UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

JANET MALAM, Petitioner-Plaintiff, - against - REBECCA ADDUCCI, *et al.*, Respondent-Defendants.	No. 2:20-cv-10829-JEL-APP

PETITIONER-PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER

Petitioner-Plaintiffs ("Plaintiffs") Qaid Alhalmi, Tomas Cardona Ramirez, Julio Fernando Medina Euceda, Damary Rodriguez Salabarria, Emanuel Rosales Borboa, and Min Dan Zhang hereby move this Court, pursuant to Fed. R. Civ. P. 65, for a temporary restraining order requiring their immediate release from the Calhoun County Correctional Center. The grounds for this motion are set forth in the Brief in Support of Plaintiffs' Motion for Temporary Restraining Order, filed herewith and the accompanying Declarations in support.

In accordance with Local Rule 7.1(a), the Plaintiffs' counsel contacted Jennifer Newby, counsel for Respondent-Defendants, and Andrew Stacer, counsel for separately-represented Petitioner-Plaintiff Janet Malam, to seek their consent of

this motion. At the time of this filing, neither Ms. Newby nor Mr. Stacer had responded to Plaintiffs' request.

Dated: April 26, 2020

Respectfully submitted,

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BRIEF IN SUPPORT OF PETITIONER-PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER

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INTRODUCTION

Qaid Alhalmi, Tomas Cardona Ramirez, Julio Fernando Medina Euceda, Damary Rodriguez Salabarria, Emanuel Rosales Borboa, and Min Dan Zhang (collectively "Plaintiffs") are non-citizen immigration detainees whose medical conditions or age make them highly vulnerable to serious illness and death from the COVID-19 disease, and who are being held in civil detention at Calhoun County Correctional Center ("Calhoun") in Battle Creek, Michigan in violation of their Due Process rights. With every passing day, the COVID-19 disease infects scores of immigrant detainees across the country because of the confined, congregate nature of the detention facilities in which immigration detainees are held. Tragically, COVID-19 has already reached over thirty detention centers across the country—including nearby St. Clair County Jail ("St. Clair") in Port Huron, Michigan, where five detainees have tested positive and Butler County Jail ("Butler") in Hamilton, Ohio, where one staff member has tested positive.

COVID-19 has no vaccine, no treatment, and no cure. Importantly, it can be transmitted by people who are completely asymptomatic. By the time a person has tested positive, or even begun to feel early symptoms, they may already have infected countless other people with whom they have had contact. The only option for medically vulnerable people to avoid serious illness and death from COVID-19 is to practice rigorous social distancing and careful hygiene. At Calhoun, because

of the close quarters in which detainees are held, it is impossible to practice either measure.

Given the nature of this pandemic, there is no way to ensure that at-risk individuals such as Plaintiffs avoid exposure to COVID-19 while they remain in detention. This near-certain exposure to a virulent, often deadly disease violates their constitutional rights. There is no way to protect them short of immediate release. Their release under an order of supervision, along with adequate public health and safety measures like home quarantine, is also in the interest of Respondent-Defendants ("Defendants"), the staff at Calhoun, and the public generally. Contagion among the detainee population and jail staff would deplete the Battle Creek and nearby area of limited medical resources, including ventilators and intensive care units.

On April 24, 2020, the media began reporting that COVID-19 may have entered Calhoun.[1] The reports indicate that one staff member and one inmate are being monitored for "probable" cases of COVID-19.[2] While there reports are not yet confirmed, it is clear that an outbreak of Calhoun is very likely. Indeed, given

[1] *See, e.g.*, Elena Durnbaugh, *2 probable coronavirus cases identified at Calhoun County Jail*, Battle Creek Enquirer (Apr. 24, 2020), https://www.battlecreekenquirer.com/story/news/2020/04/24/2-probable-coronavirus-covid-19-cases-calhoun-county-jail/3018764001/, Ngo Decl. Ex. A.

[2] *Id.*

the lack of testing, it is quite possible that COVID-19 is already present in the facility.

The Court should grant Plaintiffs' motion and order their immediate release from detention.

FACTS

As of April 26, 2020, 899,281 people in the United States have contracted COVID-19, and 46,204 people in the United States have died from the disease.[3] Plaintiffs, like other individuals who are older and/or have certain medical conditions, are acutely vulnerable and face greater chances of serious illness or death if exposed to the disease.[4] 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. *Id.* ¶ 8. So long as Plaintiffs are detained at Calhoun, they cannot take the most basic steps to protect themselves; they cannot attain any social distance, which puts them at imminent risk of substantial bodily harm and death. Even basic hygiene products, which might help but would not resolve the grave risks, are not made available to them.

[3] Coronavirus disease 2019 (COVID-19) Situation Report – 97, World Health Organization (Apr. 26, 2020), Ngo Decl. Ex. B.

[4] Amended Petition for the Writ of Habeas Corpus Pursuant to 28 U.S.C. § 2241 and Complaint for Injunctive and Declaratory Relief ("Pet.") ¶¶ 94–124.

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

Plaintiffs' underlying medical conditions or age increase their risk of serious illness or fatality if exposed to COVID-19.

Plaintiff Qaid Alhalmi is 54 years old, suffers from type 2 diabetes, and has become insulin dependent in detention. Garvock Decl. ¶ 3(b)(ii). He also suffers from hypertension. *Id.* ¶ 3(b)(i). He also been experiencing severe chest pain and shortness of breath for the last three weeks, and is concerned that it could be a sign of a cardiac event, but has not received an EKG or stress test. *Id.* ¶ 3(b)(iii). ICE has been aware of these conditions since Mr. Alhalmi's arrival in detention. As a result of his hypertension and diabetes, Mr. Alhalmi is at high risk for severe illness or death if he contracts COVID-19. Venters Decl. ¶ 40(a)(i). His age is also a high risk factor. *See also* Venters Decl. ¶ 24 ("CDC's own data reflects that the risk of complications [from COVID-19], measured by hospitalization rates, increase for those between the ages 45-56 and 55-64. This is especially appropriate for ICE's consideration of those in its custody. . . . [I]t is my expert opinion that ICE should apply the age of 50 to identify detainees who have an increased vulnerability to COVID-19[.]").

Plaintiff Tomas Cardona Ramirez suffers from type 2 diabetes, and must take insulin and other medication to regulate his blood sugar. Kessler Decl. ¶ 5(a) . In July, Mr. Cardona Ramirez was diagnosed with hypertension and prescribed

medication to lower his blood pressure, including Lisinopril, an ACE inhibitor used to treat high blood pressure. *Id.* ¶ 5(b). As a result of his diabetes and hypertension, Mr. Cardona Ramirez is at high risk for severe illness or death if he contracts COVID-19. Venters Decl. ¶ 40(a)(v).

Plaintiff Julio Fernando Medina Euceda is 54 years old. Contreras Decl. ¶ 3. As a result of his age, Mr. Medina Euceda is at high risk for severe illness or death if he contracts COVID-19. Venters Decl. ¶¶ 24, 40(a)(iii).

Plaintiff Damary Rodriguez Salabarria suffers from hypertension, chronic gastritis, a peptic ulcer, and gastroesophageal reflux. Hughes Decl. ¶ 7(a). She takes daily medication for all of these conditions. *Id.* Prior to her entry into the United States in 2019, Ms. Rodriguez Salabarria was admitted to a hospital intensive care unit due to acute pancreatitis twice. *Id.* ¶ 7(b). She has also undergone both an appendectomy and a cholecystectomy (gallbladder removal), and had multiple kidney infections. *Id.* As a result of her conditions, Ms. Rodriguez Salabarria is at high risk for severe illness or death if she contracts COVID-19. Venters Decl. ¶ 40(a)(iv).

Plaintiff Emanuel Rosales Borboa is asthmatic. Amaro-Luedtke Decl. ¶ 9. About ten years ago, Mr. Rosales Borboa was hospitalized for two days at Henry Ford Hospital in Detroit, Michigan, after experiencing shortness of breath, chest pains, and difficulty breathing. *Id.* At that time his doctors diagnosed him with

asthma, and he has been using a prescribed inhaler approximately twice a week since then. *Id.* Mr. Rosales Borboa has also been prescribed Prednisone for his asthma. *Id.* As a result of his condition, he is at high risk for severe illness or death if he contracts COVID-19. Venters Decl. ¶ 40(a)(ii).

Plaintiff Min Dan Zhang is 50 years old. De Graaf Decl. ¶ 3. As a result of her age, Ms. Zhang is at high risk for severe illness or death if she contracts COVID-19. Venters Decl. ¶¶ 24, 40(a)(vi).

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

The danger of COVID-19 to Plaintiffs is acute at Calhoun. Tragically, the situation is likely to parallel what has happened in St Clair where a medically vulnerable detainee who filed a habeas action on April 7—the same day that first case was reported for St. Clair—contracted COVID-19, and has since been hospitalized. *See* Albino-Martinez Decl. ¶¶ 3–4, 24–36, *Albino-Martinez v. Adducci*, No. 2:20-cv-10893, Dkt. 22-2 (E.D. Mich. Apr. 20, 2020); U.S. Immigration & Customs Enforcement, ICE Guidance on COVID-19: Confirmed Cases (Apr. 7, 2020), Ngo Decl. Ex. C. 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.[5] Greifinger

[5] As of April 24, 2020, there were five confirmed cases of COVID-19 among ICE detainees at St. Clair and one among ICE staff members at Butler. *See* U.S.

Decl. ¶¶ 8, 10; Venters Decl. ¶¶ 17–18; Letter from Drs. Scott A. Allen & Josiah Rich to Rep. Bennie Thompson et al. (Mar. 19, 2020), Ngo Decl. Ex. G. *See also* Venters Decl. ¶ 15 (noting rapid spread of COVID-19 among Michigan Department of Corrections detainees). Social distancing and vigilant hygiene, including frequent washing of hands with soap and water, are the only known effective measures for protecting vulnerable people from COVID-19. Ngo Decl. Ex. G at 4; Greifinger Decl. ¶¶ 4, 8. Recent ICE guidance acknowledges the risks of COVID-19 to

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Immigration & Customs Enforcement, ICE Guidance on COVID-19: Confirmed Cases (last updated Apr. 24, 2020), Ngo Decl. Ex. D. It is only a matter of time before COVID-19 reaches Calhoun, if it is not already present. Venters Decl. ¶¶ 12–13. According to ICE, 317 ICE detainees (across 30 facilities in Arizona, California, Florida, Georgia, Illinois, Louisiana, Michigan, Mississippi, New Jersey, New Mexico, New York, Pennsylvania, Texas, and Virginia) and 35 ICE detention center employees (across 11 facilities in Arizona, California, Colorado, Georgia, Louisiana, New Jersey, Ohio, and Texas) have tested positive for COVID-19. *Id.* The number of confirmed cases among ICE detainees and staff is over seventeen times what it was just three weeks ago, when Plaintiffs Escobar and Toma filed their Motion for TRO, and it will continue to grow. *See* Dkt. No. 20, at 4 n.3 (noting that ICE had confirmed 20 cases of COVID-19 among its detainees and staff as of April 5, 2020). Due to lack of testing, that number is likely an undercount of the actual numbers of positive cases. *See* Monique O. Madan, *ICE has tested a tiny fraction of its detainees for COVID-19. Most of them were positive.* (Apr. 22, 2020), https://www.miamiherald.com/news/local/immigration/article242203726.html, Ngo Decl. Ex. E (reporting that as of Tuesday, April 21, 2020, ICE had tested just 425 of its total 32,309 detainees for COVID-19, and that 253—59.5%—of those tested were positive). *See also* Greifinger Decl. ¶¶ 3, 12(c); Venters Decl. ¶ 12–13. 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. F.

detainees, calls on all ICE detention facilities to take certain protective steps where possible.[6] However, even if the guidance were being followed at Calhoun—and it is not—it would be woefully inadequate protection for the reasons enumerated below. Schriro Decl. ¶¶ 24; Venters Decl. ¶¶ 26–38; 40.

First, ICE concedes that "strict social distancing may not be possible in congregate settings such as detention facilities,"[7] and in fact, the physical structure of the Calhoun facilities makes social distancing impossible. Venters Decl. ¶ 27 (the ICE Guidance "fail[s] to address the most common scenarios in which high-risk detainees find themselves in close quarters that make social distancing impossible"). While ICE recommends that "[d]etainees who meet CDC criteria for epidemiologic risk of exposure to COVID-19 [be] housed separately from the general population," at Calhoun, medically vulnerable individuals like Plaintiffs remain housed in the general population. Greifinger Decl. ¶ 12(f), 12(h); Amaro-Luedtke Decl. ¶ 11(a); Contreras Decl. ¶ 7(a); Garvock Decl. ¶ 4(b); Hughes Decl. ¶ 9; Kessler Decl. ¶ 6(a).

More specifically, Plaintiffs and other detained individuals are kept together in groups of approximately 30-60 people who eat, live, and sleep in closely confined quarters. Amaro-Luedtke Decl. ¶ 11(a) (37 detainees are currently housed in Pod

[6] U.S. Immigration & Customs Enforcement, *COVID-19 Pandemic Response Requirements 11* (Apr. 10, 2020) ("ICE Guidance"), ice.gov/doclib/coronavirus/eroCOVID19responseReqsCleanFacilities.pdf.
[7] ICE Guidance at 13.

H); Contreras Decl. ¶ 7(a) ("Mr. Medina Euceda sleeps in a dorm with 30 bunk beds."); Garvock Decl. ¶ 4(b) (58 detainees are currently housed in Pod B); Kessler Decl. ¶ 6(a). Most detainees sleep close together in cells or small communal rooms, in which they cannot avoid being within six feet of each other; more commonly they are forced to be two or three feet apart, often in bunk beds. Amaro-Luedtke Decl. ¶ 11(b) ("Mr. Rosales Borboa shares a 20 x 8 foot cubicle with seven other detainees, who share six bunk beds" that are "at most three feet apart from each other."); De Graaf Decl. ¶ 6(a) ("Ms. Zhang shares an overcrowded cell with four other people. The beds in each cell are only one to two feet apart."); Garvock Decl. ¶ 4(a) ("Mr. Alhalmi is housed in a small, which he estimates to be approximately seven by five foot cell, with one other detainee" which "contains a [shared] bunk bed, toilet, sink, and bar of soap[.]"); Hughes Decl. ¶ 9 ("Ms. Rodriguez Salabarria shares a cell with five other cellmates" which includes "four twin-sized bunkbeds."); Kessler Decl. ¶ 6(a).

Detainees share communal showers and bathroom stalls with one another. Amaro-Luedtke Decl. ¶ 11(f) (Mr. Rosales Borboa and the other 36 Pod H detainees "share two bathrooms that contain four toilets, three showers, and four sinks"); Garvock Decl. ¶ 4(b) (Mr. Alhalmi and the other 57 Pod B detainees "share four showers" and "two common bathrooms"). Both food preparation and service are communal; detainees eat their meals together, sitting at shared tables with multiple

other people. Amaro-Luedtke Decl. ¶ 11(d)-(e); Contreras Decl. ¶ 7(a); Garvock Decl. ¶ 4(g); Hughes Decl. ¶ 9; Kessler Decl. ¶ 6(a). *See also* Schriro Decl. ¶ 36 (ICE does not have "a universal health screening protocol to ensure that all the persons preparing and serving meals and cleaning the [meal] area are not sick or symptomatic"); Amaro-Luedtke Decl. ¶ 11(e) ("The detainees who deliver and distribute food trays to Pod H also deliver and distribute food trays to the pods holding quarantined detainees, and do not wear protective gear like masks or gloves[.]"); Hughes Decl. ¶ 9 ("Correctional staff serve meals to the inmates, but do not wear masks or gloves while doing so.").

Second, because detainees are unable to maintain proper hygiene and social distancing practices, it is likely that COVID-19—which ICE confirms has already reached nearby St. Clair and Butler[8]—would spread quickly among Calhoun's detainees and staff once it enters the facility. Golob Decl. ¶ 13 ("[I]t is reasonable to expect COVID-19 will [] 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."); Amaro-Luedtke Decl. ¶ 11(f) ("When confined in their cubicles, there are only two soap dispensers for all 37 detainees in [Pod H], one for hand washing and the other for showering" and "the soap frequently runs out"—"[a]t one

[8] *See* Ngo Decl. Ex. D.

point, the detainees were without soap for two days."); De Graaf Decl. ¶ 6(d) ("Detainees do not have access to free soap. Any soap must be bought from the commissary."); Garvock Decl. ¶ 4(b) (common bathrooms in Pod B "often [have] no soap available for handwashing" and "detainees do not have access to hand sanitizer"); Hughes Decl. ¶ 8 ("Soap is not consistently provided, so inmates are sometimes required to buy their own."); Kessler Decl. ¶ 6(b) ("[D]etainees frequently run out of" the two bottles of disinfectant spray that Calhoun staff provides to detainees in Pod B "before everyone is able to clean their cells, and additional cleaning product is typically not provided."); Schriro Decl. ¶¶ 24(e), 32–34.

Detainees and staff regularly come and go. Garvock Decl. ¶ 4(c) (Mr. Alhalmi "has shared a cell with five different cellmates in the last two weeks" and his cell is "not cleaned before new cellmates arrive or after old cellmates leave."); Hughes Decl. ¶ 9 ("Ms. Rodriguez Salabarria shares a cell with five other inmates" who "change frequently"—she "has shared a cell with ten different inmates in the previous two weeks."); Kessler Decl. ¶ 6(c). It is impossible for Plaintiffs to shelter in place; instead they must interact with strangers who may be carriers for the disease. Venters Decl. ¶¶ 19–20. As a result, detainees have no way to socially distance themselves from staff members who may be carrying the virus asymptomatically. Golob Decl. ¶ 13 ("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.").

Detainees have not been provided protective equipment like gloves or face masks to wear in the normal course, and have rarely observed staff wearing such equipment. Amaro-Luedtke Decl. ¶ 11(j)–(l) (Mr. Rosales Borboa and Pod H detainees wore masks for a "brief period" in which they were moved to a different pod due to a "suspected case of COVID-19" but have since been threatened with citations and solitary confinement if they are "caught with a mask"); De Graaf Decl. ¶ 6(b); Contreras Decl. ¶ 7(b); Garvock Decl. ¶ 4(d); Hughes Decl. ¶ 8; Kessler Decl. ¶ 6(c).

Third, Calhoun has not adequately tested either staff or detainees for COVID-19, enabling its spread. ICE reportedly has tested just 425 of its total 32,309 detainees for COVID-19 as of Tuesday, April 21, 2020—1.32% across all its facilities.[9] Of those 425 detainees, 59.5% (253 detainees) tested positive.[10] Unsurprisingly, Calhoun detainees have experienced symptoms of COVID-19, but have not received medical attention or testing. Amaro-Luedtke Decl. ¶ 11(h)–(i); De Graaf Decl. ¶ 6(e) ("At least one detainee, a woman in Ms. Zhang's cell, was ill and was coughing. Ms. Zhang believes that this woman was released from

[9] *See* Ngo Decl. Ex. E.
[10] *Id.*

Calhoun."); Garvock Decl. ¶ 4(e)-(f) ("At least seven detainees" in Mr. Alhalmi's pod "are exhibiting symptoms consistent with COVID-19, including a cough and sore throat"); Hughes Decl. ¶ 8 ("Ms. Rodriguez Salabarria reports that other inmates appear to be ill."); Kessler Decl. ¶ 6(e) ("At least two detainees, who had trouble breathing and had chest pain, were not tested. Both were returned to the unit after their medical appointments").

The ICE Guidance "fails to address the lack of comprehensive COVID-19 testing in ICE facilities" and does not even instruct "clinical staff on *when* to test patients for COVID-19." Venters Decl. ¶ 34 (emphasis added). Because Calhoun cannot guarantee widespread testing for COVID-19, the government effectively concedes that staff and detainees will be unaware about who is actually contracting the disease and how far it has spread. *See Fofana v. Albence,* No. 20-10869, 2020 WL 1873307, at *9 (E.D. Mich. Apr. 15, 2020) ("It is also notable that Respondent is silent as to how many, if any, detainees have been tested for COVID-19 in the Monroe County and Chippewa County Jails. It is well documented that access to testing for COVID-19 has been difficult."). Without "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." Golob Decl. ¶ 7.

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.

