment and control, eventually total interruption of transmission within assigned areas, leading to smallpox eradication.

LANGUAGES

French: Fluent speaking, reading, writing

PUBLICATIONS

Colón-Ramos U, Roess AA, Robien K, Marghella PD, Waldman RJ, Merrigan KA. Foods distributed during Federal disaster relief response in Puerto Rico after Hurricane Maria did not fully meet Federalnutrition recommendations. J Acad Nutr Diet. 2019 Jun 11.

Jabbour S, Fouad FM, Leaning J et al. Death and suffering in Eastern Ghouta, Syria: a call for action to protect civilians and health care. Lancet 2018;391(10123);815-817.

Asgary R and Waldman RJ. The elephant in the room: toward a more ethical approach with accountability toward intended beneficiaries in humanitarian aid. Int Health 2017 Nov 1;9(6):343-348.

Yamey G, Schaferhoff M, Aars OK,… Waldman R, et al. Financing of international collective action for epidemic and pandemic preparedness. Lancet Glob Health. 2017 Aug;5(8)e742-e744.

Waldman RJ, Toole MJ. Where is the science in humanitarian health? Lancet 2017 Jun 7. doi: 10.1016/S0140-6736(17)31275-8.

Checchi F, Waldman RJ, Roberts LF, et al. World Health Organization and emergency health: if not now, when? BMJ 2016;352:i469 Jan 28

Waldman R, Nieburg P. Thoughts on alternative designs for clinical trials for Ebola treatment research. Am J Bioeth. 2015;15(4):38-40.

Waldman RJ, Newbrander W. Afghanistan's health system: moving forward in challenging circumstances, 2002-2013. Glob Public Health. 2014;;9 Suppl 1:S1-5.

Kucharski, A.J., Camacho, A., Checchi, F., Waldman, R., Grais, R.F., Cabrol, J.C., Briand, S., Baguelin, M., Flasche, S., Funk, S. and Edmunds, W.J. Evaluation of the Benefits and Risks of Introducing Ebola Community Care Centers, Sierra Leone. *Emerging Infectious Diseases* 2014; 21.

Moodley K, Hardie K, Selgelid MJ, Waldman RJ, et al. Ethical considerations for vaccination programmes in acute humanitarian emergencies. Bull World Health Organ. 2013 Apr 1;91(4):290-97.

Shelton JD, Waldman RJ. A journal for global health programming. Glob Health Sci Praact. 2013 Mar 21;1(1):3-4

Waldman RJ, Mintz ED, Papowitz HE. The cure for cholera—improving access to safe water and sanitation. N Engl J Med. 2013 Feb 14;368(7):592-4.

Newbrander W, Waldman R, Shepherd-Banigan M. Rebuilding and strengthening health systems and providing basic health services in fragile states. Disasters. 2011 Oct;35(4):639-60.

Kruk ME, Freedman LP, Anglin GA, Waldman RJ. Rebuilding health systems to improve health and promote statebuilding in post-conflict countries: a theoretical framework and research agenda. Soc Sci Med. 2010 Jan;70(1):89-97

Aceh Epidemiology Group. Outbreak of tetanus cases following the tsunami in Aceh Province, Indonesia. Glob Public Health. 2006;1(2):173-77.

Waldman R. Editorial. Glob Public Health. 2006;1(2):121-24.

Brennan R, Waldman RJ. The South Asian Earthquake Six Months Later – an Ongoing Crisis. New England Journal of Medicine 2006, Apr 27;354(17):1769-71.

Waldman RJ. Responding to catastrophes: a public health perspective. Chicago J Intl Law. 2006; 6:553-79.

Waldman R. The next two issues of Global Public Health are devoted to articles related to public health in both natural and man-made emergencies. Glob Public Health. 2006;1(2):121-4.

Nieburg PI, Waldman RJ, Krumm DM. Evacuated populations – lessons from foreign refugee crises. New England Journal of Medicine 2005;353:1547-48.

Waldman R. What Have We Learned? Filling Gaps in Available Services. Prehosp Disaster Med 2005 Nov-Dec;20(6):475-9.

Sundnes KO, Sannerkvist M, Hedger P,…Waldman R. Private commercial sector partnerships for health action in crises. Prehosp Disaster Med 2005 Nov-Dec;20(6):459-63.

Waldman RJ. First footsteps in tsunamiland. Emergency Medicine Australasia 2005;17:299-300.

Waldman RJ. Public Health in War – Pursuing the Impossible. Harvard International Review 2005; 27(1).

Freedman LP, Waldman RJ, de Pinho H, et al. Transforming health systems to improve the lives of women and children. Lancet 2005 Mar 12-18;365(9463):997-1000.

Freedman LP, Waldman RJ, De Pinho H et al. Who's Got the Power? Transforming Health Systems to Improve the Lives of Women and Children. UN Millennium Project Task Force on Child Health and Maternal Health. New York, January 2005.

Waldman R. What have we learned? Filling gaps in available services. Prehosp Disaster Med 2005 Nov-Dec;20(6):475-9.

Ahern J, Galea S, Fernandez WG, Koci B, Waldman R, Vlahov D. Gender, social support and posttraumatic stress in postwar Kosovo. J Nerv Ment Dis 2004;192:762-770.

Salama P, Spiegel P, Talley L, Waldman R. Lessons learned from complex emergencies over the past decade. Lancet 364:1801-1813, 13 Nov 13, 2004.

Fernandez WG, Galea S, Ahern J, Koci B, Waldman RJ,Vlahov D. Mental health status among ethnic Albanians seeking medical care in an emergency department two years after the war in Kosovo: a pilot project. Ann Emerg Med. 2004 Feb;43(2):E1-8.

Van Dyke M, Waldman RJ. The Sphere Project – an evaluation. January 2004. Available at www.sphereproject.org

Waldman, RJ. Rebuilding health services after conflict: lessons from East Timor and Afghanistan. Humanitarian Exchange, 24:25-27. Overseas Development Institute, London July 2003.

Benjamin ER, Clements C, McCally M, Pellett PL, VanRooyen MJ, Waldman RJ. The humanitarian cost of a war in Iraq. Lancet 361(9360):874, Mar 8, 2003.

Iacopino V, Frank MW, Bauer HM, Keller AS, Fink SL, Ford D, Pallin DJ, Waldman RJ. A Population-Based Assessment of Human Rights Abuses Committed Against Ethnic Albanian Refugees from Kosovo. American Journal of Public Health. 91: 2013-2018, December 2001.

Waldman RJ. Public Health in Times of War and Famine: What can be done? What should be done? JAMA. 289(5): 588-590, August 1, 2001.

Waldman RJ, Williams HA. Public Health in Complex Emergencies: Toward a more integrated science. National Association for the Practicing Anthropologist. 21: 89-115, 2001.

Waldman RJ. Prioritising health care in complex emergencies. Lancet 357:1427-1429, May 5, 2001.

Keely CB, Reed, HE, and Waldman RJ. Understanding Mortality Patterns in Complex Humanitarian Emergencies. In Reed HE and Keely CB, eds. Forced Migration and Mortality. A Report of the National Research Council. National Academy Press, Washington, DC, 2001.

Toole MJ, Waldman RJ, Zwi AB. Complex Humanitarian Emergencies. Chapter 9, in Merson, Black and Mills, eds. International Public Health: Diseases, Programs, Systems, and Policies. Aspen Publishers, Gaithersburg, MD, 2001, pp. 439-510.

Claeson M, Waldman RJ. The evolution of child health programmes in developing countries: from targeting diseases to targeting people. Bulletin of the World Health Organization, 2000 78(10): 1234-1245.

Kushner A, Cobey J, with the assistance of Waldman RJ, Burnham G, Krug E. Landmine Incidents and Injuries and the Capacity to Provide Care. Physicians for Human Rights, Boston, MA. 2000.

Waldman RJ, Martone G. Public Health and Complex Emergencies: New Issues, New Conditions. American Journal of Public Health. 89(10): 1483-1485, October 1999.

Physicians for Human Rights and the Program on Forced Migration and Health of Columbia University. War Crimes in Kosovo: A Population-Based Assessment of Human Rights Violations Against Kosovar Albanians. August 1999.

Iacopino V, Waldman RJ. War and Health, from Solferino to Kosovo – The Evolving Role of Physicians. JAMA 282(5): 479-481, August 4, 1999.

Cookson S, Waldman R, Gushulak B et al. Immigrant and Refugee Health. J Emerg Inf Dis.4(3):427-8. Sep 1998

Murray J, McFarland DA, Waldman RJ. Cost-effectiveness of oral cholera vaccine in a stable refugee population at risk for epidemic cholera and in a population with endemic cholera. Bulletin of the World Health Organization 76(4): 343-352, 1998.

Waldman RJ. Cholera vaccination in refugee settings. JAMA 279:552-553, 1998.

Toole MJ, Waldman RJ. The Public Health Aspects of Complex Emergencies and Refugee Situations. American Review of Public Health 18: 283-312, 1997.

Swerdlow DL, Malenga G, Begkoyian G, Nyangulu D, Toole M, Waldman RJ, Puhr ND, Tauxe RV. Epidemic cholera among refugees in Malawi, Africa: Treatment and Transmission. Epidemiol Infect 118: 207-214, 1997.

Waldman RJ, Bartlett AV, Campbell CC, Steketee RW. Overcoming Barriers: The Pathway to Survival. BASICS, Child Survival Series, 1996.

Healing TD, Drysdale SF, Black ME, Buyers M, Acheson ED, Waldman RJ, Hall SM, Bartlett CLR. Monitoring Health in the War-Affected Areas of the Former Yugoslavia, 1992-93. European Journal of Public Health 6(4): 245-251, 1996.

Goma Epidemiology Group. Public health impact of Rwandan refugee crisis: what happened in Goma, Zaire, in July, 1994? Lancet 345:339-44, February 11, 1995.

Swerdlow DL, Levine O. Toole MJ, Waldman RJ, Tauxe RV. Correction: Cholera control among Rwandan refugees in Zaire. Lancet 1302:266, November 5, 1995.

Kahn JG, Mokdad AH, Deming MS, Roungou JB, Boby AM, Excler JL, Waldman RJ. Avoiding missed opportunities for immunization in the Central African Republic: potential impact on vaccination coverage. Bull World Health Organ 73:47-55, 1995.

Brogan D, Flagg EW, Deming M, Waldman RJ. Increasing the accuracy of the Expanded Programme on Immunization's cluster survey design. Ann Epidemiol 4:302-11, July 1994.

Claeson M, Hogan RC, Torres A, Waldman RJ. Double think and double talk. World Health Forum 15:382-6, 1994.

Hatch DL, Waldman RJ, Lungu GW, Piri C. Epidemic cholera during refugee resettlement in Malawi. Int J Epidemiol 23: 1292-99, 1994.

Waldman RJ. A framework for survival: health human rights, and humanitarian assistance in conflicts and disasters. JAMA 270:646, August 4, 1993. (Book review)

Toole MJ, Waldman RJ. Refugees and displaced persons. War, hunger, and public health. JAMA 270:600-5, August 4, 1993.

Cutts FT, Waldman RJ, Zoffman HM. Surveillance for the Expanded Programme on Immunization. Bull World Health Organ 71:633-9, 1993.

Toole MJ, Malkki RM, Blake P, Lee L, Mast E, Nieburg P, Snider D, Sketee RW, Sutter R, Waldman RJ, Yip R. Famine-Affected, Refugees, and Displaced Populations: Recommendations for Public Health Issues. MMWR 41(RR-13): 1-76, July 1992.

Claeson M, Waldman RJ. In the time of cholera. Encyclopedia Britannica, Medical and Health Annual, 1992.

Waldman RJ. Public health surveillance on the world health agenda. Morb Mortal Wkly Rep 41 Suppl:201-5, December 1992.

Bryce J. Toole MJ, Waldman RJ, Voigt A. Assessing the quality of facility-based child survival services. Health Policy Plann 7:155-163, 1992.

Glass RI, Claeson M, Blake PA, Waldman RJ, Pierce NF. Cholera in Africa: lessons on transmission and control for Latin America. Lancet 338:791-5, Sepember 28, 1991.

Hatch DL, Vreuls RC, Toole MJ, Moteetee MM, Monoang I, Ngatane CM, Gittelman DM, Waldman RJ. The effective case management of childhood diarrhea with oral rehydration therapy in the Kingdom of Lesotho. Int J Epidemiol 19:1066-71, December 1990.

Toole MJ, Waldman RJ. Health problems in developing countries: an overview. Int Ophthalmol Clin 30:2-6, Winter 1990.

Toole MJ, Waldman RJ. Priority health interventions in developing countries. Int Ophthalmol Clin 30:7-11, Winter 1990.

Toole MJ, Waldman RJ. Prevention of excess mortality in refugee and displaced populations in developing countries. JAMA 263:3296-302, 1990.

Redd S, Moteetee M, Waldman RJ. Diagnosis and management of acute respiratory infections in Lesotho. Health Policy Plann 5:255-260, 1990.

Dabis F, Waldman RJ, Deming M. Re: 'The epidemiology of measles in a partially vaccinated population in an African City: Implications for immunization programs' (I: Reply). Am J Epidemiol 132:193-194, 1990.

Cliff J, Cutts F, Waldman RJ. Using surveys in Mozambique for evaluation of diarrheal disease control. Health Policy Plann 5:219-225, 1990.

Moore PS, Toole MJ, Nieburg P. Waldman RJ, Broome CV. Surveillance and control of meningococcal meningitis epidemics in refugee populations. Bull World Health Organ 68: 587-96, 1990.

Toole MJ, Nieburg P, Waldman RJ, Person-Karell B. Adequacy of refugee relief rations (letter, comment). Lancet 2:268, July 29, 1989.

Rieder HL, Snider DE Jr, Toole MJ, Waldman RJ, Leowski J, ten Dam HG, Styblo K, Gabaudan M, Tailhades M. Tuberculosis control in refugee settlements. Tubercle 70:127-34, Jun 1989.

Dabis F. Waldman RJ, Mann GF, Commenges D, Madzou G, Jones TS. Loss of maternal measles antibody during infancy in an African city. Int J Epidemiol 18:264-8, Mar 1989.

Toole MJ, Steketee RW, Waldman RJ, Nieburg P. Measles prevention and control in emergency settings. Bull World Health Organ 67:381-8, 1989.

Griffin PM, Ryan CA, Nyaphisi M, Hargrett-Bean N. Waldman RJ, Blake PA. Risk factors for fatal diarrhea: a case-control study of African children. Am J Epidemiol 128: 1322-9, December 1988.

Toole MJ, Nieburg P, Waldman RJ. The association between inadequate rations, undernutrition prevalence, and mortality in refugee camps: case studies of refugee populations in eastern Thailand, 1979-1980, and eastern Sudan, 1984-1985. J Trop Pediatr 34:218-24, October 1988.

Dabis F, Sow A, Waldman RJ, Bikakouri P, Senga J, Madzou G, Jones TS. The epidemiology of measles in a partially vaccinated population in an African city: implications for immunization programs. Am J Epidemiol 127:171-8, January 1988.

Nieburg P, Waldman RJ, Leavell R, Sommer A, DeMaeyer EM. Vitamin A supplementation for refugees and famine victims. Bull World Health Organ 66:689-97, 1988.

Toole MJ, Waldman RJ. An analysis of mortality trends among refugee populations in Somalia, Sudan, and Thailand. Bull World Health Organ 66:237-47, 1988.

Dabis F, Roisin A, Breman JG, Helal A, Waldman RJ. Improper practices for diarrhoea treatment in Africa. Trans R Soc Trop Med Hyg 82:935-6, 1988.

Waldman RJ, England AC, Tauxe R, Kline T, Weeks RJ, Ajello L, Kaufman L, Wentworth B, Fraser DW. A winter outbreak of acute histoplasmosis in northern Michigan. Am J Epidemiol 117:68-75, January 1983.

Grimstad PR, Shabino CL, Calisher CH, Waldman RJ. A case of encephalitis in a human associated with a serologic rise to Jamestown Canyon virus. Am J Trop Med Hyg 31:1238-44, November 1982.

Waldman RJ, Hall WN, McGee H, Van Amburg G. Aspirin as a risk factor in Reye's syndrome. JAMA 247:3089-94, June 11, 1982.

Blaser MJ, Waldman RJ, Barrett T, Erlandson AL. Outbreaks of Campylobacter enteritis in two extended families: evidence for person-to-person transmission. J Pediatr 98:254-7, February 1981.

APPOINTMENTS

President, Board of Directors and Executive Committee, Doctors of the World--USA 2014-present

Board of Overseers, International Rescue Committee, 2005-2018

Associate Editor, Journal of Global Public Health (peer-review journal), 2005-present

Editorial Board, Disasters (peer-review journal), 2003-present

Board of Directors, Physicians for Human Rights, 2004-2010

Health Unit Advisory Board, International Rescue Committee, 2000-present

Associate of the International Health Unit, Burnet Centre for Medical Research and Public Health, Melbourne, Australia, 2000-present

Scientific Advisory Committee, Action Against Hunger, 1999-2003

Co-coordinator, Task Force #4 – Child Health and Maternal Health, UN Millennium Project, 2003-2005

Co-chairman, Global Health Council Annual Conference, "Global Health in Times of Crisis", 2002

Past Chairman, International Health Section, American Public Health Association.

Program Committee, Doctors of the World--USA, 1999-2005.

Roundtable on the Demography of Forced Migration, Committee on Population, National Academy of Sciences, 1999-2005

DECLARATION OF DR. JULIE DEAUN GRAVES

I, Julie DeAun Graves, declare as follows:

1. I am Associate Director of Clinical Services at Nurx, a practicing physician with board certification in Family Medicine, and I am a public health physician, previously serving as Medical Director for the Texas Department of State Health Services for the Houston region, as Medical Services Coordinator for the Texas Department of Aging and Disability Services, and as a medical consultant to the Texas Medical Board. I managed the H1N1 influenza outbreak for the Texas State Supported Living Centers and oversaw public health efforts for the Houston region (population 7 million) for Ebola virus, Zika virus, West Nile virus, highly pathogenic avian influenza, tuberculosis outbreaks, and natural disasters. I obtained my medical degree and completed a surgical internship then family medicine residency at the University of Texas Southwestern Medical School in Dallas, Texas. I earned a Master's degree in Public Health and a Doctor of Philosophy in Management, Policy, and Statistics at the University of Texas School of Public Health. I have practiced family medicine and public health since 1989, and in 2018-2019 I was Associate Professor and Vice-Chair for Education at Georgetown University School of Medicine. I attach a copy of my curriculum vitae.

2. COVID-19 is an illness caused by the SARS-CoV-2 virus, which is a coronavirus that was first detected in humans during the outbreak (now a pandemic) we are experiencing now. The Centers for Disease Control and Prevention reports that as of March 18, 2020 at noon, there are 7,038 cases in the United States, with some cases reported in every state in the US, and there are 97 deaths so far. The Texas Department of State Health Services reports 83 cases and two deaths as of March 18, 2020. The U.S. and Texas are in the early stages of the pandemic, and because there has been insufficient testing for cases, the reported cases numbers are low despite the high probability that there are many more infected individuals in the population. Spread is faster and more dangerous when people are in close quarters. People must maintain distance from others of six feet or more to reduce spread of the virus from person to person.

