UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

JANET MALAM,

Plaintiff,

- against -

REBECCA ADDUCCI, in her official capacity as Detroit District Director of U.S. Immigration & Customs Enforcement; MATTHEW T. ALBENCE, in his official capacity as Deputy Director and Senior Official Performing the Duties of the Director of the U.S. Immigration & Customs Enforcement; CHAD WOLF, in his official capacity as Acting Secretary, U.S. Department of Homeland Security; WILLIAM P. BARR, in his official capacity as Attorney General, U.S. Department of Justice; U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT; HEIDI E. WASHINGTON, in her capacity of Director of Michigan Department of Corrections Calhoun Correctional Center,

Defendants,

And

RUBY BRISELDA ESCOBAR; AMER TOMA,

Plaintiff-Intervenors.

No. 2:20-cv-10829-JEL-APP

PLAINTIFF-INTERVENORS' MOTION FOR TEMPORARY RESTRAINING ORDER

Plaintiff-Intervenors Ruby Briselda Escobar and Amer Toma hereby move this Court, pursuant to Fed. R. Civ. P. 65, for a temporary restraining order. The grounds for this motion are set forth in the Brief in Support of Plaintiff-Intervenors'

Motion for Temporary Restraining Order, filed herewith and the accompanying Declarations in support.

In accordance with Local Rule 7.1(a), the Plaintiff-Intervenors' counsel contacted counsel for the parties to seek their consent of this motion. Counsel for Plaintiff has no objection to this motion. Counsel for Defendants object to this motion.

Dated: April 5, 2020

Respectfully submitted,

/s/ Miriam J. Aukerman
Miriam J. Aukerman (P63165)
Ayesha Elaine Lewis*
American Civil Liberties Union
Fund of Michigan
1514 Wealthy Street SE, Suite 260
Grand Rapids, MI 49506
Telephone: (616) 301-0930
maukerman@aclumich.org

Daniel S. Korobkin (P72842)
Monica C. Andrade (P81921)
American Civil Liberties Union
Fund of Michigan
2966 Woodward Avenue
Detroit, MI 48201
(313) 578-6824
dkorobkin@aclumich.org

David C. Fathi*
Eunice H. Cho*
American Civil Liberties Union
Foundation, National Prison
Project
915 15th St. N.W., 7th Floor
Washington, DC 20005
Telephone: (202) 548-6616
dfathi@aclu.org
echo@aclu.org

Anand V. Balakrishnan*
Michael K.T. Tan*
Omar C. Jadwat*
American Civil Liberties Union
Foundation Immigrants'
Rights Project
125 Broad Street, 18th Floor
New York, New York 10004
(212) 549-2660
abalakrishnan@aclu.org
mtan@aclu.org
ojadwat@aclu.org

My Khanh Ngo*
American Civil Liberties Union
Foundation Immigrants'
Rights Project
39 Drumm Street

San Francisco, CA 94111
Telephone: (415) 343-0770
mngo@aclu.org

PAUL, WEISS, RIFKIND, WHARTON &
GARRISON LLP

/s/ Jeannie S. Rhee
Jeannie S. Rhee
Mark F. Mendelsohn*
Rachel M. Fiorill*
Peter E. Jaffe
2001 K Street NW Washington, D.C. 20006-1047
Telephone: 202-223-7300
Facsimile: 202-223-7420
jrhee@paulweiss.com
mmendelsohn@paulweiss.com
pjaffe@paulweiss.com
rfiorille@paulweiss.com

Jonathan M. Silberstein-Loeb*
1285 Avenue of the Americas
New York, N.Y. 10019-6064
Telephone: 212-373-3000
Facsimile: 212-757-3990
jsilberstein-loeb@paulweiss.com

Attorneys for Plaintiff-Intervenors
* Application for admission forthcoming

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Plaintiff,

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REBECCA ADDUCCI, in her official capacity as Detroit District Director of U.S. Immigration & Customs Enforcement; MATTHEW T. ALBENCE, in his official capacity as Deputy Director and Senior Official Performing the Duties of the Director of the U.S. Immigration & Customs Enforcement; CHAD WOLF, in his official capacity as Acting Secretary, U.S. Department of Homeland Security; WILLIAM P. BARR, in his official capacity as Attorney General, U.S. Department of Justice; U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT; HEIDI E. WASHINGTON, in her capacity of Director of Michigan Department of Corrections Calhoun Correctional Center,

Defendants,

And

Ruby Briselda Escobar; Amer Toma,

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No. 2:20-cv-10829-JEL-APP

BRIEF IN SUPPORT OF PLAINTIFF-INTERVENORS' MOTION FOR TEMPORARY RESTRAINING ORDER

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INTRODUCTION

Ruby Briselda Escobar and Amer Toma are non-citizen detainees with pre-existing medical conditions that make them highly vulnerable to serious illness and death from the COVID-19 disease, who are being held in civil detention at the Calhoun County Correctional Center ("Calhoun") in Battle Creek, Michigan in violation of their Due Process rights. Tragically, the COVID-19 disease is likely to infect scores of immigrant detainees across the country because of the confined, congregate nature of the detention facilities in which immigration detainees are held. COVID-19 has no vaccine, no treatment, and no cure. The only option for medically vulnerable people to avoid serious illness and death from COVID-19 is to practice social distancing. At Calhoun, because of the close quarters in which detainees are held, it is impossible to practice social distancing to avoid infection.

Given the nature of this pandemic, there is no way to ensure that at-risk individuals such as Ms. Escobar and Mr. Toma (collectively "Plaintiffs") receive adequate protection from COVID-19 while they remain in detention. Unless they are immediately released from detention, their constitutional rights will afford them no protection from contagion. Their release, along with adequate public health and safety measures, is also in the interest of Defendants and the public generally because a rapid outbreak with severe

consequences for the detainee population would drain the Battle Creek metropolitan area of limited resources, including ventilators.

For these reasons, and for the reasons explained further below, the Court should grant Plaintiffs' motion and order their immediate release from detention.

FACTS

As of April 4, 2020, 241,703 people in the United States have contracted COVID-19, and 5,854 people in the United States have died from the disease.[1] Greifinger Decl. ¶ 3. Plaintiffs, like other older individuals and individuals with certain medical conditions, are acutely vulnerable to the disease and face greater chances of serious illness or death.[2] Golob Decl. ¶ 3. People with these medical conditions who contract COVID-19 typically require advanced support, including highly specialized equipment and a team of medical providers. Golob Decl. ¶ 8. As explained below, Plaintiffs are at grave risk of serious illness or death if exposed to COVID-19. So long as Plaintiffs are detained at Calhoun, they cannot protect themselves, including by practice social distancing, and they do not have access to the necessary

[1] Coronavirus disease 2019 (COVID-19) Situation Report – 75, World Health Organization (Apr. 4, 2020), Ngo Decl. Ex. A.

[2] Plaintiff-Intervenors' Petition for the Writ of Habeas Corpus Pursuant to 28 U.S.C. § 2241 ("Pet.") ¶¶ 44-49.

hygiene services and facilities to avoid infection, which puts them at imminent risk of substantial bodily harm and death. As explained further below, for these reasons, and for the reasons in the supporting declarations, Plaintiffs should be released from detention.

I. PLAINTIFFS ARE ESPECIALLY SUSCEPTIBLE TO AND ARE AT GRAVE RISK OF HARM FROM COVID-19.

Plaintiffs have underlying medical conditions that increase their risk of serious illness or fatality if exposed to COVID-19. Ruby Briselda Escobar suffers from a brain aneurysm and a congenital heart murmur, which may have developed into heart disease. Hobballah Decl. ¶ 7(d)–(f). As a result, Ms. Escobar regularly experiences heart problems that manifest in heavy sweating, weakness, chest pain, and difficulty breathing. *Id*. ¶ 7(e). Moreover, the brain aneurysm often causes headaches, brain fogginess and forgetfulness, dizziness, nausea, vomiting, double vision, and trouble speaking clearly. *Id*. ¶ 7(g). During her time in detention, Ms. Escobar has not received regular medical treatment from a licensed physician. *Id*. ¶ 7(h)–(i).

Amer Toma is wheelchair bound as a result of three bullets lodged in his body from being shot during the Iran-Iraq war. These injuries cause intense back pain, and at times cause infection and swelling. Kaplovits Decl. ¶¶ 7-8. In addition, Mr. Toma has been hospitalized for prostate issues, for

which he has not received medical care while in detention. *Id.* ¶¶ 9–10. After Mr. Toma recently reported blood in his stool, his doctor recommended that Mr. Toma undergo cancer testing. Mr. Toma has been unable to receive testing for bowel or prostate cancer while in detention. *Id.* ¶¶ 9–10.

II. DETENTION AT CALHOUN PUTS PLAINTIFFS AT IMMINENT RISK OF SUBSTANTIAL BODILY HARM.

The danger of COVID-19 to Plaintiffs is especially acute at Calhoun. Infectious diseases like COVID-19, which are communicable by air and touch, are exponentially more likely to spread in "congregate environments," such as immigration detention centers.[3] Greifinger Decl. ¶¶ 8, 10; Letter from Drs. Scott A. Allen & Josiah Rich to Rep. Bennie Thompson et al. (Mar. 19, 2020), Ngo Decl. Ex. D. Social distancing and vigilant hygiene, including

[3] COVID-19 may already be at Calhoun: as of April 4, 2020, thirteen ICE detainees (across eight facilities in Arizona, California, Louisiana, New Jersey, and Pennsylvania) tested positive for COVID-19; seven ICE detention center employees (across five facilities in Colorado, New Jersey, Louisiana and Texas) tested positive for the virus. *See* U.S. Immigration & Customs Enforcement, ICE Guidance on COVID-19: Confirmed Cases (last updated Apr. 4, 2020), Ngo Decl. Ex. B. Due to lack of testing, that number is likely an undercount of the actual numbers of positive results. *See* Greifinger Decl. ¶¶ 3, 12(c). An internal ICE COVID-19 report states that, as of March 19, 2020, ICE's Health Services Corps had isolated nine detainees and it was monitoring 24 more in ten different ICE facilities, and 1,444 officials with ICE and DHS were in precautionary self-quarantine. *See* Ken Klippenstein, *Exclusive: ICE Detainees Are Being Quarantined*, The Nation (Mar. 24, 2020), Ngo Decl. Ex. C.

frequent washing of hands with soap and water, are the only known effective measures for protecting vulnerable people from COVID-19. Ngo Decl. Ex. D at 4; Greifinger Decl. ¶¶ 4, 8.

Recent guidance issued by the United States Immigration and Customs Enforcement ("ICE") acknowledges the risks of COVID-19 to civil detainees.[4] However, even if the guidance were being followed at Calhoun– and it is not–it is impractical, does not reflect the reality of conditions at Calhoun, and is "wholly insufficient to adequately face the crisis at hand" for the reasons enumerated below. Greifinger Decl. ¶ 12.

First, the structure of the Calhoun facility makes social distancing impossible. *Id.* ¶ 10 ("People [housed in Calhoun] live in close quarters and *cannot* achieve the 'social distancing' needed to effectively prevent the spread of COVID-19.") (emphasis added). ICE recommends that "[d]etainees who meet CDC criteria for epidemiologic risk of exposure to COVID-19 [be] housed separately from the general population," but at Calhoun medically vulnerable individuals like Plaintiffs remain housed in the general population. Greifinger Decl. ¶ 12(f), 12(h); Hobballah Decl. ¶ 8(a); Kaplovitz Decl. ¶¶ 12–13. Plaintiffs and other detained individuals are kept together in "pods"—

[4] *ICE Guidance on COVID-19* ("ICE Guidance"), U.S. Immigration & Customs Enforcement, www.ice.gov/covid19.

groups of fifty to sixty people who eat, live, and sleep in closely confined quarters. Gai Decl. ¶¶ 3–4, 10–16; Kaplovitz Decl. ¶¶ 12–13.

Most detainees sleep close together in cells, in which they are always within six feet of each other, and share one toilet and sink. Gai Decl. ¶ 16; Hobballah Decl. ¶ 8(a)–(c); Kaplovitz Decl. ¶¶ 12–13. Both food preparation and service are communal, with little opportunity for surface disinfection. Greifinger Decl. ¶ 10. Detainees eat all meals in a communal dining hall, where they sit at tables with four to six other people, all approximately two feet apart from each other. Gai Decl. ¶ 21; Kaplovitz Decl. ¶ 13. In the past few weeks, at least one "pod" at Calhoun has been on "lockdown." Gai Decl. ¶ 19; Hobballah Decl. ¶ 8(b). During "lockdown," detainees are forced to stay in their cells with multiple other cellmates in close proximity. Hobballah Decl. ¶ 8(b). Other detainees are visibly ill. Gai Decl. ¶ 20; Hobballah Decl. ¶ 8(d). And, new detainees arrive almost daily, including recently one detainee who "was not allowed to get on an airplane because he was coughing and had a fever," and thereafter was returned to Calhoun. Gai Decl. ¶¶ 14, 20.

Second, Plaintiffs, and other detainees at Calhoun do not have access to the necessary hygiene services or facilities. Detainees do not have access to hand sanitizer. Gai Decl. ¶ 7. In addition to the toilet and sink in their cells,

detainees share a communal toilet, sink, and shower–without disinfection between use–with other detainees in their pod on the main floor of the facility. Gai Decl. ¶¶ 10–12; Greifinger Decl. ¶ 10. At least one communal sink has been broken for an extended period of time, and none provided soap for handwashing. *Id*. ¶¶ 8, 11.

Finally, the steps Defendants have taken at Calhoun to prevent the spread of contagion offer no protection to Plaintiffs and little for the detainee population generally. For example, Detainees have rarely, if ever, observed Calhoun employees wearing gloves or masks, nor have they noticed the implementation of any additional cleaning measures, and reported receiving little to no information about the pandemic. Gai Decl. ¶ 12–13; Hobballah Decl. ¶ 8(e); Kaplovitz Decl. ¶¶ 11, 14. Detainees have been unable to obtain testing for COVID-19, even when they have exhibited symptoms. Gai Decl. ¶ 2 ("Last week I had a fever and cough, and I requested a test for Covid-19 but I was not tested[.]"); . Greifinger Decl. ¶ 12(c) ("[T]here is no protocol for testing of asymptomatic detainees or staff and other individuals, like vendors and attorneys, who enter the detention facility.").

Defendants cannot adequately ensure Plaintiffs' safety. It is specious to suggest that Calhoun could possibly adhere to the CDC's social distancing guidelines. Calhoun is a crowded detention facility. Detainees and staff

regularly come and go. It is impossible for Plaintiffs to shelter in place, free from the risk of interacting with strangers who may be carriers for the disease. Moreover, no evidence suggests that Calhoun can regularly provide testing to staff or new detainees as they come and go. Nor can Calhoun provide the sanitization and hygiene required to protect Plaintiffs adequately. The facilities simply do not exist.

Calhoun also cannot ensure adequate treatment of infected detainees. People with certain pre-existing conditions who contract COVID-19 often need intensive medical assistance. Golob Decl. ¶ 8. Such an advanced level of supportive care requires specialized equipment, as well as an entire team of providers, including nurses, respiratory therapists, and intensive care physicians, which Calhoun does not possess. *Id.* Finally, because Calhoun cannot guarantee widespread testing for COVID-19, the government effectively concedes that Calhoun detainees and employees will be entirely unaware about who is actually contracting the disease and how far it has spread.

For these reasons and others enumerated in the supporting declarations, Plaintiffs are at risk of imminent and substantial bodily harm.

III. RELEASE FROM DETENTION IS THE ONLY WAY TO PROTECT PLAINTIFFS' SAFETY AND THEIR DUE PROCESS RIGHTS.

Plaintiffs cannot find safety at Calhoun. Only their release from detention will vindicate their Due Process rights. Public health experts and prison administrators across the country have made it abundantly clear that medically vulnerable populations kept in detention facilities must be released for their own safety and for the safety of others.[5] In Michigan, Governor Gretchen Whitmer has authorized enhanced early-release for county jails,

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[5] Multiple other jurisdictions, including Los Angeles, CA, Chicago, IL, Harris County, TX, New York City, and the entire states of New Jersey and Iowa, have released thousands of people from custody, acknowledging the grave threat posed by a viral outbreak in jails and detention centers. *See* Letter from Bd. of Correction of the City of New York to Criminal Justice Leaders (Mar. 21, 2020), Ngo Decl. Ex. E at 2 (detailing efforts of jurisdictions around the country to lower jail and prison populations, including Los Angeles (CA), San Francisco (CA), Cook County (IL), Autauga County (AL), Augusta County (VA), Allegheny County (PA), Hamilton County (OH), Harris County(TX), Travis County (TX), and Cuyahoga County (OH)); *see also*, *e.g.*, News Release, *California Chief Justice Issues Second Advisory on Emergency Relief Measures* (Mar. 20, 2020), Ngo Decl. Ex. F; Linh Ta, *Iowa's prisons will accelerate release of approved inmates to mitigate COVID-19*, Times Republican (Mar. 23, 2020), Ngo Decl. Ex. G (announcing Iowa Department of Corrections' plans to expedite release of about 700 inmates to mitigate spread of COVID-19); Frank Fernandez, *Coronavirus Preparation Prompts Volusia Jail to Release Some Non-Violent Offenders*, The Daytona Beach News-Journal (Mar. 20, 2020), Ngo Decl. Ex. H (describing Florida correctional facility's release of 88 individuals from jail); BBC News, *US Jails Begin Releasing Prisoners to Stem Covid-19 Infections* (Mar. 19, 2020), Ngo Decl. Ex. I.

local lockups, and juvenile detention centers.[6] Similarly, Chief Justice Bridget M. McCormack and Sheriff Matt Saxton have urged judges and sheriffs to do all they can to reduce and suspend jail sentences.[7]

DHS's own subject matter experts have also stressed that Defendants should release "all detainees in high risk medical groups, such as older people and those with chronic disease." Ngo Decl. Ex. D at 5-6.[8] The same analysis applies with equal force to Calhoun. *See* Greifinger Decl. ¶ 17 (correctional medical expert recommending release of high-risk individuals as a "key part of a risk mitigation strategy"); Golob Decl. ¶ 14 (infectious disease specialist concluding there are "many reasons" that vulnerable people are at grave risk).

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6 *See* Mich. Exec. Order No. 2020-29 (dated Apr. 26, 2020), https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-523422--,00.html, Ngo Decl. Ex. J.

7 *See* Joint Statement (Mar. 26, 2020), *available at* https://courts.michigan.gov/News-Events/press_releases/Documents/CJ%20and%20MSA%20Joint%20Statement%20draft%202%20%28003%29.pdf, Ngo Decl. Ex. K.

8 Likewise, former Acting Director of ICE John Sandweg has also publicly called on the agency to release "thousands" of people in order to prevent an outbreak amongst detainees, ICE agents and officers, medical personnel, contract workers, and others who work in ICE's facilities. *See* John Sandweg, *I Used to Run ICE. We Need to Release the Nonviolent Detainees*, The Atlantic (Mar. 22, 2020), https://www.theatlantic.com/ideas/archive/2020/03/release-ice-detainees/608536/, Ngo Decl. Ex. L.

ARGUMENT

Plaintiffs easily meet the legal requirements for the Court to grant them a temporary restraining order. As explained below, (1) they are likely to succeed on the merits of their claims; (2) they are likely to suffer irreparable harm in the absence of relief; (3) the balance of equities tips in their favor; and, (4) an injunction is in the public interest. *See Winter v. Nat. Res. Def. Council, Inc*., 555 U.S. 7, 20 (2008); *McKinney v. Villalva*, No. 10-11581, 2010 WL 2730759, at *1 (E.D. Mich. July 9, 2010) (citing *Ohio Republican Party v. Brunner*, 543 F.3d 357, 361 (6th Cir. 2008) ("The same factors are considered in determining whether to grant a request for either a temporary restraining order or a preliminary injunction."). The court must balance each of the four factors and "no single factor is dispositive." *City of Dearborn v. Comcast of Mich.*, 558 F. Supp. 2d 750, 754 (E.D. Mich. 2008). Where plaintiffs demonstrate "irreparable harm which decidedly outweighs any potential harm to the defendant," the "degree of likelihood of success required" is less, and a plaintiff need only "serious questions going to the merits." *In re DeLorean Motor Co.*, 755 F.2d 1223, 1229 (6th Cir. 1985).

IV. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS.

Plaintiffs are likely to establish that Defendants violated—and continue to violate—Plaintiffs' constitutional rights by condemning them,

notwithstanding their particular medical vulnerabilities, to confined quarters with inadequate hygiene supplies and non-functioning facilities, where they are unable to practice social distancing. As explained above, Defendants *cannot* fully remedy any potential harm suffered by Plaintiffs as a result of COVID-19. Accordingly, Plaintiffs' continual detention at Calhoun violates their Fifth Amendment rights.[9]

A. Plaintiffs' Continued Detention at Calhoun Violates the Fifth Amendment.

Defendants have violated, and continue to violate, Plaintiffs' constitutional Due Process rights by detaining them in conditions that in no way "reasonably relate[] to a legitimate governmental purpose." *Bell*, 441 U.S. at 539. Under the Fifth Amendment, civil detention may not "amount to punishment of the detainee." *Id.* at 535. Because of their underlying health

[9] As civil detainees, Plaintiffs' detention is governed by the Fifth Amendment. *Bell v. Wolfish*, 441 U.S. 520, 539 (1979). However, Plaintiffs' continued detention would also violate the Eighth Amendment's prohibition of cruel and unusual punishment—a much stricter standard than the Fifth Amendment's ban on any punishment, which applies here. This is because Defendants have ignored "a condition of confinement that is sure or very likely to cause serious illness" by crowding Plaintiffs into living quarters with others who have "infectious maladies . . . even though the possible infection might not affect all of those exposed." *Helling*, 509 U.S. at 32-33. *See Bell*, 441 U.S. at 539; *Thakker*, No. 1:20-cv-480, at *22 n.15 (ordering immediate release of immigration detainees due to COVID-19 under the Fifth Amendment, and, citing *Helling*, finding that plaintiffs had also met the "more exacting Eighth Amendment standard").

conditions, which make them especially vulnerable to infection from COVID-19, the condition of Plaintiffs' confinement is not "reasonably related to a legitimate governmental objective"; instead it is "arbitrary or purposeless[.]" *Id.* at 539*; see also J.H. v. Williamson Cty., Tenn.*, 951 F.3d 709, 717 (6th Cir. 2020) (applying *Bell* test to pre-trial detainee's conditions of confinement claim); *Turner v. Stumbo*, 701 F.2d 567, 572–73 (6th Cir. 1983) (same).[10]

Plaintiffs' detention is not "reasonably related" to its objective because it creates a serious risk of imminent illness and death. *See Bell*, 441 U.S. at

[10] Defendants have focused their briefing on deliberate indifference, focusing heavily on cases that predate the Supreme Court's decision *Kingsley v. Hendrickson*, —— U.S. ——, 135 S. Ct. 2466, 192 L.Ed.2d 416 (2015); Gov. Br., ECF No. 11. In *Kingsley*, the Court held that a pretrial detainee's Fourteenth Amendment excessive force claim need only meet the objective component of a deliberate indifference claim by showing that "the force purposely or knowingly used against him was objectively unreasonable." 135 S. Ct. at 2473. As the Sixth Circuit has recognized, "this shift in Fourteenth Amendment deliberate indifference jurisprudence calls into serious doubt whether [a plaintiff] need even show that the individual defendant-officials were subjectively aware of [the plaintiff's] serious medical conditions and nonetheless wantonly disregarded them." *Richmond v. Huq*, 885 F.3d 928, 938 n.3 (6th Cir. 2018). *See also Martin v. Warren Cty.*, Kentucky, __ F. App'x __, __ n. 4, 2020 WL 360436, at *4 n.4 (6th Cir. Jan. 22, 2020), reh'g denied (Feb. 4, 2020); *Griffith v. Franklin County, Kentucky*, 2019 WL 1387691, at * 5 (E.D. Kent. 2019) (holding that after *Kingsley*, a pretrial detainee need not show subjective deliberate indifference). Plaintiffs here meet the due process standard under either the traditional or a post-*Kingsley* test. However, there is no need for the Court to reach these issues. It can simply apply the *Bell* test, as recently reaffirmed by the Sixth Circuit in *Williamson Cty*.

539. In all likelihood, there are already detainees or workers at Calhoun carrying the novel coronavirus asymptomatically, making it only a matter of time before they begin to show symptoms of COVID-19. *See supra* Factual Background Sec. II-III. This risk is urgent, imminent, and unrelated to any legitimate governmental goal, as several federal courts have already held. *See, e.g.*, *Xochihua-Jaimes v. Barr*, No. 18-71460, 2020 WL 1429877 (9th Cir. Mar. 24, 2020) (*sua sponte* ordering immediate release of immigrant petitioner "[i]n light of the rapidly escalating public health crisis, which public health authorities predict will especially impact immigration detention centers"); *Thakker v. Doll*, No. 1:20-cv-480 (M.D. Pa. Mar. 31, 2020) (ordering immediate release of immigrant petitioners because "we can see no rational relationship between a legitimate government objective and keeping Petitioners detained in unsanitary, tightly-packed environments").