In the current, unprecedented circumstances produced by this pandemic, it is impossible for Plaintiffs to remain safe while still detained at Calhoun. Only their immediate 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 people kept in detention facilities must be released for their own safety and for the safety of others.[11] In Michigan, Governor Gretchen Whitmer has authorized early release for county jails, local lockups, and juvenile

[11] Multiple other jurisdictions have collectively released thousands of people from custody, acknowledging the grave threat posed by a viral outbreak in jails and detention centers. *See* Schriro Decl. ¶¶ 49–52; Letter from Bd. of Correction of the City of New York to Criminal Justice Leaders (Mar. 21, 2020), Ngo Decl. Ex. H 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. I; Linh Ta, *Iowa's Prisons Will Accelerate Release of Approved Inmates to Mitigate COVID-19*, Times Republican (Mar. 23, 2020), Ngo Decl. Ex. J (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. K (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. L.

detention centers.[12] Similarly, Chief Justice Bridget M. McCormack and Sheriff Matt Saxton of the Michigan Sheriffs' Association have urged judges and sheriffs to do all they can to reduce and suspend jail sentences.[13]

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. G at 5-6.[14] 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); Venters Decl. ¶ 43 (correctional health expert and epidemiologist agreeing that "ICE and Calhoun must

[12] *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. M.

[13] *See* Chief Justice Bridget M. McCormack, Michigan Supreme Court Sheriff Matt Saxton (ret.), Executive Director, Michigan Sheriffs' Association Joint Statement (Mar. 26, 2020), https://courts.michigan.gov/News-Events/press_releases/Documents/CJ%20and%20MSA%20Joint%20Statement%20draft%202%20%28003%29.pdf, Ngo Decl. Ex. N.

[14] 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. O.

immediately release Plaintiffs who possess risk factors to prevent their serious illness and/or death.").

ARGUMENT

Plaintiffs easily meet the legal requirements for the Court to grant them a temporary restraining order: (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 show "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, close quarters, where it is impossible to practice social distancing and maintain good hygiene. Defendants *cannot* adequately remedy any potential harm suffered by Plaintiffs as a result of COVID-19. Accordingly, Plaintiffs' continued detention at Calhoun violates their Fifth Amendment rights.

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 v. Wolfish,* 441 U.S. 520, 539 (1979). As civil detainees, Plaintiffs' detention is governed by the Fifth Amendment. *Id.* Under the Fifth Amendment, civil detention may not "amount to punishment of the detainee." *Id.* at 535. Because of their underlying health 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).[15]

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 539. As of today, over three hundred and fifty detainees and staff at dozens of immigration detention centers across the country—including nearby St. Clair and Butler—have confirmed cases of COVID-19.[16] In all likelihood, there are also detainees or staff 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* Facts II-III.

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[15] Although Plaintiffs' claims are governed by the Fifth Amendment, their continued detention would also violate the Eight Amendment's much more stringent "deliberate indifference" standard. The government is deliberately indifferent, and therefore violates the Eighth Amendment, when it "ignores 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 v. McKinney*, 509 U.S. 25, 32–33 (1993). This Court has previously applied the "deliberate indifference" standard to the detention of Plaintiffs Malam and Toma, while finding that after *Kingsley v. Hendrickson*, 135 S. Ct. 2466, 2473 (2015), it is uncertain whether a pretrial/civil detainee must establish both the objective and subjective prongs of that analysis. *Malam v. Adducci*, 2020 WL 1809675, at *5 n.1. The Court found it need not decide that issue, because the plaintiff "satisfies both the objective and subjective components of a deliberate indifference claim." *Id.* Here too Plaintiffs satisfy both prongs of the deliberate indifference test (although Plaintiffs contend that they need not make this showing). As explained in detail above, the overwhelming evidence shows that COVID-19 poses a serious risk to Plaintiffs, and that continued detention constitutes both objective and subjective deliberate indifference under the circumstances. *See Malam*, 2020 WL 1672662 at *12; *Malam*, 2020 WL 1809675, at *5.

[16] *See* Ngo Decl. Ex. C.

This risk is urgent, imminent, and unrelated to any legitimate governmental goal, as several federal courts have already held.[17]

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 here. When the government fails to meet its obligations to provide adequate medical care, courts have a responsibility to remedy the constitutional violation. *See Brown v. Plata*, 563 U.S. 493, 511 (2011) ("When necessary to ensure

[17] *See e.g.*, *Xochihua-Jaimes v. Barr*, No. 18-71460, 2020 WL 1429877 (9th Cir. Mar. 24, 2020); *Basank v. Decker*, No. 20-cv-2518, --- F. Supp. 3d ----, 2020 WL 1481503 (S.D.N.Y. Mar. 26, 2020); *Bravo Castillo v. Barr*, No. 20-605-TJH (AFMx), --- F. Supp. 3d ----, 2020 WL 1502864 (C.D. Cal. Mar. 27, 2020); *Coronel v. Decker*, No. 20-cv-2472, --- F.3d ----, 2020 WL 1487274 (S.D.N.Y. Mar. 27, 2020); *Thakker v. Doll*, No. 1:20-CV-480, --- F.3d ----, 2020 WL 1671563 (M.D. Pa. Mar. 31, 2020); *Hernandez v. Wolf*, No. 20-cv-617, Dkt. 17 (C.D. Cal. Apr. 1, 2020); *Robles v. Wolf*, No. 5:20-cv-627-TJH-GJS, Dkt. 32, 35-39 (C.D. Cal. Apr. 2, 2020); *Hope v. Doll*, No. 20-cv-00562, ECF No. 11 (M.D. Pa. Apr. 7, 2020), *motion for reconsideration denied*, ECF No. 22 (Apr. 10, 2020); *Bahena Ortuño v. Jennings*, No. 20-cv-2064, 2020 WL 1701724 (N.D. Cal. Apr. 8, 2020); *Rafael L.O. v. Tsoukaris*, No. 2:20-cv-3481-JMV, 2020 WL 1808843 (D.N.J. Apr. 9, 2020); *Bent v. Barr*, No. 4:19-cv-06123, 2020 WL 1812850 (N.D. Cal. Apr. 9, 2020); *John Doe v. Barr*, No. 3:20-cv-02141-LB, 2020 WL 1820667 (N.D. Cal. Apr. 12, 2020); *Ixchop Perez v. Wolf*, No. 19-cv-05191, 2020 WL 1865303 (N.D. Cal. Apr. 14, 2020); *Arriaga Reyes v. Decker*, No. 20-cv-3600, ECF No. 27 (D. N.J. Apr. 14, 2020); *Vazquez Barrera v. Wolf*, No. 20-cv-01241, 2020 WL 1904497 (S.D. Tex. April 17, 2020); *Amaya-Cruz v. Adducci*, No. 1:20-cv-789, 2020 WL 1903123 (D. Oh. Apr. 18, 2020); *Durel B. v. Decker*, No. 2:20-cv-03430-KM, 2020 WL 1922140 (D.N.J. Apr. 21, 2020); *Hernandez Roman v. Wolf*, No. 5:20-cv-00768-TJH-PVC, Dkt. 52 (C.D. Cal. Apr. 23, 2020); *Hernandez Roman v. Wolf*, No. 5:20-cv-00768-TJH-PVC, 2020 WL 1952656 (C.D. Cal. Apr. 23, 2020).

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 v. Finney*, 437 U.S. 678, 687 n.9 (1978).

To vindicate detainees' Due Process rights in the face of the COVID-19 pandemic, federal and state courts across the country—including this Court—have ordered the release of detained individuals. *See, e.g.*, *See, e.g.*, *L.O. v. Tsoukaris*, No. 20-3481 (JMV) (D.N.J. Apr. 9, 2020); *Bent v. Barr*, No. 19-cv-06123-DMR (N.D. Cal. Apr. 9, 2020); *Bahena Ortuño v. Jennings*, No. 20-cv-020640-MMC (N.D. Cal. Apr. 8, 2020); *Malam*, 2020 WL 1672662; *Coronel v. Decker*, No. 20-cv-2472, 2020 WL 1487274 (S.D.N.Y. Mar. 27, 2020); *Calderon Jimenez v. Wolf*, No. 18-10225-MLW, ECF No. 507 (D. Mass. Mar. 26, 2020).[18]

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. Social distancing is essential to mitigate the spread of contagion. *See supra* Facts 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.

[18] *See also* Schriro Decl. ¶¶ 49–52

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. Both are appropriate vehicles.

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. ¶ 15. 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). Accordingly, numerous federal courts across the circuits have found habeas jurisdiction proper to order release to remedy the same injury faced by Plaintiffs here.[19] As this Court has

[19] *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

already found it has habeas jurisdiction because the initial immigrant detainee petitioner (Janet Malam) argued "that no matter what steps [were] taken [to mitigate the risk of infection], due to her underlying serious health conditions, there [was] no communal holding facility where she could be incarcerated during the Covid-19 pandemic that would be constitutional." *Malam v. Adducci*, __ F. Supp. 3d __, No. 20-10829, 2020 WL 1672662, at *4 (E.D. Mich. Apr. 5, 2020).

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 public schools); *Bell v. Hood,* 327 U.S. 678, 684 (1946) ("[I]t is established practice for this Court to sustain the jurisdiction of

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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").

federal courts to issue injunctions to protect rights safeguarded by the Constitution"). Thus, as this Court has previously explained, "[s]hould Petitioner's habeas petition fail on jurisdictional grounds, the Fifth Amendment provides Petitioner with an implied cause of action, and accordingly 28 U.S.C. 1331 would vest the Court with jurisdiction." *Malam*, 2020 WL 1672662, at *4. In sum, 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.

Finally, as this Court has likewise already found, sovereign immunity poses no bar to Plaintiffs' challenge. *Malam*, 2020 WL 1672662, at *5. 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 appropriate 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, subject

to appropriate public health and safety precautions like GPS monitoring, regular reporting, and/or home confinement and self-quarantine, will also promote Defendants' interests in ensuring the safety of other detainees, the facility staff, and the community at large. Greifinger Decl. ¶ 17.

An occurrence of COVID-19 at Calhoun would create a "tinderbox scenario" with dire consequences for detainees and workers as well as the Battle Creek 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. Golob Decl. ¶ 8. *See Calderon Jimenez*, No. 18-10225-MLW at 4.[20]

CONCLUSION

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

[20]As detained, indigent individuals, Plaintiff 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.").

Dated: April 26, 2020

Respectfully submitted,

/s/ Miriam J. Aukerman

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Attorneys for Plaintiffs

* Application for admission forthcoming

CERTIFICATE OF SERVICE

I, Jeannie S. Rhee, certify that on April 26, 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,

Petitioner-Plaintiff,

- against -

REBECCA ADDUCCI, *et al.*,

Respondent-Defendants.

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

INDEX OF EXHIBITS

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

Bibliography

Peer-Reviewed Journals and Publications

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5. **Golob JL**, Paige SL, Muskheli V, Pabon L, Murry CE: Chromatin Remodeling During Mouse and Human Embryonic Stem Cell Differentiation. *Developmental Dynamics* 237(5): 1389-1398, 2008.
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10. Bhattacharyya A, Hanafi LA, Sheih A, **Golob JL**, Srinivasan S, Boeckh MJ, Pergam SA, Mahmood S, Baker KK, Gooley TA, Milano F, Fredricks DN, Riddell SR, Turtle CJ. Graft-Derived Reconstitution of Mucosal-Associated Invariant T Cells after Allogeneic Hematopoietic Cell Transplantation. *Biol Blood Marrow Transplant* pii: S1083-8791(17)30758-9. doi: 10.1016/j.bbmt.2017.10.003. Epub 2017 Oct 9.
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.

ROBERT B. GREIFINGER, M.D.

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

ROBERT B. GREIFINGER, M.D.

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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DECLARATION OF HOMER VENTERS

I, Homer Venters, hereby declare the following:

Background

1. I am a physician, internist and epidemiologist with over a decade of experience in providing, improving and leading health services for incarcerated people. My clinical training includes residency training in internal medicine at Albert Einstein/Montefiore Medical Center (2007) and a fellowship in public health research at the New York University School of Medicine (2009). My experience in correctional health includes two years visiting immigration detention centers and conducting analyses of physical and mental health policies and procedures for persons detained by the U.S. Department of Homeland Security. This work included and resulted in collaboration with ICE on numerous individual cases of medical release, formulation of health-related policies as well as testimony before U.S. Congress regarding mortality inside ICE detention facilities.

2. After my fellowship training, I became the Deputy Medical Director of the NYC Jail Correctional Health Service. This position included both direct care to persons held in NYC's 12 jails, as well as oversight of medical policies for their care. This role included oversight of chronic care, sick call, specialty referral and emergency care. I subsequently was promoted to the positions of Medical Director, Assistant Commissioner, and Chief Medical Officer. In the latter two roles, I was responsible for all aspects of health services including physical and mental health, addiction, quality improvement, re-entry and morbidity and mortality reviews as well as all training and oversight of physicians, nursing and pharmacy staff. In these roles, I was also responsible for evaluating and making recommendations on the health implications of numerous security policies and practices including use of force and restraints. During this time I managed multiple communicable disease outbreaks including H1N1 in 2009, which impacts almost 1/3 of housing areas inside the adolescent jail, multiple seasonal influenza outbreaks, a recurrent legionella infection and several other smaller outbreaks.

3. In March 2017, I left Correctional Health Services of NYC to become the Director of Programs for Physicians for Human Rights. In this role, I oversaw all programs of Physicians for Human Rights, including training of physicians, judges and law enforcement staff on forensic evaluation and documentation, analysis of mass graves and mass atrocities, documentation of torture and sexual violence, and analysis of attacks against healthcare workers.

4. In December 2018, I became the Senior Health and Justice Fellow for Community Oriented Correctional Health Services (COCHS), a nonprofit organization that promotes evidence-based improvements to correctional practices across the U.S. In January 2020, I became the president of COCHS. I also work as a medical expert in cases involving correctional health and I have a book on the health risks of jail (*Life and Death in Rikers Island*) that was published in early 2019 by Johns Hopkins University Press.

5. A copy of my curriculum vitae is attached to this report which includes my publications, a listing of cases in which I have been involved and a statement of my compensation.

6. In the previous four years, I have testified as an expert at trial or by deposition in the following cases:

    a. *Benjamin v. Horn*, No. 75 Civ. 3073 (HB) (S.D.N.Y.) (2015) as expert for defendants;
    b. *Rodgers v. Martin*, No. 2:16-cv-00216 (U.S.D.C. N.D. Tx.) (Oct. 19, 2017) as expert for plaintiffs;
    c. *Fikes v. Abernathy*, No. 2017 7:16-cv-00843-LSC (N.D. Ala.) (Oct. 30, 2017) as expert for plaintiffs;
    d. *Fernandez v. City of New York*, No. 17-CV-02431 (GHW)(SN) (S.D.N.Y.) (Apr. 10, 2018) as defendant in role as City Employee;
    e. *Charleston v. Corizon Health Inc.*, No. 17-3039 (E.D. Pa.) (Apr. 20, 2018) as expert for plaintiffs;
    f. *Gambler v. Santa Fe County*, No. 1:17-cv-00617 (WJ/KK) (Jul. 23, 2018) as expert for plaintiffs;
    g. *Hammonds v. Dekalb County AL*, No. 4:16-cv-01558-KOB (N.D. Ala.) as expert for plaintiffs;
    h. *Mathiason v. Rio Arriba County NM*, No. D-117-CV-2007-00054 (D. N.M.) (Feb. 7, 2019) as expert for plaintiff;
    i. *Hutchinson v. Bates et. al.*, No. 2:17-CV-00185-WKW- GMB (Mar. 27, 2019) as expert for plaintiff;
    j. *Lewis v. East Baton Rouge Parish Prison LA*, No. 3:16-CV-352-JWD-RLB (E.D. La.) (Jun. 24, 2019) as expert for plaintiff;
    k. *Belcher v. Lopinto*, No. 2:2018cv07368 (E.D. La. 2019) (Dec. 5, 2019) as expert for plaintiffs; and,
    l. *Imoerati v. Semple*, No. 3:18cv01847 (RNC) (D. Conn) (Mar. 11, 2020), on behalf of plaintiffs.

Expert Assignment

7. Plaintiffs' Class Complaint alleges that the officials in charge of ICE detainees in the Calhoun County Correctional Center ("Calhoun") in Battle Creek, Michigan, are placing Plaintiffs at risk of significant harm or death due to COVID-19.

8. Plaintiffs' counsel has asked me to:

    a. Evaluate whether existing policies and practices concerning ICE detainees in Calhoun comply with current, standard protocols for preventing the spread of coronavirus in detention facilities and for addressing prevention and treatment for detained people who are at high risk of serious illness or death from COVID-19; and,

b. Evaluate whether existing policies and practices concerning ICE detainees in the Calhoun create a risk that Plaintiffs will suffer significant harm or death from COVID-19 while detained in the facility.

COVID-19 in ICE Detention

9. Coronavirus disease of 2019 ("COVID-19") is a viral pandemic. This is a novel virus for which there is no established curative medical treatment and no vaccine.

10. COVID-19 infection rates are growing exponentially in the U.S. As of this date, the outbreak curve is in the early stages, meaning that communities are beginning to see their first cases, and that the number of cases overall is rising rapidly, with doubling times of cases and deaths in many communities between one and three days. The Governor of California predicted that over half of all residents will become infected with COVID-19 and the Commissioner of Health for New Jersey predicted, "I'm definitely going to get it, we all will."[1] The Centers for Disease Control and Prevention ("CDC") now reports COVID-19 cases in all 50 states, the District of Columbia, Guam, Puerto Rico, the Northern Mariana Islands, and the U.S. Virgin Islands.[2]

11. The State of Michigan reports that as of April 25, 2020, the number of people who have tested positive for COVID-19 in Michigan is 37,203, and 3,274 of these people have died from the disease so far.[3]

12. ICE will not be able to stop the entry of COVID-19 into ICE facilities: the reality is that the infection is inside multiple facilities already. When COVID-19 impacts a community, it will also impact the detention facilities. ICE reported its first confirmed case of a detainee who tested positive in New Jersey on March 24, 2020.[4] As predicted, COVID-19 has spread rapidly in immigration detention centers. ICE reports that, as of April 24, there have been 317 detainees in 30 facilities across 15 states, 35 ICE employees in 11 facilities across 8 states, and 89 ICE employees not assigned to a facility who have all tested positive for COVID-19.[5] These statistics do not include third-party contractors who work in ICE facilities who have tested positive for COVID-19, as ICE has stated that this information "isn't something we have to provide."[6]

13. This is likely just the tip of the iceberg in terms of the number of ICE staff and detainees who are already infected but are unaware due to the lack of testing nationwide, and the fact that people who are infected can be asymptomatic for several days. In New York, one of the areas

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[1] Mark Saunders, *Newsom: 56 Percent of California Expect to Get Coronavirus*, ABC 10 NEWS (Mar. 19, 2020), https://www.10news.com/news/coronavirus/newsom-56-percent-of-california-expect-to-get-coronavirus.

[2] *Coronavirus Disease 2019 (COVID-19): Cases in U.S.*, CENTERS FOR DISEASE CONTROL & PREVENTION (Updated Apr. 24, 2020), https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html.

[3] State of Michigan, Coronavirus Virus, https://www.michigan.gov/coronavirus (Updated Apr. 25, 2020).