3. People with health conditions such as diabetes, asthma, emphysema, heart disease, kidney disease, pregnancy, cancer, HIV, and autoimmune diseases like lupus and rheumatoid arthritis are at higher risk for severe illness, complications, and death from COVID-19. People over age 60 have higher death rates, but severe cases of illness and deaths are reported in people of all ages. The ratio of cases of COVID-19 to deaths from this illness is much higher than for other contagious diseases like influenza.

4. The SARS-CoV-2 virus damages the lung tissue, which means that even those who recover need prolonged medical care and rehabilitation. They are likely to have permanent disability from loss of lung capacity. The heart itself can be infected, and kidneys and the nervous system can also be impacted and damaged permanently.

5. There is no vaccine and no treatment for COVID-19. We only have prevention as a tool to stop the pandemic. If we don't move people out of congregate settings, most of them plus the staff who work with them will become infected, and many will die or have permanent disability. People must be in small family groups and should distance 6-10 feet from anyone not in their family group. People should not be in large buildings full of many people, and people must practice thorough hand washing. If we don't do these two steps – distancing and hand washing – the pandemic will not end.

6. COVID-19 is transmitted from person to person by breathing in air that contains the droplets they've coughed or the virus they've shed, or by touching a surface with the virus on it, unless there is full personal protective equipment: mask, gloves, gown, plus thorough handwashing before putting on the equipment and after removing it.

7. As Medical Director for the Texas Department of State Health Services Houston region, I collaborated with the Department of Health and Human Services during disease outbreaks among children who were held in facilities in central and south Texas. I am familiar with these facilities and the conditions faced by people held and by those who work there. In August of 2019 I volunteered with a Catholic Charities facility in Laredo, Texas and provided medical care to people just released from detention in Customs and Border Patrol facilities. I observed the ill health, exhaustion, and malnutrition evident in these people. Additionally, because of my work as Medical Services Coordinator for the Texas Department of Aging and Disability Services overseeing health care in the State Supported Living Centers, which are congregate living settings, I am familiar with the risks to residents and staff of any infectious disease, and particularly those with high infectivity, such as this coronavirus SARS-CoV-2.

8. I have read and analyzed the March 18, 2020 Immigration and Customs Enforcement documentation found at https://www.ice.gov/covid19. The guidance regarding personal protective equipment is insufficient to maintain the health and safety of the people held and those who work in these facilities. The document states that Immigration and Customs Enforcement follows guidance from the Centers for Disease Control and Prevention regarding masks and other personal protective equipment. The Centers for Disease Control and Prevention guidance includes using bandanas, scarves, and other home-made protection when sufficient masks are not available. Unless every person with any respiratory symptoms and all workers who are in contact with more than one detainee are wearing properly fit-tested N-95 masks, they are not protected from spread of this

coronavirus SARS-CoV-2. Additionally, the Immigration and Customs Enforcement does not discuss the transmission of SARS-CoV-2 on surfaces. This virus can live and be infectious on surfaces for up to 10 days. There is no guidance in the document about use of surface cleaning agents and any strategies for containing spread by touching of surfaces, nor is there mandate for wearing protective gloves.

9. The March 18, 2020 Immigration and Customs Enforcement documentation states that there are no confirmed cases of COVID-19 in Immigration and Customs Enforcement facilities. However, there is no evidence that any testing for this virus has been performed. There cannot be confirmed cases without testing. The risk is very high that there are indeed unconfirmed cases in these facilities, and that detainees are not being provided with appropriate testing. This guidance document notes that new detainees are screened for risk of COVID-19. However, we are now in a pandemic, and all are at risk. Plus, detainees enter an area of risk when they enter a facility. Detainees who meet risk criteria are housed separately from others, but they are not quarantined alone, but instead held in groups. This does not meet quarantine standards. Also, the document notes that symptomatic detainees are transported to medical appointments with only a mask. This is insufficient. The masks should be N-95, and a thorough fit testing must be performed in order for this N-95 to protect others from an ill person's respiratory secretions. No protective equipment to prevent transmission from surfaces is in place. Those detainees who are transported out of the United States by airplane have not been tested for SARS-CoV-19 and are not transported in appropriate personal protective equipment.

10. Proper procedure in Immigration and Customs Enforcement facilities should be that all detainees and staff practice social distancing as delineated by the Centers for Disease Control and Prevention. Only family groups should be in a space that is sealed off from others, and these groups should maintain distance of at least six feet from other persons. All detainees should be informed about safety protocols and proper hand washing procedures and frequency and monitored to ensure that they are following these protocols and procedures.

11. Even if all of the recommendations made by Immigration and Customs Enforcement and that I have provided are followed, the conditions of detention are such that the detained families would still be at high risk. Because this virus is transmitted through droplets, through the air, and on surfaces, and because people who do not have symptoms but are infected transmit the virus to others, even one infected person in a facility, either a detainee or a staff member, can infect the majority of people in the facility. This is worsened by the crowded conditions in the facilities.

12. For the reasons above, in order to contain the unchecked spread of the COVID-19 virus, we must relocate as many people as possible out of institutional settings. This would also

include civil immigration detention centers. If we do not take steps to permit people to practice social distancing in small family units, these institutional centers will become sites of massive numbers of COVID-19 cases placing both people held there as well as those who work there at high risk of infection with the SARS-CoV-2 virus. Based on indications from countries around the world, many will develop COVID-19 illness with seriousness and sequelae ranging from mild illness to permanent disability to death.

Pursuant to 28 U.S.C. 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 20th day in March 2020, in North Bay Village, Florida.

Dr. Julie DeAun Graves

Julie D. Graves, M.D., M.P.H., Ph.D., F.A.A.F.P.

Current positions:

Family medicine and public health physician in private practice

Associate Director of Clinical Services, Nurx

Education:

06/1979 Bachelor of Arts, Rice University, Houston, Texas
Majors: Biology, Health and Physical Education

06/1983 Doctor of Medicine
The University of Texas Southwestern Medical School, Dallas, Texas

12/1992 Master of Public Health
The University of Texas Health Science Center (UTHealth) School of Public Health, Houston, Texas
Concentration: Health Services Organizations
Thesis: Preferences for Perinatal Health Decisions: A Critical Appraisal

12/2011 Doctor of Philosophy
The University of Texas Health Science Center (UTHealth) School of Public Health, Houston, Texas
Division of Management, Policy, and Community Health
Major: Health Policy
Minors: Management, Biostatistics
Dissertation: Analysis of Policy Issues Surrounding the Electronic Medical Record

Medical licensure:

State: Texas

License No: G5110

Initial Date: 08/23/1983

Renewal/Expiration Date: 02/28/2020

State: Wisconsin

License No: 53273

Initial Date: 06/23/2009

Renewal/Expiration Date: 10/31/2021

State: Alabama

License No: 12408

Initial Date: 10/22/1985

Renewal/Expiration Date: 12/31/1986

State: Nebraska

License No: TX-G5110

Initial Date: 07/20/1985

Renewal/Expiration Date: 07/26/1985

State: Florida

License No: ME134326

Initial Date: 10/25/2017

Renewal/Expiration Date: 01/31/2022

State: District of Columbia

License No: MD045899

Initial Date: 02/26/2018

Renewal/Expiration Date: 12/31/2020

State: Maryland

License No: D84791

Initial Date: 02/16/2018

Renewal/Expiration Date: 09/30/2020

Certifications:

American Board of Family Medicine: Certificate Number 1070893973

Date certified: 07/1989
Dates of Re-certification:
Jul 14, 1989 - Jul 13, 1995
Jul 14, 1995 - Jul 12, 2001
Jul 13, 2001 - Aug 01, 2008
Aug 02, 2008 - Apr 09, 2017
Apr 10, 2017 -12/2027

Advanced Cardiac Life Support 5/1983-12/94, 01/1997-12/2001, 01/2003-12/2018

Advanced Trauma Life Support 01/2003-12/2019

Pediatric Advanced Life Support 01/2004-12/2017

Languages Spoken
English – mother tongue
Spanish – basic medical
German – basic

Previous Academic Appointments and Activities

03/2018-03/2019
Vice-Chair for Education, Department of Family Medicine, Georgetown University School of Medicine

05/2017-12/2017
Associate Professor of Epidemiology, University of Medicine and Health Sciences, St. Kitts and Nevis

06/2015-08/2019
Adjunct Associate Professor of Management, Policy, and Community Health, The University of Texas Health Science Center (UTHealth) School of Public Health

Lecturer: PH 3620, Principles and Practice of Public Health
Lecturer: PH 5220, Gender and Leadership

Preceptor: Occupational Medicine Residency program

Dissertation Committee member: PhD student Stella Okoroafor, MD, MPH (in process)

06/2015-05/17
Faculty, Texas Department of State Health Services Preventive Medicine Residency program

Infectious Diseases and Chronic Disease Preventive Lectures Series Coordinator

06/2014
Visiting Faculty, Tanzania Training Center for International Health

03/2013-08/2014
Associate Professor of Behavioral and Clinical Medicine and Public Health, University of Sint Eustatius School of Medicine

Course director: Epidemiology, Medical Ethics, Biostatistics

09/2012-08/2013
Adjunct Assistant Professor of Epidemiology, The University of Texas Health Science Center (UTHealth) School of Public Health

Dissertation Committee Member, DrPH student Christina Socias (completed)

Associate Professor of Behavioral and Clinical Medicine, American University of the Caribbean School of Medicine, Sint Maarten

Course director and principal faculty, Medical Ethics

Faculty, Introduction to Clinical Medicine

01/2012-09/2012
Assistant Professor of Family and Community Medicine, The University of Texas Health Science Center at San Antonio, Texas

06/2009-08/2009
Graduate Teaching Assistant, The University of Texas Health Science Center (UTHealth) School of Public Health

PH 3620 Principles and Practice of Public Health (on-line course)

11/2002-05/2005
Faculty physician, Austin Medical Education Programs, Family Medicine residency program, Austin, Texas

01/1995-12/1999
Clinical Assistant Professor of Family Medicine, Texas A&M University Brazos Valley Family Medicine residency program, College Station, Texas

11/1992-05/1995
Clinical Assistant Professor of Family Medicine, Baylor College of Medicine, Houston, Texas

Obstetrics fellowship co-coordinator

08/1989-08/1991
Assistant Professor of Family and Community Medicine, The University of Texas Houston Health Science Center

Founding course director, Family Medicine Clinical Clerkship

Co-author, HRSA Primary care training grant

Research Activities

01/2012-09/2012
ReACH Scholar, Center for Research to Advance Community Health, University of Texas Health Science Center at San Antonio
Project: Quality assurance using electronic health records
Principle Investigator: Barbara J. Turner, MD, MSED, MSCP
Internal funding.

01/2007-12/-2009
Research Associate, Health Policy Institute, University of Texas School of Public Health
Projects: Translational research applications of public policy analysis; Food oases
Principle investigators: Stephen Linder, PhD and Eduardo Sanchez, MD, MPH
Internal funding

01/1991-12/1992
Research Associate, Center for Health Policy Studies, University of Texas School of Public Health
Project: Health manpower analysis for primary care in Texas
Principle investigators: Virginia Kennedy, PhD and Frank Moore, PhD
Funding: Texas Higher Education Coordinating Board

08/1989-08/1991
Project staff, University of Texas Houston Health Science Center
Project: Cholesterol reduction with high rice fiber diets
Principle investigator: Mark E. Clasen, MD, PhD
Funding: National Rice Council

09/1988-06/1989
Principle investigator, McLennan County Medical Education and Research Foundation
Project: Obstetrical Practice by Texas Family Physicians
Funding: Texas Higher Education Coordinating Board

Governmental Public Health Practice

06/2017-3/2019
Consultant to Ministry of Health, St. Kitts and Nevis, for disaster preparedness and cannabis health effects

02/2015-05/2017
Regional Medical Director, Texas Department of State Health Services, Health Services Region 6/5S (Houston area, population 7 million)

01/2009-12/2011
Medical consultant, Texas Medicaid Office of Inspector General, Austin, Texas

01/2005-12/2012
Quality monitor and investigator, Texas Medical Board, Austin, Texas

09/2009-05/2011
Medical Services Coordinator for State Supported Living Centers, Texas Department of Aging and Disability Services, Texas (statewide)

Member, Institutional Review Board

05/2001-22/2002
Medical Consultant, Texas Department of Health, Children's Health and Infectious Disease Epidemiology and Surveillance, Austin, Texas (statewide)

Chair, Institutional Review Board, Texas Department of Health

06/1995-12/1999
Educational consultant, Texas WIC (Women, Infants, and Children) nutrition program

01/1994-12/1995
Utilization Review Physician, Lone Star Texas Medicaid managed care program

Clinical Experience

04/2005-02/2015 and 06/2017 – 3/2018
Private practice of family, hospitalist, and emergency medicine, Texas, Sint Maarten, Croatia, Carnival Cruises

09/2005 - 11/2005
Emergency Room Physician, U.S. Army MEDDAC, Wuerzburg, Germany Combat Support Hospital

01/2000-12/2001
Medical Director, Mother's Milk Bank at Austin (volunteer, co-founder)

09/1991-08/1992
Family physician, University of Houston student health service

09/1988-06/1989
Fellowship in Faculty Development, McClennan County Medical Education Research Foundation, Waco, Texas

06/1986-09/1988
Residency in Family Medicine, St. Paul Medical Center, Dallas, Texas

06/1985-05/1986
Locum tenens primary care and emergency medicine physician, CompHealth, Inc., Florida, Alabama, Nebraska, Texas

07/1984-05/1985
Residency training in Anesthesiology, University of Florida Shands Hospital, Gainesville, Florida

07/1983-06/1984
Internship in General Surgery, Parkland Memorial Hospital, Dallas, Texas

Private Sector

01/2009-12/2012
Principal, InGenius Strategies, LLC (health information technology consulting)

01/2005-12/2009
Consultant, Texas Medical Foundation Health Quality Institute (Medicare Quality Improvement Organization for Texas)

05/2005-08/2009
Chief Medical Officer, Practice IT, LLC (health information technology vendor)

01/1995-12/1996
Public policy advocacy, Texas Tobacco Education Project

Honors and Awards:

Outstanding Faculty, Texas Department of State Health Services Preventive Medicine Residency, 06/2017

Team Spirit Award, Texas Department of Health, 11/2002

C. Frank Webber Award for Excellence in Oncology, M.D. Anderson Cancer Center and the Texas Academy of Family Physicians, 05/1998

Fellow of the American Academy of Family Physicians, granted 09/1996

Bibliography

Textbook chapters

1. **Moy, Julie Graves**. “Cardiac Arrest”, in Swanson’s Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.

2. **Moy, Julie Graves**. **“**Advanced Trauma Life Support”, in Swanson’s Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.

3. **Moy, Julie Graves**. **“**Domestic Violence”, in Swanson’s Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.

4. **Moy, Julie Graves**. “The Limping Child”, in Swanson’s Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.

5. **Moy, Julie Graves**. “Sickle Cell Anemia”, in Swanson’s Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.

6. **Moy, Julie Graves**. “Lymphomas and Leukemias”, in Swanson’s Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.

7. **Moy, Julie** Graves. “Common Problems in the Newborn”, in Swanson’s Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.

8. **Moy, Julie Graves**, Pfenninger, John. “Peripheral Nerve Blocks and Field Blocks,” in Pfenninger JL, Fowler GC (eds.). Procedures for Primary Care Physicians. St. Louis, Missouri: Mosby, 1994, 2002.

9. **Moy, Julie Graves**. “Induction of Labor,” in Rakel RE. Conn’s Current Therapy. WB Saunders, 1997.

10. **Moy, Julie Graves**. “Development of Clinical Guidelines,” in Mengel M, Fields S (eds.). Guide to Clinical Expertise. New York: Plenum Press, 1996.

11. **Moy, Julie Graves.** “Bites and Stings,” in Taylor RB (ed.). Family Medicine: Principles and Practice. New York: Springer-Verlag, 1994.

12. **Moy, Julie Graves.** “Nasogastric Tube and Salem Sump Insertion,” in Pfenninger JL, Fowler GC (eds.). Procedures for Primary Care Physicians. St. Louis, Missouri: Mosby, 1994.

13. **Moy, Julie Graves**. “Informed Consent,” in Pfenninger JL, Fowler GC (eds.). Procedures for Primary Care Physicians. St. Louis, Missouri, Mosby, 1994.

14. Duiker SS, **Moy, Julie Graves**. “Dyspareunia,” in Griffith HW, Dambro M (eds.). The Five-Minute Clinical Consult. Philadelphia: Lea and Febiger, 1993 – 1997.

15. **Moy, Julie Graves**, Duiker, SS. "Sexual Dysfunction in Women", in Griffith HW, Dambro M (eds.). The Five-Minute Clinical Consult. Philadelphia: Lea and Febiger, 1993, 1994, 1995.

16. Duiker SS, **Moy, Julie Graves**. "Community Intervention Strategies in Preventive Cardiology," in Fuentes F (ed.). Preventive Cardiology Computer Modules, Houston: University of Texas Houston Health Science Center, 1991.

Peer-reviewed publications

1. Nguyen DT, Teeter LD, **Graves J**, Graviss EA. Characteristics Associated with Negative Interferon-γ Release Assay Results in Culture-Confirmed Tuberculosis Patients, Texas, USA, 2013–2015. Emerging Infectious Diseases. Volume 24, Number 3—March 2018.

2. Liu EL, Morshedi B, Miller BL, Isaacs SM, Fowler RL, Chung W, Blum R, Ward B, Carlo J, Hennes H, WEbseter F, Perl T, Noah C, Monaghan R, Tran AH, Benitez F, **Graves J**, Kibbey C, Kelin KR, Swienton RE. Dallas MegaShelter Medical Operations Response to Hurricane Harvey. Disaster Medicine and Public Health Preparedness. 2017 Dec 6:1-4.

3. Wiseman R, Weil L, Lozano C, Johnson T, Jin S, Moorman AC, Foster MA, Mixcon-Hayden T, Khudyahov Y, Kuhar DT, **Graves JG**. Healthcare-associated Hepatitis A Outbreak, Texas, 2015. MMWR, April 29, 2016 / 65(16);425–426.

4. Socias C, Liang Y, Delclos G, **Graves J**, Hendrickson E, Cooper S. The Feasibility of Using Electronic Health Records to Describe Demographic and Clinical Indicators of Migrant and Seasonal Farmworkers. Journal of Agromedicine, 21:71-81, 2016.

5. **Moy, Julie Graves**. Texas State-wide Health Information Technology Policy in 2007: Regional and constituency-specific initiatives move forward, but risk failure without coordination and funding from state government. Texas Medicine 105(1):55-63, 2009.

6. **Moy, Julie Graves.** Spirometry in Urgent Care. Urgent Care, May 2007.

7. Holleman W, Holleman MC, **Moy, Julie Graves**. Continuity of Care and Ethics in Managed Care. Archives of Family Medicine, 1999;8.

8. Mullen PD, Pollack KI, Titus JP, Sockrider MM, **Moy, Julie Graves**. Smoking Cessation Practices of Texas Obstetricians. Birth, 1998; 25:25-30.

9. Roberts R, Bell H, Wall E, **Moy, Julie Graves**, Hess G, Bower G. Trial of Labor or Repeat Caesarean Section: The Woman's Choice. Archives of Family Medicine. 1997;6:120-125.

10. Holleman W, Holleman MC, **Moy, Julie Graves**. Managed Care and Ethics: A Match Made in Heaven or Strange Bedfellows? The Lancet 1997; February 8.