B. Plaintiffs' Release Is the Sole Effective Remedy for the Constitutional Violation at Issue.

Plaintiffs' immediate release is the sole effective remedy for the constitutional violation faced by Plaintiffs. When the government fails to meet its obligations to provide adequate medical care, courts have a responsibility to remedy the resulting constitutional violation. *See Brown*, 563 U.S. at 511 ("When necessary to ensure compliance with a constitutional mandate, courts may enter orders placing limits on a prison's population.").

The power to remedy constitutional violations arising from government confinement falls within the Court's broad power to fashion equitable relief. *See Hutto*, 437 U.S. at 687 n.9.

To vindicate detainees' Due Process rights in the face of the COVID-19 pandemic, federal and state courts across the country have ordered the release of detained individuals. *See, e.g.*, *Velaszquez v. Wolf*, No. EDCV 20-00627 TJH (C.D. Cal. April 2, 2020) (ordering release of detainee in California due to threat of COVID-19); *Coronel v. Decker*, No. 20-cv-2472, 2020 WL 1487274 (S.D.N.Y. Mar. 27, 2020) (ordering release of four medically vulnerable immigrant plaintiffs held in New York and New Jersey detention centers due to thread of COVID-19); *Basank v. Decker*, No. 20-cv-2518, 2020 WL 1481503, at *1 (S.D.N.Y. Mar. 26, 2020) (same, for ten immigrant plaintiffs who "suffer[] from chronic medical conditions, and face[] an imminent risk of death or serious injury in immigration detention if exposed to COVID-19"); *Calderon Jimenez v. Wolf*, No. 18-10225-MLW, ECF No. 507 (D. Mass. Mar. 26, 2020) (ordering grant of bail for an immigrant detainee held in Plymouth County, Massachusetts because "being in jail enhances risk").[11] On March 23, 2020, the Ninth Circuit ordered, *sua*

[11] *See also United States v. Garlock.*, No. 18-CR-00418, 2020 WL 1439980, at *1 (N.D. Cal. Mar. 25, 2020) (ordering, *sua sponte*, extension of convicted defendant's surrender date and noting "[b]y now

sponte, the release of an immigrant petitioner "[i]n light of the rapidly escalating public health crisis, which public health authorities predict will

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it almost goes without saying that we should not be adding to the prison population during the COVID-19 pandemic if it can be avoided"); *In re Extradition of Toledo Manrique*, No. 19-71055, 2020 WL 1307109, at *1 (N.D. Cal. Mar. 19, 2020) (granting bail for 74-year-old detainee subject to extradition proceedings due to concerns regarding COVID-19); *Umana Jovel v. Decker et al.*, 20 Civ. 308, 2020 WL 1467397, at *2 (S.D.N.Y. Mar. 26, 2020) (granting emergency request for release of petitioner from immigration detention in light of the COVID-19 crisis); *United States v. Stephens*, 15 Cr. 95 (AJN), 2020 WL 1295155 (S.D.N.Y. Mar. 19, 2020) (granting motion for reconsideration of defendant's bail conditions and releasing him from jail to home confinement, recognizing inmates may be at a heightened risk of contracting COVID-19); *United States v. Martin*, No. 19-cr-140-13, 2020 WL 1274857, at *2 (D. Md. Mar. 17, 2020) (explaining that exposure to COVID-19 can lead to "serious (potentially fatal, if the detainee is elderly and with underlying medical complications) illness"); *In re Request to Commute or Suspend County Jail Sentences*, Dkt. No. 084230 (N.J. Mar. 22, 2020) (ordering, based on the dangers posed by COVID-19, release of any inmate in New Jersey serving a county jail sentence as a condition of probation or as a result of a municipal court conviction); *People ex rel. Stoughton on behalf of Little et al. v. Brann*, Index No. 260154/2020 (Bronx Sup. Ct. Mar. 25, 2020) (releasing 106 individuals held at Rikers Island jail on parole violations who are particularly vulnerable to illness or death if infected by COVID-19); *People ex rel. Stoughton on behalf of Hogan et al. v. Brann* (N.Y. Sup. Ct. Mar. 27, 2020) (releasing 16 individuals held at Rikers Island jail on pre-trial detention who were particularly vulnerable to illness or death due to COVID-19); Memorandum from Donald W. Beatty, Chief Justice of South Carolina Supreme Court, to Magistrates, Municipal Judges, and Summary Court Staff (Mar. 16, 2020), Ngo Decl. Ex. M (ordering that everyone held on bond in a non-capital case be released, unless there exists an "unreasonable danger" or "extreme flight risk").

especially impact immigration detention centers." *Xochihua-Jaimes*, No. 18-71460, 2020 WL 1429877, at *1.

In this case, as in the many similar cases listed above, the Plaintiffs' immediate release from detention is the only effective remedy for the constitutional violation they are suffering. There is no known cure or treatment for COVID-19, no known vaccine, and no known natural immunity. The only way to mitigate the spread of contagion is through social distancing and enhanced hygiene. *See supra* Factual Background II. At Calhoun, Plaintiffs cannot maintain the necessary distance from either their fellow detainees or the staff at the facility sufficient to protect their health. Nor do Plaintiffs have access to the requisite supplies and facilities to adhere to the government's hygiene guidelines for preventing infection.

Because Plaintiffs have shown that their continued detention would cause an unacceptably high risk of grave injury, Plaintiffs are likely to succeed on the merits of their claim that their continued detention violates their rights under the Fifth Amendment, and that release from custody is the only permissible way to ensure their safety and the safety of others with whom they are currently in close and daily contact.

C. Plaintiffs May Seek Relief Through Both Habeas and An Implied Action Under the Due Process Clause.

Plaintiffs may seek relief both under 28 U.S.C. § 2241, as a habeas corpus petition, and 28 U.S.C. § 1331, as an independent cause of action for injunctive relief under the Due Process clause. Defendants' threshold arguments regarding the lack of a vehicle for relief here therefore fail.

1. Plaintiffs' Claims for Release Are Within the Core of Habeas Corpus.

28 U.S.C. § 2241(d) provides habeas jurisdiction over an individual held "in custody in violation of the Constitution or laws or treaties of the United States"—precisely the position that Plaintiffs are in. Defendants misconstrue Plaintiffs' claims as challenges to their conditions of confinement and argue that such claims do not lie in habeas. *See* ECF No. 11 at 7–8. But claims for "immediate discharge from . . . confinement" fall within the "core of habeas corpus," *Prieser v. Rodriguez*, 411 U.S. 475, 487 (1973), and Plaintiffs seek immediate release. *See* Pet. ¶ 7. Indeed, the claim brought by Plaintiffs—a due process challenge to the fact of their civil immigration detention—is regularly reviewed in habeas proceedings. *See, e.g.*, *Zadvydas v. Davis*, 533 U.S. 678, 684–85, 690 (2001) (due process challenge to detention brought in habeas); *Ly v. Hansen*, 351 F.3d 263, 266 (6th Cir. 2003) (abrogation on other grounds recognized by *Hamama v. Adducci*, 946 F.3d

875, 879 (6th Cir. 2020)) (same). Accordingly, numerous federal courts across the circuits have found habeas jurisdiction proper to order release to remedy the same injury faced by Plaintiffs here.[12]

Defendants cite cases holding that challenges to conditions of confinement *per se* fall outside the scope of habeas. ECF No. 11 (Gov. Br.) at 7–8. Crucially, the relief sought in those cases was *not* release from detention but rather modification of the conditions of detention. *See Luedtke v. Berkebile*, 704 F.3d 465, 465–66 (6th Cir. 2013) (challenge to lack of compensation and conditions of work performed in prison); *Sullivan v. United States*, 90 Fed. App'x 862, 862 (6th Cir. 2004) (seeking medical treatment in prison); *Lutz v. Hemingway*, 476 F.Supp. 2d 715, 718 (E.D. Mich. 2007) (seeking restoration of mail privileges in prison); *see also Nelson v. Campbell*, 541 U.S. 637, 643–44 (2004) (challenge to lethal injection protocol); *Muhammad v. Close*, 540 U.S. 749, 753–54 (2004) (seeking to expunge misconduct charge in prison record); *Martin v. Overton*, 391 F.3d 710, 712

[12] *See, e.g.*, *Coronel v. Decker*, No. 20-cv-2472 (AJN),——F. Supp. 3d.––—, 2020 WL 1487274, at *1 (S.D.N.Y. Mar. 27, 2020) (granting TRO based on similar habeas claim); *Bravo Castillo v. Barr*, No. 20-cv-00605 TJH (AJMx), ——F. Supp. 3d——, 2020 WL 1502864, at *6 (C.D. Cal. Mar. 27, 2020) (same); *Thakker v. Doll*, No. 1:20-cv-480, ECF No. 47, at 22, 25 (M.D. Pa. Mar. 31, 2020) (same); *see also Coreas v. Bounds*, No TDC-20-0780, ECF No. 56, at 14–15 (D. Md. Apr. 3, 2020) (agreeing that "a claim by an immigration detainee seeking release . . . is cognizable under § 2241").

(6th Cir. 2004) (seeking transfer).[13] Plaintiffs are not seeking the amelioration of their conditions of confinement. In fact, just the opposite: given Plaintiffs' vulnerabilities, and the manner in which COVID 19 is spread in congregate settings like Calhoun, there are *no* detention conditions that can adequately or constitutionally house them, and release is the necessary relief.

2. Plaintiffs Also Have An Independent Action In Equity Under the Fifth Amendment.

Federal courts have long recognized an implicit private right of action under the Constitution "as a general matter" to issue prospective injunctive relief against government action. *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 561 U.S. 477, 491 n.2 (2010); *accord Corr. Servs. Corp. v. Malesko*, 534 U.S. 61, 74 (2001) (equitable relief "has long been recognized as the proper means for preventing entities from acting unconstitutionally"); *Bolling v. Sharpe*, 347 U.S. 497 (1954) (holding that the Fifth Amendment and § 1331 created a remedy for unconstitutional racial discrimination in the Washington D.C. public school system); *Bell v. Hood*, 327 U.S. 678, 684 (1946) ("[I]t is established practice for this Court to sustain the jurisdiction of

[13] Moreover, petitioners in these cases were convicted federal or state prisoners. Plaintiffs here are civil immigration detainees, who have, as noted above, traditionally used § 2241 for constitutional challenges to their detention.

federal courts to issue injunctions to protect rights safeguarded by the Constitution").

Thus, there is both jurisdiction under 28 U.S.C. § 1331 and a cause of action under the Fifth Amendment to enjoin the Defendants' unconstitutional actions. *See Simmat v. U.S. Bureau of Prisons*, 413 F.3d 1225, 1231 (10th Cir. 2005) (implied cause of action under Eighth Amendment to enjoin unconstitutional prison conditions); *see also* Pet. ¶¶ 15–16.

Sovereign immunity poses no bar to Plaintiffs' challenge. First, Plaintiffs are suing for injunctive relief against federal officers in their official capacity. "The ability to sue to enjoin unconstitutional actions by state *and* federal officers is the creation of courts of equity, and reflects a long history of judicial review of illegal executive action, tracing back to England." *Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320, 327 (2015) (emphasis added). Second, Section 702 of the Administrative Procedures Act (5 U.S.C. § 702), operates as a waiver of sovereign immunity in "*all* non-monetary claims against federal agencies and their officers sued in their official capacity." *Muniz-Muniz v. U.S. Border Patrol*, 741 F.3d 668, 672 (6th Cir. 2013) (emphasis added). Thus, Plaintiffs can prevail under both theories.

V. PLAINTIFFS HAVE SATISFIED ALL OTHER FACTORS REQUIRED FOR THIS COURT TO GRANT A TEMPORARY RESTRAINING ORDER.

A. Plaintiffs' Exposure to COVID-19 Constitutes Irreparable Harm.

Plaintiffs, because of their underlying medical conditions, which make them especially susceptible to severe infection from COVID-19, confront immediate danger in violation of their Due Process rights. "When constitutional rights are threatened or impaired, irreparable injury is presumed." *Obama for Am. v. Husted*, 697 F.3d 423, 436 (6th Cir. 2012). Further, Plaintiffs' continued detention will inevitably delay or prevent them from obtaining medical services, which threatens to worsen Plaintiffs' health. *See Wilson v. Gordon*, 822 F.3d 934, 958 (6th Cir. 2016) (noting that delay in medical treatment can constitute irreparable injury and acknowledging that "[c]ourts routinely uphold preliminary injunctions where the alleged irreparable harm involves delay in or inability to obtain medical services").

B. The Public Interest and the Balance of Equities Weigh Heavily in Plaintiffs' Favor.

So long as they continue to be confined at Calhoun, Plaintiffs' lives are in danger in violation of their Due Process rights. Releasing them from detention with the proper public health and safety precautions will protect their safety and remedy the continued violation of their constitutional rights, which is in the public interest. *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217,

222 (6th Cir. 2016) (holding that protection of constitutional rights is "a purpose that is always in the public interest"). Plaintiffs' release from detention, subject to appropriate public health and safety precautions, will also promote Defendants' interests in ensuring the safety of other detainees, the staff at Calhoun, and the community at large. Greifinger Decl. ¶ 17.

A rapid and severe outbreak at Calhoun would create a "tinderbox scenario" with dire consequences for detainees and workers at Calhoun as well as the Battle Creek metropolitan area, which would be drained of its limited medical resources, including intensive care unit beds and ventilators. In Michigan, the COVID-19 outbreak has already resulted in unprecedented public health measures and has strained the local health care system. Releasing vulnerable individuals will reduce the burden on the local community and health infrastructure and is clearly in the public interest. *See Calderon Jimenez*, No. 18-10225-MLW at 4.[14]

[14] As detained, indigent individuals, Plaintiffs request this Court to exercise its discretion to require no security in issuing this relief. *Urbain v. Knapp Bros. Mfg. Co.*, 217 F.2d 810, 815–16 (6th Cir. 1954) ("[T]he matter of requiring security in each case rests in the discretion of the District Judge.").

CONCLUSION

For the foregoing reasons, this Court should grant Plaintiffs' motion for a temporary restraining order and direct Plaintiffs' immediate release from Calhoun.

Dated: April 5, 2020

Respectfully submitted,

/s/ Miriam J. Aukerman
Miriam J. Aukerman (P63165)
Ayesha Elaine Lewis*
American Civil Liberties Union Fund of Michigan
1514 Wealthy Street SE, Suite 260
Grand Rapids, MI 49506
Telephone: (616) 301-0930
maukerman@aclumich.org

Daniel S. Korobkin (P72842)
Monica C. Andrade (P81921)
American Civil Liberties Union Fund of Michigan
2966 Woodward Avenue
Detroit, MI 48201
(313) 578-6824
dkorobkin@aclumich.org

David C. Fathi*
Eunice H. Cho*
American Civil Liberties Union Foundation, National Prison Project
915 15th St. N.W., 7th Floor
Washington, DC 20005
Telephone: (202) 548-6616
dfathi@aclu.org
echo@aclu.org

Anand V. Balakrishnan*
Michael K.T. Tan*
Omar C. Jadwat*
American Civil Liberties Union Foundation Immigrants' Rights Project
125 Broad Street, 18th Floor
New York, New York 10004
(212) 549-2660
abalakrishnan@aclu.org
mtan@aclu.org
ojadwat@aclu.org

My Khanh Ngo*
American Civil Liberties Union Foundation Immigrants' Rights Project
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 343-0770
mngo@aclu.org

PAUL, WEISS, RIFKIND, WHARTON &
GARRISON LLP

/s/ Jeannie S. Rhee
Jeannie S. Rhee
Mark F. Mendelsohn*
Rachel M. Fiorill*
Peter E. Jaffe
2001 K Street NW Washington, D.C. 20006-1047
Telephone: 202-223-7300
Facsimile: 202-223-7420
jrhee@paulweiss.com
mmendelsohn@paulweiss.com
pjaffe@paulweiss.com
rfiorille@paulweiss.com

Jonathan M. Silberstein-Loeb*
1285 Avenue of the Americas
New York, N.Y. 10019-6064
Telephone: 212-373-3000
Facsimile: 212-757-3990
jsilberstein-loeb@paulweiss.com

Attorneys for Plaintiff-Intervenors

* Application for admission forthcoming

CERTIFICATE OF SERVICE

I, Jeannie S. Rhee, certify that on April 5, 2020, I caused a true and correct copy of the foregoing document to be filed and served electronically via the ECF system. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system.

Respectfully submitted,

/s/ Jeannie S. Rhee

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

JANET MALAM,

Plaintiff,

- against -

REBECCA ADDUCCI, in her official capacity as Detroit District Director of U.S. Immigration & Customs Enforcement; MATTHEW T. ALBENCE, in his official capacity as Deputy Director and Senior Official Performing the Duties of the Director of the U.S. Immigration & Customs Enforcement; CHAD WOLF, in his official capacity as Acting Secretary, U.S. Department of Homeland Security; WILLIAM P. BARR, in his official capacity as Attorney General, U.S. Department of Justice; U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT; HEIDI E. WASHINGTON, in her capacity of Director of Michigan Department of Corrections Calhoun Correctional Center,

Defendants,

And

Ruby Briselda Escobar; Amer Toma,

Plaintiff-Intervenors.

No. 2:20-cv-10829-JEL-APP

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Exhibit 1: Declaration of Dr. Jonathan Louis Golob

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Exhibit 3: Declaration of My Khanh Ngo, Esq., Attorney for Intervenor-Plaintiffs

Exhibit 4: Declaration of Ronald Kaplovitz, Esq., Attorney for Amer Toma

Exhibit 5: Declaration of Farrah Hobballah, Esq., Attorney for Ruby Briselda Escobar

Exhibit 6: Declaration of Pay Par Gai

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

JANET MALAM,

Plaintiff,

- against -

REBECCA ADDUCCI, in her official capacity as Detroit District Director of U.S. Immigration & Customs Enforcement; MATTHEW T. ALBENCE, in his official capacity as Deputy Director and Senior Official Performing the Duties of the Director of the U.S. Immigration & Customs Enforcement; CHAD WOLF, in his official capacity as Acting Secretary, U.S. Department of Homeland Security; WILLIAM P. BARR, in his official capacity as Attorney General, U.S. Department of Justice; U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT; HEIDI E. WASHINGTON, in her capacity of Director of Michigan Department of Corrections Calhoun Correctional Center,

Defendants,

And

Ruby Briselda Escobar; Amer Toma,

Plaintiff-Intervenors.

No. 2:20-cv-10829-JEL-APP

DECLARATION OF DR. JONATHAN LOUIS GOLOB IN FURTHER SUPPORT OF PLANINTFF-INTERVENORS RUBY BRISELDA ESCOBAR AND AMER TOMA'S MOTION FOR TEMPORARY RESTRAINING ORDER

DECLARATION OF DR. JONATHAN LOUIS GOLOB

I, Jonathan Louis Golob, declare as follows:

1. I am an Assistant Professor at the University of Michigan School of Medicine in Ann Arbor, Michigan, where I am a specialist in infectious diseases and internal medicine. I am also a member of the Physicians for Human Rights. At the University of Michigan School of Medicine, I am a practicing physician and a laboratory-based scientist. My primary subspecialization is for infections in immunocompromised patients, and my recent scientific publications focus on how microbes affect immunocompromised people. I obtained my medical degree and completed my residency at the University of Washington School of Medicine in Seattle, Washington, and also completed a Fellowship in Internal Medicine Infectious Disease at the University of Washington. I am actively involved in the planning and care for patients with COVID-19. Attached as Exhibit A is a copy of my curriculum vitae.

2. COVID-19 is an infection caused by a novel zoonotic coronavirus SARS-COV-2 that has been identified as the cause of a viral outbreak that originated in Wuhan, China in December 2019. The World Health Organization has declared that COVID-19 is causing a pandemic. As of April 2, 2020, there are over 800,000 confirmed cases of COVID-19 worldwide. COVID-19 has caused over 45,000 deaths, with exponentially growing outbreaks occurring at multiple sites worldwide, including within the United States in regions like New York, New Jersey, Louisiana, Michigan and Illinois.

3. COVID-19 makes certain populations of people severely ill. People over the age of fifty are at higher risk, with those over 70 at serious risk. As the Center for Disease Control and Prevention has advised, certain medical conditions increase the risk of serious COVID-19 for people of any age. These medical conditions include: those with lung disease, heart disease, diabetes, or immunocompromised (such as from cancer, HIV, autoimmune diseases), blood disorders (including sickle cell disease), chronic liver or kidney disease, inherited metabolic disorders, stroke, developmental delay, or pregnancy.

4. For all people, even in advanced countries with very effective health care systems such as the Republic of Korea, the case fatality rate of this infection is about ten fold higher than that observed from a severe seasonal influenza. In the more vulnerable groups, both the need for care, including intensive care, and death is much higher than we observe from influenza infection: In the highest risk populations, the case fatality rate is about 15%. For high risk patients who do not die from COVID-19, a prolonged recovery is expected to be required, including the need for extensive rehabilitation for profound

deconditioning, loss of digits, neurologic damage, and loss of respiratory capacity that can be expected from such a severe illness.

5. In most people, the virus causes fever, cough, and shortness of breath. In high-risk individuals as noted above, this shortness of breath can often be severe. Even in younger and healthier people, infection of this virus requires supportive care, which includes supplemental oxygen, positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation.

6. The incubation period (between infection and the development of symptoms) for COVID-19 is typically 5 days, but can vary from as short as two days to an infected individual never developing symptoms. There is evidence that transmission can occur before the development of infection and from infected individuals who never develop symptoms. Thus, only with aggressive testing for SARS-COV-2 can a lack of positive tests establish a lack of risk for COVID-19.

7. When a community or institution lacks a comprehensive and rigorous testing regime, a lack of proven cases of COVID-19 is functionally meaningless for determining if there is a risk for COVID-19 transmission in a community or institution.

8. Most people in the higher risk categories will require more advanced support: positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation. Such care requires highly specialized equipment in limited supply as well as an entire team of care providers, including but not limited to 1:1 or 1:2 nurse to patient ratios, respiratory therapists and intensive care physicians. This level of support can quickly exceed local health care resources.

9. COVID-19 can severely damage the lung tissue, requiring an extensive period of rehabilitation and in some cases a permanent loss of respiratory capacity. The virus also seems to target the heart muscle itself, causing a medical condition called mycocarditis, or inflammation of the heart muscle. Myocarditis can affect the heart muscle and electrical system, which reduces the heart's ability to pump, leading to rapid or abnormal heart rhythms in the short term, and heart failure that limits exercise tolerance and the ability to work lifelong. There is emerging evidence that the virus can trigger an over-response by the immune system in infected people, further damaging tissues. This cytokine release syndrome can result in widespread damage to other organs, including permanent injury to the kidneys (leading to dialysis dependence) and neurologic injury.

10. There is no cure and vaccine for this infection. Unlike influenza, there is no known effective antiviral medication to prevent or treat infection from COVID-19. Experimental therapies are being attempted. The only known effective measures to reduce the risk for a vulnerable person from injury or death from COVID-19 are to prevent individuals from being infected with the COVID-19 virus. Social distancing, or remaining physically separated from known or potentially infected individuals, and hygiene, including washing with soap and water, are the only known effective measures for protecting vulnerable communities from COVID-19.

11. Nationally, without effective public health interventions, CDC projections indicate about 200 million people in the United States could be infected over the course of the epidemic, with as many as 1.5 million deaths in the most severe projections. Effective public health measures, including social distancing and hygiene for vulnerable populations, could reduce these numbers.

12. In early March, the highest known person-to-person transmission rates for COVID-19 were in a skilled nursing facility in Kirkland, Washington and on afflicted cruise ships in Japan and off the coast of California. More recently, the highest transmission rates have been recorded in the Rikers Island jail complex in New York City, which is over seven times the rate of transmission compared to the spread in New York City. To illustrate, the number of confirmed cases among inmates soared from one to nearly 200 in the matter of 12 days.

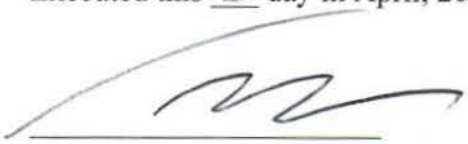
13. This is consistent with the spread of previous viruses in congregate settings. During the H1N1 influenza ("Swine Flu") epidemic in 2009, jails and prisons were sites of severe outbreaks of viral infection. Given the avid spread of COVID-19 in skilled nursing facilities and cruise ships, it is reasonable to expect COVID-19 will also readily spread in detention centers such as prisons and jails, particularly when residents cannot engage in social distancing measures, cannot practice proper hygiene, and cannot isolate themselves from infected residents or staff. With new individuals and staff coming into the detention centers who may be asymptomatic or not yet presenting symptoms, the risk of infection rises even with symptom screening measures.

14. This information provides many reasons to conclude that vulnerable people, people over the age of 50 and people of any age with lung disease, heart disease, diabetes, or immunocompromised (such as from cancer, HIV, autoimmune diseases), blood disorders (including sickle cell disease), chronic liver or kidney disease, inherited metabolic disorders, stroke, developmental delay, or pregnancy living in an institutional setting, such as a prison, or jail, or an immigration detention center, with limited access to

adequate hygiene facilities, limited ability to physically distance themselves from others, and exposure to potentially infected individuals from the community are at grave risk of severe illness and death from COVID-19.