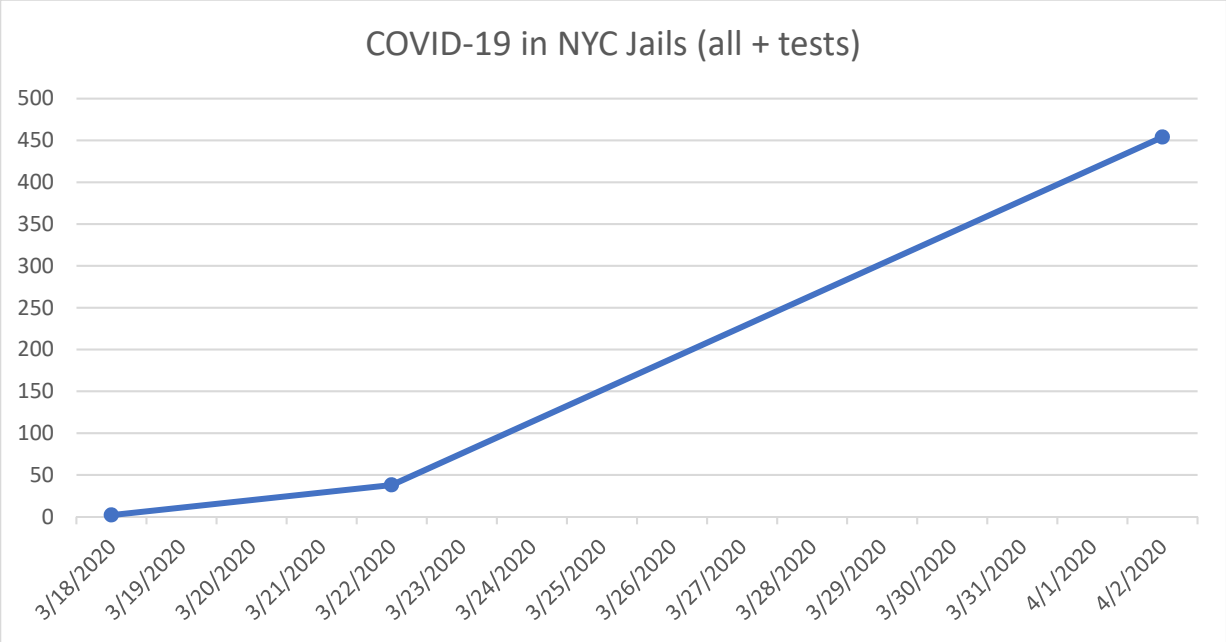
[4] *ICE Detainee Tests Positive for COVID-19 at Bergen County Jail*, IMMIGRATION & CUSTOMS ENFORCEMENT (Mar. 24, 2020), https://www.ice.gov/news/releases/ice-detainee-tests-positive-covid-19-bergen-county-jail.

[5] *ICE Guidance on COVID-19*, IMMIGRATION & CUSTOMS ENFORCEMENT (Updated Apr. 24, 2020), https://www.ice.gov/coronavirus.

[6] Monique O. Madan, *Two Workers at ICE Detention Center in Miami Test Positive for Coronavirus*, MIAMI HERALD, Apr. 6, 2020, https://www.miamiherald.com/news/local/immigration/article241791511.html.

of early spread in the United States, multiple correctional officers and jail and prison inmates have become infected with COVID-19. The Legal Aid Society reports that the infection rate at Rikers was 7.22% as of April 10, compared to 1.16% in New York City and .88% in New York State.[7] The medical leadership in the NYC jail system have announced that they will be unable to stop COVID from entering their facility and have called for release as the primary response to this crisis.[8] Staff are more likely to bring COVID-19 into a facility, based solely on their movement in and out every day.

14. The data from the NYC jail system illustrates the extremely rapid rate of COVID-19 infection spread in correctional settings. In the space of two weeks, the facility went from zero confirmed infections, to 2, then 38 then 574.[9]



15. Similarly, COVID-19 has spread rapidly among those in the custody of the Michigan Department of Corrections (MDOC). From March 23 to April 17, the number of confirmed cases of coronavirus in just one jail, Parnall Correctional Facility, multiplied from one inmate to 227 people—163 inmates and 64 staff—meaning that one out of every ten inmates had tested

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[7] *COVID-19 Infection Tracking in NYC Jails*, THE LEGAL AID SOCIETY (Updated Apr. 10, 2020), https://www.legalaidnyc.org/covid-19-infection-tracking-in-nyc-jails/.

[8] Meagan Flynn, *Top Doctor at Rikers Island Calls the Jail a "Public Health Disaster Unfolding Before Our Eyes,"* WASHINGTON POST (Mar. 31, 2020), https://www.washingtonpost.com/nation/2020/03/31/rikers-island-coronavirus-spread/.

[9] *Board of Correction Daily Covid-19 Update*, NEW YORK BD. OF CORR. (updated Apr. 3, 2020), https://www1.nyc.gov/assets/boc/downloads/pdf/News/covid-19/Public_Reports/Board%20of%20Correction%20Daily%20Public%20Report_4_3_2020_TO%20PUBLISH.pdf.

positive for COVID-19.[10] As of April 17, this was higher than the rates of facilities in Chicago and New York.[11] As of April 25, MDOC has reported 1,026 confirmed cases and 31 deaths in their facilities across the state of Michigan.[12]

16. COVID-19 has already arrived at one Michigan detention facility where ICE detainees are housed. As of April 24, five ICE detainees at the St. Clair County Jail in Michigan tested positive for COVID-19.[13]

17. Once COVID-19 is inside a facility, ICE will be unable to stop the spread of the virus throughout the facility given long-existing inadequacies in ICE's medical care and also in light of how these facilities function. Newly released CDC guidance for correctional facilities makes clear that detention settings should plan for increased staffing shortages as COVID-19 impacts security and health staff.[14] Based on my experience in ICE facilities, ICE has faced longstanding challenges in maintaining adequate staffing of health staff for many years, and the outbreak of this pandemic will dramatically worsen this problem.

18. I have been inside multiple ICE detention facilities, both county jails that house ICE detainees and dedicated facilities. My experience is that the densely packed housing areas, the manner in which health services, food services, recreation, bathroom and shower facilities for detained people, as well as the entry points, locker rooms, meal areas, control rooms for staff, all contribute to many people being in small spaces.

19. One of the most ubiquitous aspects of detention, the sally-port, or control port, a series of two locked gates that bring every staff member and detained person past a windowed control room as they stop between locked gates, provides but one example of this concern. The normal functioning of detention centers demands that during shift change for staff, or as the security count approaches for detained people, large numbers of people press into sally-ports as they move into or out of other areas of the facility. This process creates extremely close contact, and the windows in these sally ports that are used to hand out radios, keys and other equipment to staff ensure efficient passage of communicable disease from the control rooms into the sally port areas on a regular basis. Detention facilities are designed to force close contact between people and rely on massive amounts of movement every day from one part of the facility to another, e.g., for programming, access to cafeterias, commissary, medical, just to name a few. This movement is required of detained people as well as staff.

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10 Ross Jones, 227 Inmates, Staff at Michigan Prison Have COVID-19, ABC 7 WXYZ Detroit, Apr. 17, 2020, https://www.wxyz.com/news/local-news/investigations/227-inmates-staff-at-michigan-prison-have-covid-19.

11 *Id*.

[12] State of Michigan, Coronavirus: Michigan Data, https://www.michigan.gov/coronavirus/0,9753,7-406-98163_98173---,00.html (Updated Apr. 25, 2020).

13 *ICE Guidance on COVID-19*, IMMIGRATION & CUSTOMS ENFORCEMENT (Updated Apr. 24, 2020), https://www.ice.gov/coronavirus.

14 *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, CENTERS FOR DISEASE CONTROL & PREVENTION (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html [hereinafter CDC Interim Guidance].

20. My experience managing smaller outbreaks is that it is impossible to apply hospital-level infection control measures on security staff. In a hospital or nursing home, staff may move up and down a single hallway over their shift, and they may interact with one patient at a time. In detention settings, officers move great distances, are asked to shout or yell commands to large numbers of people, routinely apply handcuffs and operate heavy doors/gates, operate large correctional keys and are trained in the use of force. These basic duties cause the personal protective equipment they are given to quickly break and become useless, and even when in good working order, may impede their ability talk and be understood, in the case of masks. As a result, correctional officers will generally not wear the protective equipment that is an important part of preventing spread of the virus.

21. ICE's protocols (addressed separately below) are simply insufficient to address the structural aspects of detention facilities that make transmission of COVID-19 so rapid.

22. For instance, data has shown that COVID-19 appears to be transmissible through aerosolized fecal matter. This is relevant because the plume of aerosolized fecal material that occurs when a toilet is flushed is not addressable by closing the lid of toilets in correctional and detention facilities, which lack a lid and often include a sink used for drinking and washing. This mode of transmission would pose a threat to anyone sharing a cell with a person who has COVID-19 and could occur before a person becomes symptomatic. This mode of transmission could also extend beyond cellmates, especially in circumstances where common bathrooms exist or where open communication between cells exists.[15]

23. ICE currently detains thousands of people with risk factors that increase their risk of serious complications from COVID-19, including death and long-lasting complications after recovery, such as fibrotic changes to the lung. The risk factors listed by the CDC include older age and underlying medical conditions such as: blood disorders, chronic kidney or liver disease, compromised immune system, endocrine disorders (including diabetes mellitus), metabolic disorders, heart and lung disease ("including asthma or chronic obstructive pulmonary disease (chronic bronchitis or emphysema) or other chronic conditions associated with impaired lung function"), neurological and neurologic and neurodevelopmental conditions "[including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy (seizure disorders), stroke, intellectual disability…"], and current or recent pregnancy.[16] The CDC also identifies individuals with a body mass index (BMI) at or above 40 to be at a higher risk for severe illness.[17] Additional risk factors also include being a current smoker or having history of smoking,[18] and hypertension, which the CDC has associated with increased illness

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[15] Diana Swift, *Study: COVID-19 Is Also Spread by Fecal-Oral Route*, MEDPAGE TODAY (Mar. 9, 2020), https://www.medpagetoday.com/infectiousdisease/covid19/85315.

[16] *Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission*, CENTERS FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf (accessed Apr. 24, 2020).

[17] *People Who Are at Higher Risk for Severe Illness*, CENTERS FOR DISEASE CONTROL & PREVENTION (Apr. 15, 2020) https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html.

[18] *Id*.

severity and outcomes.[19] With time, hypertension has risen to become the most common comorbidity for individuals hospitalized for COVID-19 treatment.[20]

24. The CDC identifies age 65 and above as a risk factor for serious illness or death from COVID-19. However, the CDC's own data reflects that the risk of complications, measured by hospitalization rates, increase for those between ages 45-54 and 55-64.[21] This is especially appropriate for ICE's consideration of those in its custody. In correctional settings, the age of 50 or 55 is often used to identify older patients, because of the extremely high level of physical and behavioral health problems among this cohort of people.[22] In addition, there is recent data on the critical risk of smoking for serious illness and death from COVID-19 infection, as well as data that reveals the rates of smoking to be highest among detained people over 50.[23] For these reasons, it is my expert opinion that ICE should apply the age of 50 to identify detainees who have an increased vulnerability to COVID-19 based on their age for the same reason.[24]

25. Lastly, people with serious mental illness should be viewed as being at high risk for serious illness and death in detention settings. Many people with serious mental illness are prescribed antipsychotic medications, which tend to impair the brain's ability to regulate heat.[25] This is relevant during times of high environmental heat, but is also critical when a person becomes infected with a virus such as COVID-19 that produces fatigue, dehydration and high fevers. In addition, people with serious mental illness may face particular challenges in recognizing and reporting symptoms of COVID-19.[26]

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[19] *Preliminary Estimates of the Prevalence of Selected Underlying Health Conditions Among Patients with Coronavirus Disease 2019 — United States, February 12–March 28, 2020*, CENTERS FOR DISEASE CONTROL & PREVENTION (Apr. 3, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6913e2.htm.

[20] *See, e.g.*, Safiya Richardson et al., *Presenting Characteristics, Comorbidities, and Outcomes Among 5700 Patients Hospitalized With COVID-19 in the New York City Area*, J. OF THE AM. MEDICAL ASS'N (Apr. 22, 2020), https://jamanetwork.com/journals/jama/articlepdf/2765184/jama_richardson_2020_oi_200043.pdf.

[21] Shika Garg, et al., *Hospitalization Rates and Characteristics of Patients with Laboratory-Confirmed Coronavirus Disease 2019, March 1-30, 2020,* COVID-NET, 14 States, March 1–30, 2020. MMWR Morb Mortal Wkly Rep. (Apr. 8, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm.

[22] Kimberly A Skarupski et al., *The Health of America's Aging Prison Population*, 40 EPIDEMIOLOGIC REV. 157 (2018), https://academic.oup.com/epirev/article/40/1/157/4951841.

[23] Sara M. Kennedy et al., *Cigarette Smoking Among Inmates by Race/Ethnicity*, 18 NICOTINE & TOBACCO RESEARCH S73 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5100810/; Berkeley Lovelace, *CDC Says Diabetes, Lung or Heart Disease and Smoking May Increase Risk of Severe Coronavirus Illness*, CNBC.com, Mar. 31, 2020, https://www.cnbc.com/2020/03/31/cdc-says-diabetes-lung-disease-heart-disease-and-smoking-may-increase-risk-of-severe-coronavirus-illness.html.

[24] Sara M. Kennedy et al., *Cigarette Smoking Among Inmates by Race/Ethnicity*, 18 NICOTINE & TOBACCO RESEARCH S73 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5100810/; Berkeley Lovelace, *CDC Says Diabetes, Lung or Heart Disease and Smoking May Increase Risk of Severe Coronavirus Illness*, CNBC.com, Mar. 31, 2020, https://www.cnbc.com/2020/03/31/cdc-says-diabetes-lung-disease-heart-disease-and-smoking-may-increase-risk-of-severe-coronavirus-illness.html.

[25] *See, e.g.*, Ohio Mental Health & Addiction Services, *Heat-Related Illness in Individuals Using Psychiatric Medication* (2016), https://www.mhrbeo.org/Downloads/2016%20heat-related%20illness%20brochure.pdf; Nora Eckert, *How High Heat Can Impact Mental Health*, Nat'l Public Radio (Sept. 4, 2019), https://www.npr.org/2019/09/04/757034136/how-high-heat-can-impact-mental-health.

[26] Jeffrey L. Geller et al., *Patients With SMI in the Age of COVID-19: What Psychiatrists Need to Know*, PSYCHIATRIC NEWS (Apr. 7, 2020), https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.4b39.

ICE Guidelines Contradict or Omit Several Important CDC Guidelines

26. I have reviewed the following documents setting forth ICE policy and practice concerning COVID-19 in detention facilities where ICE detainees are housed:

    a. ICE's March 6, 2020 Memorandum addressing COVID-19, a true and correct copy of which is attached to this declaration as Exhibit B ("ICE March 6 Memo").

    b. ICE's March 27, 2020 Memorandum addressing COVID-19, a true and correct copy of which is attached to this declaration as Exhibit C ("ICE March 27 Memo").

    c. The April 3, 2020 declaration of James Jacobs, Assistant Field Office Director with the Detroit Field Office, concerning Calhoun ("Jacobs Decl."). *See* Dkt. 11-3, PAGEID 221-227.

    d. The webpage that ICE has established concerning "ICE Guidance on COVID-19," which is located at https://www.ice.gov/coronavirus (last visited Apr. 24, 2020) ("ICE Guidance on COVID-19 webpage").

    e. The April 4, 2020 guidance from ICE Enforcement and Removal Operations ("ERO"), a true and correct copy of which is attached to this declaration as Exhibit D ("ICE April 4 Guidance").

    f. The April 10, 2020 ICE ERO COVID-19 Pandemic Response Requirements ("April 10 ERO Pandemic Response Requirements"), much of which applies to Calhoun and any setting where ICE detainees are held. A true and correct copy of the April 10 ERO Pandemic Response Requirements is attached to this declaration as Exhibit E.

    g. It is my understanding that Calhoun does not have its own COVID-19 pandemic response plan.

    I refer to these information sources collectively as the "ICE COVID-19 protocols and guidance."

27. **Social distancing**: The ICE COVID-19 protocols and guidance fail to address one of the most important CDC key recommendations: the need for social distancing in detention facilities. The ICE March 27 Memo and the April 10 ERO Pandemic Response Requirements each briefly mention social distancing, but fail to address how ICE facilities will enact modified meal or recreation times to provide for social distancing. These protocols also fail to address the most common scenarios in which high-risk detainees find themselves in close quarters that make social distancing impossible, including shared cells, medication lines, bathroom facilities, common walkways, day rooms, sally ports, and transportation. The ICE Guidance on COVID-19 webpage also fails to delineate how social distancing can be accomplished in settings like Calhoun. Again, because there is no cure for COVID-19, social distancing remains the primary means of prevention. Any guidance that treats it as merely recommended, rather than required at all times, remains inadequate to mitigate the

spread of COVID-19. As of now, ICE has still failed to meaningfully implement this precaution into its guidance.

28. **Screening**: The April 10 ERO Pandemic Response Requirements identifies a list of conditions that place detainees at high risk of serious complications from COVID-19. Both this document and prior lists promulgated by ICE fail to provide a complete list of risk factors consistent with CDC guidelines.

    a. The April 10 ERO Pandemic Response Requirements fail to identify pregnant or post-partum women and people with histories of smoking as people at high risk of serious illness from COVID-19.

    b. The ERO docket review guidelines from several days earlier failed to identify smoking history or BMI at or over 40 as risk factors, both of which are risk factors identified by the CDC.[27]

    c. The April 10 ERO Pandemic Response Requirements identify 65 as the onset of age-related heightened risk of serious illness from COVID-19, whereas the prior ERO guidance identified 60 as the triggering age. But based on correctional standards, the correct benchmark for when people begin experiencing age-related risk for serious illness or death from COVID-19 is 50. As discussed above, this is due to the extremely high degree of physical and behavioral health problems among people in correctional and detention institutions. In addition, data from U.S. COVID-19 cases have found a higher hospitalization and intensive care admission rate for those between ages 45-54 and 55-64.[28]

    d. The screening protocol provides that asymptomatic people with suspected COVID-19 contact or risk factors will be quarantined and monitored for 14 days. However, given the current prevalence of COVID-19, a majority of new admissions to detention will likely fit into this category. ICE or local facilities would have to expand medical capacity to monitor new detainees in accordance with this guideline, which have not indicated the capacity to do so.

29. The April 10 ERO Pandemic Response Requirements appear to identify patients at high-risk of serious illness from COVID-19 for the purpose of docket review, but critically fail to encourage or require any higher level of protection that facility officials must provide these detainees in order to protect them from contracting COVID-19.

    a. The April 10 ERO Pandemic Response Requirements instruct facility staff to identify high-risk detainees and to email their names, location, medical issues, medications, and facility point of contact information to ICE headquarters. The

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[27] CDC, *Groups at Higher Risk for Severe Illness, Coronavirus Disease 2019 (COVID-19)* (last visited Apr. 14, 2020); https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html (listing smoking history and body mass index of 40 or higher).

[28] *See supra*, note 21.

purpose of this action appears to be to enable ICE to review the identified high-risk detainees in order to determine who to release. *See* Exhibit E at 14.

b. But the document provides little to no guidance, however, about the specific measures that facility staff must take to ensure that these high-risk patients are protected from coronavirus infection. It notes, "If cohorting of ill detainees is unavoidable, make all possible accommodations until transfer occurs to prevent transmission of other infectious diseases to the higher-risk individual (For example, allocate more space for a higher-risk individual within a shared isolation room)." Exhibit E at 15. Nothing in the guidance requires their release or specific protective measures for high-risk detainees.

c. This guidance is entirely insufficient. It is not enough for ICE to identify some of the categories of detainees at increased risk of serious illness from COVID-19 and to delineate a process for ERO to identify these individuals. Instead, ICE must identify *all* high-risk detainees and establish clear protocols for increased surveillance of these individuals, including through twice daily symptom and temperature checks.

30. The April 10 ERO Pandemic Response Requirements create an unwieldy and unrealistic process for facilities to notify ICE headquarters about high-risk detainees.

a. As discussed above, the document contemplates a process by which each facility with ICE detainees will sends emails to ERO with identifying information about detainees who have risk factors. But this process is unwieldy and unlikely to be effective.

b. Based on my experience creating surveillance tools for high-risk patients in multiple detention scenarios, several key elements of this process are problematic.

i. The process of emailing headquarters thousands of names with relevant information, or even hundreds of spreadsheets, tables and other documents, creates an unreliable and error-prone system for alerting ERO or tracking the most vulnerable detainees inside ICE facilities.

ii. The process identified by ICE is static, meaning that as detained people move from one facility to another, there will be no way for their location to be automatically updated with their high-risk status, requiring labor intensive and error-prone records reviews.

iii. The approach delineated by the April 10 ERO Pandemic Response Requirements will not allow ICE leadership to ensure day-to-day management of the high-risk population. The process does not establish an automatic notification process or ensure that ICE leadership will automatically be notified when people are released or become ill from non-COVID-19 reasons. Nor does the process establish an automatic cross-check process or ensure that

emails to ERO regarding COVID-19 cases amongst ICE detainees will be automatically cross-checked against this initial batch of hundreds or thousands of emails from facilities identifying high-risk patients.

c. Instead of the system proposed by the April 10 ERO Pandemic Response Requirements, ICE should create a single portal into which every facility can enter data on ICE detainees who meet CDC criteria for being high risk. I employed such a portal as Chief Medical Officer of the NYC jail system. We relied on this system before and after the implementation of an electronic medical record as a way to identify high-risk patients and to track them as they moved from one facility to another. This type of approach is essential for ICE to meet its stated obligations to plan for the re-entry of people who are leaving amid the COVID-19 crisis and to coordinate with local and state public health partners.

d. The net effect of the April 10 Pandemic Response Requirements' cumbersome and inefficient process will be that far fewer high-risk detainees will be released than otherwise would be the case and more high-risk detainees will experience serious illness and death while in ICE detention.