11. **Moy, Julie Graves**, Realini JP. Guidelines for Preventive Therapy with Estrogen and Progesterone for Postmenopausal Women. Journal of the American Board of Family Practice 1993;6:153-162.

12. Berg AO, **Moy, Julie Graves.** Policy Review: Guidelines for the Diagnosis and Treatment of Asthma. Journal of the American Board of Family Practice 1992;5:629-634.

13. **Moy, Julie Graves,** Clasen ME. The Patient with Gonococcal Infection. Primary Care 1990;17:59-83.

14. **McCraney, Julie Graves.** The Status of Obstetrical Practice by Texas Family Physicians. Texas Medicine 1989;86:53-6.

Monographs, non-refereed publications, government reports, and published abstracts

1. **Moy, Julie Graves,** Sanchez E. Food Oases: A White Paper. University of Texas School of Public Health Institute for Health Policy. May 2008.

2. **Moy, Julie Graves**. Texas End-of-Life Care Law. Texas Medical Association, 2005.

3. Kaye CI, Cody JD, Canfield M, Martinez J, Van de Putte L, **Moy, Julie Graves,** Borg M, Stanley S, Wang J, Visio P. The Development of the Texas State Genetics Plan and a Plan for Integrated Data Infrastructure for Genetic Service. University of Texas Health Science Center at San Antonio and Texas Department of Health, 2002

4. **Moy, Julie Graves**. Medical Ethics and Professionalism. Texas Medical Association, February 1999, updated 2004.

5. **Moy, Julie Graves**. Family Physicians on the Internet. Texas Family Physician 1996, January/February.

6. **Moy, Julie Graves**. Catastrophe Theory and Chaos: A Means to Understand What Happens in the Clinical Setting. North American Primary Care Research Group Annual Meeting, San Diego, California, November 1993. Abstract.

7. Grimes R, Brimlow D, **Moy, Julie Graves**. HIV/AIDS Interdisciplinary Clinical Preceptorships: Design, Implementation, and Evaluation. American Public Health Association, 1991. Abstract.

8. Grimes R, **Moy, Julie Graves**. Clinical Mini-Residency for Primary Care Medical School Faculty. AIDS Education and Training Centers Annual Meeting, San Francisco, California, December 14, 1991.

9. **Moy, Julie Graves**, Fowler GC. Sexually Transmitted Disease. Home Study Self-Assessment Program, number 149. American Academy of Family Physicians, October 1991.

10. **Moy, Julie Graves**. Impact of Medicare Reform upon Family Medicine Research. Society of Teachers of Family Medicine Research News 1990:3:1-3.

11. **McCraney, Julie Graves.** The Role of the Family Physician in the Management of Breastfeeding. Texas Family Physician 1989, May/June.

12. **McCraney, Julie Graves**. The Resource-Based Relative Value Scale. Texas Family Physician 1989, March/April.

13. **McCraney, Julie Graves**. A Resident Considers AIDS. Texas Family Physician 1988, May/June.

Letters to the Editor

1. **Moy, Julie Graves**. Flu Season Offers Opportunities to Keep Patients Healthy and out of the Hospital. Travis County Medical Association Journal, 2003; 49:18-19.

2. **Moy, Julie Graves**. Putting babies "back to sleep". Journal of the American Medical Association. 1999 March 17:281 (11): 983.

3. **Moy, Julie Graves**, Rourke J. Physician's Breastfeeding Course in Texas. Academy of Breastfeeding Medicine News and Views 1996:2(1).

4. **Moy, Julie Graves**. Who Practices in the ER? Health Affairs. March 2008 27:2w84-w95.

Service on State and National Panels and Committees:

Health Policy Panel Membership

1. Texas Department of Health Panel on Infant Feeding (co-author, Texas Department of Health Position Statement on Infant Feeding) 1997

2. National Heritage Insurance Company Medical Affairs Committee on Pilot Managed Care Program for Texas Medicaid Program 1994

3. National Institutes of Health Consensus Panel on Treatment of Cervical Dysplasia, Bethesda System Classification Development Team (Report published in the Journal of the American Medical Association 1994: 271, Kurman et al.) 1994

4. Rand Corporation / Health Care Financing Administration Medicaid Necessity, Outcomes, and Appropriateness Study on Pediatric Asthma 1992

5. Texas Department of Human Services Physician Payment Advisory Committee 1990

6. March of Dimes National Committee on Perinatal Health (co-author, Toward Improving the Outcomes of Pregnancy, monograph published by March of Dimes, 1993)

7. Texas Department of Human Services Indigent Care Advisory Committee 1989

Policy Reviews for American Academy of Family Physicians Task Force on Clinical Policies 1990-94

1. Agency for Health Care Policy and Research Pressure Sore Panel

2. National Heart, Lung, and Blood Institute Panel on Treatment of Asthma During Pregnancy and Lactation

3. National Heart, Lung, and Blood Institute Guidelines for the Diagnosis and Treatment of Asthma

4. American Academy of Ophthalmology Policy on Strabismus

5. Expert Panel on Preventive Services paper on Iron Supplementation During Pregnancy

6. Expert Panel on Preventive Services paper on Testing for D Isoimmunization in Pregnancy

7. American Academy of Pediatrics practice parameter on Treatment of Acute Asthma Exacerbation in Children

8. American Academy of Pediatrics practice parameter on Hyperbilirubinemia in the Newborn
Service on Medical School Committees:

Member, Practice Council, The University of Texas Health Science Center (UTHealth) School of Public Health at Houston, 2014 -present

Member, Council on Education for Public Health (CEPH) Expanded Steering Committee, The University of Texas Health Science Center (UTHealth) School of Public Health at Houston, 2016.

Member, Curriculum Committee, The University of Texas Health Science Center Medical School, 1990

Vice-chair, Institutional Review Board, University of Medicine and Health Sciences, St. Kitts and Nevis, 2017

Editorial Review for Medical Journals:

2018-present Peer Reviewer, American Family Physician

2017-present Peer Reviewer, Texas Public Health Association Journal

2001-2016 Peer Reviewer, Journal of Family Practice

2010-2017 Peer Reviewer, Family Practice Management

1997 Peer Reviewer, Feminist Economics

1995-1998 Editorial Review Board, Journal of Human Lactation

1994-1997 Peer Reviewer, American Family Physician

1993-2013 Peer Reviewer, Texas Medicine

1992-1997 Peer Reviewer, Archives of Family Medicine

1992-1995 Peer Reviewer, Family Medicine

1990-1993 Editorial Committee, Texas Medicine

1988-1989 Editor, Texas Family Physician "Resident Forum"

Presentations at Scientific Meetings:

1. Garrison R, **Graves J.** An Analysis of Barriers to Care for Patients Requiring Rabies Post-exposure Prophylaxis in Texas Department of State Health Services Region 6/5S. Texas Public Health Association 93rd Annual Meeting. March 27, 2017, Fort Worth, Texas

2. Ramsey J, Mayes B, **Graves J.** Demographics of Child Fatality in Rural Southeast Texas. Texas Public Health Association 93rd Annual Meeting. March 27, 2017, Fort Worth, Texas (poster)

3. Jones R, Abrego D, Deeba R, Varghese C, LaBar C, Mayes B, **Graves J.** Public Health Prevention Needs for Domestic Minor Sex Trafficking in Rural Southeast Texas Counties. Texas Public Health Association 93rd Annual Meeting. March 27, 2017, Fort Worth, Texas

4. **Graves J.** Vector-borne Disease Public Policy. South Texas Tropical Medicine and Vector Borne Disease conference. February 24, 2017. South Padre Island, Texas

5. Martinez D, Jin S, Milligan S, Haynie A, Arenare B, Wiseman R, Weil L, Lozano C, Johnson T, **Graves J**. Investigation of a healthcare associated Hepatitis A cluster in and nearby Harris County, Texas. Council of State and Territorial Epidemiologists Annual Meeting. June 2017. Anchorage Alaska (poster).

6. Lin H, Weil L, Evans D, Shaw D, Rosen G, **Graves J**. Regional Epidemiology Coordination Plan: effective use during a multijurisdictional outbreak investigation. Texas Public Health Association 92nd Annual Education Conference, April 2016, Galveston, Texas

7. Rosen G, Lin H, Swanson K, Shaw D, Weil L, Evans D, **Graves J.** Local challenges to state policy: Evaluating the interim guidance for monitoring and movement of persons with potential Ebola Virus exposure in Southeast Texas --October-December, 2014. American Public Health Association Annual Meeting, October 2015, Chicago, Illinois.

8. **Graves J.** Health Information Technology Policy in Germany, Switzerland, and Austria: Lessons for US Policy Makers. American Public Health Association Annual Meeting, San Diego, California, October 2012

9. **Graves J,** Sanchez E. Meeting the Health Needs of the Emerging Majority: Applying Lessons Learned from Border Health Programs to Eliminate Health Disparities throughout the U.S. American Public Health Association Annual Meeting, San Diego, California, October 2008

10. **Graves J,** Aday L. Decision Analysis and Preferences for Perinatal Health States. Agency for Health Care Policy and Research Third Primary Care Conference. Atlanta, Georgia, January 1993

11. **Moy, Julie Graves**, Susman J, Berg A. Critiquing Clinical Policies. Society of Teachers of Family Medicine Annual Meeting, San Diego, California, April 1993

12. **Moy, Julie Graves,** Schindler J, Duiker SS. Teaching Ambulatory Care in the Urban Setting, American Association of Medical Colleges Southern Group for Educational Affairs, Houston, Texas, April 1991

13. **Moy, Julie Graves**, Clasen ME, Donnelly J. Implementation of a Required Third year Clerkship in Family Medicine after Legislative Directive. Society of Teachers of Family Medicine Predoctoral Education Conference, San Antonio, Texas, February 1991.

14. **Moy, Julie Graves**, Goertz R. Legislative Directive for a Third year Family Medicine Clerkship. Society of Teachers of Family Medicine, Seattle Washington, May 1990.

15. Conard S, Dahms L, **McCraney, Julie Graves.** Stress in Residency: External Causes, Manifestations, and Impairment in Family Medicine as Compared to Other Specialties. Texas Academy of Family Physicians, Austin, Texas, September 1988, first place; also at American Academy of Family Physicians, Los Angeles, October 1988.

Invited Lectures

1. The US Health Care System in Transition. University of Medicine and Health Sciences Health Policy Lecture Series. July 13, 2017. Basseterre, St. Kitts and Nevis.

2. Legislative Issues Regarding Syndromic Surveillance. Texas Health Information Management Systems Society Legislative Conference. April 12, 2017, Austin, Texas.

3. Cross-Jurisdictional Coordination for Super Bowl LI Planning. Local Health Authorities Symposium. Texas Public Health Association 93rd Annual Meeting. March 27, 2017, Fort Worth, Texas

4. Texas Syndromic Surveillance System. Health Information Management Systems Society, Austin Chapter, August 9, 2016

5. A Congressional Forum on the Zika Virus and a Discussion of an Action Plan for Houston and Harris County. Good Neighbor Health Clinic, Houston, March 10, 2016.

6. Telemedicine for Children with Special Health Care Needs. Caring for Children with Special Health Care Needs in Medicaid Managed Care, Texas Health and Human Services Commission, Austin, Texas, March 8, 2002. With Nora Taylor Belcher

7. Medicaid and Managed Care. Women in Government Forum on Medicaid, Austin, Texas, September 16, 1995.

8. Managed Care and Managed Competition. Southeast Texas Chapter of the International Patient Education Council, University of Texas MD Anderson Cancer Center, June 2, 1993.

9. AIDS and Adolescents: HIV Policy Concerns. National Conference of State Legislatures Women's Network, Mobile, Alabama, May 20, 1993.

10. Vaginal Birth after Cesarean. Visiting Professor in Perinatal Health, University of Kansas School of Medicine Perinatal Conference, Kansas City, Kansas, April 3, 1992.

11. The Development of Medical Specialties in America. History of Medicine Lectures, University of Texas Houston Health Science Center, April 25, 1991.

Presentations at Professional Development Courses

1. Analysis of Policy Issues Surrounding the Electronic Medical Record. Grand Rounds. University of Texas Health Science Center at San Antonio. October 14, 2011. One hour Category I credit.

2. Barriers to Preventive Care for Women with Disabilities. Center for Health Disparities Annual Conference, University of North Texas Health Science Center, Ft. Worth, Texas, May 8, 2010. One hour Category I credit.

3. Clinical Indicators in Medicare's Hospital Quality Improvement Project. Houston, Texas. January 13, 2006. One hour Category I credit.

4. Recent Changes to Texas End-of-Life Care Law. St. David's Medical Center, Austin, Texas. October 12, 2004. One hour Category I credit, one hour Texas Ethics credit.

5. Aggressive Treatment of Type II Diabetes: What's New in Type II Diabetes and Improving Chronic Disease Management Care with a Systems Approach. Texas Academy of Family Physicians. El Paso, Texas, May 2002. Two hours Category I credit.

6. Update in Medical Ethics and Professionalism. Central Texas Continuing Education Consortium. Austin, Texas, October 1999. One hour Category I credit.

7. Breastfeeding Update. Grand Rounds. Columbia Bayshore Medical Center, Pasadena, Texas, July 16, 1998. One hour Category I credit.

8. Breastfeeding in Special Circumstances. American Academy of Family Physicians Annual Session September 17, 1997, Chicago IL, 1 hour prescribed credit. Taught again in Annual Session in 1998.

9. Breastfeeding Update. Presbyterian Hospital Combined Obstetrics/Pediatrics conference, April 1997, 1 hour AMA Category I credit.

10. Intensive Course in Breastfeeding: Lactation Management Workshop for Physicians. April 24, 1996, Houston, Texas. Four hours AAFP credit. Taught again Harlingen, Texas; Tyler, Texas; San Antonio, Texas, Dallas, Texas, Sugar Land, Texas in 1996, 1997, with Linda Zeccola, Tom Hale, Joanie Fischer, and Maryelle Van Landen

11. Intensive Course in Breastfeeding. March 11, 1996, Midland, Texas. Four hours continuing nursing education credit. Taught again in Gallup, New Mexico and Boise, Idaho.

12. Breastfeeding: Improving the Support System. Hermann Hospital/UT Houston Medical School Annual Perinatal Conference, Houston, Texas June 1996, 1 hour AMA credit.

13. Breastfeeding Update. Women's Hospital, Houston, Texas, September 1996, 1 hour AMA Category I.

14. Breastfeeding: Enlightening the Myths. Abilene Perinatal Conference, October 1996, 1 hour AMA Category I credit.

15. Family Oriented Prenatal Care. Baylor College of Medicine Advances in Family Medicine. January 20, 1995. 1/2 hour prescribed credit.

16. American Academy of Family Physicians Clinical Policies Training Course. San Diego, California, April 1993. 9.5 hours prescribed credit, with Hanan Bell

17. Preference/ Utility Assessment in Outcomes Research. Agency for Health Care Policy and Research Third Primary Care Conference, Atlanta, Georgia, January 10, 1993. 1 hour prescribed credit.

18. Hormone Replacement Therapy. Clinical Recommendations Update at American Academy of Family Physicians Scientific Assembly, Orlando Florida, October 1993. 2 hours prescribed credit.

19. Problems and Solutions in Integrating Clerkship Teaching with Residency Education. McLennan County Medical Education and Research Foundation Program Management Conference, Austin, Texas, May 18, 1990. 1 hour prescribed credit, with Donald Koester

20. The Status of Obstetrical Practice by Texas Family Physicians: Implications for Residency Training. McLennan County Medical Education and Research Foundation Program Management Conference, Austin, Texas, February, 1989. 1 hour prescribed credit.

21. The Genogram in Prevention. University of Texas Houston Health Science Center/ Texas Academy of Family Physicians Prevention for the Nineties Conference, Houston, Texas, October 30, 1989. 1 hour prescribed.

Professional Organizations:

American Public Health Association 1992-present

2020-2023	Governing Councilor
2015-2016	Joint Policy Committee member; Co-chair, 2016
2016	Executive Board member, ex officio
2014-2017	Submission Review for Annual Scientific Meeting
2012-2016	Science Board member; Chair, 2016

Medical Care Section (Mentoring Chair 2018)
International Health Section

Florida Public Health Association 2019-present

Florida Medical Association 2019-present

Travis County Medical Society 1995-2014

1998-2001	Committee on Legislation; Chair 1999-2000
1996-1999	Alternate Delegate to Texas Medical Association

Harris County Medical Society 1989-1995 and 2015-2016

2015-2016	Committee on Communication and Public Health
2015-2016	Emergency Care Committee, *ex officio*
1995	Delegate to Texas Medical Association
1994-1995	Board of Medical Legislation
1990-1995	Committee on Membership and Medical Precepts
1992-1993	Executive Board, Central Branch
1991-1994	Alternate Delegate to Texas Medical Association
1991	Medical Student Committee
1991	Chair, Young Physicians Section
2015–present	Committee on Communications and Public Health

Texas Medical Association 1987-2016

1995-2001	TexPAC (political action committee) Board of Directors
1994	Task Force on Hospital Staff-County Medical Society Relations
1993-1994	*ad hoc* Committee on Practice Parameters
1998	Council on Public Health
1991-1992	*ad hoc* Committee on International Medical Graduate Issues
1990-1994	TexPAC (political action committee) Vice-chairman
1990-1991	Young Physicians Governing Council
1989	Chairman, McLennan County MediCaring Task Force
1989-1991	Committee on Manpower
1989	Council on Socioeconomics
1987-1988	Committee on Health Insurance

American Medical Association 1987-1999, 2006-2008, 2010 -2011

1991	Executive Committee and Founding Member, Women’s Caucus
1989-1994	Medical Schools Section, Delegate for University of Texas Health Science Center, Houston

American Academy of Family Physicians 1987-present

1993-1999	Peer Reviewer, Home Study/Self-Assessment Program
1991-1995	Task Force on Clinical Policies for Patient Care; Executive Committee
1993-1994	Vaginal Birth after Caesarean Section Policy Team

Texas Academy of Family Physicians 1987-2016

1997 -1998	Task Force on Governance
1997	Task Force on Computers
1996	Task Force on Health System Reform
1997	Committee on Public Health and Scientific Affairs Chairman, 1995-1997
1994-1996	Committee on Legislation and Public Policy Vice-chair, 1996
1990	Vice-Chairman, Student Affairs Committee

Names used due to marriage:

Julie Graves 1957-1984 and 2012 - present
Julie Graves McCraney 1984 - 1999
Julie Graves Moy 1999 – 2012

Address

8000 West Drive, #314
North Bay Village, FL 33141

Email:
drjuliegraves@gmail.com

Telephone

512-689-8001

Scott A. Allen, MD, FACP
Professor Emeritus, Clinical Medicine
University of California Riverside School of Medicine
Medical Education Building
900 University Avenue
Riverside, CA 92521

Josiah "Jody" Rich, MD, MPH
Professor of Medicine and Epidemiology, Brown University
Director of the Center for Prisoner Health and Human Rights
Attending Physician, The Miriam Hospital,
164 Summit Ave.
Providence, RI 02906

March 19, 2020

The Honorable Bennie Thompson
Chairman
House Committee on Homeland Security
310 Cannon House Office Building
Washington, D.C. 20515

The Honorable Ron Johnson
Chairman
Senate Committee on Homeland Security
and Governmental Affairs
340 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Mike Rogers
Ranking Member
House Committee on Homeland Security
310 Cannon House Office Building
Washington, D.C. 20515

The Honorable Gary Peters
Ranking Member
Senate Committee on Homeland Security
and Governmental Affairs
340 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Carolyn Maloney
Chairwoman
House Committee on Oversight and Reform
2157 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Jim Jordan
Ranking Member
House Committee on Oversight and Reform
2157 Rayburn House Office Building
Washington, D.C. 20515

Dear Committee Chairpersons and Ranking Members:

We are physicians—an internist and an infectious disease specialist—with unique expertise in medical care in detention settings.[1] We currently serve as medical subject matter experts for the

---

[1] I, Dr. Scott Allen, MD, FACP, am a Professor Emeritus of Medicine, a former Associate Dean of Academic Affairs and former Chair of the Department of Internal Medicine at the University of California Riverside School of Medicine. From 1997 to 2004, I was a full-time correctional physician for the Rhode Island Department of Corrections; for the final three years, I served as the State Medical Program. I have published over 25 peer-reviewed papers in academic journals related to prison health care and am a former Associate Editor of the International Journal of Prisoner Health Care. I am the court appointed monitor for the consent decree in litigation involving

Department of Homeland Security's Office of Civil Rights and Civil Liberties (CRCL). One of us (Dr. Allen) has conducted numerous investigations of immigration detention facilities on CRCL's behalf over the past five years. We both are clinicians and continue to see patients, with one of us (Dr. Rich) currently providing care to coronavirus infected patients in an ICU setting.