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

Executed this 3 day in April, 2020 in Ann Arbor, Michigan.



Dr. Jonathan Louis Golob

Exhibit A

CV of Dr. Golob

Jonathan Louis Golob, M.D. Ph.D.
Assistant Professor
206 992-0428 (c) 734-647-3870 (o)
golobj@med.umich.edu jonathan@golob.org

Education and Training

6/1997 – 6/2001	**Bachelor of Science**, Johns Hopkins University, Baltimore, MD Dual degree in Biomedical Engineering and Computer Science conferred June 2001.
7/2001 – 6/2011	**MSTP MD/PhD Combined Degree**, University of Washington, Seattle, WA. Ph.D. on the basic science of embryonic stem cells, specifically epigenetic regulation of differentiation Ph.D. conferred in June 2009. MD conferred in June 2011.
6/2011 – 6/2013	**Internal Medicine Residency**, University of Washington, Seattle, WA
6/2013 – 6/2017	**Infectious Diseases Fellowship**, University of Washington, Seattle, WA

Certifications and Licensure

Board Certifications

2014	Diplomate in Internal Medicine**,** American Board of Internal Medicine.
2016	Diplomate in Infectious Disease**,** American Board of Internal Medicine.

Current Medical Licenses to Practice

2013	Washington State Medical License, Physician, MD60394350
2018	Michigan State Medical License, Physician, 4301114297

Academic, Administrative, and Clinical Appointments

Academic

6/2014 – 6/2018	**Senior Fellow, Vaccine and Infectious Disease Division**, Fred Hutchinson Cancer Research Center, Seattle, WA
8/2016 – 6/2018	**Joel Meyers Endowment Fellow**, Vaccine and Infectious Disease Division, Fred Hutchinson Cancer Research Center, Seattle, WA
8/2017 – 6/2018	**Research Associate, Vaccine and Infectious Disease Division**, Fred Hutchinson Cancer Research Center, Seattle, WA
8/2017 – 6/2018	**Acting Instructor**, Division of Allergy and Infectious Diseases, Department of Medicine, University of Washington, Seattle, WA
8/2018 – Present	**Assistant Professor, Division of Infectious Diseases,** Department of Medicine, University of Michigan, Ann Arbor, MI

Clinical

12/2015 – 12/2016	**Infectious Disease Locums Physician**, Virginia Mason Medical Center, Seattle, WA
7/2017 – 6/2018	**Hospitalist Internal Medicine Physician**, Virginia Mason Medical Center, Seattle, WA
8/2017 – 6/2018	**Attending Physician**, Seattle Cancer Care Alliance, Seattle, WA
8/2017 – 6/2018	**Attending Physician**, Division of Allergy and Infectious Diseases, Department of Medicine, University of Washington, Seattle, WA
8/2018 – Present	**Attending Physician,** Division of Infectious Diseases, Department of Medicine, University of Michigan, Ann Arbor, MI

Research Interests

1. I am primarily interested in understanding how the human gut microbiome *mechanistically* affects how patients respond to treatments. I have a particular focus on patients undergoing hematopoietic cell transplant, who are at risk for recurrence of their underlying disease, treatment-related colitis (from both conditioning and graft versus host disease), and infection. In human observational trials the human gut microbiome correlates with each of these aspects. My research program uses advanced stem-cell based *in-vitro* models of the human colonic mucosa to verify if the correlations in observational trials can cause similar effects *in vitro*, and then determine by which pathways (e.g. receptors) and broad mechanisms (e.g. epigenetics) the microbes affect the host.

2. Host-microbiome interactions are contextual. A beneficial interaction in health can turn pathologic. For example, my ongoing work focused on the microbial metabolite butyrate. Butyrate enhances the health of heathy and intact colonic epithelium, acting as a substrate for cellular respiration and through receptor-mediate processes reduces cellular inflammation. However, butyrate also blocks the ability of colonic stem cells to differentiate into mature epithelium. Thus, in colitis that results in a loss of colonic crypts, an intact and butyrogenic gut microbiome results in colonic stem cells being exposed to butyrate and inhibits recovery. My ongoing work uses a primary stem-cell based model of the human colonic mucusa to establish how butyrate blocks the differentiation of colonic stem cell with a hope of generating new treatments for patients with steroid-refractory colitis.

3. I am interested in validating and improving computational tools for biological research. I have a computer science and biomedical engineering background that combined with my clinical and molecular biology training positions me optimally to understand both major aspects of computational biology: what are the needs to make biological inferences from big data, and how can tools specifically be improved to achieve such inferences.

Grants

Present and Active

ASBMT New Investigator Award J. Golob (PI) 7/2018 – 7/2020
Hematopoietic Cell Transplant Outcomes and Microbial Metabolism
Role: PI
$30,000/yr for up to two years

NIH / NIAID R01 D. Fredricks (PI) 11/2017 – 11/2021
The Gut Microbiota and Graft versus Host Disease (GVHD), AI-134808
Role: Senior / key personnel
$823,701

NIH P01 T. Schmidt (PI) Pending / Reviewed
ENGINEERING MICROBIOMES AND THEIR MOLECULAR DETERMINANTS FOR PRODUCTION OF BUTYRATE AND SECONDARY BILE ACIDS FROM RESISTANT STARCH
Role: Key Personnel

NIH / NCI R21 J. Golob (PI) Pending / Submitted
Establishing a physiologic human colonic stem/progenitor cells model of regimen-related colitis
Role: PI

NIH R21 J. Golob (PI) Pending / Submitted
Manipulating Butyrate Production by the Gut Microbiome during Chronic HIV Infection
Role: PI

Completed

Joel Meyers Endowment Fellowship 6/2016 – 6/2018
Role: Research Fellow
$63,180

DCDR Grant R. Harrington (PI) 6/2014 – 6/2018
Support for data queries into the Deidentified Clinical Data Repository
Role: PI
$1000

NIH T32 Institutional Training Grant M. Boeckh (PI) 8/2016 – 8/2017
1T32AI118690-01A1
Role: Post-Doc Trainee
$315,972

NIH T32 Institutional Training Grant W. van Voorhis (PI) 7/1/14 – 6/30/16
5T32AI007044
Role: Post-Doc Trainee
$1,527,801

Honors and Awards

2001 Tau Beta Pi Engineering Honor Society
2001 Alpha Eta Mu Beta Biomedical Engineering Honor Society

2005 ARCS Fellowship
2015 Consultant of the Month Award. University of Washington Housestaff.
2016 Joel Meyer Endowment Fellow

Membership in Professional Societies

2013 Member, Infectious Diseases Society of America
2011 Member, American Board of Internal Medicine

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11. Ogimi C, Krantz EM, **Golob JL**, Waghmare A, Liu C, Leisenring WM, Woodard CR, Marquis S, Kuypers JM, Jerome KR, Pergam SA, Fredricks DN, Sorror ML, Englund JA, Boeckh M. Antibiotic Exposure Prior to Respiratory Viral Infection Is Associated with Progression to Lower Respiratory Tract Disease in Allogeneic Hematopoietic Cell

Transplant Recipients. Biol Blood Marrow Transplant. 2018 May 16. pii: S1083-8791(18)30268-4. doi: 10.1016/j.bbmt.2018.05.016. [Epub ahead of print]

12. **Golob JL**, Stern J, Holte S, Kitahata MM, Crane HM, Coombs RW, Goecker E, Woolfrey AE, Harrington RD. HIV DNA levels and decay in a cohort of 111 long-term virally suppressed patients. AIDS. 2018 Sep 24;32(15):2113-2118. doi: 10.1097/QAD.0000000000001948.
13. **Golob JL**, DeMeules MM, Loeffelholz T, Quinn ZZ, Dame MK, Silvestri SS, Wu MC, Schmidt TM, Fiedler TL, Hoostal MJ, Mielcarek M, Spence J, Pergam SA, Fredricks DN. Butyrogenic bacteria after acute graft-versus-host disease (GVHD) are associated with the development of steroid-refractory GVHD. Blood Adv. 2019 Oct 8;3(19):2866–2869.

Preprint publications

1. **Golob JL** and Minot SS. Functional Analysis of Metagenomes by Likelihood Inference (FAMLI) Successfully Compensates for Multi-Mapping Short Reads from Metagenomic Samples. Preprint. doi: https://doi.org/10.1101/295352

Other Publications

1. Science Columnist and Writer for *The Stranger*, Seattle, WA, 2004 – Present
2. Freelance contributor, Ars Technica, 2016 – Present.

Abstracts (presenter underlined)

1. **Golob JL,** Srinivasan S, Pergam SA, Liu C, Ko D, Aker S, Fredricks DN. Gut Microbiome Changes in Response to Protocolized Antibiotic Administration During Hematopoietic Cell Transplantation. ID Week, Infectious Diseases Society of America, October 2015 (Oral)
2. **Golob JL**, Stern J, Holte S, Kitahata M, Crane H, Coombs R, Goecker E, Woolfrey AE, Harrington RD. HIV reservoir size and decay in 114 individuals with suppressed plasma virus for at least seven years: correlation with age and not ARV regimen. IDWeek 2016, October 26-30, 2016, New Orleans. Abstract 953 (Oral).
3. **Golob JL** , Stohs E, Sweet A, Pergam SA, Boeckh M, Fredricks DN, and Liu C. Vancomycin is Frequently Administered to Hematopoietic Cell Transplant Recipients Without a Provider Documented Indication and Correlates with Microbiome Disruption and Adverse Events. ID Week, Infectious Diseases Society of America, October 2018 (# 72504).
4. Impact of Intestinal Microbiota on Reconstitution of Mucosal-Associated Invariant T Cells after Allogeneic Hematopoietic Stem Cell Transplantation. ASH 2018 (#3393).

Invited Lectures

1. Keynote Speaker, ARCS Foundation Annual Dinner. Seattle, WA Nov 3, 2008
2. Primary Care Conference: Direct to Consumer Genetic Testing, Seattle, WA, Mar 14, 2013
3. "IRIS and TB", Harborview Medical Center Housestaff Lunchtime Conference, Seattle, WA, Jun 9, 2014
4. "Complicated Enterococcal Endocarditis", University of Washington Medical Center (UWMC) Chief of Medicine Conference, Seattle, WA, Jul 14, 2014
5. "Coccidiomycosis", UWMC Chief of Medicine Conference, Seattle, WA, Oct 7, 2014
6. "HIV and CMV encephalitis", UWMC Chief of Medicine Conference, Seattle, WA, Apr 14, 2015
7. Research Presentation for GVHD Group Meeting, Seattle, WA, Nov 2015

8. "CMV Ventriculitis", Clinical Case Presentation to the Virology Working Group, Fred Hutchinson Cancer Research Center (Fred Hutch), Seattle, WA, Nov 2015
9. "Microbiome and HCT Outcomes". 1st Infectious Disease in the Immunocompromised Host Symposium – Tribute to Joel Meyers. Fred Hutch, Seattle, WA, Jun 13 2016.
10. "Microbiome and GVHD". Infectious Disease Sciences / Virology Symposium, Fred Hutch / UW, Seattle, WA, Jan 17 2017
11. "Microbiome and GVHD". 2nd Symposium on Infectious Disease in the Immunocompromised Host. June 19 2017
12. "The Gut Microbiome Predicts GVHD. Can It Be Engineered to Protect?". St Jude. February 18th 2019

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

JANET MALAM,

Plaintiff,

- against -

REBECCA ADDUCCI, in her official capacity as Detroit District Director of U.S. Immigration & Customs Enforcement; MATTHEW T. ALBENCE, in his official capacity as Deputy Director and Senior Official Performing the Duties of the Director of the U.S. Immigration & Customs Enforcement; CHAD WOLF, in his official capacity as Acting Secretary, U.S. Department of Homeland Security; WILLIAM P. BARR, in his official capacity as Attorney General, U.S. Department of Justice; U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT; HEIDI E. WASHINGTON, in her capacity of Director of Michigan Department of Corrections Calhoun Correctional Center,

Defendants,

And

Ruby Briselda Escobar; Amer Toma,

Plaintiff-Intervenors.

No. 2:20-cv-10829-JEL-APP

DECLARATION OF DR. ROBERT B. GREIFINGER, M.D. IN FURTHER SUPPORT OF PLANINTFF-INTERVENORS RUBY BRISELDA ESCOBAR AND AMER TOMA'S MOTION FOR TEMPORARY RESTRAINING ORDER

Declaration of Robert B. Greifinger, MD

I, Robert B. Greifinger, declare as follows:

1. I am a physician who has worked in health care for prisoners for more than 30 years. I have managed the medical care for inmates in the custody of New York City (Rikers Island) and the New York State prison system. I have authored more than 80 scholarly publications, many of which are about public health and communicable disease. I am the editor of *Public Health Behind Bars: from Prisons to Communities,* a book published by Springer (a second edition is due to be published in early 2021); and co-author of a scholarly paper on outbreak control in correctional facilities.[1]

2. I have been an independent consultant on prison and jail health care since 1995. My clients have included the U.S. Department of Justice, Division of Civil Rights (for 23 years) and the U.S. Department of Homeland Security, Section for Civil Rights and Civil Liberties (for six years). I am familiar with immigration detention centers, having toured and evaluated the medical care in approximately 20 immigration detention centers, out of the several hundred correctional facilities I have visited during my career. I currently monitor the medical care in three large county jails for Federal Courts. My resume is attached as Exhibit A.

COVID-19

3. COVID-19 is a coronavirus disease that has reached pandemic status. As of April 4, 2020, according to the World Health Organization, more than one million people – 1,051,635 to be precise – have been diagnosed with COVID-19 around the world and 56,985 people have died. In the United States, about 241,703 people have been diagnosed and 5,854 people have died thus far.[2] These numbers are likely an underestimate, due to the lack of availability of testing, in countries like the United States.

4. COVID-19 is a serious disease, ranging from no symptoms or mild ones for people at low risk, to respiratory failure and death in older patients and patients with chronic underlying conditions. There is no vaccine to prevent COVID-19. There is no known cure or anti- viral treatment for COVID-19 at this time. The only way to mitigate COVID-19 is to use scrupulous hand hygiene and social distancing.

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[1] Parvez FM, Lobato MN, Greifinger RB. Tuberculosis Control: Lessons for Outbreak Preparedness in Correctional Facilities. Journal of Correctional Health Care OnlineFirst, published on May 12, 2010 as doi:10.1177/1078345810367593.

[2] World Health Organization, Coronavirus Disease 2019 (COVID-19) Situation Report-75, Apr. 4, 2020, https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200404-sitrep-75-covid-19.pdf?sfvrsn=99251b2b_2.

5. People in the high-risk category for COVID-19, i.e., adults over 50 years old or those with underlying disease, are likely to suffer serious illness and death. According to preliminary data from China, 20% of people in high risk categories who contract COVID-19 have died.

6. Those who do not die have prolonged serious illness, for the most part requiring expensive hospital care, including ventilators that will likely be in very short supply.

7. The Centers for Disease Control and Prevention (CDC) has identified underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age: blood disorders, chronic kidney or liver disease, compromised immune system, endocrine disorders, including diabetes, metabolic disorders, heart and lung disease, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy.

8. Social distancing and hand hygiene are the only known ways to prevent the rapid spread of COVID-19. For that reason, public health officials have recommended extraordinary measures to combat the spread of COVID-19. Schools, courts, collegiate and professional sports, theater and other congregate settings have been closed as part of risk mitigation strategy.

The Risks of COVID-19 in Immigration Detention

9. The conditions of immigration detention facilities pose a heightened public health risk to the spread of COVID-19, even greater than other non-carceral institutions.

10. Immigration detention facilities are enclosed environments, much like the cruise ships and nursing homes that were the site of the largest concentrated outbreaks of COVID-19. Immigration detention facilities have even greater risk of infectious spread because of conditions of crowding, the proportion of vulnerable people detained, and often scant medical care resources. People live in close quarters and cannot achieve the "social distancing" needed to effectively prevent the spread of COVID-19. Toilets, sinks, and showers are shared, without disinfection between use. Food preparation and food service is communal, with little opportunity for surface disinfection. Staff arrive and leave on a shift basis; there is little to no ability to adequately screen staff for new, asymptomatic infection.

11. Many immigration detention facilities lack adequate medical care infrastructure to address the spread of infectious disease and treatment of high-risk people in detention. As examples, immigration detention facilities often use practical nurses who practice beyond the scope of their licenses; have part-time physicians who have limited availability to be on-site; and facilities with no formal linkages with local health departments or hospitals.

ICE Has Failed to Adequately Respond to COVID-19 at Calhoun Detention Center

12. In addition to these challenges, ICE has failed to adequately respond to the COVID-19 pandemic. I have reviewed the March 6, 2020 interim guidance sheet[3] produced by ICE Health Services Corps, the body that oversees ICE detention facilities' medical care, ICE's guidance on its website,[4] as well as the declaration of James Jacobs filed on April 3, 2020 regarding the Calhoun Detention Facility in Battle Creek, Michigan. These protocols are wholly insufficient to adequately face the crisis at hand. They fail in these ways:

    a) ICE's protocol focuses on travel history and contact with confirmed cases of COVID-19. This misses the mark. At this point in the course of the virus, nearly everyone who is not practicing social distancing is in contact with someone who has the virus.

    b) While the protocol provides for testing for symptomatic detainees, there is no guidance on cohorting and monitoring contacts of test-positive detainees for a 14-day period.

    c) Moreover, there is no protocol for testing of asymptomatic detainees or staff and other individuals, like vendors and attorneys, who enter the detention facility.

    d) Staff is an especially important vector in this outbreak. Since they go back and forth between the outside world, detention centers will be hit by COVID-19 when the rest of the community is, staff and their families included.

    e) The ICE protocol does not follow the measures in the CDC guidelines for long term care facilities. Specifically, it does not ensure access to hand sanitizer nor does it provide masks for individuals with a cough.

    f) The ICE protocol does not provide guidance on how to deal with surge capacity, which will almost certainly be necessary as the number of cases in the detention facility increase and the number of healthy staff to treat detained people decreases.

    g) The Jacobs declaration does not mention any protections provided for contacts of test-positive patients, thought the protocol does require people with suspected COVID-19 close contacts to be monitored for 14 days for symptoms. But this is impossible based upon the staffing and space constraints inherent in ICE detention. Nearly every person who newly arrives at the detention facility will have had close contact to someone with COVID-19. The detention facility's medical unit simply cannot handle the volume of patients that would need this level of monitoring. There needs to be significantly more facilities and staffing to meet these needs, but, to my knowledge, ICE has not made the appropriate changes to accommodate such a level.

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[3] ICE Health Service Corps, *Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19)* (Mar. 6, 2020), https://www.aila.org/infonet/ice-interim-reference-sheet-coronavirus.

[4] U.S. Immigration and Customs Enforcement, *ICE Guidance on COVID-19*, ICE.GOV (last updated Mar. 27, 2020), https://www.ice.gov/covid19.

h) There is no guidance in the protocol to identify high-risk patients or steps to protect them from contracting COVID-19. The plan needs to include an improved intake process, cohorted housing areas for high risk patients, increased infection control measures, and increased medical surveillance, including daily checks for signs and symptoms.

i) Although detainees are instructed on the importance of social distancing, there is no guarantee that social distancing of six feet, as recommended by the CDC, will be carried out in all ICE facilities. In fact, social distancing is likely impossible in such facilities, especially in light of the common practice of facility lockdowns.

j) There are no clear criteria for hospital transfer. As clinical staff have no experience with this disease, ICE should develop rational clinical criteria for transfer to an acute care hospital.

13. The ICE response envisions using isolation rooms to monitor individuals with COVID-19 symptoms. However, many facilities only have 1-4 of these rooms available in the facility. There will be many more than 1-4 people with COVID-19 in the detention center. Instead, ICE must create entire housing units reserved for people with COVID-19 symptoms, so that symptomatic patients can live separately from those who are asymptomatic or at risk. Because of how full ICE facilities are, this will be nearly impossible.

14. Isolation is not a proper solution for people without symptoms or confirmed disease. Detainees who are isolated are monitored less frequently. If they develop COVID-19 symptoms, or their symptoms escalate, they may not be able to get the medical attention they desperately need in a timely fashion. It also makes it more likely that these detained people will attempt suicide or self-harm, giving rise to more medical problems in the midst of a pandemic. Isolation also increases the amount of physical contact between staff and detained people—in the form of increased handcuffing, escorting individuals to and from the showers, and increased use of force due to the increased psychological stress of isolation. My expert opinion is that the use of isolation or lockdown is not a medically appropriate method for abating the substantial risks of COVID-19.

15. Transferring individuals between facilities, a common ICE practice, is medically inappropriate during the outbreak. ICE does not have the staffing needed to monitor the transferred patients for the appropriate 14-day period to check for symptoms.

16. ICE must release all people with risk factors to prevent serious illness including death. ICE's response has made abundantly clear that they do not plan to establish special protections for high-risk patients, instead waiting for them to become symptomatic. This will lead to unnecessary illness and death for the people most vulnerable to this disease. ICE is walking willingly into a preventable disaster by keeping high-risk and vulnerable patients in detention facilities during the rapid spread of COVID-19.

17. The only viable public health strategy available is risk mitigation. Even with the best-laid plans to address the spread of COVID-19 in detention facilities, the release of high-risk individuals is a key part of a risk mitigation strategy. In my opinion, the public health recommendation is to release high-risk people from detention, given the heightened risks

to their health and safety, especially given the lack of a viable vaccine for prevention or effective treatment at this stage. Release of the most vulnerable people also reduces the burden on these facilities' limited health care infrastructure, as it lessens the likelihood that an overwhelming number of people will become seriously ill from COVID-19 at the same time. Release also reduces the burden on regional hospitals and health centers, which will otherwise bear the brunt of having to treat these individuals when infected, thus reducing the number of hospital beds and equipment available for the general population.

18. To the extent that vulnerable detainees have had exposure to known cases with laboratory-confirmed infection with the virus that causes COVID-19, they should be tested immediately in concert with the local health department. Those who test negative should be released.

19. This release cohort can be separated into two groups. Group 1 could be released to home quarantine for 14 days, assuming they can be picked up from detention by their families or sponsors. Group 2 comprises those who cannot be easily transported to their homes by their families or sponsors. Group 2 could be released to a housing venue for 14 days, determined in concert with local or state public health authorities.

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

Executed this __*5th*__ day in April, 2020 in New York City, New York.

Robert B. Greifinger, M.D.

Exhibit A

CV of Dr. Greifinger

ROBERT B. GREIFINGER, M.D.

380 Riverside Drive, Apt 4F
New York, New York 10025

(646) 559-5279
bob@rgreifinger.com

Physician consultant with extensive experience in development and management of complex community and institutional health care programs. Demonstrated strength in leadership, program development, negotiation, communication, operations and the bridging of clinical and public policy interests. Teacher of health and criminal justice.

SUMMARY OF EXPERIENCE

MEDICAL MANAGEMENT AND QUALITY IMPROVEMENT SERVICES 1995-Present

Consultant on the design, management, operations, quality improvement, and utilization management for correctional health care systems.

- Recent clients include (among others) the U.S. Department of Justice Civil Rights Division, monitoring multiple correctional systems and the U.S. Department of Homeland Security Office of Civil Rights and Civil Liberties. Federal court monitor for the Metropolitan Detention Center, Albuquerque, New Mexico, Orleans Parish Sheriff's Office, New Orleans, Louisiana, and Miami-Dade Corrections and Rehabilitation Department.
- National Commission on Correctional Health Care. Principal Investigator for an NIJ funded project to make recommendations to Congress on identifying public health opportunities in soon-to-be-released inmates.
- Associate Editor, Puisis M (ed), Clinical Practice in Correctional Medicine, Second Edition, St. Louis. Mosby 2006.
- Editor, Greifinger, RB (ed), Public Health Behind Bars: From Prisons to Communities, New York. Springer 2007.
- John Jay College of Criminal Justice. Professor (adjunct) of Health and Criminal Justice and Distinguished Research Fellow 2005 – 2016.
- Co-Editor, International Journal of Prison Health 2010 – 2016.

NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES 1989 - 1995

Operating budget of $1.4 Billion. Responsible for inmate safety, program, and security. Sixty-nine facilities housing over 68,000 inmates with 30,000 employees.

Deputy Commissioner/Chief Medical Officer, 1989 - 1995

- Operating budget of $140 million; health services staff of 1,100. Accountable for inmate health services and public health. Directed major initiatives in policy and program development, quality and utilization management.
- Developed and implemented comprehensive program for HIV prevention, surveillance, education, and treatment in nation's largest AIDS medical practice.
- Managed the rapid implementation of an infection control program responding to a major outbreak of multidrug-resistant tuberculosis. Helped bring the nation's tuberculosis epidemic to public attention.
- Developed $360 million five-year capital plan for inmate health services. Opened the first of five regional medical units for multispecialty ambulatory and long-term care.
- Implemented a centralized and regional pharmacy system, improving quality, service and cost management.

MONTEFIORE MEDICAL CENTER, Bronx, NY 1985 - 1989

A major academic medical center with 8,000 employees and annual revenue of $500 million.

Vice President, Health Care Systems, 1986 - 1989

Director, Alternative Delivery Systems, 1985 - 1986

Operating budget of $60 million with 1,100 employees. Managed a multi-specialty group, a home health agency, and prison health programs.