31. The April 10 ERO Pandemic Response Plan fails to include vital elements of CDC guidance on preventing the spread of COVID-19 inside detention facilities.

a. Notably, the April 10 ERO Pandemic Response Requirements fail to mention or provide guidance on key aspects of social distancing including: how to ensure that staff and detainees maintain 6 feet of distance between themselves and others in

1. intake pens,
2. clinical and medication lines,
3. bathroom and shower areas,
4. sally ports,
5. staff entry,
6. the symptom checking process, and
7. locker room areas;
8. other areas of crowded housing units.

b. The April 10 ERO Pandemic Response Requirements fails to include guidance on the importance of staff communication with detainees about changes to their daily routine and how they can contribute to risk reduction, both of which are explicitly identified by the CDC guidelines as necessary to protect the health and safety of people in detention facilities.

c. The April 10 ERO Pandemic Response Requirements fails to include many critical aspects of cleaning and disinfection outlined in CDC guidelines including the following.

i. CDC guidelines identify a higher level of intervention after a person has been identified as suspected COVID-19 case. This common-sense approach, which includes use of PPE for the person cleaning, as well as waiting for one say to perform cleaning and ensuring no people come into contact with the area is critical to ensuring that the most high-risk scenarios encountered by detainees and staff alike are addressed with an appropriate response.

ii. The April 10 ERO Pandemic Response Requirements instructs that vehicles should be cleaned after transport of a known/suspected case, and generically notes that "surfaces and objects that are frequently touched, especially in common areas," should be cleaned and disinfected "several times a day," but fails to specifically instruct frequent cleaning and disinfection of all high-touch surfaces in the computers, equipment, and belongings of staff, and in detainees' housing area, cell, bunk, and personal belongings. This cleaning is in addition to any routine cleaning that occurs in common areas, and must occur as part of the response to any new known or suspected case.

iii. CDC guidelines indicate that in settings where people are held overnight, response to a known or suspected COVID-19 case should include closing off areas used by the person who is sick, opening outside doors and windows to increase air circulation in the area and waiting 24 hours (or as long as possible) before cleaning/disinfecting. If 24 hours is not feasible, wait as long as possible.[29]

iv. The April 10 ERO Pandemic Response Requirements fail to establish what PPE should be utilized by staff or detainees when cleaning areas occupied by a person known or suspected to have COVID-19.

d. The April 10 ERO Pandemic Response Requirements instructs that everyone in detention facilities must engage in hand washing for 20 seconds with soap and water, but fails to address how this can be accomplished in facilities that utilize metered faucets that make this process essentially impossible.

e. The April 10 ERO Pandemic Response Requirements fail to counsel against reliance on detainees for conducting critical environmental cleaning. Such reliance, without proper training, protection or supervision, represents a gross deviation from correctional practices will likely contribute to the spread of COVID-19 throughout the ICE detention system.

f. The April 10 ERO Pandemic Response Requirements fail to establish or mandate a respiratory protection program, a critical CDC guideline: **"**If not already in place, employers operating within the facility should establish a respiratory protection program as appropriate, to ensure that staff and incarcerated/detained

[29] CDC, Cleaning and Disinfection for Community Facilities, Coronavirus Disease 2019, https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html (last checked Apr. 15, 2020).

persons are fit tested for any respiratory protection they will need within the scope of their responsibilities." Simply giving out N95 or other masks to staff and detainees and failing to train them and identify the high-risk tasks or scenarios they will encounter serves only to decrease the overall effectiveness of infection control, and increase the risk of serious illness and death of high-risk detainees in ICE facilities.

32. The April 10 ERO Pandemic Response Requirements fail to address what facilities must do to meet the re-entry needs of people leaving ICE custody. This is a critical failure given ERO's ongoing docket review, which should result in some releases of high-risk detainees. The requirements should follow the following CDC recommendations, which seek to protect the health and safety of detainees, staff, and the communities to which detainees return:

    a. If an individual set for release does not clear the screening process, facilities should follow the protocol for a suspected COVID-19 case, including by providing a face mask to the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing;[30]

    b. If the individual is released before the recommended medical isolation period is complete, discuss release of the individual with state, local, tribal, and/or territorial health departments to ensure safe medical transport and continued shelter and medical care, as part of release planning. Make direct linkages to community resources to ensure proper medical isolation and access to medical care; and

    c. Before releasing an incarcerated/detained individual with COVID-19 symptoms to a community-based facility, such as a homeless shelter, contact the facility's staff to ensure adequate time for them to prepare to continue medical isolation, or contact local public health to explore alternate housing options.

33. **Use of isolation**: The ICE COVID-19 protocols and guidance specify that "isolation rooms" will be used to monitor people who are symptomatic with COVID-19. *See* Ex. B. My experience in visiting and working in detention facilities across the nation is that each facility has one to four cells located in or near the medical clinic that meet this definition. When COVID-19 arrives in a facility, there will be many more people who meet this criteria of being symptomatic, and ICE will need to designate entire housing areas for this level of increased surveillance of symptomatic patients. This approach requires that empty housing areas be available, so that small numbers of symptomatic patients can be cohorted together away from those without symptoms. Facilities that are over 80% capacity will find this basic approach impossible once they start to see multiple symptomatic patients. Based on my experience visiting ICE detention facilities, this process will be essentially impossible.

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[30] CDC, *Medical Isolation of Confirmed or Suspected COVID-19 Cases,* https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#Medicalisolation (last visited Apr. 14, 2020).

a. Each confirmed case results in loss of staff or isolation of detainees and quarantine of their close (housing area) contacts. Unless a detention setting is at well less than 50% of capacity in terms of daily census, it is extremely improbable that the facility will be able to manage the physical separation of symptomatic and known COVID-19 patients, quarantine of their contacts for 14 days, and increased surveillance of people who are asymptomatic and have known risk factors. The maximum percentage capacity needed to allow proper quarantine and isolation may be even much lower than 50%, depending on the physical layout of the facility and available staff capacity.[31]

b. While the ICE COVID-19 Guidance webpage indicates a desire to reduce the population of detention facilities to 70 percent or less,[32] none of the ICE COVID-19 protocols and guidance mandate that Calhoun ensures that the facility is at any particular percentage of capacity as required to provide sufficient space for proper isolation and quarantine of people with COVID-19 symptoms or known exposure to laboratory confirmed cases of COVID-19.

c. Moreover, ICE should not employ isolation in locked cells as a primary means to protect either at risk patients, or patients who are symptomatic. When patients are placed into locked cells, the level of monitoring is dramatically reduced. In addition, this practice causes new health problems in the form of risk for suicide and self-harm. Also, isolation units often drive increased physical interaction between staff and patients, in the form of increased handcuffing, escorting individuals to and from showers and other out of cell encounters, and increased uses of force due to the psychological stress these units cause.

d. In sum, it is my expert opinion, and that of other correctional experts, that the use of security isolation and/or lockdown is not a medically appropriate method for abating the substantial risk of harm from COVID-19.[33]

34. **Testing**: The April 10 ERO Pandemic Response Requirements fails to address the lack of comprehensive COVID-19 testing in ICE facilities. There is no guidance for clinical staff on when to test patients for COVID-19, which leaves detained patients at a significant disadvantage. Without any clear guidance for testing, ICE will be unable to identify "confirmed cases," to timely take necessary precautions to contain the spread of COVID-19. While the guidelines for testing may evolve over time, the protocol should create a structure for daily dissemination of testing criteria from ICE leadership, and time for daily briefings among all health staff at the start of every shift, to review this and other elements of the COVID-19 response. This briefing must include participation by epidemiologists tasked to a COVID-19 response who are also coordinating with local and federal COVID-19 activities.

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[31] Note that ICE's guidance as to the proper percentage of reduction is inconsistent. ICE's April 10 Guidance, Ex. E, specifies reduction to 75 percent capacity; ICE's website specifies reduction to 70 percent capacity. *See* ICE, ICE Guidance on COVID-19, https://www.ice.gov/coronavirus (last visited Apr. 14, 2020).

[32] ICE, ICE Guidance on COVID-19, https://www.ice.gov/coronavirus (last visited Apr. 14, 2020).

[33] David Cloud, et al., *The Ethical Use of Medical Isolation—Not Solitary Confinement—to Reduce COVID-19 Transmission in Correctional Settings*, Apr. 9, 2020, https://amend.us/wp-content/uploads/2020/04/Medical-Isolation-vs-Solitary_Amend.pdf.

35. **Staffing**: The ICE COVID-19 protocols and guidance fail to address the key CDC recommendation on the need for adequate staffing and training of staff. ICE's March 27 Memo simply states that "facilities are expected to be appropriately staffed," but provides no guidance whatsoever on how that can be accomplished in the context of existing staffing gaps, a decreased workforce, and increased needs resulting from steps required to screen, monitor and treat detainees for COVID-19. See Exhibit C.

    a. CDC guidelines make clear the need for a concrete plan for ensuring adequate staffing as part of the COVID-19 response. These guidelines also make clear the need to orient staff to the critical need to stay home if and when they experience symptoms of COVID-19 infection. In sum, aside from the ICE March 27 Memo's "expectation" of appropriate staffing levels, ICE has not implemented any meaningful oversight system to ensure that staffing levels are met.

    b. Critically, appropriate staffing levels refers not only to a sufficient number of staff but also to a sufficient number of qualified staff. In my experience, many facilities rely heavily on guards and LPNs to do medical work that they are not qualified to do; likewise, many facilities rely on RNs to do medical work that only doctors or physician-assistants are qualified to do. There is no indication whatsoever that ICE is implementing procedures in Calhoun to ensure not only sufficient numbers of staff but also sufficient numbers of qualified staff. The current shortages in staffing for health staff in particular, stretch across all communities, and staffing shortages represent a real emergency in many settings already. This is particularly concerning given that many ICE facilities are located in rural areas far from qualified medical professionals. This is a very serious defect that must be immediately remediated because access to qualified medical professionals is crucial during this rapidly evolving pandemic.

Lack of COVID-19 Plan in Place for Calhoun

36. The April 10 ERO Pandemic Response Requirements mandate that every facility holding ICE detainees have a COVID-19 mitigation plan in place. The document specifies:

    "Consistent with ICE detention standards, all facilities housing ICE detainees are required to have a COVID-19 mitigation plan that meets the following four objectives:
    - To protect employees, contractors, detainees, visitors to the facility, and stakeholders from exposure to the virus;
    - To maintain essential functions and services at the facility throughout the pendency of the pandemic;
    - To reduce movement and limit interaction of detainees with others outside their assigned housing units, as well as staff and others, and to promote social distancing within housing units; and
    - To establish means to monitor, cohort, quarantine, and isolate the sick from the well." Ex. E.

37. The key aspects of the CDC guidance regarding COVID-19 response involve active preparation before the arrival of COVID-19, clear and evidence-based responses once cases are identified. Preparation includes communication with staff and inmates about risks infection control and that reflect an evidence-based emergency COVID-19 plan that is widely disseminated. Once COVID-19 arrives, this plan is updated and may evolve, but the plan itself is a document that every person in the facility understands and is part of, much like a suicide prevention or sexual abuse reporting plan.

38. I have reviewed the declarations of Heather Garvock (attorney of Plaintiff Qaid Ahmed Alhalmi), Caterina Amaro-Luedtke (attorney of Plaintiff Emanuel Rosales Borboa), Jonathan Contreras (attorney of Plaintiff Julio Fernando Medina Euceda), Joseph S. Hughes (attorney of Damary Rodriguez Salabarria), Richard Kessler (attorney of Tomas Cardona Ramirez), and Kai Da Graff (attorney of Min Dan Zhang). I have also reviewed the declarations of Pay Par Gai, Amer Toma and Ruby Briselda Escobar, all of whom were previously detained at Calhoun. Based on their description of current practices in Calhoun, no COVID-19 mitigation plan appears to exist for Calhoun County. In addition, the lack of basic access to medical evaluation and treatment for serious and potentially life-threatening health problems reported in these declarations raises concern that if and when people become seriously ill in Calhoun, their medical emergencies will not result in treatment. This represents a stark and dangerous departure from ICE's own policies and CDC guidelines for COVID-19 response in detention settings.[34]

Plaintiffs Are at High-Risk If They Remain in ICE Custody

39. As noted, I have reviewed the declarations concerning six Plaintiffs in this matter: Mr. Alhalmi, Mr. Rosales Borboa, Mr. Medina Euceda, Ms. Rodriguez Salabarria, Mr. Cardona Ramirez and Ms. Zhang, who are all currently detained by ICE in Calhoun.

40. Based on this information, I have specific concerns about the health status of the six Plaintiffs and their lack of access to even the most basic infection control, and other COVID-19 measures included in basic CDC guidelines including:

    a. Based on their declarations, these six Plaintiffs have pre-existing conditions that place them at heightened risk of serious illness or death should they contract COVID-19 infection.

        i. Mr. Alhalmi is 58 years old and suffers from hypertension and Type 2 diabetes. Prior to being detained, Mr. Alhalmi managed his diabetes through diet and medication. In detention, his blood sugar has increased and he has become insulin dependent. He has reported experiencing chest pain and shortness of breath over the last three weeks. His age and medical conditions place him at high risk of severe illness or death if he contracts COVID-19.

[34] CDC, Resources for Correctional and Detention Facilities: Before and During an Outbreak, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/index.html (last visited Apr. 14, 2020).

ii. Mr. Rosales Borboa has been diagnosed with asthma. He suffered an asthma attack about ten years ago when he experienced shortness of breath, chest pains and difficulty breathing. Mr. Rosales Borboa was hospitalized for two days, after which he was diagnosed with asthma and prescribed an Albuterol inhaler, which he uses multiple times a week. He has also been prescribed Prednisone, an immunosuppressant medication, for his breathing problems. His medical problems place him at high risk of severe illness or death if he contracts COVID-19.

iii. Mr. Medina Euceda is 54 years old. His age places him at a high risk of severe illness or death if he contracts COVID-19.

iv. Ms. Rodriguez Salabarria suffers from hypertension, chronic gastritis, a peptic ulcer and gastroesophageal reflux. She takes daily medication to treat these conditions. She has previously been hospitalized in the ICU for acute pancreatitis, and had an appendectomy and cholecystectomy. Since being detained, Ms. Rodriguez Salabarria has had multiple kidney infections. Her medical conditions place her at a high risk of severe illness or death if she contracts COVID-19.

v. Mr. Cardona Ramirez suffers from Type 2 diabetes, for which he has been prescribed insulin and other medication to regulate his blood sugar. He has also been diagnosed with hypertension. Mr. Cardona Ramirez also takes medication, including Lisinopril, to treat his high blood pressure. His medical conditions place him at a high risk of severe illness or death if he contracts COVID-19.

vi. Ms. Zhang is 50 years old. Her age places her at a high risk of severe illness or death if she contracts COVID-19.

b. Plaintiffs report a lack of basic infection control measures within Calhoun, including:

i. Lack of social distancing as prescribed by the CDC guidance for detention settings, including extremely close sleeping quarters and living areas.

1. Mr. Alhalmi described being housed in a small, 7 by 5 foot cell shared with one other detainee. The cell is in window-less Pod that contains about 58 other detainees, who must share four showers and two common bathrooms. He and other detainees must eat within arm's reach of one another and experience lock downs at least four times a day, requiring them to be at their bunk beds near their cell mates. He has had five different cellmates over the last two weeks, without cleaning in between.

2. Mr. Rosales Borboa described being housed in a Pod with a total of 37 to 42 detainees who share two bathrooms with four toilets, three showers and four sinks. He shares a 20 by 8 feet cubicle with seven other detainees in bunk beds that are at most three feet apart from each other. He too undergoes lockdowns four times a day, for about 9.5 hours, during which he is confined to this small space with seven other detainees. Mr. Rosales Borboa is also constantly at arms-length distance from others during recreation and meal times.

3. Mr. Medina Euceda described sleeping in a dorm with 30 bunk beds and eating in a communal space, both places where no one is able to practice social distancing.

4. Ms. Rodriguez Salabarria described sharing a cell with four twin-sized beds and six other detainees who change frequently. She has had ten different detainees over the past two weeks. She is unable to maintain six feet distance between her and other inmates in this space nor when she is eating.

5. Ms. Zhang described sharing a cell with four other people, where the beds are only one to two feet apart. She is also unable to practice social distancing.

ii. Lack of access to hand washing and sanitizing supplies.

1. Mr. Alhalmi described how there is often no soap available for handwashing in their shared bathrooms. Detainees also do not have access to hand sanitizer, gloves or masks.

2. Mr. Rosales Borboa described how detainees are responsible for cleaning their sleeping areas, but are not provided masks, gloves, or hand sanitizer. Other than a short period when detainees were given masks while being transferred from one pod to another, because of a suspected case of COVID-19, detainees are now penalized with solitary confinement if caught with a mask. Detainees can go for up to two days without being provided soap.

3. According to Mr. Medina Euceda, detainees have not been provided masks, personal protective equipment, or any additional cleaning supplies.

4. Ms. Rodriguez Salabarria reported that soap is not consistently provided to detainees. They are also not provided sufficient time to properly wash up in the bathroom.

5. Ms. Zhang reported that detainees do not have access to free soap and that nay soap must be bought from the commissary, meaning that those who cannot afford soap end up without any. She also noted that staff have not provided any education or instruction to detainees on frequent and vigorous handwashing.

iii. Failure to establish standards of use of gloves and masks by security personnel.

1. Mr. Alhalmi described not seeing any Calhoun staff wear masks, including a nurse caring for another inmate.

2. Mr. Rosales Borboa did not see staff at Calhoun consistently wear masks or gloves, describing it as a "hit or miss."

3. Mr. Medina Euceda has seen guards wear masks or gloves at two quarantined units, but not any other staff wearing protective gear.

4. Ms. Rodriguez Salabarria reported that she has not seen correctional guards wear masks or gloves while serving food to detainees.

5. Ms. Zhang reported seeing guards at Calhoun wear gloves, but not masks.

iv. Failure to provide for testing, even to symptomatic detainees.

1. Mr. Alhalmi and at least seven detainees in his Pod have displayed COVID-19 symptoms, including a cough and sore throat, but have not been tested despite requesting testing.

2. Mr. Rosales Borboa described how he was ill for two days, during which he had chest pain and fever with sweats. Despite informed a guard about his symptoms, he was never evaluated nor tested for COVID-19.

c. These statements are corroborated by those of Mr. Gai, Mr. Toma and Ms. Escobar, who were until recently detained at Calhoun and describe a lack of basic social distancing, failure to provide sanitizing and personal protection equipment, and lack of environmental cleaning in the facility, all basic elements of CDC guidelines for management of COVID-19 risks in correctional settings. In addition, the declaration of Ms. Escobar relates a lack of attention to serious history and symptoms of potentially life-threatening medical problem that raises concern that once detained people become seriously ill from COVID-19, they may not receive access to appropriate health services. The declaration of Mr. Gai also raises the troubling concern that Colhoun medical staff did not provide a COVID-19 test because of a lack of availability, despite concerning symptoms that included fever and cough.

d. The MDOC has reported posting guidance from the CDC on COVID-19 concerns, but this is not enough. CDC guidelines make clear that preparation for COVID-19 in a detention setting involves multiple levels of active work. The key aspects of the CDC guidance regarding COVID-19 response involve active preparation before the arrival of COVID-19, and clear and evidence-based responses once cases are identified. Preparation includes communication with staff and inmates about infection control, ensuring that environmental cleaning and access to hand washing is occurring per CDC guidelines, limiting large group events and initiating social distancing, creating communication with local public health partners, identifying high risk patients, and creating an emergency COVID-19 plan. Once COVID-19 arrives, efforts should include screening, testing, identification, and tracking of new cases, quarantining of close contacts, continuation of infection control, staffing and other aspects of the emergency plan, and increased coordination with the local health department, especially regarding testing, isolation, quarantining and hospitalization.[35]

41. The failure to implement a basic COVID-19 emergency plan, and the omission of basic elements of the CDC guidelines within Calhoun places people at a high risk of contracting COVID-19 and suffering serious complications—including death.