As experts in the field of detention health, infectious disease, and public health, we are gravely concerned about the need to implement immediate and effective mitigation strategies to slow the spread of the coronavirus and resulting infections of COVID-19. In recent weeks, attention has rightly turned to the public health response in congregate settings such as nursing homes, college campuses, jails, prisons and immigration detention facilities (clusters have already been identified in Chinese and Iranian prisons according to news reports[2] and an inmate and an officer have reportedly just tested positive at New York's Rikers Island).[3] Reporting in recent days reveals that immigrant detainees at ICE's Aurora facility are in isolation for possible exposure to coronavirus.[4] And a member of ICE's medical staff at a private detention center in New Jersey has now been reported to have tested positive for coronavirus.[5]

We have shared our concerns about the serious medical risks from specific public health and safety threats associated with immigration detention with CRCL's Officer Cameron Quinn in an initial letter dated February 25, 2020, and a subsequent letter of March 13, 2020. We offered to

---

medical care at Riverside County Jails. I have consulted on detention health issues both domestically and internationally for the Open Society Institute and the International Committee of the Red Cross, among others. I have worked with the Institute of Medicine on several workshops related to detainee healthcare and serve as a medical advisor to Physicians for Human Rights. I am the co-founder and co-director of the Center for Prisoner Health and Human Rights at Brown University (www.prisonerhealth.org), and a former Co-Investigator of the University of California Criminal Justice and Health Consortium. I am also the founder and medical director of the Access Clinic, a primary care medical home to adults with developmental disabilities.

I, Dr. Josiah (Jody) Rich, MD, MPH, am a Professor of Medicine and Epidemiology at The Warren Alpert Medical School of Brown University, and a practicing Infectious Disease Specialist since 1994 at The Miriam Hospital Immunology Center providing clinical care for over 22 years, and at the Rhode Island Department of Corrections caring for prisoners with HIV infection and working in the correctional setting doing research. I have published close to 190 peer-reviewed publications, predominantly in the overlap between infectious diseases, addictions and incarceration. I am the Director and Co-founder of The Center for Prisoner Health and Human Rights at The Miriam Hospital (www.prisonerhealth.org), and a Co-Founder of the nationwide Centers for AIDS Research (CFAR) collaboration in HIV in corrections (CFAR/CHIC) initiative. I am Principal Investigator of three R01 grants and a K24 grant all focused on incarcerated populations. My primary field and area of specialization and expertise is in the overlap between infectious diseases and illicit substance use, the treatment and prevention of HIV infection, and the care and prevention of disease in addicted and incarcerated individuals. I have served as an expert for the National Academy of Sciences, the Institute of Medicine and others.

[2] Erin Mendel, "Coronavirus Outbreaks at China Prisons Spark Worries About Unknown Clusters," *Wall Street Journal*, February 21, 2020, available at: https://www.wsj.com/articles/coronavirus-outbreaks-at-china-prisons-spark-worries-about-unknown-clusters-11582286150; Center for Human Rights in Iran, "Grave Concerns for Prisoners in Iran Amid Coronavirus Outbreak," February 28, 2020, available at https://iranhumanrights.org/2020/02/grave-concerns-for-prisoners-in-iran-amid-coronavirus-outbreak/.

[3] Joseph Konig and Ben Feuerherd, "First Rikers Inmate Tests Positive for Coronavirus" New York Post. March 18, 2020, available at: https://nypost.com/2020/03/18/first-rikers-island-inmate-tests-positive-for-coronavirus/

[4] Sam Tabachnik, "Ten detainees at Aurora's ICE detention facility isolated for possible exposure to coronavirus," *The Denver Post*, March 17, 2020, available at https://www.denverpost.com/2020/03/17/coronavirus-ice-detention-geo-group-aurora-colorado/.

[5] Emily Kassie, "First ICE Employees Test Positive for Coronavirus," *The Marshall Project*, March 19, 2020, available at https://www.themarshallproject.org/2020/03/19/first-ice-employees-test-positive-for-coronavirus

work with DHS in light of our shared obligation to protect the health, safety, and civil rights of detainees under DHS's care. Additionally, on March 17, 2020 we published an opinion piece in the *Washington Post* warning of the need to act immediately to stem the spread of the coronavirus in jails and prisons in order to protect not only the health of prisoners and corrections workers, but the public at large.[6]

In the piece we noted the parallel risks in immigration detention. We are writing now to formally share our concerns about the imminent risk to the health and safety of immigrant detainees, as well as to the public at large, that is a direct consequence of detaining populations in congregate settings. We also offer to Congress, as we have to CRCL, our support and assistance in addressing the public health challenges that must be confronted as proactively as possible to mitigate the spread of the coronavirus both in, and through, immigration detention and congregate settings.

Nature of the Risk in Immigration Detention and Congregate Settings

One of the risks of detention of immigrants in congregant settings is the rapid spread of infectious diseases. Although much is still unknown, the case-fatality rate (number of infected patients who will die from the disease) and rate of spread for COVID-19 appears to be as high or higher than that for influenza or varicella (chicken pox).

In addition to spread within detention facilities, the **extensive transfer of individuals** (who are often without symptoms) throughout the detention system, which occurs with great frequency in the immigration context, could rapidly disseminate the virus throughout the entire system with devastating consequences to public health.[7]

Anyone can get a coronavirus infection. While healthy children appear to suffer mildly if they contract COVID-19, they still pose risk as carriers of infection, particularly so because they may not display symptoms of illness.[8] Family detention continues to struggle with managing outbreaks of influenza and varicella.[9] Notably, seven children who have died in and around

---

[6] Josiah Rich, Scott Allen, and Mavis Nimoh, "We must release prisoners to lessen the spread of coronavirus," *Washington Post*, March 17, 2020, available at https://www.washingtonpost.com/opinions/2020/03/17/we-must-release-prisoners-lessen-spread-coronavirus/.

[7] See Hamed Aleaziz, "A Local Sheriff Said No To More Immigrant Detainees Because of Coronavirus Fears. So ICE Transferred Them All To New Facilities," *BuzzFeed News*, March 18, 2020 (ICE recently transferred170 immigrant detainees from Wisconsin to facilities in Texas and Illinois. "'In order to accommodate various operational demands, ICE routinely transfers detainees within its detention network based on available resources and the needs of the agency…' an ICE official said in a statement."), available at https://www.buzzfeednews.com/article/hamedaleaziz/wisconsin-sheriff-ice-detainees-coronavirus

[8] Interview with Jay C. Butler, MD, Deputy Director for Infectious Diseases, Centers for Disease Control and Prevention, "Coronovirus (COVID-19) Testing," *JAMA Network*, March 16, 2020, available at https://youtu.be/oGiOi7eV05g (min 19:00).

[9] Indeed, I (Dr. Allen) raised concerns to CRCL, the DHS Office of Inspector General, and to Congress in July 2018, along with my colleague Dr. Pamela McPherson, about the risks if harm to immigrant children in family detention centers because of specific systemic weaknesses at those facilities in their ability to provide for the medical and mental health needs of children in detention. *See*, e.g., July 17, 2018 Letter to Senate Whistleblower Caucus Chairs from Drs. Scott Allen and Pamela McPherson, available at https://www.wyden.senate.gov/imo/media/doc/Doctors%20Congressional%20Disclosure%20SWC.pdf. Those concerns, including but not limited to inadequate medical staffing, a lack of translation services, and the risk of

immigration detention, according to press reports, six died of infectious disease, including three deaths from influenza.[10] Containing the spread of an infection in a congregate facility housing families creates the conditions where many of those infected children who do not manifest symptoms will unavoidably spread the virus to older family members who may be a higher risk of serious illness.

Finally, as you well know, social distancing is essential to slow the spread of the coronavirus to minimize the risk of infection and to try to reduce the number of those needing medical treatment from the already-overwhelmed and inadequately prepared health care providers and facilities. However, social distancing is an oxymoron in congregate settings, which because of the concentration of people in a close area with limited options for creating distance between detainees, are at very high risk for an outbreak of infectious disease. This then creates an enormous public health risk, not only because disease can spread so quickly, but because those who contract COVID-19 with symptoms that require medical intervention will need to be treated at local hospitals, thus increasing the risk of infection to the public at large and overwhelming treatment facilities.

As local hospital systems become overwhelmed by the patient flow from detention center outbreaks, precious health resources will be less available for people in the community.To be more explicit, a detention center with a rapid outbreak could result in multiple detainees—five, ten or more—being sent to the local community hospital where there may only be six or eight ventilators over a very short period. As they fill up and overwhelm the ventilator resources, those ventilators are unavailable when the infection inevitably is carried by staff to the community and are also unavailable for all the usual critical illnesses (heart attacks, trauma, etc). In the alternate scenario where detainees are released from high risk congregate settings, the tinderbox scenario of a large cohort of people getting sick all at once is less likely to occur, and the peak volume of patients hitting the community hospital would level out. In the first scenario, many people from the detention center *and the community* die unnecessarily for want of a ventilator. In the latter, survival is maximized as the local mass outbreak scenario is averted.

It is additionally concerning that dozens of immigration detention centers are in remote areas with limited access to health care facilities. Many facilities, because of the rural locations, have only one on-site medical provider. If that provider gets sick and requires being quarantined for at least fourteen days, the entire facility could be without any medical providers at all during a foreseeable outbreak of a rapidly infectious disease. We simply can’t afford a drain on resources/medical personnel from any preventable cases.

---

communication breakdowns and confusion that results from different lines of authority needing to coordinate between various agencies and partners from different government programs and departments responsible for detention programs with rapid turnover, all continue to contribute to heightened risks to meeting the medical challenges posed by the spread of the coronavirus.

[10] Nicole Acevedo, “Why are children dying in U.S. custody?,” *NBC News*, May 29, 2019, available at https://www.nbcnews.com/news/latino/why-are-migrant-children-dying-u-s-custody-n1010316

Proactive Approaches Required

Before coronavirus spreads through immigration detention, proactivity is required in three primary areas: 1) Processes for screening, testing, isolation and quarantine; 2) Limiting transport and transfer of immigrant detainees; and 3) Implementing alternatives to detention to facilitate as much social distancing as possible.

Protocols for early screening, testing, isolation and quarantine exist in detention settings to address infectious diseases such as influenza, chicken pox and measles. However, the track record of ICE facilities implementing these protocols historically has been inconsistent. In the current scenario, with widespread reporting about the lack of available tests for COVID-19 and challenges for screening given the late-onset display of symptoms for what is now a community-spread illness, detention facilities, like the rest of country, are already behind the curve for this stage of mitigation.

Detention facilities will need to rapidly identify cases and develop plans to isolate exposed cohorts to limit the spread, as well as transfer ill patients to appropriate facilities. Screening should occur as early as possible after apprehension (including at border holding facilities) to prevent introduction of the virus into detention centers. We strongly recommend ongoing consultation with CDC and public health officials to forge optimal infection prevention and control strategies to mitigate the health risks to detained patient populations and correctional workers. Any outbreak in a facility could rapidly overwhelm the capacity of healthcare programs. Partnerships with local public health agencies, hospitals and clinics, including joint planning exercises and preparedness drills, will be necessary.

Transferring detainees between facilities should be kept to an absolute minimum. The transfer process puts the immigrants being transferred, populations in the new facilities, and personnel all at increased risk of exposure. The nationwide network of detention centers, where frequent and routine inter-facility transfers occur, represents a frighteningly efficient mechanism for rapid spread of the virus to otherwise remote areas of the country where many detention centers are housed.

Finally, regarding the need to implement immediate social distancing to reduce the likelihood of exposure to detainees, facility personnel, and the general public, ***it is essential to consider releasing all detainees who do not pose an immediate risk to public safety.***

Congregant settings have a high risk of rapid spread of infectious diseases, and wherever possible, public health mitigation efforts involve moving people out of congregate settings (as we are seeing with colleges and universities and K-12 schools).[11] Minimally, DHS should consider releasing all detainees in high risk medical groups such as older people and those with

---

[11] Madeline Holcombe, "Some schools closed for coronavirus in US are not going back for the rest of the academic year," *CNN*, March 18, 2020, available at https://www.cnn.com/2020/03/18/us/coronavirus-schools-not-going-back-year/index.html; Eric Levenson, Chris Boyette and Janine Mack, "Colleges and universities across the US are canceling in-person classes due to coronavirus," *CNN*, March 12, 2020, available at https://www.cnn.com/2020/03/09/us/coronavirus-university-college-classes/index.html.

chronic diseases. COVID-19 infection among these groups will require many to be transferred to local hospitals for intensive medical and ventilator care—highly expensive interventions that may soon be in short supply.

Given the already established risks of adverse health consequences associated with the detention of children and their families,[12] the policy of detention of children and their families in should be reconsidered in light of these new infectious disease threats so that children would only be placed in congregate detention settings when lower risk community settings are not available and then for as brief a time as possible.

In addition, given the low risk of releasing detainees who do not pose a threat to public safety—i.e., those only charged with immigration violations—releasing *all* immigration detainees who do not pose a security risk should be seriously considered in the national effort to stop the spread of the coronavirus.

Similarly, the practice of forcing asylum seekers to remain in Mexico has created a *de facto* congregate setting for immigrants, since large groups of people are concentrated on the US southern border as a result of the MPP program in the worst of hygienic conditions without any basic public health infrastructure or access to medical facilities or the ability to engage in social distancing as they await asylum hearings, which are currently on hold as a consequence of the government's response to stop the spread of the coronavirus.[13] This is a tinderbox that cannot be ignored in the national strategy to slow the spread of infection.

ICE recently announced that in response to the coronavirus pandemic, it will delay arresting immigrants who do not pose public safety threats, and will also stop detaining immigrants who fall outside of mandatory detention guidelines.[14] But with reporting that immigrant detainees at ICE facilities are already being isolated for possible exposure to coronavirus, it is not enough to simply stop adding to the existing population of immigrant detainees. Social distancing through release is necessary to slow transmission of infection.[15]

Reassessing the security and public health risks, and acting immediately, will save lives of not only those detained, but also detention staff and their families, and the community-at-large.

---

[12] Report of the DHS Advisory Committee on Family Residential Centers, September 30, 2016, available at https://www.ice.gov/sites/default/files/documents/Report/2016/ACFRC-sc16093.pdf

[13] *See* Rick Jervis, "Migrants waiting at US-Mexico border at risk of coronavirus, health experts warn," *USA Today*, March 17, 2020, available at https://www.usatoday.com/story/news/nation/2020/03/17/us-border-could-hit-hard-coronavirus-migrants-wait-mexico/5062446002/.

[14] ICE website, Guidance on COVID-19, Immigration and Enforcement Check-Ins, Updated March 18, 2020, 7:45 pm, available at https://www.ice.gov/covid19.

[15] Release of immigrants from detention to control the coronavirus outbreak has been recommended by John Sandweg, former acting head of ICE during the Obama administration, who further noted, "'The overwhelming majority of people in ICE detention don't pose a threat to public safety and are not an unmanageable flight risk.'…'Unlike the Federal Bureau of Prisons, ICE has complete control over the release of individuals. ICE is not carrying out the sentence imposed by a federal judge….It has 100% discretion.'" *See* Camilo Montoya-Galvez, "'Powder kegs': Calls grow for ICE to release immigrants to avoid coronavirus outbreak, *CBS News*, March 19, 2020, available at https://www.cbsnews.com/news/coronavirus-ice-release-immigrants-detention-outbreak/.

Our legal counsel, Dana Gold of the Government Accountability Project, is supporting and coordinating our efforts to share our concerns with Congress and other oversight entities about the substantial and specific threats to public health and safety the coronavirus poses by congregate settings for immigrants. As we similarly offered to DHS, we stand ready to aid you in any way to mitigate this crisis and prevent its escalation in light of our unique expertise in detention health and experience with ICE detention specifically. Please contact our attorney, Dana Gold, at danag@whistleblower.org, or her colleague, Irvin McCullough, at irvinm@whistleblower.org, with any questions.

Sincerely,

/s/

Scott A. Allen, MD, FACP
Professor Emeritus, University of California, School of Medicine
Medical Subject Matter Expert, CRCL, DHS

/s/

Josiah D. Rich, MD, MPH
Professor of Medicine and Epidemiology
The Warren Alpert Medical School of Brown University
Medical Subject Matter Expert, CRCL, DHS

Cc: Dana Gold, Esq. and Irvin McCullough, Government Accountability Project
Senate Committee on the Judiciary
House Committee on the Judiciary
White House Coronavirus Task Force

Declaration of Dr. Jaimie Meyer

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

I. Background and Qualifications

1. I am Dr. Jaimie Meyer, an Assistant Professor of Medicine at Yale School of Medicine and Assistant Clinical Professor of Nursing at Yale School of Nursing in New Haven, Connecticut. I am board certified in Internal Medicine, Infectious Diseases and Addiction Medicine. I completed my residency in Internal Medicine at NY Presbyterian Hospital at Columbia, New York, in 2008. I completed a fellowship in clinical Infectious Diseases at Yale School of Medicine in 2011 and a fellowship in Interdisciplinary HIV Prevention at the Center for Interdisciplinary Research on AIDS in 2012. I hold a Master of Science in Biostatistics and Epidemiology from Yale School of Public Health.

2. I have worked for over a decade on infectious diseases in the context of jails and prisons. From 2008-2016, I served as the Infectious Disease physician for York Correctional Institution in Niantic, Connecticut, which is the only state jail and prison for women in Connecticut. In that capacity, I was responsible for the management of HIV, Hepatitis C, tuberculosis, and other infectious diseases in the facility. Since then, I have maintained a dedicated HIV clinic in the community for patients returning home from prison and jail. For over a decade, I have been continuously funded by the NIH, industry, and foundations for clinical research on HIV prevention and treatment for people involved in the criminal justice system, including those incarcerated in closed settings (jails and prisons) and in the community under supervision (probation and parole). I have served as an expert consultant on infectious diseases and women's health in jails and prisons for the UN Office on Drugs and Crimes, the Federal Bureau of Prisons, and others. I also served as an expert health witness for the US Commission on Civil Rights Special Briefing on Women in Prison.