- Negotiated contracts, including bundled service, risk capitation, fee-for-service arrangements, and major service contracts. Developed a high technology home care joint venture.
- Taught epidemiology and health care organization at Albert Einstein College of Medicine. Lectured nationally on health care delivery and managed care.
- Conceived and collaborated in development of a consortium of six academic medical centers, leading to a metropolitan area-wide, joint venture HMO. Organized a network of physicians to contract with HMO's preparing for cost-containment.

WESTCHESTER COMMUNITY HEALTH PLAN, White Plains, NY 1980 - 1985

Independent, not-for-profit, staff-model HMO, acquired by Kaiser-Permanente in 1985. Operating revenue $17 million with 200 employees and 27,000 members.

Vice President and Medical Director

Chief medical officer and COO. Managed the delivery of comprehensive medical services. Accountable to the Board of Directors for quality assurance and utilization management. Practiced pediatrics.

- Accomplished turnaround with automated utilization management, improved service, sound personnel management principles, and quality management programs.
- Implemented performance based compensation program.

COMMUNITY HEALTH PLAN OF SUFFOLK, INC. 1977 - 1980

Community based, not-for-profit, staff model HMO, with enrollment of 18,000.

Medical Director

- Developed and operated clinical services. Accountable for quality of care. Practiced clinical pediatrics, and taught community health and medical ethics at SUNY Stony Brook School of Medicine.

MONTEFIORE MEDICAL CENTER, Bronx, NY 1976 - 1977

Residency Program in Social Medicine, Deputy Director, 1976-1977

Unique clinical training program focused on community health and change agentry. Developed curriculum and supervised 40 residents in internal medicine, pediatrics and family medicine.

UNITED STATES PUBLIC HEALTH SERVICE 1972 - 1974

Commissioned officer in the National Health Service Corps. Functioned as medical director and family physician in a federally funded neighborhood health center in Rock Island, Illinois. Honorable Discharge.

ROBERT B. GREIFINGER, M.D.

FACULTY APPOINTMENTS

1976 - 2002
Assistant Professor of Epidemiology and Social Medicine, Albert Einstein College of Medicine

2005 - 2016
Professor (adjunct) of Health and Criminal Justice and Distinguished Research Fellow, John Jay College of Criminal Justice

NATIONAL COMMITTEE FOR QUALITY ASSURANCE

Worked with NCQA since its inception in 1980. Began training surveyors in 1989, and continued as faculty for NCQA sponsored educational sessions. Served for six years as a charter member of the Review Oversight (accreditation) Committee. Served on the Reconsideration (appeals) Committee for six years. Surveyed dozens of managed care organizations, and reviewed several hundred quality management programs.

OTHER PROFESSIONAL ACTIVITIES

2012 – present	Member, Board of Directors, Prison Legal Services, New York
2012 – present	Member, Board of Directors, National Health Law Program
2011 – 2015	Member, Board of Directors, Academic Consortium of Criminal Justice Health
2010 - 2016	Co-editor, International Journal of Prisoner Health
2009	Recipient, B. Jaye Anno Award for Lifetime Achievement in Communication
2007-2015	Member, National Advisory Group on Academic Correctional Health Care
2007	Recipient, Armond Start Award, Society of Correctional Physicians
2005 - 2011	Member, Advisory Board to the Prisoner Reentry Institute, John Jay College
2002 - present	Member, Editorial Board, Journal of Correctional Health Care
2002 - present	Peer reviewer for multiple journals, including Journal of Correctional Health Care, International Journal of Prison Health, Journal of Urban Health, Journal of Public Health Policy, Annals of Internal Medicine, American Journal of Public Health, Health Affairs, and American Journal of Drug and Alcohol Abuse.
2001 - 2003	Member, Advisory Board to CDC on Prevention of Viral Hepatitis in Correctional Facilities
1999 - 2003	Member, Advisory Board to CDC on Prevention and Control of Tuberculosis in Jails
1997 - 2003	Member, Reconsideration Committee, NCQA
1997 - 2001	Moderator, Optimal Management of HIV in Correctional Systems, World Health Communications
1997 - 2000	Member, Reproductive Health Guidelines Task Force, CDC
1993 - 1995	Co-chair, AIDS Clinical Trial Community Advisory Board, Albany Medical Center
1992 - Present	Society of Correctional Physicians
1991 - 1997	Member, Review Oversight (accreditation) Committee, NCQA

1983 - 1985 Executive Committee, Medical Directors' Division, Group Health Association of America (Secretary, 1984-1985)

EDUCATION

University of Pennsylvania, College of Arts and Sciences, Philadelphia; B.A., 1967 (Amer. Civilization)

University of Maryland, School of Medicine, Baltimore; M.D., 1971

Residency Program in Social Medicine (Pediatrics), Montefiore Medical Center, Bronx, NY; 1971-1972, 1974-1976, Chief Resident 1975-1976

CERTIFICATION

Diplomate, National Board of Medical Examiners, 1971

Diplomate, American Board of Pediatrics, 1976

Fellow, American Academy of Pediatrics, 1977

Fellow, American College of Physician Executives, 1983

Fellow, American College of Correctional Physicians (formerly Society of Correctional Physicians), 2000

License: New York, Pennsylvania (inactive)

ROBERT B. GREIFINGER, M.D.

Updated February 2018

PUBLICATIONS

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

JANET MALAM,

Plaintiff,

- against -

REBECCA ADDUCCI, in her official capacity as Detroit District Director of U.S. Immigration & Customs Enforcement; MATTHEW T. ALBENCE, in his official capacity as Deputy Director and Senior Official Performing the Duties of the Director of the U.S. Immigration & Customs Enforcement; CHAD WOLF, in his official capacity as Acting Secretary, U.S. Department of Homeland Security; WILLIAM P. BARR, in his official capacity as Attorney General, U.S. Department of Justice; U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT; HEIDI E. WASHINGTON, in her capacity of Director of Michigan Department of Corrections Calhoun Correctional Center,

Defendants,

And

Ruby Briselda Escobar; Amer Toma,

Petitioner-Plaintiffs.

No. 2:20-cv-10829-JEL-APP

DECLARATION OF MY KHANH NGO IN SUPPORT OF PETITIONER-PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER

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

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

2. I am a Staff Attorney with the American Civil Liberties Union Foundation, Immigrants' Rights Project, and am one of the counsel of record for Petitioner-Plaintiffs.

3. I certify that the attached exhibits are true and correct copies of the following:

Exhibit	**Document**
A	Coronavirus disease 2019 (COVID-19) Situation Report – 75, World Health Organization (Apr. 4, 2020), https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200404-sitrep-75-covid-19.pdf?sfvrsn=99251b2b_2.
B	U.S. Immigration & Customs Enforcement, ICE Guidance on COVID-19: Confirmed Cases (last updated Apr. 4, 2020), https://www.ice.gov/coronavirus.
C	Ken Klippenstein, *Exclusive: ICE Detainees Are Being Quarantined*, The Nation (Mar. 24, 2020), https://www.thenation.com/article/society/corona-covid-immigration-detention/.
D	Letter from Drs. Scott A. Allen & Josiah Rich to Rep. Bennie Thompson et al. (Mar. 19, 2020), https://whistleblower.org/wp-content/uploads/2020/03/Drs.-Allen-and-Rich-3.20.2020-Letter-to-Congress.pdf.
E	Letter from Bd. of Correction of the City of New York to Criminal Justice Leaders (Mar. 21, 2020), https://www1.nyc.gov/assets/boc/downloads/pdf/News/covid-19/Letter-from-BOC-re-NYC-Jails-and-COVID-19-2020-03-21.pdf.

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

Executed on this 5th day of April, 2020, in Oakland, California.

/s/ My Khanh Ngo

My Khanh Ngo
American Civil Liberties Union Foundation, Immigrants' Rights Project
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 343-0770
mngo@aclu.org

Exhibit A

April 4, 2020 Coronavirus disease 2019 (COVID-19) Situation Report - 75, World Health Organization

Coronavirus disease 2019 (COVID-19)
Situation Report – 75

World Health Organization

Data as reported by national authorities by 10:00 CET 4 April 2020

HIGHLIGHTS

- One new country/territory/area reported cases of COVID-19 in the past 24 hours: Bonaire, Sint Eustatius and Saba.
- As worldwide cases climb above 1 million and deaths over 50 000, Dr Tedros stressed that the best way for countries to end restrictions and ease their economic effects was to attack the virus with an aggressive and comprehensive package of measures. His speech can be found here.
- WHO has released new technical guidance recommending universal access to public hand hygiene stations and making their use obligatory on entering and leaving any public or private commercial building and any public transport facility. It also recommends that healthcare facilities improve access to and practice of hand hygiene. Find more here.
- WHO/Europe has received a €30 million contribution from the European Commission for 6 WHO European Region Member States – Armenia, Azerbaijan, Belarus, Georgia, the Republic of Moldova and Ukraine – to meet immediate needs in their responses to COVID-19. More information is available here.

SITUATION IN NUMBERS
total (new) cases in last 24 hours

Globally
1 051 635 confirmed (79 332)
56 985 deaths (6664)

Western Pacific Region
110 362 confirmed (1432)
3809 deaths (49)

European Region
583 141 confirmed (41 333)
42 334 deaths (5231)

South-East Asia Region
6528 confirmed (647)
267 deaths (22)

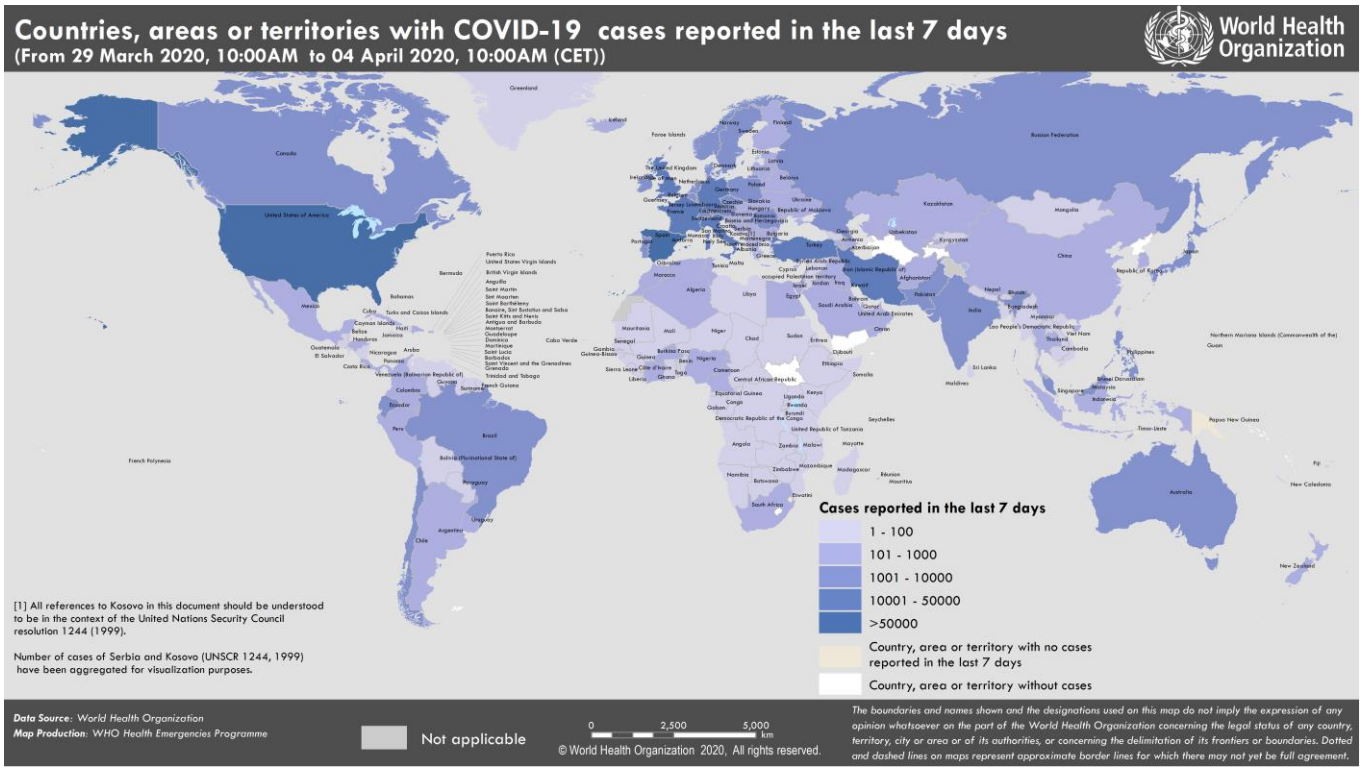
Eastern Mediterranean Region
65 903 confirmed (3667)
3592 deaths (154)

Region of the Americas
279 543 confirmed (32 070)
6802 deaths (1202)

African Region
5446 confirmed (183)
170 deaths (6)

WHO RISK ASSESSMENT
Global Level Very High

Figure 1. Countries, territories or areas with reported confirmed cases of COVID-19, 4 April 2020



SURVEILLANCE

Table 1. Countries, territories or areas with reported laboratory-confirmed COVID-19 cases and deaths. Data as of 4 April 2020*

Reporting Country/ Territory/Area†	Total confirmed ‡ cases	Total confirmed new cases	Total deaths	Total new deaths	Transmission classification§	Days since last reported case
Western Pacific Region						
China	82875	73	3335	4	Local transmission	0
Republic of Korea	10156	94	177	3	Local transmission	0
Australia	5454	230	28	5	Local transmission	0
Malaysia	3333	217	53	3	Local transmission	0
Philippines	3018	385	136	29	Local transmission	0
Japan	2920	303	69	4	Local transmission	0
Singapore	1114	65	5	1	Local transmission	0
New Zealand	824	50	1	0	Local transmission	0
Viet Nam	239	6	0	0	Local transmission	0
Brunei Darussalam	134	1	1	0	Local transmission	0
Cambodia	114	4	0	0	Local transmission	0
Mongolia	14	0	0	0	Imported cases only	2
Lao People's Democratic Republic	10	0	0	0	Local transmission	2
Fiji	7	0	0	0	Local transmission	1
Papua New Guinea	1	0	0	0	Imported cases only	14
Territories**						
Guam	84	2	3	0	Local transmission	0
French Polynesia	39	2	0	0	Local transmission	0
New Caledonia	18	0	0	0	Local transmission	1
Northern Mariana Islands (Commonwealth of the)	8	0	1	0	Local transmission	1
European Region						
Italy	119827	4585	14681	764	Local transmission	0
Spain	117710	7472	10935	932	Local transmission	0
Germany	85778	6082	1158	141	Local transmission	0
France	63536	5209	6493	2003	Local transmission	0
The United Kingdom	38172	4450	3605	684	Local transmission	0
Turkey	20921	2786	425	69	Local transmission	0
Switzerland	19706	862	607	71	Local transmission	0
Belgium	16770	1422	1143	132	Local transmission	0
Netherlands	15723	1026	1487	148	Local transmission	0
Austria	11525	396	168	10	Local transmission	0
Portugal	9886	852	246	37	Local transmission	0
Israel	7030	819	36	7	Local transmission	0
Sweden	6078	612	333	51	Local transmission	0
Norway	5208	273	44	2	Local transmission	0
Ireland	4273	424	120	22	Local transmission	0
Czechia	4190	332	53	9	Local transmission	0

Russian Federation	4149	601	34	4	Local transmission	0
Denmark	3757	371	139	16	Local transmission	0
Poland	3383	437	71	14	Local transmission	0
Romania	3183	445	133	39	Local transmission	0
Luxembourg	2612	125	31	1	Local transmission	0
Finland	1615	97	20	1	Local transmission	0
Greece	1613	99	59	6	Local transmission	0
Serbia	1476	305	39	26	Local transmission	0
Iceland	1364	45	4	0	Local transmission	0
Ukraine	1096	109	28	5	Local transmission	0
Croatia	1079	68	8	1	Local transmission	0
Estonia	961	103	12	1	Local transmission	0
Slovenia	934	37	20	4	Local transmission	0
Lithuania	771	122	9	0	Local transmission	0
Armenia	736	96	7	3	Local transmission	0
Hungary	678	93	32	11	Local transmission	0
Republic of Moldova	591	0	9	1	Local transmission	1
Bosnia and Herzegovina	586	65	18	2	Local transmission	0
Latvia	493	35	1	1	Local transmission	0
Bulgaria	485	28	14	4	Local transmission	0
Kazakhstan	460	25	3	0	Local transmission	0
Slovakia	450	24	0	0	Local transmission	0
Azerbaijan	443	43	5	0	Local transmission	0
Andorra	442	13	16	1	Local transmission	0
North Macedonia	430	46	12	1	Local transmission	0
Cyprus	396	40	11	2	Local transmission	0
Albania	333	56	17	1	Local transmission	0
Belarus	254	0	4	0	Local transmission	1
San Marino	252	7	32	2	Local transmission	0
Uzbekistan	241	20	2	0	Local transmission	0
Malta	202	7	0	0	Local transmission	0
Montenegro	160	20	2	0	Local transmission	0
Georgia	157	9	0	0	Local transmission	0
Kyrgyzstan	144	14	1	0	Local transmission	0
Liechtenstein	76	1	0	0	Under investigation	0
Monaco	37	0	0	0	Local transmission	3
Holy See	7	0	0	0	Under investigation	1
Territories**						
Faroe Islands	179	2	0	0	Local transmission	0
Kosovo[1]	132	6	1	0	Local transmission	0
Jersey	118	37	2	0	Local transmission	0
Guernsey	114	23	2	1	Local transmission	0
Isle of Man	114	43	1	0	Local transmission	0
Gibraltar	95	14	1	1	Local transmission	0
Greenland	10	0	0	0	Under investigation	6
South-East Asia Region						
India	2301	336	56	6	Local transmission	0
Indonesia	1986	196	181	11	Local transmission	0

Thailand	1978	103	19	4	Local transmission	0
Sri Lanka	151	3	4	1	Local transmission	0
Bangladesh	61	5	6	0	Local transmission	0
Myanmar	20	4	1	0	Local transmission	0
Maldives	19	0	0	0	Local transmission	1
Nepal	6	0	0	0	Imported cases only	1
Bhutan	5	0	0	0	Imported cases only	1
Timor-Leste	1	0	0	0	Imported cases only	14
Eastern Mediterranean Region						
Iran (Islamic Republic of)	53183	2715	3294	134	Local transmission	0
Pakistan	2450	0	35	0	Local transmission	1
Saudi Arabia	2039	154	25	4	Local transmission	0
United Arab Emirates	1264	240	9	1	Local transmission	0
Qatar	1075	126	3	0	Local transmission	0
Egypt	985	120	66	8	Local transmission	0
Morocco	844	109	50	3	Local transmission	0
Iraq	820	48	54	0	Local transmission	0
Bahrain	673	30	4	0	Local transmission	0
Lebanon	508	0	17	0	Local transmission	1
Tunisia	495	40	18	4	Local transmission	0
Kuwait	417	0	0	0	Local transmission	1
Jordan	310	11	5	0	Local transmission	0
Oman	277	25	1	0	Local transmission	0
Afghanistan	270	1	5	0	Local transmission	0
Djibouti	50	9	0	0	Local transmission	0
Libya	17	7	1	0	Local transmission	0
Syrian Arab Republic	16	0	2	0	Imported cases only	1
Sudan	10	2	2	0	Local transmission	0
Somalia	7	2	0	0	Imported cases only	0
Territories**						
occupied Palestinian territory	193	28	1	0	Local transmission	0
Region of the Americas						
United States of America	241703	28103	5854	1061	Local transmission	0
Canada	11732	1618	152	25	Local transmission	0
Brazil	7910	1074	299	58	Local transmission	0
Chile	3737	333	22	4	Local transmission	0
Ecuador	3163	0	120	0	Local transmission	1
Mexico	1510	132	50	13	Local transmission	0
Dominican Republic	1488	108	68	8	Local transmission	0
Panama	1475	158	37	5	Local transmission	0
Peru	1414	91	51	10	Local transmission	0
Argentina	1265	132	37	6	Local transmission	0
Colombia	1161	96	19	2	Local transmission	0
Costa Rica	396	21	2	0	Local transmission	0
Uruguay	369	19	4	0	Local transmission	0
Cuba	269	36	6	0	Local transmission	0
Honduras	222	3	15	1	Local transmission	0

Venezuela (Bolivarian Republic of)	144	0	3	0	Local transmission	1
Bolivia (Plurinational State of)	132	9	9	1	Local transmission	0
Trinidad and Tobago	97	7	6	1	Local transmission	0
Paraguay	92	15	3	0	Local transmission	0
Guatemala	50	3	1	0	Local transmission	0
Jamaica	47	3	3	0	Local transmission	0
El Salvador	46	5	2	0	Local transmission	0
Barbados	45	0	0	0	Local transmission	1
Bahamas	24	3	3	2	Local transmission	0
Guyana	19	0	4	0	Local transmission	2
Haiti	18	2	0	0	Imported cases only	0
Saint Lucia	13	0	0	0	Local transmission	2
Dominica	11	0	0	0	Local transmission	8
Grenada	10	0	0	0	Local transmission	1
Suriname	10	2	0	0	Local transmission	0
Saint Kitts and Nevis	8	0	0	0	Imported cases only	3
Antigua and Barbuda	7	0	0	0	Imported cases only	7
Nicaragua	5	0	1	0	Imported cases only	2
Belize	3	0	0	0	Local transmission	4
Saint Vincent and the Grenadines	3	1	0	0	Imported cases only	0
Territories**						
Puerto Rico	378	62	15	3	Local transmission	0
Martinique	138	7	3	0	Local transmission	0
Guadeloupe	130	2	7	1	Local transmission	0
Aruba	62	2	0	0	Local transmission	0
French Guiana	57	2	0	0	Local transmission	0
United States Virgin Islands	37	4	0	0	Local transmission	0
Bermuda	35	3	0	0	Local transmission	0
Cayman Islands	28	6	1	0	Local transmission	0
Sint Maarten	23	5	2	1	Imported cases only	0
Saint Martin	22	0	2	0	Under investigation	1
Curaçao	11	0	1	0	Imported cases only	4
Saint Barthélemy	6	0	0	0	Under investigation	4
Montserrat	5	0	0	0	Imported cases only	7
Turks and Caicos Islands	5	0	0	0	Local transmission	4
Anguilla	3	1	0	0	Local transmission	0
British Virgin Islands	3	0	0	0	Imported cases only	3
Bonaire, Sint Eustatius and Saba	2	2	0	0	Imported cases only	0
African Region						
South Africa	1505	43	7	2	Local transmission	0
Algeria	986	0	83	0	Local transmission	1
Burkina Faso	261	0	15	1	Local transmission	3
Cameroon	246	0	7	0	Local transmission	1
Senegal	207	12	1	0	Local transmission	0

Ghana	204	0	5	0	Local transmission	1
Côte d'Ivoire	203	13	1	0	Local transmission	0
Nigeria	190	16	2	0	Local transmission	0
Mauritius	186	17	7	0	Local transmission	0
Democratic Republic of the Congo	134	0	13	0	Local transmission	1
Kenya	122	12	4	1	Local transmission	0
Niger	98	24	5	0	Local transmission	0
Rwanda	89	5	0	0	Local transmission	0
Madagascar	65	0	0	0	Local transmission	1
Guinea	52	0	0	0	Local transmission	1
Uganda	45	1	0	0	Local transmission	0
Congo	41	0	3	1	Local transmission	1
Togo	39	0	2	0	Local transmission	1
Zambia	39	0	1	0	Local transmission	1
Mali	36	8	3	0	Local transmission	0
Ethiopia	35	4	0	0	Local transmission	0
Gabon	21	3	1	0	Imported cases only	0
Eritrea	20	0	0	0	Local transmission	1
United Republic of Tanzania	20	0	1	0	Local transmission	2
Equatorial Guinea	15	0	0	0	Local transmission	1
Guinea-Bissau	15	6	0	0	Imported cases only	0
Benin	13	0	0	0	Imported cases only	2
Namibia	13	0	0	0	Local transmission	1
Angola	10	2	2	0	Imported cases only	0
Mozambique	10	0	0	0	Local transmission	2
Seychelles	10	0	0	0	Imported cases only	2
Eswatini	9	0	0	0	Imported cases only	7
Zimbabwe	9	1	1	0	Local transmission	0
Central African Republic	8	0	0	0	Imported cases only	2
Chad	7	0	0	0	Imported cases only	3
Liberia	7	1	0	0	Local transmission	0
Mauritania	6	1	1	1	Imported cases only	0
Cabo Verde	5	0	1	0	Imported cases only	7
Botswana	4	0	1	0	Imported cases only	1
Gambia	4	0	1	0	Imported cases only	1
Burundi	3	1	0	0	Local transmission	0
Malawi	3	0	0	0	Local transmission	1
Sierra Leone	2	0	0	0	Imported cases only	2
Territories**						
Réunion	321	13	0	0	Local transmission	0
Mayotte	128	0	2	0	Local transmission	1
Subtotal for all regions	**1 050923**	**79 332**	**56 974**	**6664**		
International conveyance (Diamond Princess)	712	0	11	0	Local transmission	19
Grand total	**1 051635**	**79 332**	**56 985**	**6664**		

*Numbers include both domestic and repatriated cases

†The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

‡Case classifications are based on WHO case definitions for COVID-19.