42. In my expert opinion, ICE and Calhoun should reduce the facility census to the point where social distancing can be accomplished at all times in order to reduce the risk of transmission to lower risk detainees. This will also reduce the burden on the local health care infrastructure, which will otherwise bear the consequences of having to treat individuals at Calhoun when infected and limit the resources available for others in the community.

43. Furthermore, ICE and Calhoun must immediately release Plaintiffs who possess risk factors to prevent their serious illness and/or death. The most recent ERO protocol (Ex. E) makes clear that they do not plan to establish specific protections for high-risk patients and will wait for them to become symptomatic. This approach will result in preventable morbidity and mortality. Both the oversight authority of the NYC jail system, and the current medical director for geriatrics and complex care of the system have called for high-risk patients to be immediately transferred out of detention.[36] ICE's medical subject matter experts have similarly called for the release of high-risk patients and "*all* immigration detainees who do not pose a security risk" as part of a nationwide effort to stop the spread of the coronavirus.[37]

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[35] CDC, Resources for Correctional and Detention Facilities: Before and During an Outbreak, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/index.html (last visited Apr. 14, 2020).

[36] Jennifer Gonnerman, *A Rikers Island Doctor Speaks Out to Save Her Elderly Patients from the Coronavirus*, NEW YORKER (Mar. 20, 2020), https://www.newyorker.com/news/news-desk/a-rikers-island-doctor-speaks-out-to-save-her-elderly-patients-from-the-coronavirus; *NYC Officials Call for Release of "Most at Risk" on Rikers Island as More Test Positive for Virus*, NBC4 NEW YORK (Mar. 18, 2020), https://www.nbcnewyork.com/news/local/nyc-officials-call-for-release-of-most-at-risk-on-rikers-prison-as-more-test-positive-for-virus/2333348/.

[37] 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.

44. ICE faces a completely preventable disaster by continuing to detain high-risk patients and others who could otherwise be released as COVID-19 arrives in facilities where the virus will quickly spread, especially in settings like Calhoun, which has failed to even develop and implement a COVID-19 Emergency Plan or develop practices that are consistent with CDC guidelines. The basic limitations of the physical plant and looming staffing concerns make clear that these patients are in peril of serious illness or death if they remain in detention. In addition, transfer of these patients to other ICE detention facilities will only compound exposure and transmission of COVID-19. They must be released immediately.

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

Executed this 25th day in April 2020 in Port Washington, New York

Signed,

Homer Venters MD, MS

Exhibit A

Dr. Homer D. Venters

10 ½ Jefferson St., Port Washington, NY, 11050
hventers@gmail.com, Phone: 646-734-5994

HEALTH ADMINISTRATOR PHYSICIAN EPIDEMIOLOGIST

Professional Profile

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

Professional Experience

President, Community Oriented Correctional Health Services (COCHS), 1/1/2020-present.

- Lead COCHS efforts to provide technical assistance, policy guidance and research regarding correctional health and justice reform.
- Oversee operations and programmatic development of COCHS
- Serve as primary liaison between COCHS board, funders, staff and partners.

Senior Health and Justice Fellow, Community Oriented Correctional Health Services (COCHS), 12/1/18-12/31/2018

- Lead COCHS efforts to expand Medicaid waivers for funding of care for detained persons relating to Substance Use and Hepatitis C.
- Develop and implement COCHS strategy for promoting non-profit models of diversion and correctional health care.

Medical/Forensic Expert, 3/2016-present

- Provide expert input, review and testimony regarding health care, quality improvement, electronic health records and data analysis in detention settings.

Director of Programs, Physicians for Human Rights, 3/16-11/18.

- Lead medical forensic documentation efforts of mass crimes against Rohingya and Yazidi people.
- Initiate vicarious trauma program.
- Expand forensic documentation of mass killings and war crimes.
- Develop and support sexual violence capacity development with physicians, nurses and judges.
- Expand documentation of attacks against health staff and facilities in Syria and Yemen.

Chief Medical Officer/Assistant Vice President, Correctional Health Services, NYC Health and Hospitals Corporation 8/15-3/17.

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

Assistant Commissioner, Correctional Health Services, New York Department of Health and Mental Hygiene, 6/11-8/15.

- Implemented nation's first electronic medical record and health information exchange for 1,400 staff and 75,000 patients in a jail.
- Developed bilateral agreements and programs with local health homes to identify incarcerated patients and coordinate care.
- Increased operating budget of health service from $115 million to $140 million.
- Established surveillance systems for injuries, sexual assault and mental health that drove new program development and received American Public Health Association Paper of the Year 2014.
- Personally care for and reported on over 100 patients injured during violent encounters with jail security staff.

Medical Director, Correctional Health Services, New York Department of Health and Mental Hygiene, 1/10-6/11.

- Directed all aspects of medical care for 75,000 patients annually in 12 jails, including specialty, dental, primary care and emergency response.
- Direct all aspects of response to infectious outbreaks of H1N1, Legionella, Clostridium Difficile.
- Developed new protocols to identify and report on injuries and sexual assault among patients.

Deputy Medical Director, Correctional Health Services, New York Department of Health and Mental Hygiene, 11/08-12/09.

- Developed training program with Montefiore Social internal medicine residency program.
- Directed and delivered health services in 2 jails.

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

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

Education and Training

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

Academic Appointments, Licensure

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

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

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

Media

TV
i24 Crossroads re Suicide in U.S. Jails 8/13/19.

i24 Crossroads re re *Life and Death in Rikers Island* 6/13/19.

Amanpour & Company, NPR/PBS re *Life and Death in Rikers Island* 4/15/19.

CNN, Christiane Amanpour re Forensic documentation of mass crimes against Rohingya. 7/11/18.

i24 Crossroads with David Shuster re health crisis among refugees in Syria. 7/6/18.

Canadian Broadcasting Corporation TV with Sylvie Fournier (in French) re crowd control weapons. 5/10/18

i24 Crossroads with David Shuster re Cholera outbreak in Yemen. 2/15/18.

China TV re WHO guidelines on HIV medication access 9/22/17.

Radio/Podcast
Morning Edition, NPR re Health Risks of Criminal Justice System. 8/9/19.

Fresh Air with Terry Gross, NPR re *Life and Death in Rikers Island*, 3/6/19.

Morning Edition, NPR re *Life and Death in Rikers Island*, 2/22/19.

LeShow with Harry Sherer re forensic documentation of mass crimes in Myanmar, Syria,

Iraq. 4/17/18.

Print articles and public testimony
Oped: Four ways to protect our jails and prisons from coronavirus. The Hill 2/29/20.

Oped: It's Time to Eliminate the Drunk Tank. The Hill 1/28/20.

Oped: With Kathy Morse. A Visit with my Incarcerated Mother. The Hill 9/24/19.

Oped: With Five Omar Muallim-Ak. The Truth about Suicide Behind Bars is Knowable. The Hill 8/13/19.

Oped: With Katherine McKenzie. Policymakers, provide adequate health care in prisons and detention centers. CNN Opinion, 7/18/19.

Oped: Getting serious about preventable deaths and injuries behind bars. *The Hill*, 7/5/19.

Testimony: Access to Medication Assisted Treatment in Prisons and Jails, New York State Assembly Committee on Alcoholism and Drug Abuse, Assembly Committee on Health, and Assembly Committee on Correction**.** NY, NY, 11/14/18.

Oped: Attacks in Syria and Yemen are turning disease into a weapon of war, *STAT News*, 7/7/17.

Testimony: Connecticut Advisory Committee to the U.S. Commission on Civil Rights: Regarding the use of solitary confinement for prisoners. Hartford CT, 2/3/17.

Testimony: Venters HD, New York Advisory Committee to the U.S. Commission on Civil Rights: Regarding the use of solitary confinement for juveniles in New York. July 10, 2014. NY NY.

Testimony: New York State Assembly Committee on Correction with the Committee on Mental Health: Regarding Mental Illness in Correctional Settings. November 13, 2014. Albany NY.
Testimony: New York State Assembly Committee on Correction with the Committee on Mental Health: Regarding Mental Illness in Correctional Settings. November 13, 2014. Albany NY.

Oped: Venters HD and Keller AS, The Health of Immigrant Detainees. Boston Globe, April 11, 2009.

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

Peer Reviewed Publications

Parmar PK, Leigh J, **Venters H**, Nelson T. Violence and mortality in the Northern Rakhine State of Myanmar, 2017: results of a quantitative survey of surviving community leaders in Bangladesh. Lancet Planet Health. 2019 Mar;3(3):e144-e153.

Venters H. Notions from Kavanaugh hearings contradict medical facts. *Lancet.* 10/5/18.

Taylor GP, Castro I, Rebergen C, Rycroft M, Nuwayhid I, Rubenstein L, Tarakji A, Modirzadeh N, **Venters H**, Jabbour S. Protecting health care in armed conflict: action towards accountability. *Lancet.* 4/14/18.

Katyal M, Leibowitz R, **Venters H**. IGRA-Based Screening for Latent Tuberculosis Infection in Persons Newly Incarcerated in New York City Jails. *J Correct Health Care.* 2018 4/18.

Harocopos A, Allen B, Glowa-Kollisch S, **Venters H**, Paone D, Macdonald R. The Rikers Island Hot Spotters: Exploring the Needs of the Most Frequently Incarcerated.
J Health Care Poor Underserved. 4/28/17.

MacDonald R, Akiyama MJ, Kopolow A, Rosner Z, McGahee W, Joseph R, Jaffer M, **Venters H**. Feasibility of Treating Hepatitis C in a Transient Jail Population.
Open Forum Infect Dis. 7/7/18.

Siegler A, Kaba F, MacDonald R, **Venters H**. Head Trauma in Jail and Implications for Chronic Traumatic Encephalopathy. *J Health Care Poor and Underserved.* In Press (May 2017).

Ford E, Kim S, **Venters H**. Sexual abuse and injury during incarceration reveal the need for re-entry trauma screening. *Lancet.* 4/8/18.

Alex B, Weiss DB, Kaba F, Rosner Z, Lee D, Lim S, **Venters H,** MacDonald R. Death After Jail Release. *J Correct Health Care*. 1/17.

Akiyama MJ, Kaba F, Rosner Z, Alper H, Kopolow A, Litwin AH, **Venters H**, MacDonald R. Correlates of Hepatitis C Virus Infection in the Targeted Testing Program of the New York City Jail System. *Public Health Rep.* 1/17.

Kalra R, Kollisch SG, MacDonald R, Dickey N, Rosner Z, **Venters H**. Staff Satisfaction, Ethical Concerns, and Burnout in the New York City Jail Health System. *J Correct Health Care.* 2016 Oct;22(4):383-392.

Venters H. A Three-Dimensional Action Plan to Raise the Quality of Care of US Correctional Health and Promote Alternatives to Incarceration. *Am J Public Health*. April 2016.104.

Glowa-Kollisch S, Kaba F, Waters A, Leung YJ, Ford E, **Venters H**. From Punishment to Treatment: The "Clinical Alternative to Punitive Segregation" (CAPS) Program in New York City Jails. *Int J Env Res Public Health.* 2016. 13(2),182.

Jaffer M, Ayad J, Tungol JG, MacDonald R, Dickey N, Venters H. Improving Transgender Healthcare in the New York City Correctional System. *LGBT Health.* 2016 1/8/16.

Granski M, Keller A, Venters H. Death Rates among Detained Immigrants in the United States. *Int J Env Res Public Health.* 2015. 11/10/15.

Michelle Martelle, Benjamin Farber, Richard Stazesky, Nathaniel Dickey, Amanda Parsons, **Homer Venters**. Meaningful Use of an Electronic Health Record in the NYC Jail System. *Am J Public Health*. 2015. 8/12/15.

Fatos Kaba, Angela Solimo, Jasmine Graves, Sarah Glowa-Kollisch, Allison Vise, Ross MacDonald, Anthony Waters, Zachary Rosner, Nathaniel Dickey, Sonia Angell, **Homer Venters**. Disparities in Mental Health Referral and Diagnosis in the NYC Jail Mental Health Service. *Am J Public Health.* 2015. 8/12/15.

Ross MacDonald, Fatos Kaba, Zachary Rosner, Alison Vise, Michelle Skerker, David Weiss, Michelle Brittner, Nathaniel Dickey, **Homer Venters**. The Rikers Island Hot Spotters. *Am J Public Health*. 2015. 9/17/15.

Selling Molly Skerker, Nathaniel Dickey, Dana Schonberg, Ross MacDonald, **Homer Venters**. Improving Antenatal Care for Incarcerated Women: fulfilling the promise of the Sustainable Development Goals. *Bulletin of the World Health Organization*.2015.

Jasmine Graves, Jessica Steele, Fatos Kaba, Cassandra Ramdath, Zachary Rosner, Ross MacDonald, Nathanial Dickey, **Homer Venters**. Traumatic Brain Injury and Structural Violence among Adolescent males in the NYC Jail System *J Health Care Poor Underserved.* 2015;26(2):345-57.

Glowa-Kollisch S, Graves J, Dickey N, MacDonald R, Rosner Z, Waters A, **Venters H**. Data-Driven Human Rights: Using Dual Loyalty Trainings to Promote the Care of Vulnerable Patients in Jail. *Health and Human Rights*. Online ahead of print, 3/12/15.

Teixeira PA[1], Jordan AO, Zaller N, Shah D, **Venters H**. Health Outcomes for HIV-Infected Persons Released From the New York City Jail System With a Transitional Care-Coordination Plan. 2014. *Am J Public Health*. 2014 Dec 18.

Selling D, Lee D, Solimo A, **Venters H.** A Road Not Taken: Substance Abuse Programming in the New York City Jail System. *J Correct Health Care.* 2014 Nov 17.

Glowa-Kollisch S, Lim S, Summers C, Cohen L, Selling D, **Venters H**. Beyond the Bridge: Evaluating a Novel Mental Health Program in the New York City Jail System. *Am J Public Health*. 2014 Sep 11.

Glowa-Kollisch S, Andrade K, Stazesky R, Teixeira P, Kaba F, MacDonald R, Rosner Z, Selling D, Parsons A, **Venters H**. Data-Driven Human Rights: Using the Electronic Health Record to Promote Human Rights in Jail. *Health and Human Rights*. 2014. Vol 16 (1): 157-165.

MacDonald R, Rosner Z, **Venters H**. Case series of exercise-induced rhabdomyolysis in the New York City Jail System. *Am J Emerg Med*. 2014. Vol 32(5): 446-7.

Bechelli M, Caudy M, Gardner T, Huber A, Mancuso D, Samuels P, Shah T, **Venters H.** Case Studies from Three States: Breaking Down Silos Between Health Care and Criminal Justice. *Health Affairs*. 2014. Vol. 3. 33(3):474-81.

Selling D, Solimo A, Lee D, Horne K, Panove E, **Venters H**. Surveillance of suicidal and non-suicidal self-injury in the new York city jail system. *J Correct Health Care*. 2014. Apr:20(2).

Kaba F, Diamond P, Haque A, MacDonald R, **Venters H**. Traumatic Brain Injury Among Newly Admitted Adolescents in the New York City Jail System. *J Adolesc Health*. 2014. Vol 54(5): 615-7.

Monga P, Keller A, **Venters H**. Prevention and Punishment: Barriers to accessing health services for undocumented immigrants in the United States. *LAWS*. 2014. 3(1).

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

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

Parvez FM, Katyal M, Alper H, Leibowitz R, **Venters H.** Female sex workers incarcerated in New York City jails: prevalence of sexually transmitted infections and associated risk behaviors. *Sexually Transmitted Infections*. 89:280-284. 2013.

Brittain J, Axelrod G, **Venters H.** Deaths in New York City Jails: 2001 – 2009. *Am J Public Health*. 2013 103:4.

Jordan AO, Cohen LR, Harriman G, Teixeira PA, Cruzado-Quinones J, **Venters H.** Transitional Care Coordination in New York City Jails: Facilitating Linkages to Care for People with HIV Returning Home from Rikers Island. *AIDS Behav. Nov.* 2012.

Jaffer M, Kimura C, **Venters H.** Improving medical care for patients with HIV in New York City jails. *J Correct Health Care*. 2012 Jul;18(3):246-50.

Ludwig A, Parsons, A, Cohen, L, **Venters H.** Injury Surveillance in the NYC Jail System, *Am J Public Health* 2012 Jun;102(6).

Venters H, Keller, AS. *Psychiatric Services*. (2012) Diversion of Mentally Ill Patients from Court-ordered care to Immigration Detention. Epub. 4/2012.

Venters H, Gany, F. *Journal of Immigrant and Minority Health* (2011) Mental Health Concerns Among African Immigrants. 13(4): 795-7.

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

Venters H, McNeely J, Keller AS. *Health and Human Rights.* (2010) HIV Screening and Care for Immigration Detainees. 11(2) 91-102.

Venters H, Keller AS. *Journal of Health Care for the Poor and Underserved*. (2009) The Immigration Detention Health Plan: An Acute Care Model for a Chronic Care Population. 20:951-957.

Venters H, Gany, F. *Journal of Immigrant and Minority Health* (2009) African Immigrant Health. 4/4/09.

Venters H, Dasch-Goldberg D, Rasmussen A, Keller AS, *Human Rights Quarterly* (2009) Into the Abyss: Mortality and Morbidity among Detained Immigrant. 31 (2) 474-491.

Venters H, *The Lancet* (2008) Who is Jack Bauer? 372 (9653).

Venters H, Lainer-Vos J, Razvi A, Crawford J, Shaf'on Venable P, Drucker EM, *Am J Public Health* (2008) Bringing Health Care Advocacy to a Public Defender's Office. 98 (11).

Venters H, Razvi AM, Tobia MS, Drucker E. *Harm Reduct J*. (2006) The case of Scott Ortiz: a clash between criminal justice and public health. Harm Reduct J. 3:21

Cloez-Tayarani I, Petit-Bertron AF, **Venters HD**, Cavaillon JM (2003) *Internat. Immunol.* Differential effect of serotonin on cytokine production in lipopolysaccharide-stimulated human peripheral blood mononuclear cells.15,1-8.

Strle K, Zhou JH, Broussard SR, **Venters HD**, Johnson RW, Freund GG, Dantzer R, Kelley KW, (2002) *J. Neuroimmunol.* IL-10 promotes survival of microglia without activating Akt. 122, 9-19.

Venters HD, Broussard SR, Zhou JH, Bluthe RM, Freund GG, Johnson RW, Dantzer R, Kelley KW, (2001) *J. Neuroimmunol.* Tumor necrosis factor(alpha) and insulin-like growth factor-I in the brain: is the whole greater than the sum of its parts? 119, 151-65.

Venters HD, Dantzer R, Kelley KW, (2000) *Ann. N. Y. Acad. Sci.* Tumor necrosis factor-alpha induces neuronal death by silencing survival signals generated by the type I insulin-like growth factor receptor. 917, 210-20.

Venters HD, Dantzer R, Kelley KW, (2000) *Trends. Neurosci.* A new concept in neurodegeneration: TNFalpha is a silencer of survival signals. 23, 175-80.

Venters HD, Tang Q, Liu Q, VanHoy RW, Dantzer R, Kelley KW, (1999) *Proc. Natl. Acad. Sci. USA.* A new mechanism of neurodegeneration: A proinflammatory cytokine inhibits receptor signaling by a survival peptide, 96, 9879-9884.

Venters HD, Ala TA, Frey WH 2nd , (1998) Inhibition of antagonist binding to human brain muscarinic receptor by vanadium compounds. *Recept. Signal. Transduct.* 7, 137-142.