3. I have written and published extensively on the topics of infectious diseases among people involved in the criminal justice system including book chapters and articles in leading peer-reviewed journals (including Lancet HIV, JAMA Internal Medicine, American Journal of Public Health, International Journal of Drug Policy) on issues of prevention, diagnosis, and management of HIV, Hepatitis C, and other infectious diseases among people involved in the criminal justice system.

4. My C.V. includes a full list of my honors, experience, and publications, and it is attached as Exhibit A.

5. I am being paid $1,000 for my time reviewing materials and preparing this report.

6. I have not testified as an expert at trial or by deposition in the past four years.

II. Heightened Risk of Epidemics in Jails and Prisons

Case 1:20-cv-01803-AKH Document 1-42 Filed 03/31/20 Page 2 of 23

7. The risk posed by infectious diseases in jails and prisons is significantly higher than in the community, both in terms of risk of transmission, exposure, and harm to individuals who become infected. There are several reasons this is the case, as delineated further below.

8. Globally, outbreaks of contagious diseases are all too common in closed detention settings and are more common than in the community at large. Prisons and jails are not isolated from communities. Staff, visitors, contractors, and vendors pass between communities and facilities and can bring infectious diseases into facilities. Moreover, rapid turnover of jail and prison populations means that people often cycle between facilities and communities. People often need to be transported to and from facilities to attend court and move between facilities. Prison health is public health.

9. <u>Reduced prevention opportunities:</u> Congregate settings such as jails and prisons allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When people must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater. When infectious diseases are transmitted from person to person by droplets, the best initial strategy is to practice social distancing. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community. Spaces within jails and prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Placing someone in such a setting therefore dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases.

10. <u>Disciplinary segregation or solitary confinement is not an effective disease containment strategy.</u> Beyond the known detrimental mental health effects of solitary confinement, isolation of people who are ill in solitary confinement results in decreased medical attention and increased risk of death. Isolation of people who are ill using solitary confinement also is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms (rarely in medical units if available at all), air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other people in prison and staff.

11. <u>Reduced prevention opportunities:</u> During an infectious disease outbreak, people can protect themselves by washing hands. Jails and prisons do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. Jails and prisons are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for people detained in and working in these settings. High-touch surfaces (doorknobs, light switches, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but this is often not done in jails and prisons because of a lack of cleaning supplies and lack of people available to perform necessary cleaning procedures.

12. <u>Reduced prevention opportunities:</u> During an infectious disease outbreak, a containment strategy requires people who are ill with symptoms to be isolated and that caregivers have

access to personal protective equipment, including gloves, masks, gowns, and eye shields. Jails and prisons are often under-resourced and ill-equipped to provide sufficient personal protective equipment for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak.

13. Increased susceptibility: People incarcerated in jails and prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community.[1] This is because people in jails and prisons are more likely than people in the community to have chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and lower immune systems from HIV.

14. Jails and prisons are often poorly equipped to diagnose and manage infectious disease outbreaks. Some jails and prisons lack onsite medical facilities or 24-hour medical care. The medical facilities at jails and prisons are almost never sufficiently equipped to handle large outbreaks of infectious diseases. To prevent transmission of droplet-borne infectious diseases, people who are infected and ill need to be isolated in specialized airborne negative pressure rooms. Most jails and prisons have few negative pressure rooms if any, and these may be already in use by people with other conditions (including tuberculosis or influenza). Resources will become exhausted rapidly and any beds available will soon be at capacity. This makes both containing the illness and caring for those who have become infected much more difficult.

15. Jails and prisons lack access to vital community resources to diagnose and manage infectious diseases. Jails and prisons do not have access to community health resources that can be crucial in identifying and managing widespread outbreaks of infectious diseases. This includes access to testing equipment, laboratories, and medications.

16. Jails and prisons often need to rely on outside facilities (hospitals, emergency departments) to provide intensive medical care given that the level of care they can provide in the facility itself is typically relatively limited. During an epidemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves.

17. Health safety: As an outbreak spreads through jails, prisons, and communities, medical personnel become sick and do not show up to work. Absenteeism means that facilities can become dangerously understaffed with healthcare providers. This increases a number of risks and can dramatically reduce the level of care provided. As health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these conditions. As supply chains become disrupted during a global pandemic, the availability of medicines and food may be limited.

18. Safety and security: As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to

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

work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public.

19. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities in Maine, resulting in two inmate deaths.[2] Subsequent CDC investigation of 995 inmates and 235 staff members across the 2 facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the H1N1-strain flu outbreak in 2009 (known as the "swine flu"), jails and prisons experienced a disproportionately high number of cases.[3] Even facilities on "quarantine" continued to accept new intakes, rendering the quarantine incomplete. These scenarios occurred in the "best case" of influenza, a viral infection for which there was an effective and available vaccine and antiviral medications, unlike COVID-19, for which there is currently neither.

III. Profile of COVID-19 as an Infectious Disease[4]

20. The novel coronavirus, officially known as SARS-CoV-2, causes a disease known as COVID-19. The virus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but may also survive on inanimate surfaces. People seem to be most able to transmit the virus to others when they are sickest but it is possible that people can transmit the virus before they start to show symptoms or for weeks after their symptoms resolve. In China, where COVID-19 originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of infection because our immune systems have never been exposed to or developed protective responses against this virus. A vaccine is currently in development but will likely not be able for another year to the general public. Antiviral medications are currently in testing but not yet FDA-approved, so only available for compassionate use from the manufacturer. People in prison and jail will likely have even less access to these novel health strategies as they become available.

---

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

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

[4] This whole section draws from Brooks J. Global Epidemiology and Prevention of COVID19, COVID-19 Symposium, Conference on Retroviruses and Opportunistic Infections (CROI), virtual (March 10, 2020); *Coronavirus (COVID-19)*, Centers for Disease Control, https://www.cdc.gov/coronavirus/2019-ncov/index.html; Brent Gibson, *COVID-19 (Coronavirus): What You Need to Know in Corrections*, National Commission on Correctional Health Care (February 28, 2020), https://www.ncchc.org/blog/covid-19-coronavirus-what-you-need-to-know-in-corrections.

Case 1:20-cv-01803-AKH Document 1-42 Filed 03/16/20 Page 5 of 23

21. Most people (80%) who become infected with COVID-19 will develop a mild upper respiratory infection but emerging data from China suggests serious illness occurs in up to 16% of cases, including death.[5] Serious illness and death is most common among people with underlying chronic health conditions, like heart disease, lung disease, liver disease, and diabetes, and older age.[6] Death in COVID-19 infection is usually due to pneumonia and sepsis. The emergence of COVID-19 during influenza season means that people are also at risk from serious illness and death due to influenza, especially when they have not received the influenza vaccine or the pneumonia vaccine.

22. The care of people who are infected with COVID-19 depends on how seriously they are ill.[7] People with mild symptoms may not require hospitalization but may continue to be closely monitored at home. People with moderate symptoms may require hospitalization for supportive care, including intravenous fluids and supplemental oxygen. People with severe symptoms may require ventilation and intravenous antibiotics. Public health officials anticipate that hospital settings will likely be overwhelmed and beyond capacity to provide this type of intensive care as COVID-19 becomes more widespread in communities.

23. COVID-19 prevention strategies include containment and mitigation. Containment requires intensive hand washing practices, decontamination and aggressive cleaning of surfaces, and identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment. Jails and prisons are totally under-resourced to meet the demand for any of these strategies. As infectious diseases spread in the community, public health demands mitigation strategies, which involves social distancing and closing other communal spaces (schools, workplaces, etc.) to protect those most vulnerable to disease. Jails and prisons are unable to adequately provide social distancing or meet mitigation recommendations as described above.

24. The time to act is now. Data from other settings demonstrate what happens when jails and prisons are unprepared for COVID-19. News outlets reported that Iran temporarily released 70,000 prisoners when COVID-19 started to sweep its facilities.[8] To date, few state or federal prison systems have adequate (or any) pandemic preparedness plans in

---

[5] *Coronavirus Disease 2019 (COVID-19): Situation Summary*, Centers for Disease Control and Prevention (March 14, 2020), https://www.cdc.gov/coronavirus/2019-ncov/summary.html.
[6] *Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study.* The Lancet (published online March 11, 2020), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext
[7] *Coronavirus Disease 2019 (COVID-19): Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease*, Centers for Disease Control and Prevention (March 7, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.
[8] *Iran temporarily releases 70,000 prisoners as coronavirus cases surge*, Reuters (March 9, 2020), https://www.reuters.com/article/us-health-coronavirus-iran/iran-temporarily-releases-70000-prisoners-as-coronavirus-cases-surge-idUSKBN20W1E5.

Case 1:20-cv-10786 Document 4-42 Filed 03/21/20 Page 6 of 23

place.[9] Systems are just beginning to screen and isolate people on entry and perhaps place visitor restrictions, but this is wholly inadequate when staff and vendors can still come to work sick and potentially transmit the virus to others.

IV. Risk of COVID-19 in ICE's NYC-Area Detention Facilities

25. I have reviewed the following materials in making my assessment of the danger of COVID-19 in the Bergen, Essex, Hudson, and Orange County jails ("ICE's NYC-area jails"): (1) a declaration by Marinda van Dalen, a Senior Attorney in the Health Justice Program at New York Lawyers for the Public Interest (NYLPI); (2) the report *Detained and Denied: Healthcare Access in Immigration Detention*, released by NYLPI in 2017; and (3) the report *Ailing Justice*: *New Jersey*, *Inadequate Healthcare, Indifference, and Indefinite Confinement in Immigration Detention*, released by Human Rights First in 2018.

26. Based on my review of these materials, my experience working on public health in jails and prisons, and my review of the relevant literature, it is my professional judgment that these facilities are dangerously under-equipped and ill-prepared to prevent and manage a COVID-19 outbreak, which would result in severe harm to detained individuals, jail and prison staff, and the broader community. The reasons for this conclusion are detailed as follows.

27. The delays in access to care that already exist in normal circumstances will only become worse during an outbreak, making it especially difficult for the facilities to contain any infections and to treat those who are infected.

28. Failure to provide individuals with continuation of the treatment they were receiving in the community, or even just interruption of treatment, for chronic underlying health conditions will result in increased risk of morbidity and mortality related to these chronic conditions.

29. Failure to provide individuals adequate medical care for their underlying chronic health conditions results in increased risk of COVID-19 infection and increased risk of infection-related morbidity and mortality if they do become infected.

30. People with underlying chronic mental health conditions need adequate access to treatment for these conditions throughout their period of detention. Failure to provide adequate mental health care, as may happen when health systems in jails and prisons are taxed by COVID-19 outbreaks, may result in poor health outcomes. Moreover, mental health conditions may be exacerbated by the stress of incarceration during the COVID-19 pandemic, including isolation and lack of visitation.

---

[9] Luke Barr & Christina Carrega, *State prisons prepare for coronavirus but federal prisons not providing significant guidance, sources say*, ABC News (March 11, 2020), https://abcnews.go.com/US/state-prisons-prepare-coronavirus-federal-prisons-providing-significant/story?id=69433690.

31. Failure to keep accurate and sufficient medical records will make it more difficult for the facilities to identify vulnerable individuals in order to both monitor their health and protect them from infection. Inadequate screening and testing procedures in facilities increase the widespread COVID-19 transmission.

32. Language barriers will similarly prevent the effective identification of individuals who are particularly vulnerable or may have symptoms of COVID-19. Similarly, the failure to provide necessary aids to individuals who have auditory or visual disabilities could also limit the ability to identify and monitor symptoms of COVID-19.

33. The commonplace neglect of individuals with acute pain and serious health needs under ordinary circumstances is also strongly indicative that the facilities will be ill-equipped to identify, monitor, and treat a COVID-19 epidemic.

34. The failure of these facilities to adequately manage single individuals in need of emergency care is a strong sign that they will be seriously ill-equipped and under-prepared when a number of people will need urgent care simultaneously, as would occur during a COVID-19 epidemic.

35. For individuals in these facilities, the experience of an epidemic and the lack of care while effectively trapped can itself be traumatizing, compounding the trauma of incarceration.

V. Conclusion and Recommendations

36. For the reasons above, it is my professional judgment that individuals placed in ICE's NYC-area jails are at a significantly higher risk of infection with COVID-19 as compared to the population in the community and that they are at a significantly higher risk of harm if they do become infected. These harms include serious illness (pneumonia and sepsis) and even death.

37. Reducing the size of the population in jails and prisons can be crucially important to reducing the level of risk both for those within those facilities and for the community at large.

38. As such, from a public health perspective, it is my strong opinion that individuals who can safely and appropriately remain in the community not be placed in ICE's NYC-area jails at this time. I am also strongly of the opinion that individuals who are already in those facilities should be evaluated for release.

39. This is more important still for individuals with preexisting conditions (e.g., heart disease, chronic lung disease, chronic liver disease, suppressed immune system, diabetes) or who are over the age of 60. They are in even greater danger in these facilities, including a meaningfully higher risk of death.

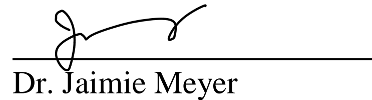
40. It is my professional opinion that these steps are both necessary and urgent. The horizon of risk for COVID-19 in these facilities is a matter of days, not weeks. Once a case of

COVID-19 identified in a facility, it will likely be too late to prevent a widespread outbreak.

41. Health in jails and prisons is community health. Protecting the health of individuals who are detained in and work in these facilities is vital to protecting the health of the wider community.

I declare under penalty of perjury that the foregoing is true and correct.

March 15, 2020
New Haven, Connecticut



Dr. Jaimie Meyer

Case 1:20-cv-01803-AKH Document 1-42 Filed 03/16/20 Page 9 of 23

EXHIBIT A

CURRICULUM VITAE

Date of Revision: November 20, 2019
Name: Jaimie Meyer, MD, MS, FACP
School: Yale School of Medicine

Education:

BA, Dartmouth College Anthropology 2000
MD, University of Connecticut School of Medicine 2005
MS, Yale School of Public Health Biostatistics and Epidemiology 2014

Career/Academic Appointments:

2005 - 2008	Residency, Internal Medicine, NY Presbyterian Hospital at Columbia, New York, NY
2008 - 2011	Fellowship, Infectious Diseases, Yale University School of Medicine, New Haven, CT
2008 - 2012	Clinical Fellow, Infectious Diseases, Yale School of Medicine, New Haven, CT
2010 - 2012	Fellowship, Interdisciplinary HIV Prevention, Center for Interdisciplinary Research on AIDS, New Haven, CT
2012 - 2014	Instructor, AIDS, Yale School of Medicine, New Haven, CT
2014 - present	Assistant Professor, AIDS, Yale School of Medicine, New Haven, CT
2015 - 2018	Assistant Clinical Professor, Nursing, Yale School of Medicine, New Haven, CT

Board Certification:

AB of Internal Medicine, Internal Medicine, 08-2008, 01-2019
AB of Internal Medicine, Infectious Disease, 10-2010
AB of Preventive Medicine, Addiction Medicine, 01-2018

Professional Honors & Recognition:

International/National/Regional

2018	NIH Center for Scientific Review, Selected as Early Career Reviewer
2017	Doris Duke Charitable Foundation, Doris Duke Charitable Foundation Scholar
2016	American College of Physicians, Fellow
2016	NIH Health Disparities, Loan Repayment Award Competitive Renewal
2016	AAMC, Early Career Women Faculty Professional Development Seminar
2014	NIH Health Disparities, Loan Repayment Program Award
2014	NIDA, Women & Sex/Gender Differences Junior Investigator Travel Award
2014	International Women's/Children's Health & Gender Working Group, Travel Award
2014	Patterson Trust, Awards Program in Clinical Research
2013	Connecticut Infectious Disease Society, Thornton Award for Clinical Research
2011	Bristol Myers-Squibb, Virology Fellows Award

2006 NY Columbia Presbyterian, John N. Loeb Intern Award
2005 American Medical Women's Association, Medical Student Citation
2005 Connecticut State Medical Society, Medical Student Award
2000 Dartmouth College, Hannah Croasdale Senior Award
2000 Dartmouth College, Palaeopitus Senior Leadership Society Inductee

Yale University
2014 Women's Faculty Forum, Public Voices Thought Leadership Program Fellow

Grants/Clinical Trials History:

Current Grants

Agency: Center for Interdisciplinary Research on AIDS (CIRA)
I.D.#: 2019-20 Pilot Project Awards
Title: Optimizing PrEP's Potential in Non-Clinical Settings: Development and Evaluation of a PrEP Decision Aid for Women Seeking Domestic Violence Services
P.I.: Tiara Willie
Role: Principal Investigator
Percent effort: 2%
Direct costs per year: $29,993.00
Total costs for project period: $29,993.00
Project period: 7/11/2019 - 7/10/2020

Agency: SAMHSA
I.D.#: H79 TI080561
Title: CHANGE: Comprehensive Housing and Addiction Management Network for Greater New Haven
Role: Principal Investigator
Percent effort: 20%
Direct costs per year: $389,054.00
Total costs for project period: $1,933,368.00
Project period: 11/30/2018 - 11/29/2023

Agency: Gilead Sciences, Inc.
I.D.#: Investigator Sponsored Award, CO-US-276-D136
Title: Delivering HIV Pre-Exposure Prophylaxis to Networks of Justice-Involved Women
Role: Principal Investigator
Percent effort: 8%
Direct costs per year: $81,151.00
Total costs for project

period: $306,199.00
Project period: 6/19/2018 - 1/31/2020

Agency: NIDA
I.D.#: R21 DA042702
Title: Prisons, Drug Injection and the HIV Risk Environment
Role: Principal Investigator
Percent effort: 22%
Direct costs per year: $129,673.00
Total costs for project period: $358,276.00
Project period: 8/1/2017 - 7/31/2020

Agency: Doris Duke Charitable Foundation
I.D.#: Clinical Scientist Development Award
Title: Developing and Testing the Effect of a Patient-Centered HIV Prevention Decision Aid on PrEP uptake for Women with Substance Use in Treatment Settings
Role: Principal Investigator
Percent effort: 27%
Direct costs per year: $149,959.00
Total costs for project period: $493,965.00
Project period: 7/1/2017 - 6/30/2020

Past Grants

Agency: NIDA
I.D.#: K23 DA033858
Title: Evaluating and Improving HIV Outcomes in Community-based Women who Interface with the Criminal Justice System
Role: Principal Investigator
Percent effort: 75%
Direct costs per year: $149,509.00
Total costs for project period: $821,147.00
Project period: 7/1/2012 - 11/30/2017

Agency: Robert Leet & Clara Guthrie Patterson Trust
I.D.#: R12225, Award in Clinical Research
Title: Disentangling the Effect of Gender on HIV Treatment and Criminal Justice Outcomes
Role: Principal Investigator
Percent effort: 10%
Direct costs per year: $75,000.00

Total costs for project period: $75,000.00
Project period: 1/31/2014 - 10/31/2015

Agency: Bristol-Myers Squibb
I.D.#: HIV Virology Fellowship Award
Title: Effect of newer antiretroviral regimens on HIV biological outcomes in HIV-infected prisoners: a 13 year retrospective evaluation
Role: Principal Investigator
Percent effort: 10%
Direct costs per year: $34,390.00
Total costs for project period: $34,390.00
Project period: 12/1/2011 - 11/30/2012

Pending Grants

Agency: NIMH
I.D.#: R01 MH121991
Title: Identifying Modifiable Risk and Protective Processes at the Day-Level that Predict HIV Care Outcomes among Women Exposed to Partner Violence
P.I.: Sullivan, Tami
Role: Principal Investigator
Percent effort: 30%
Direct costs per year: $499,755.00
Total costs for project period: $4,148,823.00
Project period: 1/1/2020 - 12/31/2024

Invited Speaking Engagements, Presentations, Symposia & Workshops Not Affiliated With Yale:

International/National

2019: CME Outfitters, Washington, DC. "A Grassroots Approach to Weed out HIV and HCV in Special OUD Populations"
2019: US Commission on Civil Rights, Washington, DC. "An Analysis of Women's Health, Personal Dignity and Sexual Abuse in the US Prison System"
2018: College of Problems on Drug Dependence, College of Problems on Drug Dependence, San Diego, CA. "Research on Women who Use Drugs: Knowledge and Implementation Gaps and A Proposed Research Agenda"
2018: Clinical Care Options, Washington, DC. "Intersection of the HIV and Opioid Epidemics"
2016: Dartmouth Geisel School of Medicine, Hanover, NH. "Incarceration as Opportunity: Prisoner Health and Health Interventions"
2010: Rhode Island Chapter of the Association of Nurses in AIDS Care, Providence, RI. "HIV and Addiction"

Regional

2018: Clinical Directors Network, New York, NY. "PrEP Awareness among Special Populations of Women and People who Use Drugs"

2018: Frank H. Netter School of Medicine, Quinnipiac University, Hamden, CT. "HIV prevention for justice-involved women"

2017: Clinical Directors Network, New York, NY. "Optimizing the HIV Care Continuum for People who use Drugs"

2016: Frank H. Netter School of Medicine, Quinnipiac University, Hamden, CT. "Topics in Infectious Diseases"

2016: Connecticut Advanced Practice Registered Nurse Society, Wethersfield, CT. "Trends in HIV Prevention: Integration of Biomedical and Behavioral Approaches"

Peer-Reviewed Presentations & Symposia Given at Meetings Not Affiliated With Yale:

International/National

2019: CPDD 81st Annual Scientific Meeting, CPDD, San Antonio, TX. "Punitive approaches to pregnant women with opioid use disorder: Impact on health care utilization, outcomes and ethical implications"

2019: 14th International Conference on HIV Treatment and Prevention Adherence, IAPAC Adherence, Miami, FL. "Decision-Making about HIV Prevention among Women in Drug Treatment: Is PrEP Contextually Relevant?"