§Transmission classification is based on WHO analysis of available official data and may be subject to reclassification as additional data become available. Countries/territories/areas experiencing multiple types of transmission are classified in the highest category for which there is evidence; they may be removed from a given category if interruption of transmission can be demonstrated. It should be noted that even within categories, different countries/territories/areas may have differing degrees of transmission as indicated by the differing numbers of cases and other factors. Not all locations within a given country/territory/area are equally affected.

Terms:

- **Community transmission** is evidenced by the inability to relate confirmed cases through chains of transmission for a large number of cases, or by increasing positive tests through sentinel samples (routine systematic testing of respiratory samples from established laboratories).
- **Local transmission** indicates locations where the source of infection is within the reporting location.
- **Imported cases only** indicates locations where all cases have been acquired outside the location of reporting.
- **Under investigation** indicates locations where type of transmission has not been determined for any cases.
- **Interrupted transmission** indicates locations where interruption of transmission has been demonstrated (details to be determined)

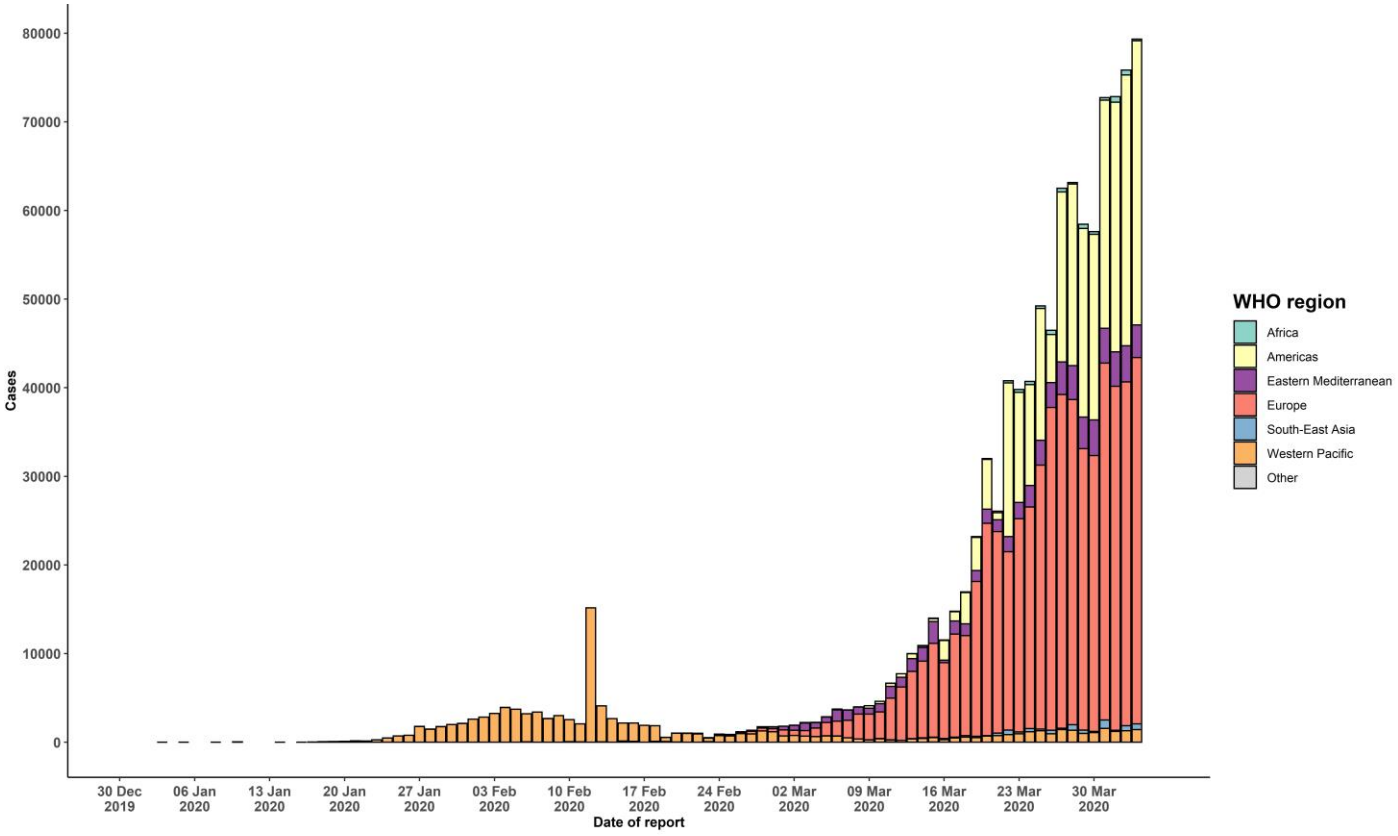
** "Territories" include territories, areas, overseas dependencies and other jurisdictions of similar status

[1] All references to Kosovo should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).

Due to differences in reporting methods, retrospective data consolidation, and reporting delays, the number of new cases may not always reflect the exact difference between yesterday's and today's totals. WHO COVID-19 Situation Reports present official counts of confirmed COVID-19 cases, thus differences between WHO reports and other sources of COVID-19 data using different inclusion criteria and different data cutoff times are to be expected.

New countries/territories/areas are shown in red.

Figure 1. Epidemic curve of confirmed COVID-19, by date of report and WHO region through 4 April 2020



STRATEGIC OBJECTIVES

WHO's strategic objectives for this response are to:

- Interrupt human-to-human transmission including reducing secondary infections among close contacts and health care workers, preventing transmission amplification events, and preventing further international spread*;
- Identify, isolate and care for patients early, including providing optimized care for infected patients;
- Identify and reduce transmission from the animal source;
- Address crucial unknowns regarding clinical severity, extent of transmission and infection, treatment options, and accelerate the development of diagnostics, therapeutics and vaccines;
- Communicate critical risk and event information to all communities and counter misinformation;
- Minimize social and economic impact through multisectoral partnerships.

*This can be achieved through a combination of public health measures, such as rapid identification, diagnosis and management of the cases, identification and follow up of the contacts, infection prevention and control in health care settings, implementation of health measures for travelers, awareness-raising in the population and risk communication.

PREPAREDNESS AND RESPONSE

- To view all technical guidance documents regarding COVID-19, please go to this webpage.
- WHO has developed interim guidance for laboratory diagnosis, advice on the use of masks during home care and in health care settings in the context of the novel coronavirus (2019-nCoV) outbreak, clinical management, infection prevention and control in health care settings, home care for patients with suspected novel coronavirus, risk communication and community engagement and Global Surveillance for human infection with novel coronavirus (2019-nCoV).
- WHO is working closely with International Air Transport Association (IATA) and have jointly developed a guidance document to provide advice to cabin crew and airport workers, based on country queries. The guidance can be found on the IATA webpage.
- WHO has been in regular and direct contact with Member States where cases have been reported. WHO is also informing other countries about the situation and providing support as requested.
- WHO is working with its networks of researchers and other experts to coordinate global work on surveillance, epidemiology, mathematical modelling, diagnostics and virology, clinical care and treatment, infection prevention and control, and risk communication. WHO has issued interim guidance for countries, which are updated regularly.
- WHO has prepared a disease commodity package that includes an essential list of biomedical equipment, medicines and supplies necessary to care for patients with 2019-nCoV.
- WHO has provided recommendations to reduce risk of transmission from animals to humans.
- WHO has published an updated advice for international traffic in relation to the outbreak of the novel coronavirus 2019-nCoV.
- WHO has activated the R&D blueprint to accelerate diagnostics, vaccines, and therapeutics.
- OpenWHO is an interactive, web-based, knowledge-transfer platform offering online courses to improve the response to health emergencies. COVID-19 courses can be found here and courses in additional national languages here. Specifically, WHO has developed online courses on the following topics:
    - A general introduction to emerging respiratory viruses, including novel coronaviruses (available in Arabic, Chinese, English, French, Russian, Spanish, Hindi, Indian Sign Language, Persian, Portuguese, Serbian and Turkish);
    - Clinical care for Severe Acute Respiratory Infections (available in English, French, Russian, Indonesian and Vietnamese);
    - Health and safety briefing for respiratory diseases - ePROTECT (available in Chinese, English, French, Russian, Spanish, Indonesian and Portuguese);
    - Infection Prevention and Control for Novel Coronavirus (COVID-19) (available in Chinese, English, French, Russian, Spanish, Indonesian, Italian, Japanese, Portuguese and Serbian); and
    - COVID-19 Operational Planning Guidelines and COVID-19 Partners Platform to support country preparedness and response (available in English and coming soon in additional languages).
- WHO is providing guidance on early investigations, which are critical in an outbreak of a new virus. The data collected from the protocols can be used to refine recommendations for surveillance and case definitions, to characterize the key epidemiological transmission features of COVID-19, help understand spread, severity, spectrum of disease, impact on the community and to inform operational models for implementation of countermeasures such as case isolation, contact tracing and isolation. Several protocols are available here. One such protocol is for the investigation of early COVID-19 cases and contacts (the "First Few X (FFX) Cases and contact investigation protocol for 2019-novel coronavirus (2019-nCoV) infection"). The protocol is designed to gain an early understanding of the key clinical, epidemiological and virological characteristics of the first cases of COVID-19 infection detected in any individual country, to inform the development and updating of public health guidance to manage cases and reduce the potential spread and impact of infection.

RECOMMENDATIONS AND ADVICE FOR THE PUBLIC

If you are not in an area where COVID-19 is spreading or have not travelled from an area where COVID-19 is spreading or have not been in contact with an infected patient, your risk of infection is low. It is understandable that you may feel anxious about the outbreak. Get the facts from reliable sources to help you accurately determine your risks so that you can take reasonable precautions (see Frequently Asked Questions). Seek guidance from WHO, your healthcare provider, your national public health authority or your employer for accurate information on COVID-19 and whether COVID-19 is circulating where you live. It is important to be informed of the situation and take appropriate measures to protect yourself and your family (see Protection measures for everyone).

If you are in an area where there are cases of COVID-19 you need to take the risk of infection seriously. Follow the advice of WHO and guidance issued by national and local health authorities. For most people, COVID-19 infection will cause mild illness however, it can make some people very ill and, in some people, it can be fatal. Older people, and those with pre-existing medical conditions (such as cardiovascular disease, chronic respiratory disease or diabetes) are at risk for severe disease (See Protection measures for persons who are in or have recently visited (past 14 days) areas where COVID-19 is spreading).

CASE DEFINITIONS

WHO periodically updates the Global Surveillance for human infection with coronavirus disease (COVID-19) document which includes case definitions.

For easy reference, case definitions are included below.

Suspect case

A. A patient with acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath), AND a history of travel to or residence in a location reporting community transmission of COVID-19 disease during the 14 days prior to symptom onset.

OR

B. A patient with any acute respiratory illness AND having been in contact with a confirmed or probable COVID-19 case (see definition of contact) in the last 14 days prior to symptom onset;

OR

C. A patient with severe acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath; AND requiring hospitalization) AND in the absence of an alternative diagnosis that fully explains the clinical presentation.

Probable case

A. A suspect case for whom testing for the COVID-19 virus is inconclusive.
    a. Inconclusive being the result of the test reported by the laboratory.

OR

B. A suspect case for whom testing could not be performed for any reason.

Confirmed case

A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.

- Technical guidance for laboratory testing can be found here.

Definition of contact

A contact is a person who experienced any one of the following exposures during the 2 days before and the 14 days

after the onset of symptoms of a probable or confirmed case:

1. Face-to-face contact with a probable or confirmed case within 1 meter and for more than 15 minutes;
2. Direct physical contact with a probable or confirmed case;
3. Direct care for a patient with probable or confirmed COVID-19 disease without using proper personal protective equipment[1]; OR
4. Other situations as indicated by local risk assessments.

Note: for confirmed asymptomatic cases, the period of contact is measured as the 2 days before through the 14 days *after the date on which the sample was taken* which led to confirmation.

[1] World Health Organization. Infection prevention and control during health care when COVID-19 is suspected https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected-20200125

Exhibit B

U.S. Immigration & Customs Enforcement, ICE Guidance on COVID-19: Confirmed Cases

Official Website of the Department of Homeland Security

ICE

Report Crimes: Email or Call 1-866-DHS-2-ICE

NOTICE

Click here for the latest ICE guidance on COVID-19

ICE Guidance on COVID-19

Overview & FAQs | Confirmed Cases | Previous Statements

Latest Statement

As of April 3, there are four individuals in U.S. Immigration and Customs Enforcement (ICE) custody at Pike County Correctional Facility in Hawley, Pennsylvania, who have tested positive for COVID-19. Those individuals include 31-year-old and 37-year-old Mexican nationals, a 41-year-old Dominican national and a 28-year-old Guatemalan national. Additionally, a 37-year-old Mexican national in ICE custody at the York County Prison, in York, Pennsylvania and a 54-year-old Mexican national in ICE custody at Otay Mesa Detention Center in San Diego, California have tested positive for COVID-19. The individuals have been quarantined and are receiving care. Consistent with CDC guidelines, those who have come in contact with these individuals have been cohorted and are being monitored for symptoms.

April 3rd Statment

A 31-year-old Mexican national in U.S. Immigration and Customs Enforcement custody at Pike County Correctional Facility in Hawley, Pennsylvania, and a 52-year-old Mexican national in ICE custody at the Pine Prairie ICE Processing Center in Pine Prairie, Louisiana, have tested positive for COVID-19. The individuals have been quarantined and are receiving care. Consistent with CDC guidelines, those who have come in contact with the individuals have been cohorted and are being monitored for symptoms.

April 1st Statment

A 33-year-old Dominican national in ICE custody at the Hudson County Correctional Center in Kearny, New Jersey, and a 45 year-old Guatemalan national in ICE custody at the at the La Palma Correctional Center in Eloy, Arizona, have tested positive for COVID-19. Consistent with CDC guidelines, those who have come in contact with the individual have been cohorted and are being monitored for symptoms.

March 30th Statement

A 40-year-old Salvadoran national in ICE custody at the Bergen County Jail and a 22-year-old Salvadoran national in ICE custody at the Hudson County Correctional Center have tested positive for COVID-19. Consistent with CDC guidelines, those who have come in contact with the individuals have been cohorted and are being monitored for symptoms.

Last Reviewed/Updated: 04/04/2020

Exhibit C

March 24, 2020 Ken Klippenstein, Exclusive: ICE Detainees Are Being Quarantined, The Nation

Exclusive: ICE Detainees Are Being Quarantined

thenation.com/article/society/corona-covid-immigration-detention/

By Ken Klippenstein Twitter March 24, 2020

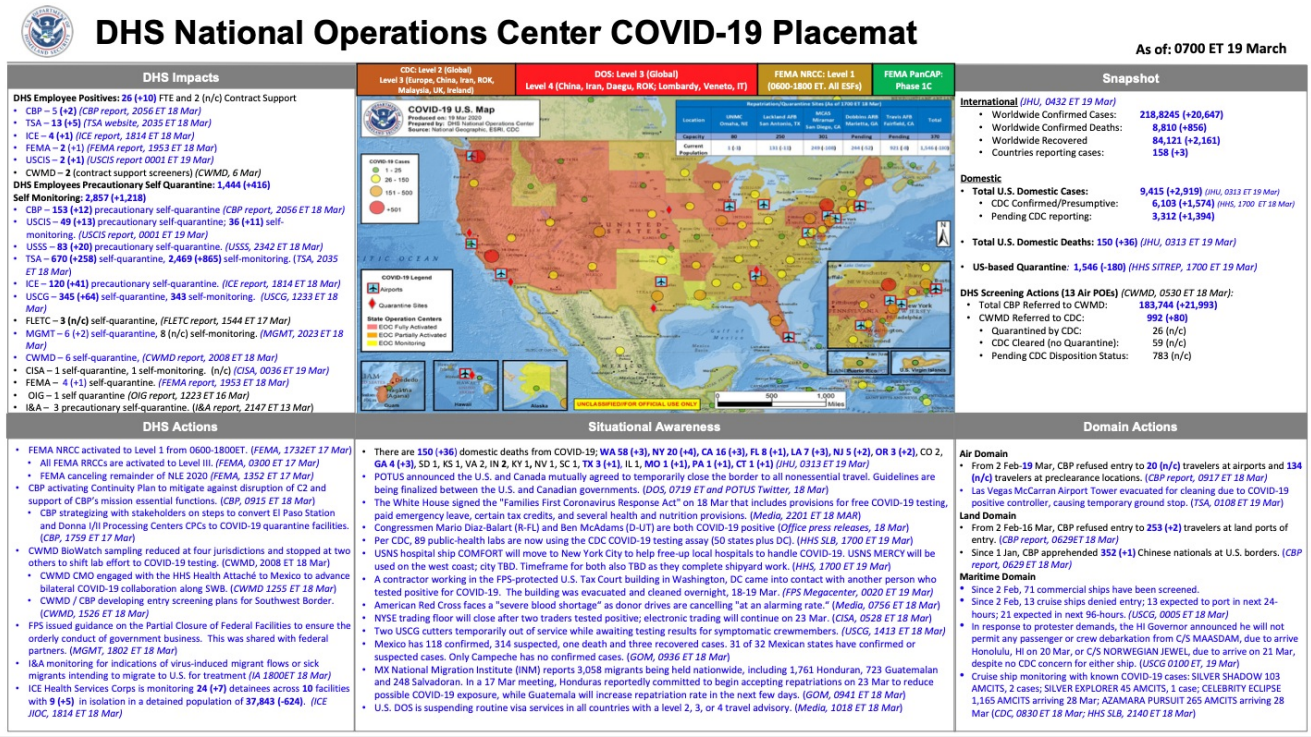
March 24, 2020

Men stand in a US Immigration and Border Enforcement detention center in McAllen, Texas. (Josh Dawsey / The Washington Post via AP, Pool)

EDITOR'S NOTE: The Nation believes that helping readers stay informed about the impact of the coronavirus crisis is a form of public service. For that reason, this article, and all of our coronavirus coverage, is now free. Please subscribe to support our writers and staff, and stay healthy.

Multiple Immigration and Customs Enforcement (ICE) detainees have been put in isolation for medical reasons, according to an internal Department of Homeland Security (DHS) coronavirus report obtained exclusively by *The Nation*.

The report, marked "For Official Use Only" and dated March 19, states that ICE's Health Services Corps had isolated nine detainees and that it was monitoring 24 more in 10 different ICE facilities.



DHS National Operations Center COVID-19 Placemat

As of: 0700 ET 19 March

DHS Impacts

DHS Employee Positives: 26 (+10) FTE and 2 (n/c) Contract Support
- CBP – 5 **(+2)** *(CBP report, 2056 ET 18 Mar)*
- TSA – **13 (+5)** *(TSA website, 2035 ET 18 Mar)*
- ICE – **4 (+1)** *(ICE report, 1814 ET 18 Mar)*
- FEMA – **2** (+1) *(FEMA report, 1953 ET 18 Mar)*
- USCIS – **2 (+1)** *(USCIS report 0001 ET 19 Mar)*
- CWMD – **2** (contract support screeners) *(CWMD, 6 Mar)*

DHS Employees Precautionary Self Quarantine: 1,444 (+416)

Self Monitoring: 2,857 (+1,218)
- CBP – **153 (+12)** precautionary self-quarantine *(CBP report, 2056 ET 18 Mar)*
- USCIS – **49 (+13)** precautionary self-quarantine; **36 (+11)** self-monitoring. *(USCIS report, 0001 ET 19 Mar)*
- USSS – **83 (+20)** precautionary self-quarantine. *(USSS, 2342 ET 18 Mar)*
- TSA – **670 (+258)** self-quarantine, **2,469 (+865)** self-monitoring. *(TSA, 2035 ET 18 Mar)*
- ICE – **120 (+41)** precautionary self-quarantine. *(ICE report, 1814 ET 18 Mar)*
- USCG – **345 (+64)** self-quarantine, **343** self-monitoring. *(USCG, 1233 ET 18 Mar)*
- FLETC – **3 (n/c)** self-quarantine, *(FLETC report, 1544 ET 17 Mar)*
- MGMT – 6 (+2) self-quarantine, 8 (n/c) self-monitoring. *(MGMT, 2023 ET 18 Mar)*
- CWMD – 6 self-quarantine, *(CWMD report, 2008 ET 18 Mar)*
- CISA – 1 self-quarantine, 1 self-monitoring. (n/c) *(CISA, 0036 ET 19 Mar)*
- FEMA – 4 (+1) self-quarantine. *(FEMA report, 1953 ET 18 Mar)*
- OIG – 1 self quarantine *(OIG report, 1223 ET 16 Mar)*
- I&A – 3 precautionary self-quarantine. (*I&A report, 2147 ET 13 Mar*)

CDC: Level 2 (Global) Level 3 (Europe, China, Iran, ROK, Malaysia, UK, Ireland) | DOS: Level 3 (Global) Level 4 (China, Iran, Daegu, ROK; Lombardy, Veneto, IT) | FEMA NRCC: Level 1 (0600-1800 ET. All ESFs) | FEMA PanCAP: Phase 1C

COVID-19 U.S. Map

Snapshot

International *(JHU, 0432 ET 19 Mar)*
- Worldwide Confirmed Cases: **218,8245 (+20,647)**
- Worldwide Confirmed Deaths: **8,810 (+856)**
- Worldwide Recovered **84,121 (+2,161)**
- Countries reporting cases: **158 (+3)**

Domestic
- **Total U.S. Domestic Cases: 9,415 (+2,919)** *(JHU, 0313 ET 19 Mar)*
  - CDC Confirmed/Presumptive: **6,103 (+1,574)** *(HHS, 1700 ET 18 Mar)*
  - Pending CDC reporting: **3,312 (+1,394)**
- **Total U.S. Domestic Deaths: 150 (+36)** *(JHU, 0313 ET 19 Mar)*
- **US-based Quarantine: 1,546 (-180)** *(HHS SITREP, 1700 ET 19 Mar)*

DHS Screening Actions (13 Air POEs) *(CWMD, 0530 ET 18 Mar)*:
- Total CBP Referred to CWMD: **183,744 (+21,993)**
- CWMD Referred to CDC: **992 (+80)**
  - Quarantined by CDC: 26 (n/c)
  - CDC Cleared (no Quarantine): 59 (n/c)
  - Pending CDC Disposition Status: 783 (n/c)

DHS Actions
- FEMA NRCC activated to Level 1 from 0600-1800ET. (*FEMA, 1732ET 17 Mar*)
  - All FEMA RRCCs are activated to Level III. *(FEMA, 0300 ET 17 Mar)*
  - FEMA canceling remainder of NLE 2020 *(FEMA, 1352 ET 17 Mar)*
- CBP activating Continuity Plan to mitigate against disruption of C2 and support of CBP's mission essential functions. (*CBP, 0915 ET 18 Mar*)
  - CBP strategizing with stakeholders on steps to convert El Paso Station and Donna I/II Processing Centers CPCs to COVID-19 quarantine facilities. (*CBP, 1759 ET 17 Mar*)
- CWMD BioWatch sampling reduced at four jurisdictions and stopped at two others to shift lab effort to COVID-19 testing. (CWMD, 2008 ET 18 Mar)
  - CWMD CMO engaged with the HHS Health Attaché to Mexico to advance bilateral COVID-19 collaboration along SWB. (*CWMD 1255 ET 18 Mar*)
  - CWMD / CBP developing entry screening plans for Southwest Border. (*CWMD, 1526 ET 18 Mar*)
- FPS issued guidance on the Partial Closure of Federal Facilities to ensure the orderly conduct of government business. This was shared with federal partners. (*MGMT, 1802 ET 18 Mar*)
- I&A monitoring for indications of virus-induced migrant flows or sick migrants intending to migrate to U.S. for treatment *(IA 1800ET 18 Mar)*
- ICE Health Services Corps is monitoring **24 (+7)** detainees across **10** facilities with **9 (+5)** in isolation in a detained population of **37,843 (-624)**. *(ICE JIOC, 1814 ET 18 Mar)*

Situational Awareness
- There are **150 (+36)** domestic deaths from COVID-19; **WA 58 (+3), NY 20 (+4), CA 16 (+3), FL 8 (+1), LA 7 (+3), NJ 5 (+2), OR 3 (+2),** CO 2, **GA 4 (+3),** SD 1, KS 1, VA 2, IN **2**, KY **1**, NV 1, SC 1, **TX 3 (+1)**, IL **1**, **MO 1 (+1), PA 1 (+1), CT 1 (+1)** *(JHU, 0313 ET 19 Mar)*
- POTUS announced the U.S. and Canada mutually agreed to temporarily close the border to all nonessential travel. Guidelines are being finalized between the U.S. and Canadian governments. (*DOS, 0719 ET and POTUS Twitter, 18 Mar*)
- The White House signed the "Families First Coronavirus Response Act" on 18 Mar that includes provisions for free COVID-19 testing, paid emergency leave, certain tax credits, and several health and nutrition provisions. (*Media, 2201 ET 18 MAR*)
- Congressmen Mario Diaz-Balart (R-FL) and Ben McAdams (D-UT) are both COVID-19 positive (*Office press releases, 18 Mar*)
- Per CDC, 89 public-health labs are now using the CDC COVID-19 testing assay (50 states plus DC). (*HHS SLB, 1700 ET 19 Mar*)
- USNS hospital ship COMFORT will move to New York City to help free-up local hospitals to handle COVID-19. USNS MERCY will be used on the west coast; city TBD. Timeframe for both also TBD as they complete shipyard work. (*HHS, 1700 ET 19 Mar*)
- A contractor working in the FPS-protected U.S. Tax Court building in Washington, DC came into contact with another person who tested positive for COVID-19. The building was evacuated and cleaned overnight, 18-19 Mar. *(FPS Megacenter, 0020 ET 19 Mar)*
- American Red Cross faces a "severe blood shortage" as donor drives are cancelling "at an alarming rate." (*Media, 0756 ET 18 Mar*)
- NYSE trading floor will close after two traders tested positive; electronic trading will continue on 23 Mar. (*CISA, 0528 ET 18 Mar*)
- Two USCG cutters temporarily out of service while awaiting testing results for symptomatic crewmembers. *(USCG, 1413 ET 18 Mar)*
- Mexico has 118 confirmed, 314 suspected, one death and three recovered cases. 31 of 32 Mexican states have confirmed or suspected cases. Only Campeche has no confirmed cases. (*GOM, 0936 ET 18 Mar*)
- MX National Migration Institute (INM) reports 3,058 migrants being held nationwide, including 1,761 Honduran, 723 Guatemalan and 248 Salvadoran. In a 17 Mar meeting, Honduras reportedly committed to begin accepting repatriations on 23 Mar to reduce possible COVID-19 exposure, while Guatemala will increase repatriation rate in the next few days. (*GOM, 0941 ET 18 Mar*)
- U.S. DOS is suspending routine visa services in all countries with a level 2, 3, or 4 travel advisory. (*Media, 1018 ET 18 Mar*)

Domain Actions

Air Domain
- From 2 Feb-19 Mar, CBP refused entry to **20 (n/c)** travelers at airports and **134 (n/c)** travelers at preclearance locations. (*CBP report, 0917 ET 18 Mar*)
- Las Vegas McCarran Airport Tower evacuated for cleaning due to COVID-19 positive controller, causing temporary ground stop. (*TSA, 0108 ET 19 Mar*)

Land Domain
- From 2 Feb-16 Mar, CBP refused entry to **253 (+2)** travelers at land ports of entry. (*CBP report, 0629ET 18 Mar*)
- Since 1 Jan, CBP apprehended **352 (+1)** Chinese nationals at U.S. borders. (*CBP report, 0629 ET 18 Mar*)

Maritime Domain
- Since 2 Feb, 71 commercial ships have been screened.
- Since 2 Feb, 13 cruise ships denied entry; 13 expected to port in next 24-hours; 21 expected in next 96-hours. (*USCG, 0005 ET 18 Mar*)
- In response to protester demands, the HI Governor announced he will not permit any passenger or crew debarkation from C/S MAASDAM, due to arrive Honolulu, HI on 20 Mar, or C/S NORWEGIAN JEWEL, due to arrive on 21 Mar, despite no CDC concern for either ship. (*USCG 0100 ET, 19 Mar*)
- Cruise ship monitoring with known COVID-19 cases: SILVER SHADOW 103 AMCITS, 2 cases; SILVER EXPLORER 45 AMCITS, 1 case; CELEBRITY ECLIPSE 1,165 AMCITS arriving 28 Mar; AZAMARA PURSUIT 265 AMCITS arriving 28 Mar (*CDC, 0830 ET 18 Mar; HHS SLB, 2140 ET 18 Mar*)

An internal DHS coronavirus report, obtained by The Nation, states that ICE's Health Services Corps had isolated 9 detainees.