Venters HD, Tang Q, Liu Q, VanHoy RW, Dantzer R, Kelley KW, (1999) *Proc. Natl. Acad. Sci. USA.* A new mechanism of neurodegeneration: A proinflammatory cytokine inhibits receptor signaling by a survival peptide, 96, 9879-9884.

Venters HD, Ala TA, Frey WH 2nd , (1998) Inhibition of antagonist binding to human brain muscarinic receptor by vanadium compounds. *Recept. Signal. Transduct.* 7, 137-142**.**

Venters HD, Bonilla LE, Jensen T, Garner HP, Bordayo EZ, Najarian MM, Ala TA, Mason RP, Frey WH 2nd, (1997) Heme from Alzheimer's brain inhibits muscarinic receptor binding via thiyl radical generation. *Brain. Res.* 764, 93-100.

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

Honors and Presentations (past 10 years)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Poster Presentation, Mental Health Training for Immigration Judges. American Public Health

Association Annual Meeting, New Orleans LA, 2014.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

November 2009.

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

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

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

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

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

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

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

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

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

Grants: Program

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

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

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

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

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

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

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

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

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

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

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

Teaching

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

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

Other Health & Human Rights Activities

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

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

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

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

-*Secondary Project;* Malaria Prevention.

Books

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

Chapters in Books

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

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

Membership in Professional Organizations

American Public Health Association

Foreign Language Proficiency

French	Proficient
Ewe	Conversant

Prior Testimony and Deposition

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

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

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

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

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

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

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

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

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

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

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

Fee Schedule

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

Exhibit B

Immigration and Customs Enforcement
Washington, DC 20536

ICE Health Service Corps

Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19)

ICE Health Service Corps (IHSC)

Version 6.0, March 6, 2020

WHAT'S NEW

Version 6.0

- Information added to convey that revised CDC guidance expands testing to a wider group of symptomatic patients. Providers should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Decisions on which patients receive testing should be based on the epidemiology of COVID-19, as well as the clinical course of illness. Providers are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.
- Information added to covey that testing is now available through LabCorp and other commercial laboratories.

Version 5.1

- Information added to emphasize that medical staff should educate detainees to include hygiene, covering coughs, and requesting sick call if ill.
- Add a link to Illness Prevention and Patient Education resources in multiple languages on SharePoint, including signage.
- Added a link to COVID-19 Questions and Responses on SharePoint for submitting questions, receiving responses from IHSC subject matter experts, and viewing all questions and responses.
- Added a link to a 2019 Novel Coronavirus Resource Page on SharePoint.

Version 5.0

- Updates have been made for screening to identify detainees with revised CDC criteria for epidemiologic risk of COVID-19 exposure and to specify the start of the 14-day monitoring period from the date of initial DHS apprehension.
- Epidemiologic travel risk now includes travel from or through geographic areas with widespread or sustained community transmission.

Situation Summary

The CDC is closely monitoring an outbreak caused by a novel (new) coronavirus (COVID-19). The situation is evolving and expanding with community transmission occurring in multiple countries. For the most current information, check the CDC information pages at https://www.cdc.gov/coronavirus/2019-ncov/index.html frequently for updates.

CDC interim guidance for health care professionals, including clinical criteria, is available at https://www.cdc.gov/coronavirus/2019-nCoV/clinical-criteria.html.

ICE Health Service Corps Recommendations

Note: recommendations will be updated if and as necessary to address the evolving public health situation.

1. ***During intake medical screening:***
   a. **Ask all detainees if they have had close contact[1] with a person with laboratory-confirmed COVID-19 in the past 14 days**
   b. **Ask all detainees what countries they have traveled from or through in the past two weeks**
      i. Check whether these countries include geographic area(s) with widespread or sustained community transmission.*
      ii. ***Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html.**
      iii. **If the detainee responded yes to 1a and/or the detainee traveled from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days (1b),** assess for fever and symptoms of respiratory illness.
         a. If the detainee has a fever and/or symptoms of respiratory illness, refer to #4 ISOLATION below.
         b. If the detainee does not have fever or respiratory illness, refer to #2 MONITORING, below.
         c. For IHSC-staffed medical clinics, add a Global Alert / Medical Alert in the electronic health record that states, *"Epidemiologic risk of possible COVID-19 exposure. The last reported date of possible exposure was mm/dd/yyyy.""* Click here for the eCW guide for adding a Global Alert.
   c. If the detainee has fever and/or symptoms or respiratory illness and has not traveled from or through area(s) with sustained community transmission* in the past 14 days and if they have not had close contact[1] with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days → refer to a medical provider (see #3 ENCOUNTER below).

d. Educate all detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
   i. Illness Prevention and Patient Education resources in multiple languages are available on the 2019 Novel Coronavirus Resource Page.

2. **MONITORING of detainees with exposure risk who do not present with fever or symptoms:**

a. See also IHSC Interim COVID-19 Risk Assessment on the 2019 Novel Coronavirus Resource Page.
b. For detainees with travel history from or through geographic area(s) with sustained community transmission* in the past 14 days and/or detainees who have had close contact[1] with a person with laboratory-confirmed COVID-19 in the past 14 days who do not present with fever or symptoms of respiratory illness → monitor for 14 days after initial DHS apprehension and observe daily for fever and/or symptoms of respiratory illness.
   i. ***Please see CDC website listing of international area(s) with sustained transmission at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html.**
c. House detainees under monitoring in a single cell room if available or as a cohort for 14 days after initial DHS apprehension.
d. Refer also to appendix A, Intake Screening Questions and Intake Screening and Early Management Algorithm on the 2019 Novel Coronavirus Resource Page.
e. If detainee is housed in a facility without IHSC medical staffing, medical staff should notify their assigned IHSC Field Medical Coordinator.
f. Request a medical alert in following usual protocols stating that "the detainee is under observation through mm/dd/yyyy due to recent travel from or through geographic area(s) with widespread or sustained community transmission" Release the medical alert at the completion of the 14-day monitoring period.
g. During the 14-day monitoring period, if an asymptomatic detainee under monitoring must be released in the U.S., notify the local health department and provide information on the detainee including the intended address and telephone number of the detainee's intended destination.
h. Document any asymptomatic detainee under monitoring on the Lower Respiratory Illness Tracking Tool.
i. For monitoring of asymptomatic detainees, it is not necessary to contact the local health department.

3. ***ENCOUNTER. During sick call, health assessment, or other clinical encounter in which a detainee presents with or complains of fever and/or respiratory illness, or is observed with signs of fever and/or respiratory illness:***
   a. Ask all detainees what countries they have traveled from or through in the past two weeks.
      i. Check whether these countries include international area(s) with sustained transmission.*
      ii. *Please see CDC website listing of international area(s) with sustained transmission at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html.
   b. If the detainee has traveled from or through area(s) with sustained community transmission*in the past 14 days, or if they have had close contact[1] with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days
      i. → refer to #4 ISOLATION below.
   c. If the detainee has not traveled from or through area(s) with sustained community transmission* in the past 14 days and if they have not had close contact[1] with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days then
      i. → Providers should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Decisions on which patients receive testing should be based on the epidemiology of COVID-19, as well as the clinical course of illness. Providers are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.
      ii. See #5 SPECIMEN COLLECTION AND LABORATORY TESTING below.
   d. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
      i. Illness Prevention and Patient Education resources in multiple languages are available on the 2019 Novel Coronavirus Resource Page.

4. ***ISOLATION and management of detainees with fever and/or symptoms of respiratory illness and who have traveled from or through* geographic area(s) with widespread or sustained community transmission at *in the past 14 days or have had close contact[1] with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days:***
   a. See IHSC Interim COVID-19 Risk Assessment on the 2019 Novel Coronavirus Resource Page.
   b. Place a tight-fitting surgical mask on the detainee.
   c. Promptly consult with a medical provider, preferably the Clinical Director or designee.

d. Place the detainee in a private medical housing room, ideally in an airborne infection isolation room if available. If no single occupancy medical housing unit room is available, placement in other areas of the facility may be utilized to house the ill detainee separately from the general detention population.
e. **Implement strict hand hygiene and standard, airborne and contact precautions, including use of eye protection.**
    i. **Increase hand hygiene and routine cleaning of surfaces.**
    ii. **Appropriate personal protective equipment includes gloves, gowns, N95 respirators, and goggles or face shields.**
f. Call the local and/or state health department for notification and guidance.
g. Laboratory testing for COVID-19 is now available through commercial laboratories including LabCorp and through local and/or state health departments.
    i. See #5 SPECIMEN COLLECTION AND LABORTORY TESTING below.
h. If the detainee has underlying illness or is acutely ill, or symptoms do not resolve, consult with the Regional Clinical Director, and/or Infectious Disease program.
i. If the detainee is referred to a local hospital, call the hospital in advance to notify of the recent relevant travel history and respiratory symptoms and to coordinate how manage the detainee safely.
j. Promptly notify the facility's staff responsible for infection prevention and control (e.g., in IHSC facilities, notify the Infection Prevention Officer, or the Facility Healthcare Program Manager (if the facility does not have an Infection Prevention Officer position); if the Infection Prevention Officer or Facility Healthcare Program Manager is not available, IHSC staff should notify the Infection Prevention Group at #IHSC_PHSP_IPO@ice.dhs.gov.
k. Facilities without IHSC medical staffing should notify their assigned Field Medical Coordinator.
l. IHSC Infection Prevention Officers, Facility Healthcare Program Managers, Field Medical Coordinators, or designees should notify the Regional Infection Prevention Supervisory Nurse immediately.
m. Detainees isolated for respiratory illness and who have epidemiologic risk for COVID-19 exposure should wear a tight-fitting surgical mask when outside of the room under airborne and contact precautions.
n. Document any ill detainee who is suspected of having COVID-19 on the Lower Respiratory Illness Tracking Tool.
o. The contagious period for COVID-19 is still undetermined.
    i. If the detainee tests positive for COVID-19 and fever and symptoms have resolved, consult with the Infectious Disease Program and/or local health department regarding appropriate release from isolation.
    ii. If the detainee tests negative for COVID-19, had high or medium exposure risk, and fever and symptoms have resolved, release from isolation after completion of the 14-day monitoring period after initial DHS apprehension.

iii. See also IHSC Interim COVID-19 Risk Assessment on the 2019 Novel Coronavirus Resource Page.
iv. If the detainee tests negative for COVID-19 and fever and/or symptoms persist, consult with the Regional Clinical Director and/or Infectious Disease Program

p. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
i. Illness Prevention and Patient Education resources in multiple languages are available on the 2019 Novel Coronavirus Resource Page.

5. SPECIMEN COLLECTION AND LABORATORY TESTING for COVID-19

a. Laboratory testing for COVID-19 is available through commercial laboratories including LabCorp and through local and/or state health departments.
b. See **Specimen Collection instructions on the 2019 Novel Coronavirus Resource Page.**
i. LabCorp ordering codes are 2019 Novel Coronavirus (COVID-19), NAA; TEST: 139900.

6. Infectious disease public health actions:

a. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
i. Illness Prevention and Patient Education resources in multiple languages are available on SharePoint.
b. See also 05-06-G-02 Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms.
c. **Known exposure to a person with confirmed COVID-19**
i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact[1] with the ill detainee for the duration of the most recent incubation period (14 days after most recent exposure to an ill detainee).
ii. Monitor cohorted detainees daily to observe for fever and symptoms of respiratory illness.
iii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation.
iv. Discontinue cohorting when 14-day incubation period completes with no new cases.
d. **Exposure to a person with fever or symptoms being evaluated or under investigation for COVID-19 but not confirmed to have COVID-19**
i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact[1] with the ill detainee for the duration of the most recent incubation period.

ii. Monitor cohorted detainees daily to observe for fever and symptoms of respiratory illness.
iii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation.
iv. If the index patient is subsequently confirmed to have COVID-19, see section 5.b above.
v. Discontinue cohorting if the index patient receives an alternate diagnosis that excludes COVID-19.
vi. Any of the cohorted detainees with exposure risk should complete their initial 14-day monitoring period (i.e., for asymptomatic monitoring).

e. Report cohorting through routine IHSC cohort reporting protocols.
f. Document any asymptomatic and afebrile detainees under monitoring for COVID-19 on the Lower Respiratory Illness Tracking Tool.
g. Recommend to Field Office Director or designee that detainees cohorted due to high or medium exposure risk or known exposure to an ill person not be transferred or transported.
   i. See IHSC Interim COVID-19 Risk Assessment on the 2019 Novel Coronavirus Resource Page.
h. If a cohorted detainee must be released in the U.S., notify the local health department including the intended address and telephone numbers of the detainee's intended destination.

[1]**Close contact** is defined as:

a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case

– or –

b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)

Resources and references

- 2019 Novel Coronavirus Resource Page on SharePoint
- Illness Prevention and Patient Education resources in multiple languages are available on SharePoint.
- COVID-19 Questions and Responses on SharePoint for submitting questions, receiving responses from IHSC subject matter experts, and viewing all questions and responses

IHSC Official Guidance

Guidance number	Guidance name	Type
05-02	Occupational Health Directive	Policy
05-02 G-04	Occupational Health Guide: Workforce Health	Guide
05-02 G-1	Occupational Health Guide: Bloodborne Pathogens and Other Potentially Infectious Materials	Guide
05-02 G-2	Occupational Health Guide: Personal Protective Equipment Program	Guide
05-02-G-03	Occupational Health Guide: Respiratory Protection Program	Guide
05-04	Environmental Health Directive	Policy
05-04 G-01	IHSC Environmental Health Guide	Guide
05-06	Infectious Disease Public Health Actions Directive	Policy
05-06 G-01	Infectious Disease Public Health Actions Guide: Contact and Outbreak Investigation Guide	Guide
05-06 G-02	Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms	Guide
05-06 G-03	Infectious Disease Public Health Actions Guide: Surveillance and Reporting	Guide

- **Infection Control: Novel Coronavirus 2019 (COVID-19) | CDC**
- **Interim Guidance: Healthcare Professionals 2019-nCoV | CDC (including CDC website listing of geographic area(s) with widespread or sustained community transmission**
- CDC | Coronavirus Disease 2019 (COVID-19)
- 2019 Novel Coronavirus (2019-nCoV) | TDSHS
- nCOV2019 | CDPH
- Novel Coronavirus Outbreak 2020 | Washington State Department of Health

- ADHS - Highlighted Infectious Diseases for Arizona - Coronavirus Disease 2019 (COVID-19)
- Coronavirus | NYC Health
- 2019 Novel (New) Coronavirus | NYDOH
- 2019 Novel Coronavirus (2019-nCoV) | Florida Department of Health
- NJ Department of Health | Communicable Disease Service | COVID-2019 (Novel Coronavirus)
- Pennsylvania Department of Health | Coronavirus
- 2019 Novel Coronavirus (2019 nCoV) | Frequently Asked Questions | IDPH

Points of contact for questions

- IHSC Staff: COVID-19 Questions and Responses on SharePoint for submitting questions, receiving responses from IHSC subject matter experts, and viewing all questions and responses
  - Regional Infection Prevention Supervisory Nurses, PHSP Unit Senior Public Health Analyst, PHSP Unit Chief

- Facilities without IHSC Medical Staffing: Assigned Field Medical Coordinators

- Public health agencies: IHSC_InfectionPrevention@ice.dhs.gov

Appendix A: Intake Screening Questions

Updated February 28, 2020

1. **Have you been in close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days?**
   - Last date you had contact with that person: mm/dd/yyyy

   OR
2. **What countries have you traveled from or through in the past two weeks?**
   - Check whether the detainee traveled from or through geographic area(s) with widespread or sustained community transmission*in the past 14 days?
     - ***Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html**

3. If yes to #1 **or** the detainee traveled from or through geographic area(s) with widespread or sustained community transmission*in the past 14 days? (#2):
   - **Have you had fever and/or respiratory illness with onset in the past 14 days?**
     - **If yes, what date did you first notice symptoms?: mm/dd/yyyy**
     - **If yes, implement standard, airborne, and contact precautions including eye protection,** isolate and refer to a medical provider, add Medical Hold, notify FHPM, IPO, or designee.
     - **If no, implement MONITORING;** house in single room (preferred) if available, implement daily checks for 14 days after initial DHS apprehension, add Medical Hold, notify FHPM, IPO, or designee.

4. If no travel from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days AND no close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days?
   - ***Please see CDC website listing of international area(s) with sustained transmission at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html**
   - Routine intake
     - If the initial DHS apprehension date (i.e., initial CBP or ICE encounter) documented in ENFORCE is ≥ 14 days prior, the detainee is outside the 14 day window and does not require monitoring for the epidemiologic risk of COVID-19 exposure
     - Facility Infection Prevention Officers and/or PHSP Unit staff can help confirm the date of initial DHS apprehension in ENFORCE

***Please see CDC website listing of international area(s) with sustained transmission at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html**

Exhibit C

Enforcement and Removal Operations

U.S. Department of Homeland Security
500 12th Street, SW
Washington, D.C. 20536

U.S. Immigration and Customs Enforcement

March 27, 2020

MEMORANDUM FOR: Detention Wardens and Superintendents

THROUGH: Field Office Directors

FROM: Enrique M. Lucero
Executive Associate Director
Enforcement and Removal Operations

SUBJECT: Memorandum on Coronavirus Disease 2019 (COVID-19) Action Plan, Revision 1

Background:

U.S. Immigration and Customs Enforcement (ICE) continues to monitor the spread of Coronavirus Disease 2019 (COVID-19) and to work in conjunction with select U.S. Department of Homeland Security (DHS) Component leadership and the Acting Secretary to implement a mitigation strategy.

To ensure a unified and preventative response, the ICE Enforcement and Removal Operations (ERO), ICE Health Service Corps (IHSC), Custody Management Division, and Field Operations are providing the following guidance. The combination of a dense and highly transient detained population presents unique challenges for ICE efforts to mitigate the risk of infection and transmission. Consequently, these measures were developed to reduce exposure to COVID-19, protect the detained population, and optimize employee health and availability for duty.

This memorandum only applies to IHSC-staffed and non-IHSC-staffed, ICE-dedicated facilities. For intergovernmental partners and non-dedicated facilities, ICE defers to local, state, tribal, territorial, and federal public health policies and authorities, including adherence with state laws on communicable disease reporting, but recommends actions contained in this memorandum be considered as best practices. Questions and concerns related to the following Action Plan can be addressed to: ICE_ERO_CMD@ice.dhs.gov.

Please see the recently-issued Centers for Disease Control and Prevention (CDC) Interim Guidance: Managing COVID-19 in Correctional/Detention Facilities for additional information.

Action Plan:

STAFF HIRING: Wardens and facility staff should continue to meet any personnel staffing plan and staffing criteria outlined in the Performance Work Statement (PWS) and terms and conditions of their negotiated contract or agreement for medical staff and guard services. Facilities are expected to be appropriately staffed to meet established work schedules, rest periods, and to ensure the delivery of detainee medical and mental health care as it relates to the continually evolving impact of COVID-19.

LOGISTICS: Wardens and Facility Administrators should assess their inventories of food, medicine, cleaning supplies, personal protective equipment (PPE), and facility operational practices, and consistently maintain services and supplies to assure the safety, security, health, and well-being of ICE detainees. Facilities should have updated pandemic plans and policies as well as established quarantine and/or isolation areas within their facilities in the event they are needed. Alcohol-based hand sanitizer with at least 60 percent alcohol should be available in visitor entrances, exits, and waiting areas. In addition, alcohol-based hand sanitizer should be made available to staff and detainees in the secure setting to the maximum extent possible.

SOCIAL VISITATION/TELEPHONIC COMMUNICATION: As of March 13, 2020, social visits to/with ICE detainees at all detention facilities are suspended until further notice in order to mitigate the potential introduction of COVID-19 into the facilities. ICE recognizes the considerable impact of suspending personal visitation, and requests maximizing detainee use of teleconferencing, video visitation (e.g., Skype, FaceTime), email, and/or tablets, with extended hours where possible.

Detention facilities should make a timely effort to identify indigence in the detainee population. A detainee is considered "indigent" if he/she has less than $15.00 in his/her account for ten days. These detainees must be afforded the same telephone access and related privileges as other detainees. Each facility must ensure all detainees are able to make calls to the ICE-provided list of free legal service providers and consulates at no charge to the detainee or the receiving party, and that indigent detainees may request a call to immediate family or others in personal or family emergencies or on an as-needed basis to maintain community ties.