2019: 2019 NIDA International Forum, NIDA, San Antonio, TX. "Diphenhydramine Injection in Kyrgyz Prisons: A Qualitative Study Of A High-Risk Behavior With Implications For Harm Reduction"

2019: 11th International Women's and Children's Health and Gender (InWomen's) Group, InWomen's Group, San Antonio, TX. "Uniquely successful implementation of methadone treatment in a women's prison in Kyrgyzstan"

2019: Harm Reduction International, Porto, Porto District, Portugal. "How does methadone treatment travel? On the 'becoming-methadone-body' of Kyrgyzstan prisons"

2019: APA Collaborative Perspectives on Addiction Annual Meeting, APA Collaborative Perspectives on Addiction Annual Meeting, Providence, RI. "Impact of Trauma and Substance Abuse on HIV PrEP Outcomes among Women in Criminal Justice Systems. Symposium: "Partner Violence: Intersected with or Predictive of Substance Use and Health Problems among Women.""

2019: Society for Academic Emergency Medicine (SAEM), Worcester, MA. "Effects of a Multisite Medical Home Intervention on Emergency Department Use among Unstably Housed People with Human Immunodeficiency Virus"

2019: Conference on Retroviruses and Opportunistic Infections (CROI), IAS, Seattle, WA. "Released to Die: Elevated Mortality in People with HIV after Incarceration"

2019: 12th Academic and Health Policy on Conference on Correctional Health, 12th Academic and Health Policy on Conference on Correctional Health, Las Vegas, NV. "PrEP Eligibility and HIV Risk Perception for Women across the Criminal Justice Continuum in Connecticut"

2019: Association for Justice-Involved Female Organizations (AJFO), Atlanta, GA. "Treatment of Women's Substance Use Disorders and HIV Prevention During and Following Incarceration"

2018: American Public Health Association (APHA) Annual Meeting, American Public Health Association (APHA) Annual Meeting, San Diego, CA. "New Haven Syringe Service Program: A model of integrated harm reduction and health care services"

2018: 12th National Harm Reduction Conference, 12th National Harm Reduction Conference, New Orleans, LA. "Service needs and access to care among participants in the New Haven Syringe Services Program"

2018: 22nd International AIDS Conference, 22nd International AIDS Conference, Amsterdam, NH, Netherlands. "HIV risk perceptions and risk reduction strategies among prisoners in Kyrgyzstan: a qualitative study"

2018: 22nd International AIDS Conference, 22nd International AIDS Conference, Amsterdam, NH, Netherlands. "Methadone Maintenance Therapy Uptake, Retention, and Linkage for People who Inject Drugs Transitioning From Prison to the Community in Kyrgyzstan: Evaluation of a National Program"

2018: NIDA International Forum, NIDA, San Diego, CA. "HIV and Drug Use among Women in Prison in Azerbaijan, Kyrgyzstan and Ukraine"

2018: 2018 Conference on Retroviruses and Opportunistic Infections (CROI), CROI, Boston, MA. "From prison's gate to death's door: Survival analysis of released prisoners with HIV"

2018: 11th Academic and Health Policy on Conference on Correctional Health, Academic Consortium on Criminal Justice Health, Houston, TX. "Assessing Concurrent Validity of Criminogenic and Health Risk Instruments among Women on Probation in Connecticut"

2017: IDWeek: Annual Meeting of Infectious Diseases Society of America, Infectious Diseases Society of America, San Diego, CA. "Predictors of Linkage to and Retention in HIV Care Following Release from Connecticut, USA Jails and Prisons (Oral presentation)"

2017: International AIDS Society (IAS) Meeting, International AIDS Society, Paris, Île-de-France, France. "Late breaker: Predictors of Linkage to and Retention in HIV Care Following Release from Connecticut, USA Jails and Prisons"

2017: NIDA International Forum, NIDA, Montreal, QC, Canada. "A Mixed Methods Evaluation of HIV Risk among Women with Opioid Dependence in Ukraine"

2017: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Montreal, QC, Canada. "Assessing Receptiveness to and Eligibility for PrEP in Criminal Justice-Involved Women"

2017: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Montreal, QC, Canada. "A Mixed Methods Evaluation of HIV Risk among Women with Opioid Dependence in Ukraine"

2017: Annual Meeting of the Society for Applied Anthropology, Society for Applied Anthropology, Santa Fe, NM. "Where rubbers meet the road: HIV risk reduction for women on probation (Oral presentation)"

2016: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Palm Springs, CA. "An Event-level Examination of Successful Condom Negotiation Strategies among College Women"

2015: CDC National HIV Prevention Conference, CDC, Atlanta, GA. "Beyond the Syndemic: Condom Negotiation and Use among Women Experiencing Partner Violence (Oral presentation)"

2015: International Harm Reduction Conference, International Harm Reduction, Kuala Lumpur, Federal Territory of Kuala Lumpur, Malaysia. "Evidence-Based Interventions to Enhance Assessment, Treatment, and Adherence in the Chronic Hepatitis C Care Continuum"

2015: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Phoenix, AZ. "Violence, Substance Use, and Sexual Risk among College Women"

2014: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, San Juan, San Juan, Puerto Rico. "Gender Differences in HIV and Criminal Justice Outcomes"

2014: College on Problems in Drug Dependence (CPDD), College on Problems in Drug Dependence (CPDD), San Juan, San Juan, Puerto Rico. "Gender Differences in HIV and Criminal Justice Outcomes"

2014: Conference on Retroviruses and Opportunistic Infections (CROI), Conference on Retroviruses and Opportunistic Infections (CROI), Boston, MA. "Longitudinal Treatment Outcomes in HIV-Infected Prisoners and Influence of Re-Incarceration"

2013: HIV Intervention and Implementation Science Meeting, HIV Intervention and Implementation Science Meeting, Bethesda, MD. "Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study"

2013: Conference on Retroviruses and Opportunistic Infections (CROI), Conference on Retroviruses and Opportunistic Infections (CROI), Atlanta, GA. "Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study"

2012: IDWeek: Infectious Diseases Society of America Annual Meeting, Infectious Diseases Society of America, San Diego, CA. "Correlates of Retention in HIV Care after Release from Jail: Results from a Multi-site Study"

2012: IDWeek: Infectious Diseases Society of America Annual Meeting, Infectious Diseases Society of America, San Diego, CA. "Frequent Emergency Department Use among Released Prisoners with HIV: Characterization Including a Novel Multimorbidity Index"

2012: 5th Academic and Health Policy Conference on Correctional Health, 5th Academic and Health Policy Conference on Correctional Health, Atlanta, GA. "Effects of Intimate Partner Violence on HIV and Substance Abuse in Released Jail Detainees"

2011: IAPAC HIV Treatment and Adherence Conference, IAPAC, Miami, FL. "Adherence to HIV treatment and care among previously homeless jail detainees"

Regional

2019: Connecticut Infectious Disease Society, New Haven, CT. "Preliminary Findings from a Novel PrEP Demonstration Project for Women Involved in Criminal Justice Systems and Members of their Risk Networks"

2017: Connecticut Public Health Association Annual Conference, Connecticut Public Health Association, Farmington, CT. "The New Haven syringe services program"

2014: Connecticut Infectious Disease Society Annual Meeting, Connecticut Infectious Disease Society, Orange, CT. "Longitudinal Treatment Outcomes in HIV-Infected Prisoners and Influence of Re-Incarceration"

2013: Connecticut Infectious Disease Society Annual Meeting, Connecticut Infectious Disease Society, Orange, CT. "Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study"

2011: Connecticut Infectious Disease Society Annual Meeting, Connecticut Infectious Disease Society, Orange, CT. "Emergency Department Use by Released Prisoners with HIV"

Professional Service:

Peer Review Groups/Grant Study Sections

2019 - present Reviewer, NIDA, NIH Reviewer: RFA-DA-19-025: HEAL Initiative: Justice Community Opioid Innovation Network (JCOIN) Clinical Research Centers
2019 - present Reviewer, Yale DCFAR Pilot Projects
2018 - present Reviewer, Center for Interdisciplinary Research on AIDS (CIRA)
2015 - present Reviewer, University of Wisconsin-Milwaukee Research Growth Initiative

Advisory Boards

2017 Advisor, HIV Prevention and Treatment in Cis-Gendered Women, Gilead Sciences, Inc.

Journal Service

Editor/Associate Editor

2019 - present Associate Editor, Journal of the International Association of Providers of AIDS Care (JIAPAC), Section Editor: Sex and Gender Issues

Reviewer

2019 - present Reviewer, JAIDS
2012 - present Reviewer, Addiction Sci and Clin Pract
2012 - present Reviewer, Addictive Behav Reports
2012 - present Reviewer, AIDS Care
2012 - present Reviewer, Social Science and Medicine
2012 - present Reviewer, SpringerPlus
2012 - present Reviewer, Substance Abuse Treatment Prevention and Policy
2012 - present Reviewer, Women's Health Issues
2012 - present Reviewer, Yale Journal of Biology and Medicine
2012 - present Reviewer, AIMS Public Health
2012 - present Reviewer, American Journal on Addictions
2012 - present Reviewer, American Journal of Epidemiology
2012 - present Reviewer, American Journal of Public Health
2012 - present Reviewer, Annals Internal Medicine
2012 - present Reviewer, BMC Emergency Medicine
2012 - present Reviewer, BMC Infectious Diseases
2012 - present Reviewer, BMC Public Health
2012 - present Reviewer, BMC Women's Health

2012 - present Reviewer, Clinical Infectious Diseases
2012 - present Reviewer, Critical Public Health
2012 - present Reviewer, Drug and Alcohol Dependence
2012 - present Reviewer, Drug and Alcohol Review
2012 - present Reviewer, Epidemiologic Reviews
2012 - present Reviewer, Eurosurveillance
2012 - present Reviewer, Health and Justice (Springer Open)
2012 - present Reviewer, International Journal of Drug Policy
2012 - present Reviewer, International Journal of Prisoner Health
2012 - present Reviewer, International Journal of STDs and AIDS
2012 - present Reviewer, International Journal of Women's Health
2012 - present Reviewer, JAMA Internal Medicine
2012 - present Reviewer, Journal of Family Violence
2012 - present Reviewer, Journal of General Internal Medicine
2012 - present Reviewer, Journal of Immigrant and Minority Health
2012 - present Reviewer, Journal of International AIDS Society
2012 - present Reviewer, Journal of Psychoactive Drugs
2012 - present Reviewer, Journal of Urban Health
2012 - present Reviewer, Journal of Women's Health
2012 - present Reviewer, Open Forum Infectious Diseases
2012 - present Reviewer, PLoS ONE
2012 - present Reviewer, Public Health Reports

Professional Service for Professional Organizations

AAMC Group on Women in Medicine and Science (GWIMS)

2016 - present Member, AAMC Group on Women in Medicine and Science (GWIMS)

American College of Physicians

2016 - present Fellow, American College of Physicians
2013 - 2016 Member, American College of Physicians

American Medical Association

2005 - present Member, American Medical Association

American Medical Women's Association

2011 - present Member, American Medical Women's Association

American Society of Addiction Medicine

2009 - present Member, American Society of Addiction Medicine

Connecticut Infectious Disease Society

2011 - present Member, Connecticut Infectious Disease Society

Infectious Disease Society of America

2008 - present Member, Infectious Disease Society of America

InWomen's Network, NIDA International Program

2013 - present Member, InWomen's Network, NIDA International Program

New York State Medical Society

2005 - 2008 Member, New York State Medical Society

Yale University Service

University Committees

2016 - 2018 Council Member, Leadership Council, Women's Faculty Forum

Medical School Committees

2015 - 2016 Committee Member, US Health and Justice Course, Yale School of Medicine

2014 - present Committee Member, Yale Internal Medicine Traditional Residency Intern Selection Committee

Public Service

2019 - present Faculty Member, Yale University Program in Addiction Medicine
2017 - present Faculty Member, Arthur Liman Center for Public Interest Law, Yale Law School
2013 - present Mentor, Women in Medicine at Yale Mentoring Program
2012 - present Faculty Member, Yale Center for Interdisciplinary Research on AIDS
2009 - 2011 Instructor, Preclinical Clerkship Tutor, Yale School of Medicine
2002 Fellow, Soros Open Society Institute
1998 - 1999 Fellow, Costa Rican Humanitarian Foundation

Bibliography:

Peer-Reviewed Original Research

1. **Meyer JP**, Qiu J, Chen NE, Larkin GL, Altice FL. Emergency department use by released prisoners with HIV: an observational longitudinal study. PloS One 2012, 7:e42416.
2. Chen NE, **Meyer JP**, Bollinger R, Page KR. HIV testing behaviors among Latinos in Baltimore City. Journal Of Immigrant And Minority Health / Center For Minority Public Health 2012, 14:540-51.
3. Chitsaz E, **Meyer JP**, Krishnan A, Springer SA, Marcus R, Zaller N, Jordan AO, Lincoln T, Flanigan TP, Porterfield J, Altice FL. Contribution of substance use disorders on HIV treatment outcomes and antiretroviral medication adherence among HIV-infected persons entering jail. AIDS And Behavior 2013, 17 Suppl 2:S118-27.

4. Chen NE, **Meyer JP**, Avery AK, Draine J, Flanigan TP, Lincoln T, Spaulding AC, Springer SA, Altice FL. Adherence to HIV treatment and care among previously homeless jail detainees. AIDS And Behavior 2013, 17:2654-66.
5. Althoff AL, Zelenev A, **Meyer JP**, Fu J, Brown SE, Vagenas P, Avery AK, Cruzado-Quiñones J, Spaulding AC, Altice FL. Correlates of retention in HIV care after release from jail: results from a multi-site study. AIDS And Behavior 2013, 17 Suppl 2:S156-70.
6. Williams CT, Kim S, **Meyer J**, Spaulding A, Teixeira P, Avery A, Moore K, Altice F, Murphy-Swallow D, Simon D, Wickersham J, Ouellet LJ. Gender differences in baseline health, needs at release, and predictors of care engagement among HIV-positive clients leaving jail. AIDS And Behavior 2013, 17 Suppl 2:S195-202.
7. **Meyer JP**, Wickersham JA, Fu JJ, Brown SE, Sullivan TP, Springer SA, Altice FL. Partner violence and health among HIV-infected jail detainees. International Journal Of Prisoner Health 2013, 9:124-41.
8. **Meyer JP**, Qiu J, Chen NE, Larkin GL, Altice FL. Frequent emergency department use among released prisoners with human immunodeficiency virus: characterization including a novel multimorbidity index. Academic Emergency Medicine : Official Journal Of The Society For Academic Emergency Medicine 2013, 20:79-88.
9. **Meyer JP**, Cepeda J, Springer SA, Wu J, Trestman RL, Altice FL. HIV in people reincarcerated in Connecticut prisons and jails: an observational cohort study. The Lancet. HIV 2014, 1:e77-e84.
10. **Meyer JP**, Zelenev A, Wickersham JA, Williams CT, Teixeira PA, Altice FL. Gender disparities in HIV treatment outcomes following release from jail: results from a multicenter study. American Journal Of Public Health 2014, 104:434-41.
11. **Meyer JP**, Cepeda J, Wu J, Trestman RL, Altice FL, Springer SA. Optimization of human immunodeficiency virus treatment during incarceration: viral suppression at the prison gate. JAMA Internal Medicine 2014, 174:721-9.
12. **Meyer JP**, Cepeda J, Taxman FS, Altice FL. Sex-Related Disparities in Criminal Justice and HIV Treatment Outcomes: A Retrospective Cohort Study of HIV-Infected Inmates. American Journal Of Public Health 2015, 105:1901-10.
13. Boyd AT, Song DL, **Meyer JP**, Altice FL. Emergency department use among HIV-infected released jail detainees. Journal Of Urban Health : Bulletin Of The New York Academy Of Medicine 2015, 92:108-35.
14. Shrestha R, Karki P, Altice FL, Huedo-Medina TB, **Meyer JP**, Madden L, Copenhaver M. Correlates of willingness to initiate pre-exposure prophylaxis and anticipation of practicing safer drug- and sex-related behaviors among high-risk drug users on methadone treatment. Drug And Alcohol Dependence 2017, 173:107-116.
15. Peasant C, Sullivan TP, Weiss NH, Martinez I, **Meyer JP**. Beyond the syndemic: condom negotiation and use among women experiencing partner violence. AIDS Care 2017, 29:516-523.
16. Wickersham JA, Gibson BA, Bazazi AR, Pillai V, Pedersen CJ, **Meyer JP**, El-Bassel N, Mayer KH, Kamarulzaman A, Altice FL. Prevalence of Human Immunodeficiency Virus and Sexually Transmitted Infections Among Cisgender and Transgender Women Sex Workers in Greater Kuala Lumpur, Malaysia: Results From a Respondent-Driven Sampling Study. Sexually Transmitted Diseases 2017, 44:663-670.
17. Hoff E, Marcus R, Bojko MJ, Makarenko I, Mazhnaya A, Altice FL, **Meyer JP**. The effects of opioid-agonist treatments on HIV risk and social stability: A mixed methods study of women with opioid use disorder in Ukraine. Journal Of Substance Abuse Treatment 2017, 83:36-44.