The document does not specify what illness these individuals are being monitored for, and an ICE spokesperson said that "detainees can be quarantined as a result of any variety of communicable diseases."

However, the document is titled "DHS National Operations Center COVID-19 Placemat," which suggests that the agency's actions are in direct response to the Covid-19 pandemic.

Related Article

[Cuba's Welcome to a Covid-19-Stricken Cruise Ship Reflects a Long Pattern of Global Humanitarian Commitment](#)

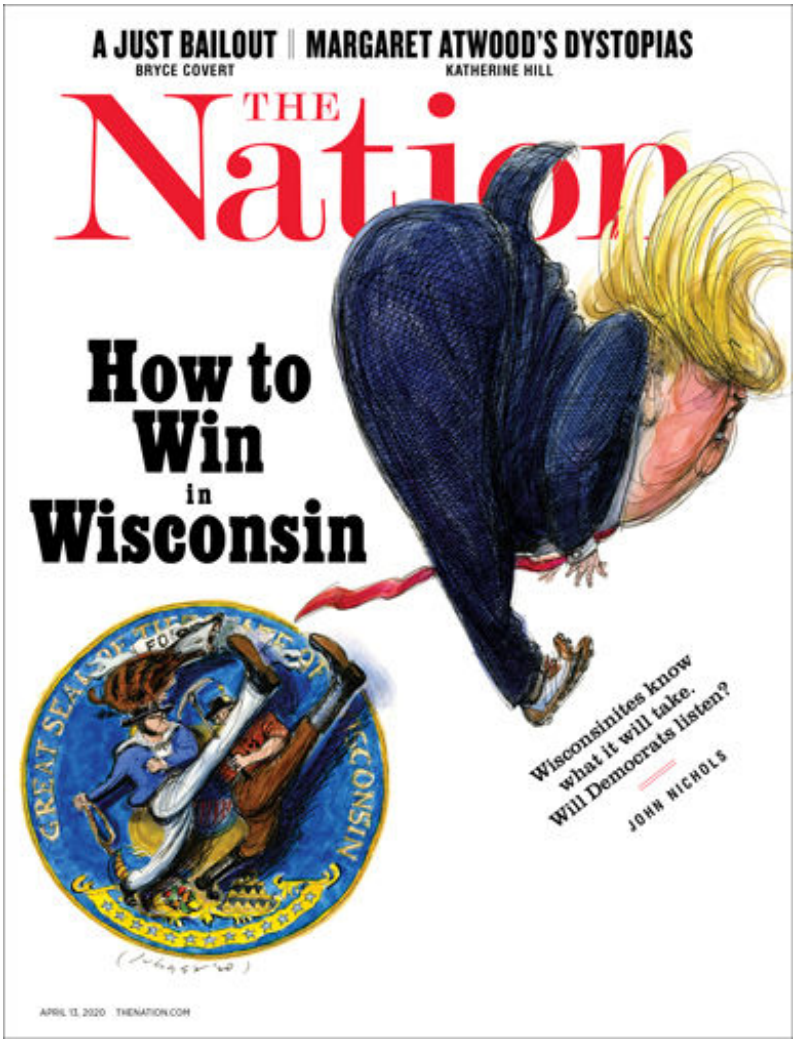
Peter Kornbluh

In addition, the document says Customs and Border Protection (CBP) is working to convert several of its major border facilities into quarantine facilities. One thousand, four hundred and forty-four officials with ICE and CBP's parent agency, the DHS, were in "precautionary self-quarantine" at the time of the document's writing, including 153 CBP officials, the report says.

The document was provided by a federal intelligence official on condition of anonymity to avoid professional reprisal.

The report goes on to state that the current number of detainees in ICE custody is 37,843. Among each of the DHS's sub-agencies, the one with the most employees in self-quarantine is the Transportation Security Administration, at 670. The US Coast Guard ranks second, with 345 employees in self-quarantine, followed by CBP and then ICE.

Current Issue



View our current issue

Unsanitary conditions in both ICE and CBP detention facilities are well-documented, and have led to concerns about facilitating the spread of coronavirus. In July, a DHS Inspector General report found "dangerous overcrowding" and squalid conditions among its southern border facilities. Last week, two doctors who work for the DHS wrote a letter to Congress warning of an "imminent risk to the health and safety of immigrant detainees" as well as the general public in the event that the coronavirus spreads among ICE detention facilities.

The letter went on to warn of a "tinderbox scenario of a large cohort of people getting sick all at once." One day before the letter was sent, ICE informed Congress that at least one of its employees had tested positive for the coronavirus.

In June, I obtained an internal ICE memo describing multiple deaths in ICE custody as having been preventable. The memo, sent from an ICE Health Services Corps (IHSC) official to ICE's then-director, Matthew Albence, in December 2018, stated: "IHSC [ICE's Health Services Corps] is severely dysfunctional and unfortunately preventable harm and death to detainees has occurred."

Despite these conditions, ICE insists no detainees have been found to have the coronavirus.

"At this time, no detainees have tested positive for the virus," Danielle Bennett, a spokeswoman for ICE, told *The Nation* on March 23. "Detainees can be quarantined as a result of any variety of communicable diseases, not just Covid-19."

Asked to clarify if each of the ICE detainees presently in isolation have been tested for Covid-19, Bennet replied: "Yes, testing is being done in accordance with CDC guidelines."

However, the report obtained by *The Nation* is titled "DHS National Operations Center COVID-19 Placemat," and the rest of the document appears to pertain entirely and explicitly to the coronavirus. It is unclear why it would include detainee isolation data pertaining to another illness. (Aside from ICE, the report does not mention detainee isolation numbers in any other DHS agency.)

Under pressure to respond to the epidemic, ICE says it has dramatically scaled back its enforcement activities. But many say that's not enough.

In addition to the two DHS doctors who warned Congress about the dangers posed by the detention facilities, 3,000 medical professionals signed an open letter urging ICE to release its detainees in order to prevent the spread of the coronavirus. 51 ICE detainees sent a letter to rights groups warning that they were being exposed to flu-like symptoms. And it's not just advocates—ICE itself appears concerned, having requested 45,000 respirators last week.

The document provides further insights into DHS's pandemic response. One segment of the report says that DHS's Intelligence & Analysis is "monitoring for indications of virus-induced migrant flows or sick migrants intending to migrate to U.S. for treatment."

Intelligence & Analysis is unique among DHS agencies for being the only one that is part of the US Intelligence Community. As the only spy agency within DHS, Intelligence & Analysis enjoys access to classified information as well as sophisticated intelligence capabilities.

The report also notes that CBP has activated its continuity plan. *The Nation* recently published CBP's pandemic response plan, which contains a continuity plan in anticipation of a substantial loss of personnel capacity as well as morale due to illness.

One passage in the pandemic response plan states: “Many Americans will die from the virus, spreading fear and panic among the population, including CBP employees…. Pandemic influenza is expected to cause massive disruptions in travel and commerce, and may challenge the essential stability of governments and society. In spite of this, CBP must continue to carry out its priority mission to prevent the entry of terrorists and their weapons, regardless of the circumstances.”

Exhibit D

March 19, 2020 Letter from Drs. Scott A. Allen & Josiah Rich to Rep. Bennie Thompson et al.

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

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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

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[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.

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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

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[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.

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[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

Exhibit E

March 21, 2020 Letter from Bd. of Correction of the City of New York to Criminal Justice Leaders

BOARD OF CORRECTION
CITY OF NEW YORK
1 CENTRE STREET, RM 2213
NEW YORK, NY 10007
212 669-7900 (Office)
212 669-7980 (Fax)

March 21, 2020

Darcel Clark
Bronx District Attorney

Eric Gonzalez
Brooklyn District Attorney

Melinda Katz
Queens District Attorney

Michael McMahon
Staten Island District Attorney

Cyrus Vance
Manhattan District Attorney

Janet DiFiore
Chief Judge of the Court of Appeals and of the State of New York

Anthony Annucci
Acting Commissioner, NYS Department of Corrections and Community Supervision

Cynthia Brann
Commissioner, NYC Department of Correction

VIA EMAIL

Dear New York City's Criminal Justice Leaders:

The New York City jails are facing a crisis as COVID-19 continues its march through the City. We write to urge you to act to (1) immediately remove from jail all people at high risk of dying of COVID-19 infection and (2) rapidly decrease the jail population.

Staff of the Department of Correction (DOC) and Correctional Health Services (CHS) are doing heroic work to keep people in custody and staff safe and healthy. The Board of Correction, the independent oversight agency for the City's jails, has closely monitored Rikers Island and the borough jails for over sixty years. From this experience, we know that DOC's and CHS's best efforts will not be enough to prevent viral transmission in the jails. Their work must be supplemented by bold and urgent action from the City's District Attorneys, New York State judges, New York State Department of Corrections and Community Supervision (DOCCS), and DOC's utilization of its executive release authority. Fewer people in the jails will save lives and minimize transmission among people in custody as well as staff. Failure to drastically reduce the jail population threatens to overwhelm the City jails' healthcare system as well its basic operations.

Over the past six days, we have learned that at least twelve DOC employees, five CHS employees, and twenty-one people in custody have tested positive for the virus. There are more than 58 individuals currently being monitored in the contagious disease and quarantine units (up from 26 people on March 17). It is likely these people have been in hundreds of housing areas and common areas over recent weeks and have been in close contact with many other people in custody and staff. Given the nature of jails (e.g. dense housing areas and structural barriers to social distancing, hygiene, and sanitation), the number of patients diagnosed with COVID-19 is certain to rise exponentially. The best path forward to protecting the community of people housed and working in the jails is to rapidly decrease the number of people housed and working in them.

Mayor de Blasio announced on March 19 that the NYPD and Mayor's Office of Criminal Justice (MOCJ) had identified 40 people for release from custody, pending approval of the District Attorneys' Offices and the courts. This number is far from sufficient to protect against the rapid spread of coronavirus in the jails.

We urge you to follow your colleagues in Los Angeles County (CA), San Francisco (CA), Cook County (IL), Autauga County (AL), Augusta County (VA), Allegheny County (PA), Hamilton County (OH), Harris County (TX), Travis County (TX), and Cuyahoga County (OH), and take action now to release people from City jails. As further detailed below, this immediate reduction should prioritize the release of people who are at higher risk from infection such as those over 50 or with underlying health conditions. Additionally, you must safely release other people in jail to decrease the overall population; this process should begin with people detained for administrative reasons (including failure to appear and parole violations) and people serving "City Sentences" (sentences of one year or less). The process should continue to identify all other people who can be released. DOC and CHS should provide discharge planning to all people you release, including COVID screening, connection to health and mental health services, and support with housing, as necessary.

People over 50 years old

The morbidity rates for COVID-19 accelerate with age, with older people being the least likely to recover from complications of the virus. There are currently 906 people in DOC custody who are over age 50. Older adults in custody have an average of between three and four medical diagnoses each, and each of them takes between six and seven medications. Of the 906 older adults in custody today, 189 are being detained on technical parole violations. Another 74 older adults are City-Sentenced, serving one year or less for low-level offenses.

People with underlying health conditions

People with underlying health conditions, including lung disease, heart disease, diabetes, cancer, or a weakened immune system, are especially at risk of dying from COVID-19. As of today, there are 62 people in the infirmary at North Infirmary Command on Rikers Island. They are housed there because they require a higher level of medical care. Twelve of them are technical parole violators and six are City-Sentenced. In addition, there are eight women currently in the infirmary at the Rose M. Singer Center, three of whom are in custody on technical parole violations.

People detained for administrative reasons
There are currently 666 people in custody being held solely for a technical violation of parole, including failure to make curfew, missing a meeting with a parole officer, or testing positive for drugs. There are an additional 811 people detained on an open case and a technical parole violation who also should be reviewed for immediate release.

People serving city sentences
There are currently 551 people in DOC custody who are serving a City Sentence of under one year for low-level offenses. The Mayor must use his executive powers to release these people.

New York must replicate the bold and urgent action it has taken in other areas to stem the tide of COVID-19 in the jails. The Board strongly urges you to take urgent action today to drastically reduce the NYC jail population using the guidelines above.

Sincerely,

Jacqueline Sherman
Interim Chair

Exhibit F

March 20, 2020 News Release,
California Chief Justice Issues Second
Advisory on Emergency Relief Measures

CALIFORNIA COURTS
THE JUDICIAL BRANCH OF CALIFORNIA

California Chief Justice Issues Second Advisory on Emergency Relief Measures

March 20, 2020

Contact: Peter Allen | 415-865-7740

California Chief Justice Tani Cantil-Sakauye issued new guidance to the state's superior courts on Friday to mitigate some of the health risks to judicial officers, court staff, and court users during the COVID-19 pandemic.

In California, unlike other states, presiding judges of county superior courts may petition the Chief Justice—as chair of the Judicial Council—for an emergency order. (So far, the Chief Justice has signed emergency orders for nearly all of California's 58 counties, available to the public **here**).

Under Gov. Gavin Newsom's executive order to shelter in place, courts are considered "essential services" that must still provide services to the public.

"I am deeply concerned about the disruption and hardships caused by the COVID-19 crisis and I have applied and will continue to apply all the constitutional and statutory powers of my office to minimize these unprecedented problems," Cantil-Sakauye said.

In Friday's advisory, Cantil-Sakauye urged court officials to consider the following measures. "These actions can be taken immediately to protect constitutional and due process rights of court users. They will require close collaboration with your local justice system partners," Cantil-Sakauye said.

In criminal cases:

> Lower bail amounts significantly for the duration of the coronavirus emergency, including lowering the bail amount to $0 for many lower level offenses.

juvenile defendants.
Identify detainees with less than 60 days in custody to permit early release, with or without supervision or community-based treatment.
Determine the nature of supervision violations that will warrant detention in county jail, or “flash incarceration," to drastically reduce or eliminate its use during the current health crisis.
Prioritize arraignments and preliminary hearings for in-custody defendants, and the issuance of restraining orders.
Prioritize juvenile dependency detention hearings to ensure they are held within the time required by state and federal law.
Allow liberal use of telephone or video appearance by counsel and defendant for routine or non-critical criminal matters.

In civil cases:

Suspend all civil trials and hearings for at least 60 days, with the exception of time-sensitive matters, such as restraining orders and urgent dependency, probate, and family matters.
When possible, provide that any urgent matters may be done telephonically.

See Chief Justice Tani Cantil-Sakauye’s advisory below, sent to all county superior court presiding judges and court executive officers on Friday:

To: Presiding Judges and Court Executive Officers of the California Courts

Dear Judicial Branch Colleagues:

I write to share information on actions we are taking at the state level regarding the current crisis in our California court system resulting from COVID-19, and to provide guidance on ways that might mitigate some of the health risks to judicial officers, court staff, and court users.

CALIFORNIA COURTS
THE JUDICIAL BRANCH OF CALIFORNIA

judicial officers and court administrators. We sought and received clarification from the Governor's office that the Governor's order is not meant to close our courts. The courts are—and continue to be—considered as an essential service. I recognize, however, that this new adjustment to health guidelines and direction likely may require further temporary adjustment or suspension of certain court operations, keeping in mind, as we all are, that we are balancing constitutional rights of due process with the safety and health of all court users and employees.

We are working at both the state and local levels to identify more options to provide relief. Aiding in these efforts are the perspectives and input from the TCPJAC and CEAC chairs and vice chairs who are dealing with local emergencies while making time to focus on the welfare of our larger judicial branch family.

In addition, we are in daily, close contact with the Governor's office, executive branch departments, and legislative leadership to make them aware of the impact on courts as well as to see where immediate and longer-term assistance may be needed to respond to a crisis of this magnitude.

I am deeply concerned about the disruption and hardships caused by the COVID-19 crisis and I have applied and will continue to apply all the constitutional and statutory powers of my office to minimize these unprecedented problems.

I, like many of you, am being contacted by justice system partners and advocates seeking immediate and direct action to address the particular needs of their constituencies. In responding to these requests, we have made clear what the limits of authority are for the Chief Justice and the Judicial Council, as well as the role of independent trial courts to manage their operations, while stressing our shared commitment to be responsive within the framework of respective constitutional and statutory responsibilities.

The relief I am authorized to grant with an emergency order is limited to the items enumerated in Government Code section 68115. In California, unlike other states, each of the 58 superior courts retains local authority to establish and maintain its own court operations. This decentralized nature of judicial authority is a statutory structure that reflects the diversity of each county.

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THE JUDICIAL BRANCH OF CALIFORNIA

requests submitted by the presiding judges in many superior courts, with the understanding that the immense diversity of our state may require variations on what is considered an essential or priority service in a particular court or community.

I will continue to grant emergency order requests while balancing fairness and access to justice. As of writing, 63 emergency orders have been processed with several more pending. In light of the continuing emergency posed by the COVID-19 pandemic, I am prepared to approve requests for further extensions as warranted, consistent with my authority under Government Code section 68115(b).

In addition to the steps you have taken under the orders you have been granted, I strongly encourage to you consider the following suggestions to mitigate the effect of reduced staffing and court closures and to protect the health of judges, court staff, and court users.

These actions can be taken immediately to protect constitutional and due process rights of court users. They will require close collaboration with your local justice system partners.

Criminal Procedures

1. Revise, on an emergency basis, the countywide bail schedule to lower bail amounts significantly for the duration of the coronavirus emergency, including lowering the bail amount to $0 for many lower level offenses – for all misdemeanors except for those listed in Penal Code section 1270.1 and for lower-level felonies. This will result in fewer individuals in county jails thus alleviating some of the pressures for arraignments within 48 hours and preliminary hearings within 10 days.
2. In setting an adult or juvenile defendant's conditions of custody, including the length, eligibility for alternative sentencing, and surrender date, the court should consider defendant's existing health conditions, and any conditions existing at defendant's anticipated place of confinement that could affect the defendant's health, the health of other detainees, or the health of personnel staffing the anticipated place of confinement.

sentence for the purpose of modifying their sentences to permit early release of such persons with or without supervision or to community-based organizations for treatment.

4. With the assistance of justice partners, calendar hearings for youth returning to court supervision from Department of Juvenile Justice following parole consideration for a Welf. & Inst. Code, §1766 hearing.
5. With the assistance of justice partners, determine the nature of supervision violations that will warrant "flash incarceration," for the purpose of drastically reducing or eliminating the use of such an intermediate sanction during the current health crisis.
6. Prioritize arraignments and preliminary hearings for in-custody defendants, and the issuance of restraining orders.
7. Prioritize juvenile dependency detention hearings to ensure they are held within the time required by state and federal law.
8. For routine or non-critical criminal matters, allow liberal use of telephonic or video appearance by counsel and the defendant, and appearance by counsel by use of waivers authorized by Penal Code, § 977. Written waivers without being obtained in open court have been approved if the waiver is in substantial compliance with language specified in section 977, subdivision (b)(1). (*People v. Edwards* (1991) 54 Cal.3d 787, 811; *People v. Robertson* (1989) 48 Cal.3d 18, 62.)

Civil Procedures

1. Suspend all civil trials, hearings, and proceedings for at least 60 days, with the exception of time-sensitive matters, such as restraining orders and urgent dependency, probate, and family matters. Consider whether an emergency order may be needed to address cases reaching 5-year deadlines under Code of Civil Procedure section 583.310.
2. When possible, provide that any urgent matters may be done telephonically, under the general policy encouraging use of telephonic appearances in Code of Civil Procedure section 367.5(a) and California Rule of Court, rule 3.670.

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address questions, share information, provide resources, and maintain open lines of communication to facilitate our branch's response.

I am immensely grateful to you and your dedicated employees for your tireless efforts to navigate this storm as you are also trying to help and protect your own families through this challenging time for us all.

Tani G. Cantil-Sakauye
Chief Justice of California

Related

California Chief Justice Issues Guidance to Expedite Court Emergency Orders
March 16, 2020

Court Emergency Orders
April 02, 2020

Exhibit G

March 23, 2020 Linh Ta, Iowa's prisons will accelerate release of approved inmates to mitigate COVID-19, Times Republican

Times-Republican

Iowa's prisons will accelerate release of approved inmates to mitigate COVID-19

Contributed photo Anamosa State Penitentiary is a maximum-security prison in Jones County.

From school districts to workplaces to restaurants, Iowans across the state are shutting their doors and keeping to themselves to mitigate the spread of COVID-19. But for inmates in Iowa's jail and prisons, social distancing is not an option.

The close quarters and transient influx of new people behind bars creates a precarious situation where a highly contagious virus like COVID-19 could spread and expose not only inmates but also the general public.

To mitigate a possible outbreak and create more room in Iowa's overcrowded prisons, the Iowa Department of Corrections plans to expedite the release of about 700 inmates who were already determined eligible for release by the Iowa Board of Parole.

"We're trying to be more efficient in our area and free up some space," said Beth Skinner, director of the Iowa Department of Corrections.

By accelerating the release wait list, more beds will open up, which can allow the correctional facility to move inmates more easily if an outbreak does occur in a prison. Iowa's eight prisons are already about 23% overcrowded, according to the Iowa Department of Corrections daily statistics.

Skinner

But releasing people without offering them a place to go doesn't help either, Skinner said. She said they're working to ensure all parolees have a place to stay once they return to their communities.

"It has to be a suitable, safe place," Skinner said.

Prisoners medically screened before intake or release

Beyond accelerating the release of people, the Iowa Department of Corrections is also medically screening all new inmates and people who are released from their facilities, Skinner said.

On average, 500 new inmates are transferred to the prisons on a monthly basis, Skinner said.

Correctional workers will take their temperatures and give them medical questionnaires to fill out. Because symptoms of COVID-19 may not immediately show, new inmates are automatically quarantined for 14 days.