LEGAL VISITS: Detainee access to legal representatives remains a paramount requirement and should be accommodated to the maximum extent practicable. Legal visitation must continue unless determined to pose a risk to the safety and security of the facility.

Non-contact legal visitation (e.g., Skype or teleconference) should be offered first to limit exposure to ICE detainees, but in person contact should be permitted if determined essential by the legal representative. Prior to the in-person visit, the legal representative must undergo the same screening required for staff entry into the facility. The ultimate legal visit approving authority lies with the Warden or Facility Administrator; however, the facility should notify its local Field Office Director as soon as possible of any denied legal visits.

LEGAL RIGHTS GROUP PRESENTATIONS: Government-sponsored Legal Orientation Programs (LOPs), carried out by the Department of Justice Executive Office for Immigration Review (EOIR) and authorized by congressional appropriations, currently operate at a limited

number of detention sites, and may continue to conduct detainee presentations. No more than four LOP presenters may be allowed in the facility at any time and must undergo the same screening required for staff entry into the facility. Non-LOP legal rights group presentations offered by volunteers are suspended until further notice.

STAFF-DETAINEE COMMUNICATION VISITS: Field Office Directors should remain aware that detainees may experience increased feelings of fear and confusion during this time. Regular communication with staff is particularly important. Detainees should have frequent opportunities for informal contact with facility managerial and supervisory staff and with ERO field office staff.

Field Office Directors should monitor both facility staff and ERO officers to ensure they continue to interact with detainees. ICE staff-detainee communication may be conducted in-person (with appropriate risk reduction protocols to protect ERO officers, detainees, and facility staff) or through non-contact visitation using videoconferencing, phone calls, e-mail, or other communication services.

CONTRACTORS: Contractors performing essential services or maintenance on essential systems in ICE detention facilities must continue to be provided facility access and must undergo the same screening required for staff entry into the facility. Examples of essential services include medical and mental health services, telephone access, cleaning, laundry, waste disposal, and critical infrastructure repairs.

Facility annual inspections by the ICE inspections contractor, The Nakamoto Group, are suspended for 30 days from the issuance date of this memorandum.

VOLUNTEERS: Volunteer visits to ICE detention facilities are suspended until further notice unless approved by the Assistant Directors for Field Operations and Custody Management. The only exception is the facility Chaplain, who may continue to offer availability for individual and group pastoral care but must undergo the same screening required for staff entry into the facility. Other volunteers, contractors, and community groups that augment and enhance the religious program are suspended until further notice to reduce the risk of possible transmission of COVID-19 to detainees.

TOURS: Facility tours are suspended until further notice, excluding Members of Congress, Congressional Member Delegations (CODELs), and Congressional Staff Delegations (STAFFDELs) who will not be prevented from accessing facilities for the purpose of conducting oversight. To safeguard visitors, detainees, ICE and facility staff, congressional visitors may be subject to special screening procedures congruent with staff facility entry screening. Congressional visitors should be advised of standard hygiene practices to help prevent the spread of disease (i.e., washing hands, avoiding close contact) and should be made aware of available hand washing stations within the facility.

STAFF TRAINING: All ERO in-person staff training related to the ICE detention standards or facility compliance is suspended until further notice, including conferences, Contracting Officer Representative (COR) training, and Field Office Compliance Training. Wardens and Facility Administrators will determine the training schedule for facility staff. All staff licenses and certifications shall be maintained.

SCREENING OF FACILITY STAFF: Enhanced health screening of both ICE and facility staff should be implemented by ICE detention facilities in geographic areas with "sustained community transmission." These geographical areas are determined by the CDC and information is available at: https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html. Health screening includes self-reporting symptoms associated with COVID-19 infection and a temperature check.

Wardens and Facility Administrators in those geographical areas should collaborate with their Health Services Administrator to designate a trained staff member available on all shifts to conduct verbal screening and record temperature checks. It is not required that the trained staff member be medical personnel; however, the staff member must have documented training and protect the privacy of those being screened.

Verbal screening for symptoms of COVID-19 and contact with COVID-19 cases should include the following questions based on Interim Guidance: Managing COVID-19 in Correctional/Detention Facilities:

- Today or in the past 24 hours, have you had any of the following symptoms?
  - Fever, felt feverish, or had chills?
  - Cough?
  - Difficulty breathing?
- In the past 14 days, have you had contact with a person known to be infected with COVID-19 where you were not wearing the recommended proper personal protective equipment (PPE)?

The following is a protocol to safely check an individual's temperature:

- Perform hand hygiene.
- Put on a face mask, eye protection (goggles or disposable face shield that fully covers the front and sides of the face), gowns/coveralls, and a single pair of disposable gloves.
- Check the individual's temperature.
- If performing a temperature check on multiple individuals, ensure that a clean pair of gloves is used for each individual and that the thermometer has been thoroughly cleaned in between each check.
- If disposable or non-contact thermometers are used and the screener did not have physical contact with an individual, gloves do not need to be changed before the next check. If non-contact thermometers are used, they should be cleaned routinely as recommended by CDC for infection control.
- Remove and discard PPE.
- Perform hand hygiene.

Staff who do not clear the screening process, or refuse the enhanced health screening must be denied entry and advised to follow CDC-recommended steps for persons who are sick with COVID-19 symptoms.

If PPE supply is limited, consider other PPE strategies based on CDC Guidance | Strategies for Optimizing the Supply of PPE.

If staff register a temperature greater than or equal to 100.4 degrees (Fahrenheit), they should be denied entry to the facility and placed on leave per the employer's administrative policies.

DETAINEE SCREENING: IHSC developed guidance for IHSC-staffed facilities to assist in the risk assessment and management of detained individuals with potential exposure to COVID-19, and guidance was disseminated to non IHSC-staffed ICE detention facilities for potential adoption of this guidance at their respective sites. This guidance addresses intake medical screenings, monitoring, encounters, laboratory testing, and public health actions. The CDC remains the authoritative source for information on how to protect individuals and reduce exposure to COVID-19. ICE continues to encourage facilities to follow CDC guidelines and those of their state and local health departments for non IHSC-staffed ICE detention facilities.

ICE requests that Wardens and Facility Administrators ensure ICE detainees are provided guidance and education in a language that they fully comprehend regarding basic hygiene and measures to maintain health. Links for detainee/patient education resources, in a variety of languages, are maintained in the IHSC guidance and information on the CDC website.

MODIFIED OPERATIONS: Wardens and Facility Administrators should implement modified operations to maximize social distancing in facilities, as much as practicable. For example, Wardens and Facility Administrators should consider staggered mealtimes and recreation times in order to limit congregate gatherings. All community service projects are suspended until further notice.

CONSIDERATIONS FOR DETAINEE RELEASE: Upon notification of a detainee's pending release, a qualified health care provider will conduct a temperature screening:

- Temperature checks will be completed no more than 12 hours prior to facility departure and documented in the detainee medical record and transfer summary.
- Temperature checks must be completed and documented prior to providing ICE with transfer summary documents.

When considering the release of detainees into the United States with confirmed or suspected COVID-19, the following must be addressed for detainees exposed to an individual with confirmed or suspected COVID-19 or detainees under monitoring for having epidemiologic risk of exposure to COVID-19:

- If the detainee will be released prior to completion of the recommended medical isolation, cohorting, or monitoring period, the state or local health department in the facility jurisdiction should be notified of the detainee's release:
    - The health department should be provided with the detainee's name, intended address, email address, and all available telephone numbers.

- Facilitate safe transport, continued shelter, and medical care, as part of release planning:
    - Provide information regarding any potential community resources to promote continuity of care.
    - Attempt to facilitate transportation coordination through a family or friend.

- Advise the detainee to avoid public transportation, commercial ride sharing (e.g., Uber, Lyft), and taxis.

- Provide the detainee the CDC's *What To Do if You Are Sick* fact sheet.

If this guidance creates any contractual issues, please contact your respective Contracting Officer Representative.

Exhibit D

From: Berg, Peter B
To: [redacted]
Cc: [redacted]
Subject: Updated Guidance: COVID-19 Detained Docket Review-- Effective Immediately
Date: Saturday, April 4, 2020 5:17:40 PM

UPDATE: Please see the updated guidance below. The previous version of this guidance is rescinded.

This message is sent from Peter B. Berg, (a)Assistant Director, Field Operations

To: Field Office Directors and Deputy Field Office Directors

Subject: COVID-19 Detained Docket Review

Background:

U.S. Immigration and Customs Enforcement (ICE) has taken a number of significant and proactive measures in response to the Coronavirus Disease 2019 (COVID-19) pandemic, in order to mitigate the spread of COVID-19 to aliens detained in its custody, its workforce, and stakeholders at its detention facilities. As more becomes known about the virus, ERO will continue to update its practices and guidance in this regard. General ICE COVID-19 guidance is available here and will be updated and supplemented on an ongoing basis.

On March 18, 2020, you were directed to review the cases of aliens detained in your area of responsibility who were over the age of 70 or pregnant to determine whether continued detention was appropriate. The Centers for Disease Control and Prevention (CDC) has developed a list of categories of individuals identified as potentially being at higher-risk for serious illness from COVID-19. Expanding on that list, ERO has identified the following categories of cases that should be reviewed to re-assess custody:

- Pregnant detainees or those having delivered in the last two weeks
- Detainees over 60 years old
- Detainees of any age having chronic illnesses which would make them immune-compromised, including but not limited to:
  - Blood Disorders
  - Chronic Kidney Disease
  - Compromised immune system (e.g., ongoing treatment such as chemotherapy or radiation, received an organ or bone marrow transplant, taking high doses of corticosteroids or other immunosuppressant medications)
  - Endocrine disorders

- Metabolic disorders
- Heart disease
- Lung disease
- Neurological and neurologic and neurodevelopment conditions

As part of your ongoing application of the CDC's Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities (available here), please identify all cases within your AOR that meet any of the criteria above and validate that list with assistance from IHSC or your Field Medical Coordinator to ensure the conditions listed are still present and do result in the detainee potentially having a higher risk for serious illness from COVID-19. After identifying a case as meeting any of the above criteria, you should review the case to determine whether continued detention remains appropriate in light of the COVID-19 pandemic.

The presence of one of the factors listed above should be considered a significant discretionary factor weighing in favor of release. To be clear, however, it may not always be determinative. Field offices must remain cognizant of the requirements of mandatory detention. Section 236(c) of the Immigration and Nationality Act (INA) mandates the detention of certain categories of criminal and terrorist aliens during the pendency of removal proceedings. Such aliens may not be released in the exercise of discretion during the pendency of removal proceedings even if potentially higher-risk for serious illness from COVID-19. INA § 236(c); 8 C.F.R. § 236.1(c)(1)(i). Such aliens may only be released following a final order issued by an immigration judge, the Board of Immigration Appeals, or a federal court granting the alien relief, dismissing proceedings, or terminating proceedings. Similarly, pursuant to section 241(a)(2), certain criminal and terrorist aliens subject to a final order of removal may not be released during the 90-day removal period even if potentially higher-risk for serious illness from COVID-19. INA § 241(a)(2). For alien's subject to discretionary detention under section 236(a), please remember that release is prohibited, even if the alien is potentially higher-risk for serious illness from COVID-19, if such release would pose a danger to property or persons. 8 C.F.R. § 236.1(c)(8).

When reviewing cases of alien's subject to discretionary detention under 236(a), the following must be completed:

- **Cases involving any arrests or convictions for any crimes that involve risk to the public regardless of the date of arrest or conviction must be reviewed and approved by a Deputy Field Office Director (DFOD) or higher before a determination is made to release.**
    - Examples of crimes that involve a risk to the public include any crime that: involves any form of violence, driving while intoxicated, threatening behaviors, terroristic threats, stalking, domestic violence, harm to a child, or any form of assault or battery. This list is not intended to be

comprehensive. If there is any doubt whether a crime involves risk to the public, consult with your Office of the Principal Legal Advisor (OPLA) field location and your respective Deputy Assistant Director for Domestic Operations before a custody redetermination is completed.

- You may consider the age of an arrest or conviction as a mitigating or an aggravating factor, but the age of an arrest or a conviction does not automatically outweigh public safety concerns.

With regard to arriving aliens and certain other aliens eligible for consideration of parole from custody, under current circumstances and absent significant adverse factors, the fact that an alien is potentially higher-risk for serious illness from COVID-19, may form the basis for a determination that "continued detention is not in the public interest," justify release under 8 C.F.R. § 212.5(b)(5).

For other aliens for whom there is discretion to release, field offices remain responsible for articulating individualized custody determinations, taking into consideration the totality of the circumstances presented in the case. The fact that an alien is potentially higher-risk for serious illness from COVID-19 should be considered a factor weighing in favor of release. You may also consider alternatives to detention consistent with ICE ATD policies, if ATD is determined to sufficiently mitigate the risk of flight.

Any releases attributed to reviews of COVID-19 susceptibility shall be documented in the ENFORCE Alien Removal Module (EARM) under Special Class - COVID-19 Chronic Care Release. As previously communicated, these individuals should be placed on ATD if possible.

Please contact your local OPLA field location should you have any questions or concerns regarding your authority to release in any individual case.

For any questions on this guidance, please contact your respective Deputy Assistant Director for Domestic Operations.

Limitation on the Applicability of this Guidance. This message is intended to provide internal guidance to the operational components of U.S. Immigration and Customs Enforcement. It does not, is not intended to, shall not be construed to, and may not be relied upon to create any rights, substantive or procedural, enforceable at law by any person in any matter, civil or criminal.

Exhibit E

ERO

U.S. Immigration and Customs Enforcement Enforcement and Removal Operations

COVID-19 Pandemic Response Requirements

U.S. Immigration and Customs Enforcement

Table of Contents

PURPOSE AND SCOPE

The U.S. Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) Coronavirus Disease 2019 (COVID-19) Pandemic Response Requirements (PRR) sets forth expectations and assists ICE detention facility operators to sustain detention operations, while mitigating risk to the safety and well-being of detainees, staff, contractors, visitors, and stakeholders due to COVID-19. Consistent with ICE's overall adjustments to its immigration enforcement posture,[1] the ERO PRR builds upon previously issued guidance and sets forth specific mandatory requirements expected to be adopted by all detention facilities housing ICE detainees, as well as best practices for such facilities, to ensure that detainees are appropriately housed and that available mitigation measures are implemented during this unprecedented public health crisis. The ERO PRR has been developed in consultation with the Centers for Disease Control and Prevention (CDC) and is a dynamic document that will be updated as additional/revised information and best practices become available.

INTRODUCTION

As the CDC has explained:

> COVID-19 is a communicable disease caused by a novel (new) coronavirus, SARS-CoV-2, that was first identified as the cause of an outbreak of respiratory illness that began in Wuhan Hubei Province, People's Republic of China (China).
>
> COVID-19 appears to spread easily and sustainably within communities. The virus is thought to transfer primarily by person-to-person contact through respiratory droplets produced when an infected person coughs or sneezes; it may transfer through contact with surfaces or objects contaminated with these droplets. There is also evidence of asymptomatic transmission, in which an individual infected with COVID-19 is capable of spreading the virus to others before exhibiting symptoms. The ease of transmission presents a risk of a surge in hospitalizations for COVID-19, which would reduce available hospital capacity. Such a surge has been identified as a likely contributing factor to the high mortality rate for COVID-19 cases in Italy and China.
>
> Symptoms include fever, cough, and shortness of breath, and typically appear 2-14 days after exposure. Manifestations of severe disease include severe pneumonia, acute respiratory distress syndrome (ARDS), septic shock, and multi-organ failure. According to the [World Health Organization], approximately 3.4% of reported COVID-19 cases have resulted in death globally. This mortality rate is higher among older adults or those with compromised immune systems. Older adults and people who have severe chronic medical conditions like heart, lung or kidney disease are also at higher risk for more serious COVID-19 illness. Early data suggest older people are twice as likely to have serious COVID-19 illness.

[1] *See, e.g.*, Attachment A, U.S. Immigration and Customs Enforcement, *Updated ICE statement on COVID-19* (Mar. 18, 2020), https://www.ice.gov/news/releases/updated-ice-statement-covid-19.

Notice of Order Under Sections 362 and 365 of the Public Health Service Act Suspending Introduction of Certain Persons From Countries Where a Communicable Disease Exists, 85 Fed. Reg. 17060 (Mar. 26, 2020) (internal citations omitted).

Given the seriousness and pervasiveness of COVID-19, ICE is taking necessary and prompt measures in response. ICE is providing guidance on the minimum measures required for facilities housing ICE detainees to implement to ensure consistent practices throughout its detention operations and the provision of medical care across the full spectrum of detention facilities to mitigate the spread of COVID-19. The ICE detention standards applicable to all facilities used to house ICE detainees have long required that each such facility have written plans that address the management of infectious and communicable diseases, including, but not limited to, testing, isolation, prevention, treatment, and education. Those requirements include reporting and collaboration with local or state health departments in accordance with state and local laws and recommendations.[2] The measures set forth in the PRR, allow ICE personnel and detention providers to properly discharge their obligations under those standards in light of the unique challenges posed by COVID-19.

OBJECTIVES

The ERO PRR is designed to establish consistency across ICE detention facilities by establishing mandatory requirements and best practices all detention facilities housing ICE detainees are expected to follow during the COVID-19 pandemic. Consistent with ICE detention standards, all facilities housing ICE detainees are required to have a COVID-19 mitigation plan that meets the following four objectives:

- To protect employees, contractors, detainees, visitors to the facility, and stakeholders from exposure to the virus;
- To maintain essential functions and services at the facility throughout the pendency of the pandemic;
- To reduce movement and limit interaction of detainees with others outside their assigned housing units, as well as staff and others, and to promote social distancing within housing units; and
- To establish means to monitor, cohort, quarantine, and isolate the sick from the well.[3]

[2] *See, e.g.,* Attachment B, ICE National Detention Standards 2019, Standard 4.3, Medical Care, at II.D.2 (p. 114), https://www.ice.gov/doclib/detention-standards/2019/4_3.pdf; Attachment C, 2011 ICE Performance-Based National Detention Standards (PBNDS), Revised 2016, Standard 4.3, Part V.C.1 (p. 261), https://www.ice.gov/doclib/detention-standards/2011/4-3.pdf; Attachment D, 2008 ICE PBNDS, Standard 4-22, Medical Care, V.C.1 (pp. 5-6), https://www.ice.gov/doclib/dro/detention-standards/pdf/medical_care.pdf.

[3] A *cohort* is a group of persons with a similar condition grouped or housed together for observation over a period of time. Isolation and quarantine are public health practices used to protect the public from exposure to individuals who have or may have a contagious disease. For purposes of this document, and as defined by the CDC, *quarantine* as the separation of a person or group of people reasonably believed to have been exposed to a communicable disease but not yet symptomatic, from others who have not been

CONCEPT OF OPERATIONS

The ERO PRR is intended for use across ICE's entire detention network, applying to all facilities housing ICE detainees, including ICE-owned Service Processing Centers, facilities operated by private vendors, and facilities operated by local government agencies that have mixed populations of which ICE detainees comprise only a small fraction.

DEDICATED ICE DETENTION FACILITIES

All ICE dedicated detention facilities[4] *must:*

- Comply with the provisions of their relevant ICE contract or service agreement.
- Comply with the ICE national detention standards applicable to the facility, generally the Performance-Based National Detention Standards 2011 (PBNDS 2011).
- Comply with the CDC's *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* (Attachment E).
- Follow ICE's March 27, 2020 Memorandum to Detention Wardens and Superintendents on COVID-19 Action Plan Revision 1, and subsequent updates (Attachment F).
- Report all confirmed and suspected COVID-19 cases to the local ERO Field Office Director (or designee), Field Medical Coordinator, and local health department immediately.
- Notify both the local ERO Field Office Director (or designee) and the Field Medical Coordinator as soon as practicable, but in no case more than 12 hours after identifying any detainee who meets the CDC's identified populations potentially being at higher-risk for serious illness from COVID-19, including:
    - People aged 65 and older
    - People of all ages with underlying medical conditions, particularly if not well controlled, including:
        - People with chronic lung disease or moderate to severe asthma
        - People who have serious heart conditions
        - People who are immunocompromised

exposed, to prevent the possible spread of the communicable disease. For purposes of this document, and as defined by the CDC, *isolation* as the separation of a person or group of people known or reasonably believed to be infected with a communicable disease and potentially infectious from others to prevent the spread of the communicable disease.