Case 1:20-cv-01803-AKH Document 42 Filed 04/16/20 Page 121 of 123

18. Rutledge R, Madden L, Ogbuagu O, **Meyer JP**. HIV Risk perception and eligibility for pre-exposure prophylaxis in women involved in the criminal justice system. AIDS Care 2018, 30:1282-1289.
19. Peasant C, Sullivan TP, Ritchwood TD, Parra GR, Weiss NH, **Meyer JP**, Murphy JG. Words can hurt: The effects of physical and psychological partner violence on condom negotiation and condom use among young women. Women & Health 2018, 58:483-497.
20. Loeliger KB, Altice FL, Desai MM, Ciarleglio MM, Gallagher C, **Meyer JP**. Predictors of linkage to HIV care and viral suppression after release from jails and prisons: a retrospective cohort study. The Lancet. HIV 2018, 5:e96-e106.
21. Odio CD, Carroll M, Glass S, Bauman A, Taxman FS, **Meyer JP**. Evaluating concurrent validity of criminal justice and clinical assessments among women on probation. Health & Justice 2018, 6:7.
22. Loeliger KB, Altice FL, Ciarleglio MM, Rich KM, Chandra DK, Gallagher C, Desai MM, **Meyer JP**. All-cause mortality among people with HIV released from an integrated system of jails and prisons in Connecticut, USA, 2007-14: a retrospective observational cohort study. The Lancet. HIV 2018, 5:e617-e628.
23. Loeliger KB, **Meyer JP**, Desai MM, Ciarleglio MM, Gallagher C, Altice FL. Retention in HIV care during the 3 years following release from incarceration: A cohort study. PLoS Medicine 2018, 15:e1002667.
24. Azbel L, Wegman MP, Polonsky M, Bachireddy C, **Meyer J**, Shumskaya N, Kurmanalieva A, Dvoryak S, Altice FL. Drug injection within prison in Kyrgyzstan: elevated HIV risk and implications for scaling up opioid agonist treatments. International Journal Of Prisoner Health 2018, 14:175-187.
25. Peasant C, Montanaro EA, Kershaw TS, Parra GR, Weiss NH, **Meyer JP**, Murphy JG, Ritchwood TD, Sullivan TP. An event-level examination of successful condom negotiation strategies among young women. Journal Of Health Psychology 2019, 24:898-908.
26. Ranjit YS, Azbel L, Krishnan A, Altice FL, **Meyer JP**. Evaluation of HIV risk and outcomes in a nationally representative sample of incarcerated women in Azerbaijan, Kyrgyzstan, and Ukraine. AIDS Care 2019, 31:793-797.
27. Rhodes T, Azbel L, Lancaster K, **Meyer J**. The becoming-methadone-body: on the onto-politics of health intervention translations. Sociology Of Health & Illness 2019, 41:1618-1636.
28. Olson B, Vincent W, **Meyer JP**, Kershaw T, Sikkema KJ, Heckman TG, Hansen NB. Depressive symptoms, physical symptoms, and health-related quality of life among older adults with HIV. Quality Of Life Research : An International Journal Of Quality Of Life Aspects Of Treatment, Care And Rehabilitation 2019.

Chapters, Books, and Reviews

29. Azar MM, Springer SA, **Meyer JP**, Altice FL. A systematic review of the impact of alcohol use disorders on HIV treatment outcomes, adherence to antiretroviral therapy and health care utilization. Drug And Alcohol Dependence 2010, 112:178-93.
30. **Meyer JP**, Springer SA, Altice FL. Substance abuse, violence, and HIV in women: a literature review of the syndemic. Journal Of Women's Health (2002) 2011, 20:991-1006.
31. **Meyer JP**, Chen NE, Springer SA. HIV Treatment in the Criminal Justice System: Critical Knowledge and Intervention Gaps. AIDS Research And Treatment 2011, 2011:680617.
32. Springer SA, Spaulding AC, **Meyer JP**, Altice FL. Public health implications for adequate transitional care for HIV-infected prisoners: five essential components. Clinical Infectious Diseases : An Official Publication Of The Infectious Diseases Society Of America 2011, 53:469-79.

33. Chen NE, **Meyer JP**, Springer SA. Advances in the prevention of heterosexual transmission of HIV/AIDS among women in the United States. Infectious Disease Reports 2011, 3.
34. **Meyer J**, Altice F. HIV in Injection and Other Drug Users. Somesh Gupta, Bhushan Kumar, eds. Sexually Transmitted Infections 2nd ed. New Delhi, India: Elsevier, 2012: 1061-80. ISBN 978-81-312-2809-8.
35. **Meyer JP**, Althoff AL, Altice FL. Optimizing care for HIV-infected people who use drugs: evidence-based approaches to overcoming healthcare disparities. Clinical Infectious Diseases : An Official Publication Of The Infectious Diseases Society Of America 2013, 57:1309-17.
36. **Meyer J**, Altice F. Chapter 47, Treatment of Addictions: Transition to the Community. Robert L. Trestman, Kenneth L. Appelbaum, Jeffrey L. Metzner, eds. Oxford Textbook of Correctional Psychiatry (Winner of the 2016 Guttmacher Award). Oxford University Press 2015. ISBN 9780199360574.
37. **Meyer JP**, Moghimi Y, Marcus R, Lim JK, Litwin AH, Altice FL. Evidence-based interventions to enhance assessment, treatment, and adherence in the chronic Hepatitis C care continuum. The International Journal On Drug Policy 2015, 26:922-35.
38. Mohareb A, Tiberio P, Mandimika C, Muthulingam D, **Meyer J**. Infectious Diseases in Underserved Populations. Onyema Ogbuagu, Gerald Friedland, Merceditas Villanueva, Marjorie Golden, eds. Current Diagnosis and Treatment- Infectious Diseases. McGraw-Hill Medical 2016.
39. **Meyer JP**, Womack JA, Gibson B. Beyond the Pap Smear: Gender-responsive HIV Care for Women. The Yale Journal Of Biology And Medicine 2016, 89:193-203.
40. **Meyer JP**, Muthulingam D, El-Bassel N, Altice FL. Leveraging the U.S. Criminal Justice System to Access Women for HIV Interventions. AIDS And Behavior 2017, 21:3527-3548.
41. Shrestha R, McCoy-Redd B, **Meyer J**. Pre-Exposure Prophylaxis (PrEP) for People Who Inject Drugs (PWID). Brianna Norton, Ed. The Opioid Epidemic and Infectious Diseases. Elsevier 2019.
42. **Meyer JP**, Isaacs K, El-Shahawy O, Burlew AK, Wechsberg W. Research on women with substance use disorders: Reviewing progress and developing a research and implementation roadmap. Drug And Alcohol Dependence 2019, 197:158-163.

Peer-Reviewed Educational Materials

43. The Fortune Society Reentry Education Project Detailing Kit. New York City Department of Health and Mental Hygiene. October 2014
44. United Nations Office on Drugs and Crime. Vienna, Austria

Invited Editorials and Commentaries

45. **Meyer JP**. Capsule Commentary on Pyra et al., sexual minority status and violence among HIV infected and at-risk women. Journal Of General Internal Medicine 2014, 29:1164.
46. Brinkley-Rubinstein L, Dauria E, Tolou-Shams M, Christopoulos K, Chan PA, Beckwith CG, Parker S, **Meyer J**. The Path to Implementation of HIV Pre-exposure Prophylaxis for People Involved in Criminal Justice Systems. Current HIV/AIDS Reports 2018, 15:93-95.
47. **Meyer JP**. The Sustained Harmful Health Effects of Incarceration for Women Living with HIV. Journal Of Women's Health (2002) 2019, 28:1017-1018.

Case 1:20-cv-00786 Document 1-15 Filed 03/31/20 Page 23 of 23

Case Reports, Technical Notes, Letters

48. **Paul J**. Bullous pemphigoid in a patient with psoriasis and possible drug reaction: a case report. Connecticut Medicine 2004, 68:611-5.
49. How J, Azar MM, **Meyer JP**. Are Nectarines to Blame? A Case Report and Literature Review of Spontaneous Bacterial Peritonitis Due to Listeria monocytogenes. Connecticut Medicine 2015, 79:31-6.
50. Vazquez Guillamet LJ, Malinis MF, **Meyer JP**. Emerging role of Actinomyces meyeri in brain abscesses: A case report and literature review. IDCases 2017, 10:26-29.
51. Harada K, Heaton H, Chen J, Vazquez M, **Meyer J**. Zoster vaccine-associated primary varicella infection in an immunocompetent host. BMJ Case Reports 2017, 2017.
52. Bernardo R, Streiter S, Tiberio P, Rodwin BA, Mohareb A, Ogbuagu O, Emu B, **Meyer JP**. Answer to December 2017 Photo Quiz. Journal Of Clinical Microbiology 2017, 55:3568.
53. Bernardo R, Streiter S, Tiberio P, Rodwin BA, Mohareb A, Ogbuagu O, Emu B, **Meyer JP**. Photo Quiz: Peripheral Blood Smear in a Ugandan Refugee. Journal Of Clinical Microbiology 2017, 55:3313-3314.

Scholarship In Press

54. Hoff E, Adams Z, Dasgupta A, Goddard D, Sheth S, **Meyer J**. Reproductive Health Justice and Autonomy: A systematic review of pregnancy planning intentions, needs, and interventions among women involved in US criminal justice systems. J Women's Health

DECLARATION OF O.M.G.

Pursuant to 28 U.S.C. § 1746 and subject to penalty of perjury, I declare that the following is true and correct:

1. I am the plaintiff identified as O.M.G. in the above-styled matter. I am the mother of the plaintiff identified as H.F.G.M., who is four years old. My daughter and I are currently detained at the South Texas Family Residential Center, 300 El Rancho Way, Dilley, Texas, 78017. We arc from Honduras and seek asylum in the United States.

2. On February 5, 2020 I was detained by ICE in Tennessee with my daughter. I was placed in detention at the South Texas Family Residential Center on February 6, 2020.

3. I am a plaintiff in this case because I fear that I will contract the Corona virus while detained. I fear me, my daughter, and my unborn fetus will die if we become sick in detention.

4. I am almost seven months pregnant and due to deliver a little girl on June 27, 2020. I have a history of complications in pregnancy that have gone untreated while detained. I have previously had a miscarriage. Prior to my detention I was under the care of an OBGYN who placed me on four different medications, in addition to my prenatal vitamins. I have not had regular access to an OBGYN in Dilley and have been denied the medications prescribed by my prior physician while detained.

5. I have developed an infection in Dilley that causes me severe pain in my uterine and pain when I urinate. When I initially sought medical care for this pain at this jail, the medical staff advised me to drink water. I was later prescribed a cream, and subsequently antibiotics. The cream and antibiotics did not resolve my pain or end the infection. The infection has progressed and I now feel excruciating pain, not only when urinating, but when walking and standing, and in my waist.

6. On March 6, 2020 I was taken to San Antonio, Texas to meet with a gynecologist. The doctor informed me that my infection continued, and could result in another miscarriage and birth defects for my child. I was told that I am also at high risk for preeclampsia, which can lead to a stroke, seizure, fluid in my chest, heart failure, blindness, or dangerous bleeding. Preeclampsia could also cause premature birth and complications for my baby, including learning disabilities, epilepsy, cerebral palsy, and hearing and vision problems.

7. There is no gynecologist at the jail in Dilley. If I have an urgent medical need regarding my pregnancy, I would need to be transported to San Antonio, which is about an hour and a half away. I am very worried about what would happen if I go into labor while detained.

8. In addition to the challenges I face in my pregnancy, I have other medical conditions. I have a history of passing out. I have blacked out two times while detained. One time I

passed out in the library, and one time in my room. People who have observed me when I have fainted say that I convulse. I also have severe allergies and an elevated heart rate. Currently, I feel dizzy and tired all of the time.

9. My daughter also has medical issues which have developed while detained and gone untreated. My daughter has a cough that has not subsided for four days. She coughs to the point of vomiting. Sometimes she vomits three times in one night. The doctors in this detention center have provided her with Vick's and given her water. This has not helped and she has stopped eating.

10. I do not have access to the medical attention I need in this jail. Despite my medical condition, the facility continues to assign me the task of sweeping my dormitory, which is difficult for me because it is hard for me to move and walk. In fact, when I have told the guards that I am in pain and cannot sweep, I have been threatened with being written up.

11. I fear the Corona virus will spread quickly in this jail if one person is infected. The guards have not given us any information about the disease, or how we can protect ourselves from getting it. The jail has not increased our access to hand soap or hand sanitizer, and there are no new efforts to ensure everyone detained here washes their hands. I have not seen any heightened cleaning procedures. The contracted cleaners clean my dorm room once a week. Detained families are required to do the additional cleaning. However, we are not given supplies other than a broom.

12. I am most afraid because I cannot keep a sufficient distance from other people to keep myself safe from contracting the virus if they have it. I must be close to others all of the time. I share a room, bathroom, and the dining hall. All locations in this jail are communal.

13. Today one of my friends told me that she spoke with a guard this morning that tested positive for the Corona virus. The guard told my friend she is better now, and did not come to work for a few days while she recovered. This guard is an older white woman with glasses and blonde hair.

14. For all of these reasons, I fear for my life, and the life of my daughter and unborn child, if we remain detained. I believe our safety requires our release.

15. This declaration was read to me in Spanish by Shalyn Fluharty, an attorney with the Dilley Pro Bono Project. It is true and correct to the best of my knowledge.

Declaration of C.L.

Pursuant to 28 U.S.C. § 1746 and subject to penalty of perjury, I declare that the following is true and correct:

1. I am the plaintiff identified as C.L. in the above-styled matter. I am the mother of the plaintiff identified as J.A. My son and I are currently detained at the South Texas Family Residential Center, 300 El Rancho Way, Dilley, Texas, 78017. I am a Haitian national; my son is a Brazilian national. We are currently seeking asylum in the United States.

2. I fled Haiti because I was threatened with death by members of my father's family who killed my relatives and burned down our house. I fled to Brazil, where I gave birth to my son. I later had to flee Brazil because I was beaten and abused by my partner there.

3. I am scared of getting sick with the coronavirus while my son and I are detained here. We have been detained here for fifty-four days, and we are both sick. In addition, my son has asthma. I have heard that people with asthma are more at risk for the coronavirus, and I am terrified of what would happen if the coronavirus got to the detention center. There is nothing being done here to protect us from the coronavirus.

My child suffers from asthma, and the doctors here have not provided him with medication.

4. My son has suffered from asthma his entire life. He was diagnosed with asthma when he was eight or nine months old. Since then, he has taken medication and had an inhaler in order to control his asthma.

5. While I was in Mexico on my way to the United States, I lost my son's inhaler. Shortly after I arrived at Dilley, I went to the medical clinic here and told them my son had asthma and asked them for an inhaler. They did not do any tests on my son to check on his breathing, and they did not give me an inhaler.

6. My son had an asthma attack in February 2020, while we were detained. He was struggling to breathe, so I took him to the clinic. They gave him medicine for his cough, and some allergy medication, but they did not give him an inhaler.

7. My son still has a cough and has had a cough the entire time we have been detained at Dilley. He has also developed a stuffy nose. At the moment, my son is without any form of medication for his asthma. I am terrified that he could have an asthma attack and die here because we have not been given the medication he needs.

I am suffering from heart palpitations and chest pain while in detention.

8. I have been experiencing chest pains while I have been detained at Dilley. On several occasions, I have had episodes where I am walking and experience strong heart palpitations. When I have these episodes, I feel like it is hard to breathe, I feel pain in my chest, and I have a hard time walking and standing upright.

9. I have also started having strong headaches. There are times that my head hurts so bad that I can't read.

Nothing is being done at the detention center to protect us from the coronavirus.

10. I am very concerned for my son's health. Because he already has breathing problems and has been coughing for almost two months now, I am very afraid that if the coronavirus gets into the detention center, he will be in great danger.

11. I am also very concerned because the people here are doing nothing to protect us from the coronavirus. My son and I are in a room with about nine other people. We sleep very close together, and there is very little space to maintain distance from other people when we are in the room. When I am laying down in my bed, I can touch the bed next to me. My son has a cough and other people in our room also have a cough. They have never quarantined the people who have a cough.

12. I don't know how I can avoid getting the coronavirus. I recently noticed a sign in our bathroom that says something about washing your hands, but it is only in Spanish and English. My primary language is Haitian Creole, and I haven't received any information in Haitian Creole. No one here has talked to me about the coronavirus.

13. We have a very hard time washing our hands as well. The soap in our room runs out very quickly, and then it takes a long time for it to be replaced. There have been occasions where it is a whole day before there is more soap in the room. There is no hand sanitizer in our room. We are also not provided with disinfectant wipes to clean our room.

14. Almost everything we do here requires us to be very close together. The school is still open here, and there are about twenty children in the classroom at a time. I am scared to send my son to school for that reason. We are also all required to eat in one cafeteria, which is very crowded. Everyone is serving themselves from the same spoon and using the same pitcher. I'm afraid that by the time they notice that someone here has the virus, it will be too late because everyone will be infected.

15. I haven't seen anyone with a facemask or with gloves. Even people that are coughing are not given facemasks. When I was at the medical clinic here last week, I saw some doctors meet with patients without facemasks.

DECLARATION OF RACHEL PEARSON

I, Rachel Pearson, swearing under penalties of perjury, make the following declaration:

1. I am a Board-certified pediatrician who specializes in the care of hospitalized children. I hold an MD and a PhD from the University of Texas Medical Branch, and I completed three years of training in the specialty of pediatrics at Seattle Children's Hospital. I am an Assistant Professor of Pediatrics in the Division of Inpatient Pediatrics at UT Health San Antonio as well as an Assistant Professor at UT Health's Center for Medical Humanities and Ethics.

2. In my medical judgment, the conditions of immigrant detention put children at a high risk for contracting infectious diseases such as the coronavirus that causes COVID-19. Furthermore, housing detained families in close quarters violates Centers for Disease Control (CDC) recommendations for social distancing and increases the risk for spread of COVID-19 in the larger community.

3. On February 27, 2020, physician-researchers writing in the *New England Journal of Medicine* described the detention centers as "tinderboxes for infectious disease outbreaks." Researchers point to crowded conditions, a lack of adequate facilities for handwashing and showering, inadequate medical care and the harm done by chronic stress to detainees' immune systems as factors that make detention centers likely to experience outbreaks.

4. In 2019, thousands of detained migrants did require quarantine during outbreaks of influenza, mumps, and chicken pox. The COVID-19 virus can travel through the air in droplets of saliva and can survive on surfaces such as doorknobs and tables.

5. Family detention puts the larger community at risk not only because infected children may pass the virus to fellow detainees, guards and others within the facility, but also because they may require hospitalization. The largest study to date of pediatric COVID-19 infections, released by the journal *Pediatrics* on March 16, 2020, showed that 6% of infected children required hospitalization, and 11% of infants under 1 year of age required hospitalization. The virus infects children's lungs, causing pneumonia; as their oxygen levels drop, they can be at risk for death without oxygen therapy in a hospital. In this country, children have already been hospitalized for COVID-19.