Visitations are also temporarily suspended to mitigate the spread of COVID-19, but the department is examining reducing the costs of mail and phone calls, Skinner said.

Inmates and correctional officers have access to soap and water and employees are also provided hand sanitizer.

A *"huge piece"* in preventing outbreaks will be COVID-19 tests, however, Skinner said. Each correctional facility will receive five to six tests, which can help them evaluate people who may have symptoms and quarantine them.

"We get the people who have the flu. What's different with this one is the unknown," Skinner said.

ACLU: Iowa should do more to reduce prison population

But an Iowa civil rights group believes the state should go even further to reduce the density of the prison population and mitigate the spread of COVID-19.

ACLU of Iowa is calling for comprehensive changes to law enforcement and correctional facilities practices.

Veronica Fowler, spokesperson for ACLU of Iowa, said limiting arrests and releasing more people not only protects the jail and prison populations, but also the general public who may be exposed to COVID-19 by a correctional officer.

"We have in any one day about 16,000 people, essentially behind bars," Fowler said of Iowa's prisons and jails. *"That is the equivalent of Clive or Boone or Oskaloosa. We're not talking about tiny little populations."*

The organization is calling for limiting the number of arrests, people in county jails and number of people being held on pretrial detention. Additionally, the group is asking the state to commute people with medical conditions who would have been released in the next two years and commuting people who were scheduled to be released in a year.

Another concern is an order from the Iowa Supreme Court, Fowler said.

On March 14, the Iowa Supreme Court ordered all criminal jury trials be postponed until April 20. Fowler said that could result in some inmates staying behind bars longer than necessary.

Fowler said ACLU plans to send a letter to the governor and state officials detailing their requests.

"If all these people get sick, that's a health crisis that overwhelms the system," Fowler said.

In Johnson County, 37 inmates were being held in the county jail. The county has the highest rate of COVID-19 with 22 confirmed cases so far. The facility was originally built to house 46 inmates, but by double-bunking inmates, it can hold 92, according to The Gazette.

No plans for early release from expanded Polk County jail

At the Polk County Jail, there are no plans to expedite the release of prisoners, said Lt. Heath Osberg of the Polk County Sheriff's Office.

In 2008, Polk County finished construction on a new jail facility that holds 1,500 inmate beds and is tripled in size from the previous jail.

Because of the larger size, Osberg, said there is not overcrowding in the jail. Around 749 inmates were being held in the jail as of Friday afternoon.

The difference between jails and prisons, however, is the more transient flow of people coming in and out.

Between Wednesday and Thursday, 24 inmates were booked into Polk County Jail, according to its website. Eleven of those detained have already been released.

Osberg said inmates who are brought into the facility are getting their temperatures checked and filling out medical questionnaires.

He said any changes in the release of inmates would have to come from county attorneys and Iowa courts.

Fowler said she hopes state officials stay aware of Iowa's jailed population, particularly people who can't afford to pay bond and those with health conditions that make them more vulnerable to COVID-19.

"The bottom line is that we already have an over-incarceration problem in our country and our state," Fowler said.

Exhibit H

March 20, 2020 Frank Fernandez, Coronavirus Preparation Prompts Volusia Jail to Release Some Non-Violent Offenders, Daytona Beach News-Journal

THE DAYTONA BEACH NEWS-JOURNAL
NEWS-JOURNALONLINE.COM
HOME OF THE WORLD'S MOST FAMOUS BEACH

Coronavirus preparation prompts Volusia jail to release some non-violent offenders

By Frank Fernandez
@frankfff
Posted Mar 20, 2020 at 6:33 AM
Updated Mar 20, 2020 at 6:04 PM

The Volusia County Branch Jail is releasing 88 inmates to help prepare for an outbreak of the coronavirus.

The Volusia County Branch Jail and Correctional Facility plans to release 88 inmates who are being held on non-violent charges to help prevent a coronavirus outbreak at the jail, which so far has had no cases of the virus.

[CORONAVIRUS: Read the latest news and information]

By Friday afternoon, 85 of 88 inmates approved to be released had been freed from the jail, according to county spokesman Gary Davidsion.

The 88 inmates were being held on a variety of misdemeanor and felony charges, including possession of cocaine, reckless driving, trespassing, possession of paraphernalia, defrauding an innkeeper, petit theft, fraudulent use of personal identification, burglary of an unoccupied dwelling, possession of heroin, according to court documents.

The Volusia County Branch Jail's plan is similar to what is being done in Hillsborough County, which is releasing some inmates to allow corrections staff to work on higher priorities.

The Volusia County Branch Jail is currently holding 930 inmates while the county's correctional facility is currently housing another 409 for a total of 1,339 inmates. The branch jail holds only men while the correctional facility holds women with pending cases and bothe men and women servicing sentences.

"We did receive approval from the court today and yes, we are working on a similar plan," rote Mark Flowers, the director of corrections for Volusia County, in an email on Thursday afternoon.

Circuit Judge Raul Zambrano , chief judge for the 7th Circuit, signed an order on Thursday granting a state motion for early release of the inmates in support of the state of emergency.

The 88 inmates are being released on their own recognizance, according to the order.

But they will still have to answer to the charges against them once courthouses get back to normal.

Davidson wrote that the jail will support any order or desire from the court as far as releasing any additional inmates.

Releasing the 88 inmates will allow staff at the jail to focus on other priorities but Davidson declined to discuss in more detail how it would help.

Volusia County Spokesman Kevin Captain wrote in an email on Thursday that there have not been any coronavirus cases at the Volusia County Branch Jail.

The Volusia County jail is working with its medical contractor, Centurion, and other health officials and are prepared if "there is contact with someone affected by the virus," Captain wrote.

The Flagler County Sheriff's Office has no plans to release any inmates from its jail unless it receives a court order, wrote Shannon Martin, a spokesperson for the Flagler County Sheriff's Office.

"All inmates are screened before admittance to the jail regardless of COVID-19," Martin wrote. "Currently no inmates are exhibiting any symptoms. Should any become symptomatic they will be quarantined and examined by our medical team who will advise on next steps. We have no plans to release any non-violent inmates unless if we are ordered by a judge."

The Florida Department of Juvenile Justice issued an emergency order suspending visitation at all state-operated juvenile detention centers and juvenile residential commitment programs until April 15.

The Department of Juvenile justice said it has no known or suspected cases at this time of COVID-19, the disease caused by the coronavirus.

Attorneys will still be allowed to meet with youth and instructional and clinical personnel will be permitted to continue to provide services to the youth, the statement said.

It has also begun additional screening of outside vendors who work within the juvenile facilities. Family members with visitation questions should contact the facility where their child is held.

None of the inmates at the St. Johns County Jail, which as of Thursday held 392, have been released yet but a judge is reviewing criteria in anticipation of releasing "select inmates," according to Chuck Mulligan, spokesman for the St. Johns County Sheriff's Office.

Hillsborough County is releasing 164 inmates from its two facilities which house about 2,700 inmates to help lower the possibility of the coronavirus spreading at the jail, according to a news account. Releasing the inmates will allow staff at the jail to focus on higher priorities, according to the news account.

Exhibit I

March 19, 2020 BBC News, US jails Begin Releasing Prisoners to Stem Covid-19 Infections

US jails begin releasing prisoners to stem Covid-19 infections

19 March 2020

Coronavirus pandemic

GETTY IMAGES

US jails are to let out inmates as cases of coronavirus infections are being reported in prisons.

New York City is releasing "vulnerable" prisoners, the mayor said on Wednesday, days after Los Angeles and Cleveland freed hundreds of inmates.

Prison reform advocates say those in jail are at higher risk of catching and passing on Covid-19.

There have been more than 9,400 cases of Covid-19 and 152 deaths in the US so far, according to estimates.

Globally there are some 220,000 confirmed cases and over 8,800 deaths.

What happened in New York City?

New York City Mayor Bill de Blasio said on Wednesday that city officials will this week identify individuals for release, including people who were arrested for minor crimes and those most vulnerable to infection due to underlying health problems.

His announcement came hours after a guard and a prisoner tested positive for coronavirus at Rikers Island prison, where disgraced former Hollywood producer Harvey Weinstein, 68, is a high-profile inmate.

Weinstein will be moved to a different state prison, an official said on Wednesday.

Other New York prisons, such as Sing Sing, have had inmates test positive for coronavirus and **one employee for the state's corrections department has died from it**.

What have other US jurisdictions done?

The Los Angeles County Sheriff's Department reduced its inmate population by 600 in the last two weeks, officials said on Tuesday.

"Our population within our jails is a vulnerable population just by who they are, where they are located, so we're protecting that population from potential exposure," Los Angeles Sheriff Alex Villanueva told reporters earlier this week.

The LA County jail system is the largest prison system in the world with an average population of around 22,000 prisoners.

Mr Villaneuva disclosed that arrests in the county are also down, from an average of 300 per weekend to only 60 in mid-March.

- A SIMPLE GUIDE: **What are the symptoms?**
- YOUR THIRD HAND: **How do you clean your smartphone?**
- BORED KIDS: **Should you let your children play with others?**
- GETTING READY: **How prepared is the US?**
- DOING GOOD: **Kind Canadians start 'caremongering' trend**

Cuyahoga County, Ohio, where the city of Cleveland is located, has also released hundreds of prisoners due to coronavirus concerns.

Judges held emergency hearings through the weekend to work out plea deals and other agreements to allow prisoners to be released early or without serving time.

Several states from New York to California are now banning in-person visitors. A ban on visits led to a deadly prison riot in Italy last week.

Federal agencies will postpone most arrests and deportations during the coronavirus crisis.

What is the danger to prisoners?

Reform campaigners say prisoners face unique risks, due to a lack of hygiene in overcrowded cells and hallways.

Handcuffed people cannot cover their mouths when they cough or sneeze, sinks often lack soap and hand sanitiser is considered contraband due to its alcohol content.

Iran has already released 85,000 people, including political prisoners, in an effort to combat the pandemic.

The US locks up more of its citizens per capita than any other country, with an estimated 2.3 million people behind bars in federal, state and local prisons.

Some high profile convicts have argued for early release over coronavirus fears.

They include President Trump's former lawyer Michael Cohen, 53, financial fraudster Bernie Madoff, 81, and Gilberto Rodriguez-Orejuela, a notorious Colombian drug lord.

Related Topics

Los Angeles **Prisons** **Coronavirus pandemic** **United States**

New York City

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Exhibit J

Michigan Executive Order No. 2020-29

Executive Order 2020-29 (COVID-19)

EXECUTIVE ORDER

No. 2020-29

Temporary COVID-19 protocols for entry into Michigan Department of Corrections facilities and transfers to and from Department custody;

temporary recommended COVID-19 protocols and enhanced early-release authorization for county jails, local lockups, and juvenile detention centers

The novel coronavirus (COVID-19) is a respiratory disease that can result in serious illness or death. It is caused by a new strain of coronavirus not previously identified in humans and easily spread from person to person. There is currently no approved vaccine or antiviral treatment for this disease.

On March 10, 2020, the Michigan Department of Health and Human Services identified the first two presumptive-positive cases of COVID-19 in Michigan. On that same day, I issued Executive Order 2020-4. This order declared a state of emergency across the state of Michigan under section 1 of article 5 of the Michigan Constitution of 1963, the Emergency Management Act, 1976 PA 390, as amended, MCL 30.401-.421, and the Emergency Powers of the Governor Act of 1945, 1945 PA 302, as amended, MCL 10.31-.33.

The Emergency Management Act vests the governor with broad powers and duties to "cop[e] with dangers to this state or the people of this state presented by a disaster or emergency," which the governor may implement through "executive orders, proclamations, and directives having the force and effect of law." MCL 30.403(1)-(2). Similarly, the Emergency Powers of the Governor Act of 1945 provides that, after declaring a state of emergency, "the governor may

promulgate reasonable orders, rules, and regulations as he or she considers necessary to protect life and property or to bring the emergency situation within the affected area under control." MCL 10.31(1).

To mitigate the spread of COVID-19, protect the public health, and provide essential protections to vulnerable Michiganders who work at or are incarcerated in prisons, county jails, local lockups, and juvenile detention centers across the state, it is reasonable and necessary to implement limited and temporary COVID-19-related protocols and procedures regarding entry into facilities operated by the Michigan Department of Corrections and transfers to and from the Department's custody; to recommend limited and temporary COVID-19-related protocols and measures for county jails, local lockups, and juvenile detention centers; and to temporarily suspend certain rules and procedures to facilitate the implementation of those recommendations.

Acting under the Michigan Constitution of 1963 and Michigan law, I order the following:

1. The Michigan Department of Corrections (the "Department") must continue to implement risk reduction protocols to address COVID-19 ("risk reduction protocols"), which the Department has already developed and implemented at the facilities it operates and which include the following:

a. Screening all persons arriving at or departing from a facility, including staff, incarcerated persons, vendors, and any other person entering the facility, in a manner consistent with guidelines issued by the Centers for Disease Control and Prevention ("CDC"). Such screening includes a temperature reading and obtaining information about travel and any contact with persons under investigation for COVID-19 infection.

b. Restricting all visits, except for attorney-related visits, and conducting those visits without physical contact to the extent feasible.

c. Limiting off-site appointments for incarcerated persons to only appointments for urgent or emergency medical treatment.

d. Developing and implementing protocols for incarcerated persons who display symptoms of COVID-19, including methods for evaluation and processes for testing, notification of the Department of Health and Human Services ("DHHS"), and isolation during testing, while awaiting test results, and in the event of positive test results. These protocols should be developed in consultation with local public health departments.

e. Notifying DHHS of any suspected case that meets the criteria for COVID-19 through communication with the applicable local public health department.

f. Providing, to the fullest extent possible, appropriate personal protective equipment to all staff as recommended by the CDC.

g. Conducting stringent cleaning of all areas and surfaces, including frequently touched surfaces (such as doorknobs, handles, light switches, keyboards, etc.), on a regular and ongoing basis.

h. Ensuring access to personal hygiene products for incarcerated persons and correctional staff, including soap and water sufficient for regular handwashing.

i. Ensuring that protective laundering protocols are in place.

j. Posting signage and continually educating on the importance of social distancing, handwashing, and personal hygiene.

k. Practicing social distancing in all programs and classrooms—meaning a distance of at least six feet between people in any meeting, classroom, or other group.

- Minimizing crowding, including interactions of groups of 10 or more people, which may include scheduling more times for meal and recreation to reduce person-to-person contact.

2. To mitigate the risk of COVID-19 spreading in county jails, strict compliance with the capacity and procedural requirements regarding county jail overcrowding states of emergency in the County Jail Overcrowding Act ("CJOA"), 1982 PA 325, MCL 801.51 et seq., is temporarily suspended. While this order is in effect, all actions that would be authorized under the CJOA in the event of a declaration of a county jail overcrowding state of emergency are authorized and shall remain authorized without regard to any reduction in jail population or any other such limitations on the duration of authorization imposed by the CJOA.

3. Anyone authorized to act under section 2 of this order is strongly encouraged to consider early release for all of the following, so long as they do not pose a public safety risk:

a. Older people, people who have chronic conditions or are otherwise medically frail, people who are pregnant, and people nearing their release date.

b. Anyone who is incarcerated for a traffic violation.

c. Anyone who is incarcerated for failure to appear or failure to pay.

d. Anyone with behavioral health problems who can safely be diverted for treatment.

4. Effective immediately, all transfers into the Department's custody are temporarily suspended. Beginning seven (7) days from the effective date of this order, and no more than once every seven (7) days, a county jail or local lockup may request that the director of the Department determine that the jail or lockup has satisfactorily implemented risk reduction protocols as described in section 1 of this order. Upon inspection, if the director of the Department determines that a county jail or local lockup has satisfactorily implemented risk reduction protocols, transfers from that jail or lockup will resume in accordance with the Department's risk reduction protocols. The director of the Department may reject transfers that do not pass the screening protocol for entry into a facility operated by the Department.

5. Parole violators in the Department's custody must not be transported to or lodged in a county jail or local lockup unless the director of the Department has determined that such

county jail or local lockup has satisfactorily implemented risk reduction protocols as described in section 1 of this order.

6. The State Budget Office must immediately seek a legislative transfer so that counties may be reimbursed for lodging incarcerated persons that would have been transferred into the Department's custody if not for the suspension of transfers described in section 4 of this order.

7. Juvenile detention centers are strongly encouraged to reduce the risk that those at their facilities will be exposed to COVID-19 by implementing as feasible the following measures:

a. Removing from the general population any juveniles who have COVID-19 symptoms.

b. Eliminating any form of juvenile detention or residential facility placement for juveniles unless a determination is made that a juvenile is a substantial and immediate safety risk to others.

c. Providing written and verbal communications to all juveniles at such facilities regarding COVID-19, access to medical care, and community-based support.

d. To the extent feasible, facilitating access to family, education, and legal counsel through electronic means (such as telephone calls or video conferencing) at no cost, rather than through in-person meetings.

8. Unless otherwise directed by court order, for juveniles on court-ordered probation, the use of out-of-home confinement for technical violations of probation and any requirements for in-person meetings with probation officers are temporarily suspended.

9. This order is effective immediately and continues through April 26, 2020 at 11:59 pm.

Given under my hand and the Great Seal of the State of Michigan.

Exhibit K

Joint Statement (March 26, 2020)

MICHIGAN COURTS NEWS RELEASE
John Nevin, Communications Director
Ph: 517-373-0129 Twitter: @MISupremeCourt FB: facebook.com/misupremecourt

March 26, 2020

Chief Justice Bridget M. McCormack, Michigan Supreme Court
Sheriff Matt Saxton (ret.), Executive Director, Michigan Sheriffs' Association
Joint Statement

Thank you to judges, sheriffs, and law enforcement statewide who have stepped up to reduce jail populations in response to the ongoing public health emergency. With a single-minded focus on keeping our communities safe, jail populations across Michigan have declined to between 25% and 75% below their maximum capacities.

We are grateful for the efforts taken so far, but we must make sure we do all we can to protect the health of Michiganders. We have half a million criminal court cases each year in Michigan and several hundred thousand people entering jails. Governor Whitmer has requested that we all do our part to limit risk, and judges and sheriffs must work together to protect court employees, jail staff, inmates, and the public at large.

We can be proactive to reduce this risk:

- Judges and Sheriffs should use the statutory authority they have to reduce and suspend jail sentences for people who do not pose a public safety risk.
- Law enforcement should only arrest people and take them to jail if they pose an immediate threat to people in the community.
- Judges should release far more people on their own recognizance while they await their day in court. For some, judges may want to release them under supervision or under a condition that they stay away from a particular place or person.
- And judges should use probation and treatment programs as jail alternatives.

In addition, see the detailed advice that the Michigan Supreme Court State Court Administrative Office previously provided to judges and court administrators statewide. Following this advice WILL SAVE LIVES. (attached below)

Guidance to Trial Courts (Provided to Trial Courts March 20, 2020)

Detention, Bail, and Pretrial Release

In an effort to slow the spread of COVID-19, especially in the confined environments of county jails, courts should collaborate with county stakeholders and consider the following recommendations:

Coordinate with law enforcement in your county about expanding the use of appearance citations (when appropriate and legally permissible) rather than custodial arrests.

Pursuant to MCL 764.9c, police officers may issue appearance tickets, subject to certain exceptions, for misdemeanor or ordinance violations for which the maximum permissible penalty does not exceed 93 days in jail. Appearance tickets save police officers' time for more pressing matters and eliminate jail confinement. Even if an offense does not qualify for an appearance ticket (e.g. felonies or misdemeanors with punishments exceeding 93 days in jail), law enforcement still has the option for many offenses to release defendants, without charges, and submit their report to the prosecutor's office for review.

Coordinate with your prosecutors and law enforcement agencies in your county regarding the possible use of summons (when appropriate) rather than arrest warrants.

Pursuant to MCR 6.103, a court may issue a summons instead of an arrest warrant upon the request of the prosecutor. This presents another opportunity to avoid incarceration and allows the court more flexibility with scheduling arraignments than with in-custody defendants.

If defendants are arrested for warrantless misdemeanor offenses, courts should coordinate with law enforcement to use their discretionary authority to set lower interim bonds for an expedited release of low-risk defendants before arraignment.

Pursuant to MCL 780.581, a police officer may, subject to certain exceptions, set interim bail if defendants are arrested without a warrant for misdemeanor offenses and a magistrate is not available. The amount of interim bail must be "a sum of money" determined by the police officer, not the court, but must not exceed the maximum possible fine for the offense nor be less than 20 percent of the minimum possible fine. Law enforcement agencies sometimes accomplish this by using a "bond schedule." Several courts utilize an Interim Bond Order for this purpose.

Courts must closely adhere to MCR 6.106(C) regarding personal or unsecured bonds to effectuate as many pretrial releases from custody as safely possible.

MCR 6.106(C) requires courts to release defendants on personal or unsecured bonds unless they will not reasonably ensure the appearance of the defendant as required or will present a danger to the public. Money bail of even modest amounts can delay, or outright deny, the release of certain presumptively innocent defendants.

When setting bail, courts should carefully weigh the public necessity of certain pretrial conditions (including drug/alcohol testing, counseling, office visits, etc.) with the risk of spreading COVID-19.

Courts should be mindful that conditions of release, while not confining defendants in jail, can still place defendants in close proximity with other individuals. MCR 6.106(D) allows courts to impose conditions of pretrial release if a personal recognizance bond will not reasonably ensure the appearance of the defendant or the safety of the public. Moreover, research suggests many conditions of pretrial release, with the exception of court date reminders, are ineffective at reducing failure to appear and rearrests rates. When balancing which bond conditions to order with minimizing the spread of the COVID-19, the court should still be mindful that behavior that is dangerous to the defendant or others should not be tolerated.

Consider using non-warrant alternatives (when appropriate) when defendants fail to appear in court or otherwise commit conditional release violations.

Pursuant to MCR 3.606(A)(1) and MCR 6.106(H)(2), a court may order a defendant to appear for a show cause hearing for an alleged bond violation or issue a summons for a modification of bond. Show Cause Orders (MC 230) and Summons Regarding Bond Violations (MC 308) are two options that will avoid custodial arrests and allow courts more control over their dockets. The court should continue to issue bench warrants in those circumstances where the defendant's conduct resulting in the alleged bond or probation violations present a danger to the defendant or others.

###

Exhibit L

Statement of The former Acting Director of ICE John Sandweg

IDEAS

I Used to Run ICE. We Need to Release the Nonviolent Detainees.

It's the only way to protect detention facilities and the people in them from COVID-19.

MARCH 22, 2020

John Sandweg
Former acting director of Immigration and Customs Enforcement

CHRIS CARLSON / AP IMAGES

With more than 37,000 detainees closely confined in facilities across the country, Immigration and Customs Enforcement (ICE) detention centers are extremely susceptible to outbreaks of infectious diseases. The design of these facilities requires inmates to remain in close contact with one another—the opposite of the social distancing now recommended for stopping the spread of the lethal coronavirus.

[Read: What you need to know about the coronavirus]

As the former Acting Director of ICE under President Obama, I know that preventing the virus from being introduced into these facilities is impossible. This week, the Trump administration announced that, in light of its concern that the virus could be introduced into detention centers, it would shift its enforcement operations to focus only on criminals and dangerous individuals. This means that the agency will arrest and place in detention only those undocumented immigrants who have serious criminal convictions. Those without a criminal record will be allowed to stay at home as they go through the deportation process. This is a necessary and crucial first step, but the administration must do more: It must release the thousands of nonviolent, low-flight-risk detainees currently in ICE custody.

ICE is fortunate that the threat posed by these detention centers can be mitigated rather easily. By releasing from custody the thousands of detainees who pose no threat to public safety and do not constitute an unmanageable flight risk, ICE can reduce the overcrowding of its detention centers, and thus make them safer, while also putting fewer people at risk.

This doesn't mean that dangerous criminals will be walking the streets. Those who threaten Americans' safety can and must continue to be detained. However, the immigration detention system is not designed to detain only those who have committed serious crimes or pose a significant flight risk. In fact, only a small percentage of those in ICE detention have been convicted of a violent crime. Many have never even been charged with a criminal offense. ICE can quickly reduce the detained population without endangering our communities.

[Read: How Trump radicalized ICE]

The large-scale release of detainees doesn't mean that undocumented immigrants should get a free pass either. Those who are released can and should continue to go through the deportation process. ICE can employ electronic monitoring and other tools to ensure their appearance at mandated hearings and remove them from the country when appropriate.

When an outbreak of COVID-19 occurs in an ICE facility, the detainees won't be the only ones at risk. An outbreak will expose the hundreds of ICE agents and officers, medical personnel, contract workers, and others who work in these facilities to the virus. Once exposed, many of them will unknowingly take the virus

home to their family and community. Moreover, once the virus tears through a detention center, crucial and limited medical resources will need to be diverted to treat those infected. ICE can, and must, reduce the risk it poses to so many people, and the most effective way to do so is to drastically reduce the number of people it is currently holding.

We want to hear what you think about this article. Submit a letter to the editor or write to letters@theatlantic.com.

Exhibit M

March 16, 2020 Memorandum from Donald W. Beatty, Chief Justice of South Carolina Supreme Court, to Magistrates, Municipal Judges, and Summary Court Staff

SC Judicial Branch

Court News ...

The Supreme Court of South Carolina

DONALD W. BEATTY
CHIEF JUSTICE

POST OFFICE BOX 3543
SPARTANBURG, SOUTH CAROLINA 29304-3543

MEMORANDUM

TO: Magistrates, Municipal Judges, and Summary Court Staff

FROM: Chief Justice Beatty

RE: Coronavirus

DATE: March 16, 2020

As the number of coronavirus cases has increased in South Carolina, and a state of emergency has been declared, the South Carolina Judicial Branch continues to consider all aspects of court operations.

As the situation continues to develop, we will provide further information and direction if and when circumstances so warrant. In the meantime, please review the following directives for your courts.

- All jury trials are postponed. Non-jury trials and other hearings may continue to be held, but only attorneys, their clients, and necessary witnesses will be allowed to appear.
- All roll calls and any other large gatherings such as traffic court are cancelled until further notice.
- If you deem it necessary to curtail operations beyond the scope of this memorandum, courthouses should remain available for the following critical functions:
    - Acceptance of filings and payments (including bonds)
    - Emergency hearings (including, but not limited to: restraining orders, orders of protection, bond revocation/modification, and vacating of bench warrants)
    - Transmission of necessary information to SLED and/or NCIC
    - Compliance with the Financial Accounting Order
- Any person charged with a non-capital crime shall be ordered released pending trial on his own recognizance without surety, unless an unreasonable danger to the community will result or the accused is an extreme flight risk.
- Bench warrants for failure to appear shall not be issued at this time.
- At a minimum, bond hearings should be held at least once per day.
    - The court shall continue to conduct probable cause determinations if a defendant is arrested and incarcerated on a Uniform Traffic Ticket.
    - The bond court shall continue to unseal bench warrants, or inform defendants of right to counsel and new court dates, and vacate bench warrants.
    - Victim's rights must be upheld. A victim advocate/notifier must be available for bond hearings.
    - If a defendant has been in jail as a pre-trial detainee for the maximum possible sentence, the court shall convert the bond to a personal recognizance bond and release the defendant.
- Court dates may be rescheduled as is necessary and prudent.
- To the extent possible and circumstances warrant, hearings that can be held by video may be held remotely. Telephonic hearings may be held remotely as a last resort.
- Counties/municipalities with orders in place whereby the Chief Magistrate may appoint magistrates to serve as municipal judges should do so as necessary if the current municipal judge(s) becomes unable to hold court.
- If a magistrates court temporarily closes, there should be adequate signs posted directing persons to the nearest other magistrates court(s) within the county where filings and payments may be tendered. The court should include this information on its voicemail and website/social media if possible.
- The courts must maintain a 24-hour judge on-call schedule and provide it to jails and law enforcement. Amend the schedule as necessary.

The SCJB's Crisis Management Team will continue to monitor this situation and provide further information as received. We remain committed to the safety of the state court system and to the public. Thank you for your assistance in implementing these measures.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

JANET MALAM,

Plaintiff,

- against -

REBECCA ADDUCCI, in her official capacity as Detroit District Director of U.S. Immigration & Customs Enforcement; MATTHEW T. ALBENCE, in his official capacity as Deputy Director and Senior Official Performing the Duties of the Director of the U.S. Immigration & Customs Enforcement; CHAD WOLF, in his official capacity as Acting Secretary, U.S. Department of Homeland Security; WILLIAM P. BARR, in his official capacity as Attorney General, U.S. Department of Justice; U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT; HEIDI E. WASHINGTON, in her capacity of Director of Michigan Department of Corrections Calhoun Correctional Center,

Defendants,

And

Ruby Briselda Escobar; Amer Toma,

Plaintiff-Intervenors.

No. 2:20-cv-10829-JEL-APP

DECLARATION OF RONALD KAPLOVITZ, ESQ. IN FURTHER SUPPORT OF PLANINTFF-INTERVENORS RUBY BRISELDA ESCOBAR AND AMER TOMA'S MOTION FOR TEMPORARY RESTRAINING ORDER

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

1. My name is Ronald Kaplovitz. I make these statements based upon my personal knowledge.

2. I am an attorney with Kaplovitz and Associates PC. I have been practicing immigration law for 30 (thirty) years. I am currently representing my client, Amer Toma, who is detained at Calhoun County Correctional Facility in Battle Creek, Michigan.

3. My client's name is Amer Toma. He is fifty-five years old. He is currently detained at the Calhoun County Correctional Facility in Battle Creek, Michigan. He has been detained at Calhoun County Correctional Facility since February 2020. From September 2019 to February 2020, he was detained at Monroe County Jail. He has been in immigration detention for over six months.

4. He was born in Iraq, and came to the United States approximately ten years ago as a refugee.

5. In 2019, Mr. Toma was charged with delivery of 5-45 kilos of marijuana. Mr. Toma ended up pleading guilty to a charge of delivery/manufacture of marijuana and received two years of probation as a first time offender.

6. Mr. Toma was ordered removed on February 26, 2020, and he was granted CAT Deferral on the same date based on his fear of persecution and torture in Iraq. The government has appealed the Immigration Judge's grant of relief to the Board, and he is being detained as a result of that appeal.

7. Mr. Toma currently has three bullets lodged in his body after being shot multiple times during the Iran-Iraq War. These bullets have caused infection and swelling in the past, including an incident three years ago that required hospitalization. He has expressed to me that he is worried that his susceptibility to infection will put him at higher risk of severe illness or death if he contracts COVID-19.

8. The bullets in his body also cause intense back pain, making it difficult to walk. This pain has forced him to use a wheelchair at various points, and he has been wheelchair-bound for the past month.

9. Mr. Toma also suffers from hypotension and was hospitalized two years ago for prostate issues. More recently, a doctor indicated that he should get tested for prostate cancer due to symptoms like blood in his stool. He also has a hernia that has gone untreated.

10. In detention, Mr. Toma has not received any medication to control his blood pressure. He also has not been able to access the medical care that he needs to get tested for prostate cancer or to treat his hernia.

11. Because of his medical conditions, he believes that he is at a high risk of being infected with COVID-19. Very few corrections officers wear gloves and masks and there is no access to antibacterial/antiviral sanitizing products in the facility. Based on his inability to access full medical care and the lack of communication, he does not believe the detention center is doing enough to treat his conditions or protect him from contracting COVID-19.

12. Mr. Toma has been shuffled from unit to unit since arriving at the detention facility, including three days ago, each time increasing his exposure to new people. He shares a cell with one other person and when they are in lockdown, they are never more than six feet from each other. The bedding is changed in his cell every four or five days.

13. Mr. Toma's unit has 56 people in, and they are rarely six feet away from each other, as the common area is not conducive to social distancing. When eating, he sits at a table with four or six other people approximately two feet from each other.

14. About two weeks ago, someone in the facility was suspected of having COVID-19, and everyone was moved to a different section of the facility while the area was cleaned. He does not know if anyone has any issues with the virus and he has not been told whether anyone in the facility has COVID-19. He also has not received any guidance on social distancing, hygiene, and other preventive measures.

15. If Mr. Toma is released, he can be reunited with his wife. His sister and cousins live in the United States and can help support him as well. At home, he will be able to get medical treatment for his conditions while maintaining a safe distance from others and/or quarantining as necessary.

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

Executed on the 5th day of April 2020, in Oakland County, Michigan.

/s/ Ronald Kaplovitz

Ronald Kaplovitz
Kaplovitz & Associates, PC
2057 Orchard Lake Road
Sylvan Lake, Michigan 48320

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

JANET MALAM,

Plaintiff,

- against -

REBECCA ADDUCCI, in her official capacity as Detroit District Director of U.S. Immigration & Customs Enforcement; MATTHEW T. ALBENCE, in his official capacity as Deputy Director and Senior Official Performing the Duties of the Director of the U.S. Immigration & Customs Enforcement; CHAD WOLF, in his official capacity as Acting Secretary, U.S. Department of Homeland Security; WILLIAM P. BARR, in his official capacity as Attorney General, U.S. Department of Justice; U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT; HEIDI E. WASHINGTON, in her capacity of Director of Michigan Department of Corrections Calhoun Correctional Center,

Defendants,

And

Ruby Briselda Escobar; Amer Toma,

Plaintiff-Intervenors.

No. 2:20-cv-10829-JEL-APP

DECLARATION OF FARAH HOBBALLAH, ESQ. IN FURTHER SUPPORT OF PLANINTFF-INTERVENORS RUBY BRISELDA ESCOBAR AND AMER TOMA'S MOTION FOR TEMPORARY RESTRAINING ORDER

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

1. My name is Farah Hobballah. I make these statements based upon my personal knowledge after having had conversations with my client.

2. I am an attorney in private practice in Dearborn, Michigan. In this capacity, I have represented Ruby Briselda Escobar in her immigration proceedings since approximately December 2019.

3. Ms. Escobar has been in civil immigration detention at Calhoun County Correction Center since November 2018. She has not been detained at any other location.

4. As part of my duties as Ms. Escobar's attorney, I conduct visits with her at Calhoun County Correctional Center and speak with her by telephone.

5. Since I began representing Ms. Escobar, I have visited Calhoun County Jail three times. Prior to the past two weeks, I have been able to speak with Ms. Escobar three times per week.

6. However, for the past two weeks, it has been extremely difficult to get in touch with my client. Calhoun County Correctional Center does not take incoming calls to detainees, and only takes messages that they promise to deliver to the detainees. Once given my message, detention staff are then supposed to have Ms. Escobar call me. At this time, Ms. Escobar has been unable to call me back for many hours, or sometimes days. I have even resorted to emailing the deputy in charge in order to get my client the message to call me back, which is an atypical procedure. My colleagues with clients in Calhoun County have complained for the last two weeks about similar issues.

7. In my visits and conversations with Ms. Escobar, and through my review of her immigration records and documents, I have learned the following about her:

    a. Ms. Escobar was born in El Salvador, and came to the United States in 2013 when she was twenty-four years old.

    b. Ms. Escobar was kidnapped and held hostage by sex traffickers immediately upon arriving at the United States-Mexico border near Arizona. From approximately June until July 2013, Ms. Escobar was held hostage. Ms. Escobar was repeatedly sexually assaulted and raped in captivity.

    c. During two of these sexual assaults, Ms. Escobar felt she was having a stroke or mild heart attack. On two occasions during her captivity, she has lost feeling in her fingers and face.

d. Prior to her captivity, Ms. Escobar's mother told her that she was born with a heart murmur. However, she did not experience significant heart problems until she was kidnapped and held hostage in 2013.

e. Ms. Escobar now regularly experiences heart problems that manifest with heavy sweating, weakness, chest pain, and difficulty breathing. Ms. Escobar believes her heart condition has deteriorated enough to become heart disease because her symptoms worsen more and more with each day. Her symptoms have become unbearable and she has been asking to see a doctor for months. She constantly feels out of breath and palpations in her chest are now more frequent than they have been since her kidnapping.

f. Ms. Escobar also suffers from a brain aneurysm that she developed while being held hostage by traffickers in 2013.

g. Because of her brain aneurysm, Ms. Escobar often experiences headaches, brain fogginess and forgetfulness, dizziness, nausea, vomiting, double vision, and trouble speaking clearly.

h. Before being detained, Ms. Escobar was seeing a doctor for her medical conditions, and was admitted to the hospital at least once to treat her symptoms. She was taking medications for her brain aneurysm, but cannot remember the names of the medications.

i. Ms. Escobar has seen a doctor about her medical conditions once or twice at the start of her time in immigration detention, but she has been seen by a nurse for every subsequent appointment. Her most recent physical exam took place several weeks ago. Ms. Escobar's last two physical exams were completed by a nurse. The nurse told Ms. Escobar to take Tylenol and ibuprofen for her symptoms, which Ms. Escobar must buy herself from the commissary. Ms. Escobar does not know if the doctor she was seeing before has been told about her ongoing symptoms since she began seeing the nurse exclusively.

j. Based on my experience and observations as her attorney, and based on descriptions of Ms. Escobar's harrowing life experiences, I believe Ms. Escobar suffers from Post-Traumatic Stress Disorder ("PTSD"). This condition aggravates her existing vulnerability and anxiety about her health and safety in detention.

k. Because of her medical conditions, Ms. Escobar is very worried about her risk of being infected with COVID-19 at Calhoun County Correctional Center. She does not believe the detention center is doing enough to keep her safe.

8. Throughout the course of my representation of Ms. Escobar, I have also learned the following about conditions in Calhoun County Jail:

    a. Ms. Escobar lives in a cell with five other female detainees, who frequently alternate between incoming and outgoing detainees. Their beds are set up as bunk beds, and there is very little space to move around inside the cell.

    b. Currently, the detention center does not allow detainees to leave their cells for any reason. They are on lockdown. This has been happening for almost two weeks. Meal trays are delivered directly to detainees' cells by staff and detainee volunteers. Ms. Escobar does not believe the facility is being sanitary in preparing and delivering detainee meals because other detainees claim that the preparers of the food are visibly sick.

    c. Even though detainees are no longer gathering in larger groups, Ms. Escobar's cell itself is small and crowded. She is not able to keep the recommended distance of six feet between herself and others inside the cell.

    d. Ms. Escobar has complained to me that "everyone around" her is sick, coughing, and weak, and they are not being treated for their symptoms.

    e. Ms. Escobar was not given any information about COVID-19 from the staff at the detention center. My office was the first to inform her about the virus.

9. Ms. Escobar has a final order of removal that was issued in 2013, when she first attempted entry into the United States. At that time, Ms. Escobar was immediately apprehended at the border by Customs and Border Patrol ("CBP"). Upon her apprehension by Immigration and Customs Enforcement ("ICE") in November 2018, Ms. Escobar indicated that she feared being removed to El Salvador. Thus, she was given a Reasonable Fear Interview. Ms. Escobar was found credible, but the ICE officer did not find that she merited any form of relief. Ms. Escobar was referred to the Immigration Judge in Detroit, Michigan for Withholding of Removal and protection under the Convention Against Torture ("CAT") only. Although both ICE and the Immigration Judge deemed Ms. Escobar's testimony credible, the Immigration Judge denied Ms. Escobar's application for Withholding of Removal and protection under the CAT.

10. When I met Ms. Escobar, she had never been screened for any other form of relief besides Withholding of Removal. Upon screening her, I found that she had a viable claim for a T-Visa as a victim of severe human trafficking. As such, I was retained to represent her in her T-Visa application. Her application is currently pending before the United States Citizenship and Immigration Services ("USCIS"), and she has completed a biometrics retrieval.

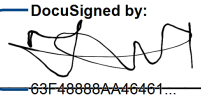
11. Finally, over the course of my representation, Ms. Escobar has divulged highly sensitive, personal information to me about her past traumatic experiences being trafficked and her sexual orientation. Ms. Escobar was unable to reveal this vital information to past attorneys, due to her ongoing trauma. I believe this information would have been outcome-determinative in her prior removal proceedings. I intend to file a Motion to Reopen Removal Proceedings, in order that Ms. Escobar's applications may be freshly heard and fully considered by an Immigration Judge.

12. Ms. Escobar has never committed a crime in the United States, or in El Salvador. She has three children who are now in foster care because Ms. Escobar is in civil immigration detention; they are between the ages of nine and fifteen years old. Her children have applied for asylum, and Ms. Escobar would like to be reunited with them and help keep them safe from COVID-19.

13. If she is released, Ms. Escobar can live with her best friend, Katherine DeLeon. At Ms. DeLeon's home in Lincoln Park, Michigan, Ms. Escobar will be able to get medical treatment for her conditions while maintain a safe distance from others and quarantining as necessary.

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

Executed on the 5th day of April 2020, in Dearborn, Michigan.

DocuSigned by:

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4/5/2020 | 9:52 AM EDT

Farah Hobballah, Esq.
16030 Michigan Avenue, Suite 100
Dearborn, MI 48126

Exhibit A

Letter of Kristen DeHaan

03/23/2020

To whom it may concern:

I am writing this letter on behalf of my clients Everson, Billy and Osmel Calvillo Salguero and their mother Ruby Salguero Escobar. Ms. Salguero Escobar is currently detained at the Calhoun County Correctional Center, in Battle Creek MI.

Everson, Billy and Osmel arrived to the United States in 2018 with the goal of reunifying with Ms. Salguero Escobar. Unfortunately, Ms. Salguero Escobar has been detained since that time, and has been unable to pursue reunification with her sons. Everson, Billy and Osmel are under the care of Bethany Christian Services in Michigan and have been able to visit their mother monthly in-person, as well as speak via video on a weekly basis. The longer that Everson, Billy and Osmel are separated from their mother, the more trauma and anxiety they will experience.

It is in the best interest for families to remain together, and I request that Ms. Salguero Escobar be released from detention. Upon her release, Bethany Christian Services will be starting the reunification process. There are no concerns with Ms. Salguero Escobar as a parent, and we expect the Office of Refugee Resettlement to approve the reunification.

Due to underlying health concerns that Ms. Salguero Escobar has, and due to the lack of appropriate medical care for her condition at Calhoun County, we request immediate release. Due to the rampant spread of COVID-19, especially in high-population areas such as jails, Ms. Salguero Escobar would be at risk for a more severe case of COVID-19, should she contract the virus.

Ms. Salguero Escobar would not present a threat to the community should she be released. Ms. Salguero Escobar has a strong circle of supportive friends, who would help ensure that she would abide by all immigration guidelines. Upon her release, Everson, Billy and Osmel would be able to visit their mother and have physical contact with her, as that is forbidden during their monthly visits to the jail. The sooner Ms. Salguero Escobar is released, the sooner the reunification process can begin, and the sooner my clients can be reunited with their mother. Being with their mother is in their best interest and we ask that all barriers be removed that are currently preventing the reunification.

Thank you,

Kristen L DeHaan, BA

Kristen DeHaan
Case Manager
Bethany Christian Services
kdehaan@bethany.org
616-307-8183

Exhibit B

Letter of Michelle R. Fitzgerald, MSW

Bethany CHRISTIAN SERVICES

March 25, 2020

RE: Ruby Salguero Escobar

To Whom it May Concern:

I write this letter out of concern for Ruby Salguero Escobar and her son Osmel, for whom I provide therapeutic services. It has come to my attention that Ruby has several underlying health conditions that make her of particularly high risk of poor outcomes should she contract COVID19. As the country and the world take unprecedented measures to prevent the spread of this virus as well as to protect our most vulnerable, I feel that I must advocate on Ruby's behalf. I ask that action be taken to reduce her risk of contracting COVID19 as well as to maintain her overall health. Specifically, I ask that she be provided appropriate medical attention, appropriate access to the medication and treatment she needs for existing medical conditions, as well as to give her release from detention to further protect her from contracting COVID19.

Osmel's emotional stability and well being is anchored in his hope and desire to be reunited with his mother. As his therapist, I see that his health and wellbeing would suffer significantly should his mother's health and life be put in jeopardy.

Sincerely,

Michelle Fitzgerald, LMSW

Michelle R. Fitzgerald, MSW
Therapist

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

JANET MALAM,

Plaintiff,

- against -

REBECCA ADDUCCI, in her official capacity as Detroit District Director of U.S. Immigration & Customs Enforcement; MATTHEW T. ALBENCE, in his official capacity as Deputy Director and Senior Official Performing the Duties of the Director of the U.S. Immigration & Customs Enforcement; CHAD WOLF, in his official capacity as Acting Secretary, U.S. Department of Homeland Security; WILLIAM P. BARR, in his official capacity as Attorney General, U.S. Department of Justice; U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT; HEIDI E. WASHINGTON, in her capacity of Director of Michigan Department of Corrections Calhoun Correctional Center,

Defendants.

No. 2:20-cv-10829-JEL-APP

DECLARATION OF PAY PAR GAI IN FURTHER SUPPORT OF NON-PARTIES RUBY BRISELDA ESCOBAR AND AMER TOMA'S MOTION TO INTERVENE

I, Pay Par Gai, hereby declare:

I make this declaration based upon my own personal knowledge and if called to testify I could and would do so competently,

1) I was held in immigration detention by the United States Immigration and Customs Enforcement (ICE) at the Calhoun County Correctional

Facility (Calhoun) in Michigan from February 20, 2020 to April 2, 2020.

2) The facility does not provide Covid-19 testing. Last week I had a fever and cough, and I requested a test for Covid-19 but I was not tested for Covid-19. I also heard and saw people couching and sneezing, but to my knowledge, none of those individuals were tested.

3) I was held in Pod B until the day before my last day in detention. I was held in Pod M on my last day in detention.

4) Both Pod B and Pod M are two-floor units. To get to the second floor for both pods, you need to walk up a stairway that has handrails.

5) It is hard to practice good hygiene at Calhoun. We were provided with one piece of soap per day and a small bottle of shampoo (smaller than travel size, the size of a free sample). The soap was about two inches long and one inch wide. You can only use it for one shower-- there is not enough soap to use it for more than one shower. I never have leftover pieces of soap remaining after I take a shower.

6) The jail gives you one uniform to wear until you are released no matter how long you stay there. The uniforms were washed twice a week. Since I had no other uniform to wear, I had to stay inside my room while my uniform was being washed.

7) There is no hand sanitizer provided for use by detainees. The other detainees and I asked the staff about getting hand sanitizer but the staff said that we were not allowed to have it.

8) The communal sinks in Pod B and Pod M do not have soap provided for detainee use. Detainees need to provide their own soap for handwashing.

9) People are allowed to buy bars of soap for handwashing from commissary. Detainees need to pay about $1.50-$2.00 for a small bar that can last about 1 or 2 days, or they can pay about $3.00-$5.00 for a larger bar that can last a week. If you couldn't afford to buy extra soap from commissary, there were no other options for washing your hands. During my time at Calhoun I did not see or hear Calhoun staff

make any offers to provide additional hand soap for people who could not afford to buy it from commissary.

10) Both Pod B and Pod M had one communal toilet with a sink in the lower level for everyone to use. The communal toilets did not have soap for handwashing provided. People often used the communal toilets, which were more convenient than going upstairs to use the toilet in your cell. Both communal toilets had an open wall so everyone could see you using the bathroom. If I wanted to have privacy when using the communal toilets, I had to take one of the cafeteria chairs that we use for mealtime and place it in front of me to block myself from view. Then when I was finished using the bathroom I would put the chair back. I saw many other detainees using cafeteria chairs in this way to have more privacy when using the communal toilets in Pod B and Pod M.

11) The button to operate the water faucet for the sink in Pod M's communal bathroom was stuck, so there was no running water for handwashing in the communal bathroom. People who used the communal bathroom in Pod M had to use the sinks in their cells to wash their hands.

12) During my time in Pod B, I was not aware of any additional steps being taken to keep the Calhoun facility clean due to Covid-19. I did not see extra cleaning being done or additional cleaning supplies being used. In fact, I never saw the Pod B showers being cleaned in my entire stay in Pod B.

13) Aside from one commissary worker wearing a facemask, I did not see jail staff taking any extra precautions to prevent the spread of Covid-19 while I was in Pod B. Specifically, I did not see jail staff wearing masks, face shields, or gloves while I was in Pod B.

14) There were about 40 people staying in Pod B while I was there. I believe that the detainees were mainly immigration detainees. Detainees would be brought out of Pod B and new people would be brought into Pod B almost every day.

15) There were about 56 people staying in Pod M with me when I was there. It was not possible to always be 6 feet away from someone else.

16) Pod B and Pod M have 2 people assigned to share cells. The cells have bunkbeds, toilets and tiny sinks. I shared a cell with an immigration detainee in Pod B and with a different immigration detainee in Pod M.

17) On the last night before I was released, Calhoun staff transferred me and all the other immigration detainees from Pod B to Pod M. They did not tell us why we were being moved. The cell I was assigned had not been cleaned. It was dirty and everything was torn up.

18) Pod M is terrible. The windows are covered up so you can't see what is going on outside. Many things are broken in Pod M, including the sink in the communal bathroom.

19) There was no deputy assigned to Pod M. It was just us immigration detainees staying there. We had our meals brought to us from the outside through a slot, but we were otherwise on our own. People were confused and scared.

20) One of the people that I was detained with in Pod B had been removed for deportation to Mexico. However, he was brought back to stay with us in Pod M. When I asked him what happened, he told me that when ICE brought him to the Detroit airport he was not allowed to get on an airplane because he was coughing and had a fever. So ICE brought him back to Calhoun with us.

21) Social distancing was not practiced in Pod B or Pod M and I do not know how that would be possible. For example, we eat our meals at communal cafeteria tables of six people. Both Pod B and Pod M were too crowded for people to be able to stay 6 feet apart from one another. Even if we stayed in our cells we would be with our roommates.

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

Dated April 3, 2020

/s/ Pay Par Gai*

Pay Par Gai

*consent for signing given telephonically

Due to the Covid-19 crisis, it was not possible to obtain a written signature on the above declaration. I am an attorney admitted to the Eastern District of Michigan. On April 3, 2020 I personally spoke with Pay Par Gai and read this declaration to him/her over the phone. Pay Par Gai told me that the information in the above declaration is true, and gave me verbal consent to sign on his behalf.

I declare under penalty of perjury, pursuant to 28 USC 1746, that the foregoing is true and correct.

/s/ Monica Andrade

Monica Andrade