6. For detained children, accessing pediatric hospital services requires triage in the detention center, transport to a local medical facility, and further transport to a facility with pediatric hospital care. Each point of contact between patients infected with COVID-19 and the healthcare system puts healthcare workers and community members at risk of infection. Furthermore, both hospital beds and medical transport

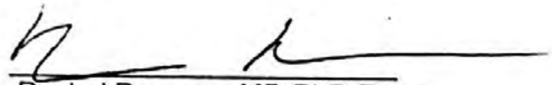
Scanned with CamScanner

could become scarce resources in the weeks to come, putting infected children at further risk of worsening or dying as they await transport.

7. The American Academy of Pediatrics has repeatedly affirmed that immigrant detention is fundamentally unhealthy for children, and that no amount of detention is safe for a child. In my medical judgment, continuing to detain children and families during the current pandemic increases the risk of COVID-19 infections both among detainees and in the larger community.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: March 21, 2020
San Antonio, Texas



Rachel Pearson, MD PhD FAAP

Scanned with CamScanner

Rachel Pearson
RachelMPearson@gmail.com
831 W Woodlawn
San Antonio, TX 78212
Cell: 512-786-1847

FACULTY APPOINTMENT

2019 **Assistant Professor of Pediatrics, Department of Pediatric Hospital Medicine**
University of Texas Health Science Center at San Antonio

Assistant Professor of Medical Humanities
Center for Medical Humanities and Ethics, UT Health San Antonio

EDUCATION

2016-2019 **Seattle Children's Hospital, University of Washington**
Resident physician, pediatrics

2009-2016 **University of Texas Medical Branch, Institute for the Medical Humanities**
Combined MD/PhD Program
Hable Hispanic Health Care Track

2001-2006 **University of Texas at Austin**
Bachelor of Arts, Plan 2 Honors Program
cum laude, Phi Beta Kappa

RESEARCH

2018 **Project Title: Quality Improvement in Resident Communication Training**
Designing and conducting semi-structured interviews to contribute to a quality-improvement project in training pediatrics residents to break serious news.

2012-2016 **Dissertation Title: "Medical Objectivity: The Narratives that Structure Knowledge and Identity in Medicine"**
Project Description: multi-disciplinary project that distinguishes medical from scientific objectivity and proposes clinical interventions to reduce the effects of racial bias on quality of care.

2010-2011 **Project Title: Characterizing the Health Effects of Family Detention**
Project Description: Community-based collaboration with Grassroots Leadership,

the Austin Immigrant Rights Coalition, and asylum-seeking Central American families. Correlating immigrants' health narratives with existing research to characterize and quantify the health effects of family detention.

PEER REVIEWED PUBLICATIONS

Pending **"To Combat Bias in Care, we Must Understand the Self: A Humanities-Based Critique of Medical Objectivity"**

Pending **"Stress, Strength and Community in Memoirs of Medical Students and Residents of Color"**

Pending **"Shaking Hands, Female Hips, and Fainting in Anatomy Lab: The Body as a Threat to Medical Student Professional Identity-Formation"**

2014 **"Inadvertent Stigmatization of Mental Disorders in a Primary Care Setting" (Austin, TX: *Texas Medicine*)**
Humanities-based interventions to reduce stigma for mentally ill patients in primary care clinics

ORAL AND POSTER PRESENTATIONS

2020 **"Physician-Writers and Politics"**
Health Humanities Consortium (Nasville, TN)

2020 **"Mobilizing Stories for Advocacy: Law, Ethics and Policy for Physician-Writers"**
Beyond Flexner 2020 (Pheonix, AZ)

2018 **"Micro-Resistance in Primary Care: Toward a Radical Welcome"**
GLOCAL, Houston Global Health Collaborative (Houston, TX)

2015 **"Cultivating Healers: A Creative Re-Imagining of the Medical Self"**
American Society for Bioethics and Humanities (Houston, TX)

2015 **"Becoming A Monster: Objectivity and Objectification in Memoirs of Hospital Wards Training,"**
American Society for Bioethics and Humanities (Houston, TX)

2014 **"The Health Effects of Immigrant Family Detention: What Pediatricians Need to Know"**
Texas Chapter of the American Academy of Pediatrics (Austin, TX)

2014 **"Can Empathetic Physicians Have Aequanimitas?"**
UTMB Osler Club (Galveston TX)

2014 **"Power and Moral Distress at UTMB: A Community Conversation"**
UTMB President's Cabinet / Students Together for Service (Galveston, TX)

2014 **"Aequanimitas and Grief of Mind: The Roman Roots of Oslerian Practice"**
American Osler Society (Oxford, United Kingdom)

2014 **"Meaning, Empathy and Moral Distress at Student-Run Clinics,"**
Society of Student-Run Free Clinics (Nashville TN)

2013 **"Ethical Issues in Correctional Managed Care"**
Nursing Ethics Continuing Medical Education Seminar (Galveston, TX)

2013 **"Medical Ethics in Texas Prisons"**
University of Texas System MD/PhD Retreat (Austin, TX)

2013 **"Psychopathy and Criminal Responsibility"**
American Osler Society (Tucson, AZ)

INVITED SPEECHES

2019 **"No Apparent Distress"**
UT Health San Antonio (San Antonio, TX)

2019 **Galveston Reads**
Keynote speaker for community literacy fair (Galveston, TX)

2019 **Association of Departments of Family Medicine 2019 Conference**
Plenary speech and book discussion (Houston, TX)

2018 **Medicine and Society speaker: "*No Apparent Distress*"**
AAMC Learn, Lead Serve 2018 (Austin, TX)

2018 **"Physician Wellness on the Front Lines of Medicine"**
Plenary Speech: Shein Lecture, American Association of Directors of Psychiatry Residency Training (New Orleans, LA)

2017 **"Medical Student Advocacy in Struggling Communities"**
Invited speaker, the Healthcare Foundation for Humanism in Medicine at Rutgers New Jersey Medical School (Newark, NJ)

2017 **"Who We Are: Humanism in an Age of Uncertainty"**
Plenary Speech, Community Learning Day, the College of New Jersey (Ewing Township, NJ)

SELECTED NON-PEER REVIEWED PUBLICATIONS

2019 **“What a Pediatrician Can Do for an Asylum-Seeking Child—And What She Can’t”** (New York: *The New Yorker Online)*

2019 **“The Durable Feeling that A Child is Always at Risk,”** (New York: *The New Yorker Online)*

2018 **“Among the Vitamin K ‘Anti-Vaxxers,’”** (New York: *The New York Review of Books)*

2018 **“The Challenge of ‘Chronic Lyme,’”** (New York: *The New York Review of Books)*

2018 **“As a Pediatrician, I Know There’s No Way to Jail Migrant Families Without Harming Kids,”** (Austin, TX: *The Texas Observer*)

2017 **"Seeing the Body”** (Austin, TX: *Texas Monthly*)

2017 **"Four Timely Memoirs from the Hall of Medicine”** (New York: *The New York Times Book Review*)

2017 ***No Apparent Distress: A Doctor’s Coming-of-Age on the Front Lines of American Medicine*** (New York: W.W. Norton)

2017 **“When Doctors Can’t Afford to Feel”** (New York: *The Daily Beast*)

2015 **“How Doctors can Confront Racial Bias in Medicine”** (New York: *Scientific American)*

2015 **“Black Residents Gain Increased Access to Grocery Stores Post-Katrina”** (London, U.K: *The Guardian)*

2015 **“Texas Abortion Law Ruling: Latinas More Likely to Avoid Clinics, Self-Terminate,”** (London, U.K.: *The Guardian)*

2014 **“Disease Threat from Immigrant Children Wildly Overstated”** (Austin, TX: *Texas Observer*)

2013 **“Texas’ Other Death Penalty: A Galveston Med Student Describes Life and Death in the Safety Net,”** (Austin, TX: *Texas Observer*)

2012 **“For an Intern on Call in Houston,”** (Alexandria, VA: *Journal of General Internal Medicine*)

TEACHING EXPERIENCE

2015 **Intro to the Medical Humanities (Teaching Assistant)**
Designed syllabus and co-taught 1-hour credit course for pre-medical Health Science Scholars students. Delivered 10 lectures. University of Texas at Austin

2015 **Writing as Patient Advocacy (Lecture)**
Texas Interdisciplinary Plan, University of Texas at Austin

2015 **Poetry Workshop for Pre-Medical Students (Workshop)**
Workshop, Joint Admissions Medical Program, UTMB

2014 **Physician-Poets and Poetry in Medical Care (Workshop)**
Health Science Scholars, University of Texas at Austin

2014 **Poetry Workshop for Pre-Medical Students (Workshop)**
Joint Admissions Medical Program, UTMB

2013 **Humanities, Ethics and Professionalism (Teaching Assistant)**
Led small-group discussions on ethics and humanities for second-year med students, UTMB

2013 **Creative Expressions Project (Graduate Student Mentor)**
Mentored medical student artists in various media, UTMB

2013 **Medical Ethics (Course Instructor)**
Co-designed and co-taught six-week ethics course for Joint Admissions Medical Program students, with focus on learning ethics through literature and art. UTMB

2011 **Community Service Learning Track (Course Director)**
Designed and facilitated lectures on indigent care, history of medicine, and medical economics for student volunteers in indigent care. UTMB

SELECTED MEDIA APPEARANCES / HEALTH ADVOCACY

2017 **KUOW, KUTX, WNPR, Minnesota Public Radio, etc**
Spoke on radio shows across the country about *No Apparent Distress* and health policy affecting working-class families

2017 **C-SPAN Book TV**

2015 **Public Radio International, *The World***
Interviewed about vaccination policies for immigrants to the U.S.

2014 **MSNBC, *The Chris Hayes Show***
Addressed myths about immigrant children bringing disease

2014 **ABC News, *Straight Talk with John McCaa***
Discussed Texas policy of detaining immigrant children

2014 **American Civil Liberties Union, *ACLU Podcast***

2014 **Pacifica Radio, *Background Briefing with Ian Masters***

2014 **Texas Public Radio, *Texas Matters***

2013 **Atlantic Media*, The Atlantic***
Interviewed for a story on Texas' refusal to expand Medicaid

2013 **Texas Democracy Foundation, *Observer Radio***

HONORS & AWARDS

2018 **Anson Jones Award, Texas Medical Association**
Award for physician-writers

2017 **Editor's Choice, *New York Times Book Review***
For *No Apparent Distress,* non-fiction book

2014 **Anson Jones Award, Texas Medical Association**

2013 **Dr. David C. Eiland Jr. Scholarship Award in Health Care and Humanities**
Competitive Academic Scholarship

2013 **Robert Harrison, M.D. Memorial M.D./Ph.D. Scholarship**
Competitive Academic Scholarship

2012 **Gold Humanism Honor Society**

2012 **Humanism in Surgery Award, UTMB Austin**

2010 **Osler Student Scholar, John P. McGovern Academy of Oslerian Medicine**
Award for compassionate care, professionalism, and incorporation of a sound scientific basis of care.

2005 **Robert C. Solomon Scholarship for Excellence in the Arts and Philosophy**

2005 **Academy of American Poets Award, University of Texas at Austin**

VOLUNTEER ACTIVITIES

2017-2018 **Founding member,** *Inklings* resident reflective-writing group
Provides reflective writing and arts-in-medicine services for resident wellness

gatherings, humanism in pediatrics events, and small-group sessions

2012-2016 **Assistant Deputy Web Editor**, *Journal of General Internal Medicine*

2013-2014 **Co-Director, St. Vincent's Student-Run Free Clinic** (15 hrs/wk)
Volunteer coordinator. Mentored medical, nursing and PA students.
Re-designed and ran training workshops to address social determinants of health and bias/stigma in indigent care. Coordinated primary and speciality care for complex patients. Liaison with social services, Medicaid, food pantry etc.

2012-2013 **Junior Director, St. Vincent's Student-Run Free Clinic** (8 hrs/wk)
Mentored pre-clinical students on providing technically and socially competent care to uninsured patients.

2009-2011 **Student provider, St. Vincent's Student-Run Free Clinic** (4 hrs/wk)
Provided direct care under faculty and senior student supervision.

PROFESSIONAL ORGANIZATIONS

American Society for Bioethics and Humanities
Gold Humanism Honor Society
American Academy of Pediatrics

LANGUAGES

Spanish: ALTA certified with "native-like fluency" in medical Spanish

PERSONAL INTERESTS

Reading, camping, art museums, animal sightings.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

O.M.G., et al., *Petitioners*, v. Chad WOLF, Acting Secretary of the Department of Homeland Security, et al. *Respondents*.	Case No. 1:20-cv-00786 **EMERGENCY VERIFIED PETITION FOR A WRIT OF MANDAMUS AND COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF**

DECLARATION OF ATTORNEY AMY MALDONADO

I, Amy Maldonado, hereby declare under penalty of perjury as prescribed in 28 U.S.C. § 1746 as follows:

1. On Wednesday, March 17, 2020, counsel for the Petitioners and I were contacted regarding the urgent situation engendered by the COVID-19 coronavirus pandemic, with insufficient precautions placing families at risk at the three family residential centers (Dilley, Berks and Karnes). We began gathering lists of potential plaintiffs.

2. On Thursday, March 18, 2020, counsel for the Petitioners and I finalized a tentative list of plaintiffs, had several planning calls, and began drafting the Petition in this case overnight. I was delegated the responsibility for complying with the Flores Settlement Agreement notice and meet and confer requirements for the minor Petitioners.

3. At 7:33 p.m. EST on the evening of Thursday, March 19, 2020, I sent an e-mail to Erez Reuveni, Assistant Director, U.S. Department of Justice Office of Immigration Litigation to notify him of the current and ongoing violations of the minor Petitioners rights under the Flores Settlement with regard to the Respondents' treatment of them under the current COVID-19 coranavirus pandemic conditions, and to notify him of the imminent litigation being drafted on an emergency basis. I stated in that e-mail that I would be faxing the required letter noticing the government of Flores violations on Friday, March 20, 2020. From that time through the signing of this declaration at approximately 8:19 p.m. EST on Saturday, March 21 2020, I have not received any response from Mr. Reuveni, including any auto-response that would indicate that he is out of the office or not checking his e-mail.

4. On the evening of Thursday, March 19, 2020, I contacted Sarah B. Fabian, Senior Litigation Counsel, U.S. Department of Justice Office of Immigration Litigation – District Court Section, to confer with her by telephone regarding the violations of the minor Petitioners rights under the Flores Settlement with regard to the Respondents' treatment of them under the current COVID-19 coranvirus pandemic conditions, and to notify her of the imminent litigation on an emergency basis. I was able to reach her and speak to her personally, and Ms. Fabian stated to me

that, of course, since the petition was still being drafted and had not been filed, she has not been assigned to this case. Further, she advised that she may be conflicted out of litigation related to the COVID-19 coronavirus.

5. The team of attorneys for the Petitioners has been continuously drafting the Emergency Verified Petition for Mandamus and Complaint for Declaratory and Injunctive relief and gathering facts and witness/expert declarations, as well as drafting various other motions and memoranda from that time through the present.

6. On Friday, March 20, 2020, at 11:53 a.m. I attempted to contact Assistant U.S. Attorney Christopher Hair at his office number and on his mobile. He did not answer his work phone and was unavailable per the automatic message of the wireless network.

7. On Friday, March 20, 2020, I faxed letters formally notifying the Respondents of their violations of the Flores Settlement Agreement. Because I did not receive a final list of the minor Petitioners until late that afternoon, the faxes were sent at 4:35 p.m. EST to the U.S. Department of Justice Office of Immigration Litigation ("DOJ OIL"), and at 4:36 p.m. EST to the Office of the U.S. Attorney, Civil Division, for the District of Columbia. I contemporaneously called the Office of the U.S. Attorney for the District of Columbia, was unable to get a person on the line, and left a message. From that time through the signing of this declaration at approximately 8:19 p.m. EST on Saturday, March 21, 2020, I have not received any response to my faxes or to my phone call.

8. On Saturday, March 21, 2020, based on my concern that we give the Respondents as much notice as possible of the issues we are raising in our litigation on an emergency basis, and given the telework situation due to the pandemic, at 11:33 a.m. EST I e-mailed: (a) the faxes; and (b) a copy of a March 19, 2020 letter to Congress from Dr. Scott A. Allen, MD, FACP, Professor Emeritus, University of California, School of Medicine, Medical Subject Matter Expert, CRCL, DHS and Dr. Josiah D. Rich, MD, MPH, Professor of Medicine and Epidemiology, The Warren Alpert Medical School of Brown University, Medical Subject Matter Expert, CRCL, DHS, to everyone for whom I have an e-mail address who works at DOJ OIL or the Office of the U.S. Attorney, Civil Division, for the District of Columbia. Those persons are: (1) for DOJ OIL, Erez Reuveni, Sarah Fabian, Archith Ramkumar, and Joshua Press; and (2) for the Office of the U.S. Attorney for the District of Columbia, Civil Division, Daniel F. Van Horn, Chief of the Civil Division, and AUSAs Christopher Hair, Nicole Murley, and Cara Alsterberg.

9. I inadvertently made an error in Mr. Van Horn's e-mail address, and forwarded the original e-mail to the correct address at 11:36 a.m. EST. (without the March 19, 2020 letter to Congress). From the time that I sent the first e-mail through the signing of this declaration at approximately 8:19 p.m. EST on Saturday, March 21, 2020, I have not received any response to my e-mail.

10. On Saturday, March 21, 2020, at 11:54 a.m. EST I called DOJ OIL attorney Joshua Press on his cell phone, which I had from prior litigation. I was able to reach him and speak to him personally, and I expressed my request that he alert whoever may be the duty

attorney for the weekend for DOJ OIL regarding the imminent litigation and request for emergency relief. Mr. Press acknowledged the request.

11. On Saturday, March 21, 2020, at 5:48 p.m., I followed the directions on the website for the Office of the U.S. Attorney for the District of Columbia, Civil Division, which state "In an emergency outside normal business hours when no one can be reached at the Civil Division's general telephone number, contact the Department of Justice Command Center at (202) 514-5000." I spoke to "Jay."

12. At 6:06 p.m. EST, "Jay" from the Department of Justice Command Center returned my call, indicated that he was able to contact someone in the office of the U.S. Attorney, and that he would take my cell phone number and e-mail down, and that person would reach out to me. From the time that I received that call through the signing of this declaration at approximately 8:19 p.m. EST on Saturday, March 21, 2020, I have not received any e-mail or telephone call.

13. Counsel for the Petitioners has worked tirelessly to finalize the Emergency Petition and other pleadings in this case. It was simply impossible to do so and gather the volume of expert and witness testimony that we have by the end of business on Friday, March 20, 2020.

14. I have made every effort possible to apprise the Respondents of the substance of the Petitioners' concerns, have made every effort to reach an attorney for the Respondents, and have spoken with two DOJ OIL attorneys (Sarah Fabian and Joshua Press) who are not assigned to this matter. Upon scheduling of an emergency hearing, I will continue to make every effort to contact DOJ OIL and the Office of the U.S. Attorney for the District of Columbia, Civil Division so that they may participate.

Executed on March 21, 2020 in East Lansing, Michigan.

By: *<u>/s/ Amy Maldonado</u>*
Amy Maldonado (IL #6256961)

Amy Maldonado, Of Counsel **
ALDEA - THE PEOPLE'S JUSTICE CENTER
532 Walnut Street
Reading, PA 19601
Phone: (484) 877-8002
Fax: (484) 926-2032
Email: amy@aldeapjc.org

Attorney for Petitioners
***Application for admission pro hac vice forthcoming*