[4] Dedicated detention facilities are facilities that house only ICE detainees. Dedicated facilities may be ICE-owned Service Processing Centers, privately owned Contract Detention Facilities, or facilities operated by state or local governments that hold no other detention populations except ICE detainees.

- Many conditions can cause a person to be immunocompromised, including cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications
- People with severe obesity (body mass index [BMI] of 40 or higher)
- People with diabetes
- People with chronic kidney disease undergoing dialysis
- People with liver disease

Notification shall be made via e-mail from the facility's Health Services Administrator (HSA) (or equivalent) and contain the following subject line for ease of identification: "Notification of COVID-19 High Risk Detainee (A-Number)." At a minimum the HSA will provide the following information:

- Detainee name
- Detention location
- Current medical issues as well as medications currently prescribed
- Facility medical Point of Contact (POC) and phone number

NON-DEDICATED ICE DETENTION FACILITIES

All non-dedicated detention facilities and local jails housing ICE detainees must:

- Comply with the provisions of their relevant ICE contract or service agreement.
- Comply with the ICE national detention standards applicable to the facility, generally PBNDS 2011.
- Comply with the CDC *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*.
- Report all confirmed and suspected COVID-19 cases to the local ERO Field Office Director (or designee), Field Medical Coordinator, and local health department immediately.
- Notify both the ERO Field Office Director (or designee) and Field Medical Coordinator as soon as practicable, but in no case more than 12 hours after identifying any detainee who meets the CDC's identified populations potentially being at higher-risk for serious illness from COVID-19, including:
  - People aged 65 and older
  - People of all ages with underlying medical conditions, particularly if not well controlled, including:
    - People with chronic lung disease or moderate to severe asthma
    - People who have serious heart conditions
    - People who are immunocompromised

- Many conditions can cause a person to be immunocompromised, including cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications
- People with severe obesity (body mass index [BMI] of 40 or higher)
- People with diabetes
- People with chronic kidney disease undergoing dialysis
- People with liver disease

Notification should be made via e-mail from the facility's HSA (or equivalent) and should contain the following subject line for ease of identification: "Notification of COVID-19 High Risk Detainee (A-Number)." Other standardized means of communicating this information to ICE are acceptable. At a minimum the HSA will provide the following information:

- Detainee name
- Detention location
- Current medical issues as well as medications currently prescribed
- Facility medical POC and phone number

ALL FACILITIES HOUSING ICE DETAINEES

In addition to the specific measures listed above, all detention facilities housing ICE detainees must also comply with the following:

PREPAREDNESS

Administrators can plan and prepare for COVID-19 by ensuring that all persons in the facility know the symptoms of COVID-19 and how to respond if they develop symptoms. Other essential actions include developing contingency plans for reduced workforces due to absences, coordinating with public health and correctional partners, and communicating clearly with staff and detainees about these preparations and how they may temporarily alter daily life.

- **Develop information-sharing systems with partners.**
  - Identify points of contact in relevant state, local, tribal, and/or territorial public health department before cases develop.
  - Communicate with other correctional and detention facilities in the same geographic area to share information including disease surveillance and absenteeism patterns among staff.
- **Review existing pandemic, influenza, all-hazards, and disaster plans, and revise for COVID-19, and ensure that they meet the requirements of ICE's detention standards.**

- **Offer the seasonal influenza vaccine to all detained persons (existing populations and new intakes) and staff throughout the influenza season, where possible.**

- **Staffing**
  - Review sick leave policies to ensure that staff can stay home when sick and determine which officials will have the authority to send symptomatic staff home. Staff who report for work with symptoms of COVID-19 must be sent home and advised to follow CDC-recommended steps for persons exhibiting COVID-19 symptoms.
  - Staff who test positive for COVID-19 must inform their workplace and personal contacts immediately. If a staff member has a confirmed COVID-19 infection, the relevant employers will inform other staff of their possible exposure to COVID-19 in the workplace consistent with any legal limitations on the sharing of such information. Exposed employees must then self-monitor for symptoms (i.e., fever, cough, or shortness of breath).
  - Identify staff whose duties would allow them to work from home and allow them to work from home in order to promote social distancing and further reduce the risk of COVID-19 transmission.
  - Determine minimum levels of staff in all categories required for the facility to function safely.
  - Follow the Public Health Recommendations for Community-Related Exposure.[5]

- **Supplies**
  - Ensure that sufficient stocks of hygiene supplies (soap, hand sanitizer, tissues), personal protective equipment (PPE) (to include facemasks, N95 respirators, eye protection, disposable medical gloves, and disposable gowns/one-piece coveralls), and medical supplies (consistent with the healthcare capabilities of the facility) are on hand, and have a plan in place to restock as needed if COVID-19 transmission occurs within the facility.
  - Note that shortages of N95 respirators are anticipated during the COVID-19 response. Based on local and regional situational analysis of PPE supplies, face masks should be used when the supply chain of N95 respirators cannot meet the demand.
  - Follow COVID-19: Strategies for Optimizing the Supply of PPE.[6]
  - Soiled PPE items should be disposed in leak-proof plastic bags that are tied at the top and not re-opened. Bags can be disposed of in the regular solid waste stream.

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[5] Attachment G, Centers of Disease Control and Prevention, *Public Health Recommendations for Community-Related Exposure*, https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html (last visited Apr. 9, 2020).

[6] Attachment H, Centers for Disease Control and Prevention, *Strategies to Optimize the Supply of PPE and Equipment*, https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/ (last visited Apr. 9, 2020).

- Cloth face coverings should be worn by detainees and staff (when PPE supply is limited) to help slow the spread of COVID-19. Cloth face masks should:

    - fit snugly but comfortably against the side of the face
    - be secured with ties or ear loops where possible or securely tied
    - include multiple layers of fabric
    - allow for breathing without restriction
    - be able to be laundered and machine dried without damage or change to shape.

➢ **Hygiene**

- Reinforce healthy hygiene practices and provide and restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms, common areas, medical, and staff-restricted areas (e.g., break rooms).
- Require all persons within the facility to cover their mouth and nose with their elbow (or ideally with a tissue) rather than with their hand when they cough or sneeze, and to throw all tissues in the trash immediately after use. Provide detainees and staff no-cost access to tissues and no-touch receptacles for disposal.
- Require all persons within the facility to maintain good hand hygiene by regularly washing their hands with soap and water for at least 20 seconds, especially after coughing, sneezing, or blowing their nose; after using the bathroom; before eating or preparing food; before taking medication; and after touching garbage.
- Provide detainees and staff no-cost, unlimited access to supplies for hand cleansing, including liquid soap, running water, hand drying machines or disposable paper towels, and no-touch trash receptacles.
- Provide alcohol-based hand sanitizer with at least 60% alcohol where permissible based on security restrictions.
- Require all persons within the facility to avoid touching their eyes, nose, or mouth without cleaning their hands first.
- Post signage throughout the facility reminding detained persons and staff to practice good hand hygiene and cough etiquette (printable materials for community-based settings can be found on the CDC website). Signage must be in English and Spanish, as well as any other common languages for the detainee population at the facility.
- Prohibit sharing of eating utensils, dishes, and cups.
- Prohibit non-essential personal contact such as handshakes, hugs, and high-fives.

➢ **Cleaning/Disinfecting Practices**

- Adhere to CDC recommendations for cleaning and disinfection during the COVID-19 response.[7]
- Several times a day using household cleaners and Environmental Protection Agency-registered disinfectants, clean and disinfect surfaces and objects that are frequently touched, especially in common areas (e.g., doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment). The Environmental Protection Agency's (EPA) list of certified cleaning products is located here.
- Staff should clean shared equipment several times per day and on a conclusion of use basis (e.g., radios, service weapons, keys, handcuffs).
- Ensure that transport vehicles are thoroughly cleaned after carrying a confirmed or suspected COVID-19 case.
- Facility leadership will ensure that there is adequate oversight and supervision of all individuals responsible for cleaning and disinfecting these areas.

CDC Recommended Cleaning Tips

Hard (Non-porous) Surfaces

- If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
- For disinfection, most common EPA-registered household disinfectants should be effective.
    - A list of products that are EPA-approved for use against the virus that causes COVID-19 is available here. Follow the manufacturer's instructions for all cleaning and disinfection products for concentration, application method and contact time, etc.
    - Additionally, diluted household bleach solutions (at least 1000ppm sodium hypochlorite) can be used if appropriate for the surface. Follow manufacturer's instructions for application, ensuring a contact time of at least 1 minute, and allowing proper ventilation during and after application. Check to ensure the product is not past its expiration date. Never mix household bleach with ammonia or any other cleanser. Unexpired household bleach will be effective against coronaviruses when properly diluted.
        - Prepare a bleach solution by mixing:
            - 5 tablespoons (1/3 cup) bleach per gallon of water or
            - 4 teaspoons bleach per quart of water

Soft (Porous) Surfaces

[7] Attachment I, Centers for Disease Control and Prevention, *Cleaning and Disinfection for Community Facilities*, https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html (last visited Apr. 9, 2020).

- For soft (porous) surfaces such as carpeted floor, rugs, and drapes, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. After cleaning:
    - If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely.
    - Otherwise, use products that are EPA-approved for use against the virus that causes COVID-19 and that are suitable for porous surfaces.[8]

Electronics

- For electronics such as tablets, touch screens, keyboards, remote controls, and ATM machines, remove visible contamination if present.
    - Follow the manufacturer's instructions for all cleaning and disinfection products.
    - Consider use of wipeable covers for electronics.
    - If no manufacturer guidance is available, consider the use of alcohol-based wipes or sprays containing at least 70% alcohol to disinfect touch screens. Dry surfaces thoroughly to avoid pooling of liquids.

Linens, Clothing, and Other Items That Go in the Laundry

- In order to minimize the possibility of dispersing virus through the air, do not shake dirty laundry.
- Wash items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely. Dirty laundry that has been in contact with an ill person can be washed with other people's items.
- Clean and disinfect hampers or other carts for transporting laundry according to guidance above for hard or soft surfaces.

PREVENTION

Detention facilities can prevent introduction of COVID-19 from the community and reduce transmission if it is already inside by reinforcing good hygiene practices among incarcerated/detained persons, staff, and visitors (including increasing access to soap and paper towels), intensifying cleaning/disinfection practices, and implementing social distancing strategies.

Because many individuals infected with COVID-19 do not display symptoms, the virus could be present in facilities before cases are identified. Both good hygiene practices and social distancing are critical in preventing further transmission.

[8] Attachment J, U.S. Environmental Protection Agency, *List N: Disinfectants for Use Against SARS-CoV-2*, https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2 (last visited Apr. 9, 2020).

- **Perform pre-intake screening for all staff and new entrants for symptoms of COVID-19.**

  Screening should take place before staff and new intakes enter the facility or just inside the facility, where practicable. For new admissions, this should occur before beginning the intake process, in order to identify and immediately isolate any detainee with symptoms before the individual comingles with others or is placed in the general population. This should include temperature screening of all staff and new entrants, as well as a verbal symptoms check.

  - Verbal screening for symptoms of COVID-19 and contact with COVID-19 cases should include the following questions based on Interim Guidance: Managing COVID-19 in Correctional/Detention Facilities:
    - Today or in the past 24 hours, have you had any of the following symptoms?
      - Fever, felt feverish, or had chills?
      - Cough?
      - Difficulty breathing?
    - In the past 14 days, have you had contact with a person known to be infected with COVID-19 where you were not wearing the recommended proper PPE?
  - If staff have symptoms of COVID-19 (fever, cough, shortness of breath): they must be denied access to the facility.
  - If any new intake has symptoms of COVID-19:
    - Require the individual to wear a face mask.
    - Ensure that staff interacting with the symptomatic individual wears recommended PPE.
    - Isolate the individual and refer to healthcare staff for further evaluation.
    - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective isolation and necessary medical care.
  - If an individual is a close contact of a known COVID-19 case or has traveled to an affected area (but has no COVID-19 symptoms), quarantine the individual and monitor for symptoms two times per day for 14 days.

- **Visitation**

  - During suspended (social) or modified (legal) visitation programs, provide access to virtual visitation options where available. When not possible, verbally screen all visitors on entry for symptoms of COVID-19 and perform temperature checks, when possible. ICE continues to explore opportunities to enhance attorney access while legal visits are being impacted. For facilities at which immigration hearings are conducted or where detainees are otherwise held who have cases pending immigration proceedings, this may include:

- Adding all immigration attorneys of record to the Talton Pro-bono platform.
- Requiring facilities to establish a process for detainees/immigration attorneys to schedule appointments and facilitate the calls.
- Leveraging technology (e.g., tablets, smartphones) to facilitate attorney/client communication.
- Working with the various detention contractors and telephone service providers to ensure that all detainees receive some number of free calls per week.

- Communicate with the public about any changes to facility operations, including visitation programs. Facilities are encouraged to prohibit or, at a minimum, significantly adopt restricted visitation programs, and to suspend all volunteer work assignments for detainees assigned to food service, and other assignments where applicable.

➢ **Where possible, restrict transfers of detained non-ICE populations to and from other jurisdictions and facilities unless necessary for medical evaluation, isolation/quarantine, clinical care, or extenuating security concerns.**

➢ **Consider suspending work release programs for inmates at shared facilities to reduce overall risk of introduction and transmission of COVID-19 into the facility.**

➢ **When feasible and consistent with security priorities, encourage staff to maintain a distance greater than six feet from an individual that appears feverish or ill and/or with respiratory symptoms while interviewing, escorting, or interacting in other ways, unless wearing PPE.**

➢ **Additional Measures to Facilitate Social Distancing**

- Although strict social distancing may not be possible in congregate settings such as detention facilities, all facilities housing ICE detainees should implement the following measures to the extent practicable:
  - Efforts should be made to reduce the population to approximately 75% of capacity.
  - Where detainee populations are such that such cells are available, to the extent possible, house detainees in individual rooms.
  - Recommend that detainees sharing sleeping quarters sleep "head-to-foot."
  - Extend recreation, law library, and meal hours and stagger detainee access to the same in order to limit the number of interactions between detainees from other housing units.
  - Staff and detainees should be directed to avoid congregating in groups of 10 or more, employing social distancing strategies at all times.

- Whenever possible, all staff and detainees should maintain a distance of six feet from one another.
- If practicable, beds in housing units should be rearranged to allow for sufficient separation during sleeping hours.

MANAGEMENT

If there has been a suspected COVID-19 case inside the facility (among incarcerated/detained persons, staff, or visitors who have recently been inside), begin implementing Management strategies while test results are pending. Essential Management strategies include placing cases and individuals with symptoms under medical isolation, quarantining their close contacts, and facilitating necessary medical care, while observing relevant infection control and environmental disinfection protocols and wearing recommended PPE.

ICE Custody Review for Potentially High-Risk Detainees

Upon being informed of a detainee who may potentially be at higher risk for serious illness from exposure to COVID-19, ERO will review the case to determine whether continued detention is appropriate.[9] ICE will make such custody determinations on a case-by-case basis, pursuant to the applicable legal standards, with due consideration of the public health considerations implicated.

- **Considerable effort should be made to quarantine all new entrants for 14 days before they enter the general population.**
  - To do this, facilities should consider cohorting daily intakes; two days of new intakes, or multiple days on new intakes, in designated areas prior to placement into the general population. Given the significant variance in facility attributes and characteristics, cohorting options and capabilities will differ across the various detention facilities housing ICE detainees. ICE encourages all facilities to adopt the most effective cohorting methods practicable based on the individual facility characteristics taking into account the number new intakes anticipated per day.

- **For suspected or confirmed COVID-19 cases:**
  - Isolate the individual immediately in a separate environment from other individuals. Facilities should make every possible effort to isolate persons individually. Each isolated individual should be assigned his or her own housing space and bathroom where possible. Cohorting should only be practiced if there are no other available options. Only individuals who are laboratory-confirmed COVID-19 cases should be isolated as a cohort. Do not cohort confirmed cases with suspected cases or case contacts.
  - Ensure that the individual is always wearing a face mask (if it does not restrict breathing) when outside of the isolation space, and whenever another individual

[9] Attachment K, Assistant Director Peter Berg, Enforcement and Removal Operations, *Updated Guidance: COVID-19 Detained Docket Review* (Apr. 4, 2020).

enters the isolation room. Masks should be changed at least daily, and when visibly soiled or wet.

- If the number of confirmed cases exceeds the number of individual isolation spaces available in the facility, then ICE must be promptly notified so that transfer to other facilities, transfers to hospitals, or release can be coordinated immediately. Until such time as transfer or release is arranged, the facility must be especially mindful of cases that are at higher risk of severe illness from COVID-19. Ideally, ill detainees should not be cohorted with other infected individuals. If cohorting of ill detainees is unavoidable, make all possible accommodations until transfer occurs to prevent transmission of other infectious diseases to the higher-risk individual (For example, allocate more space for a higher-risk individual within a shared isolation room).

- Review the CDC's preferred method of medically isolating COVID-19 cases here depending on the space available in a particular facility. In order of preference, individuals under medical isolation should be housed:
    - Separately, in single cells with solid walls (i.e., not bars) and solid doors that close fully.
    - Separately, in single cells with solid walls but without solid doors.
    - As a cohort, in a large, well-ventilated cell with solid walls and a solid door that closes fully. Employ social distancing strategies related to housing in the Prevention section above.
    - As a cohort, in a large, well-ventilated cell with solid walls but without a solid door. Employ social distancing strategies related to housing in the Prevention section above.
    - As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)
    - As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies related to housing in the Prevention section above.

- Maintain isolation until all the CDC criteria have been met:
    - The individual has been free from fever for 72 hours without the use of fever-reducing medications.
    - The individual's other symptoms have improved (e.g., cough, shortness of breath).
    - The individual has tested negative in at least two consecutive respiratory specimens collected at least 24 hours apart.

  - At least 7 days have passed since the date of the individual's first positive COVID-19 test and he or she has had no subsequent illness.

- Meals should be provided to COVID-19 cases in their isolation rooms. Isolated cases should throw disposable food service items in the trash in their isolation room. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items must clean their hands after removing gloves.
- Laundry from a COVID-19 case can be washed with other individuals' laundry.
  - Individuals handling laundry from COVID-19 cases should wear disposable gloves, discard gloves after each use, and clean their hands after handling.
  - Do not shake dirty laundry. This will minimize the possibility of dispersing the virus through the air.
  - Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
  - Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

ATTACHMENTS

ATTACHMENT LETTER	DOCUMENT NAME AND CITATION
A	U.S. Immigration and Customs Enforcement, *Updated ICE statement on COVID-19* (Mar. 18, 2020), https://www.ice.gov/news/releases/updated-ice-statement-covid-19.
B	ICE National Detention Standards 2019, Standard 4.3, Medical Care, https://www.ice.gov/doclib/detention-standards/2019/4_3.pdf.
C	2011 ICE Performance-Based National Detention Standards, Revised 2016, Standard 4.3, https://www.ice.gov/doclib/detention-standards/2011/4-3.pdf.
D	2008 ICE Performance-Based National Detention Standards, Standard 4-22, Medical Care, https://www.ice.gov/doclib/dro/detention-standards/pdf/medical_care.pdf.
E	Centers of Disease Control and Prevention, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/downloads/guidance-correctional-detention.pdf.
F	Memorandum from Executive Associate Director Enrique Lucero, Enforcement and Removal Operations, *Memorandum on Coronavirus 2019 (COVID-19) Action Plan, Revision 1* (Mar. 27. 2020).
G	Centers of Disease Control and Prevention, *Public Health Recommendations for Community-Related Exposure*, https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html (last visited Apr. 9, 2020).
H	Centers for Disease Control and Prevention, *Strategies to Optimize the Supply of PPE and Equipment*, https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/ (last visited Apr. 9, 2020).
I	Centers for Disease Control and Prevention, *Cleaning and Disinfection for Community Facilities*, https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html (last visited Apr. 9, 2020).

J	U.S. Environmental Protection Agency, *List N: Disinfectants for Use Against SARS-CoV-2*, https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2 (last visited Apr. 9, 2020).
K	Assistant Director Peter Berg, Enforcement and Removal Operations, *Updated Guidance: COVID-19 Detained Docket Review* (Apr. 4, 2020).

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

JANET MALAM,

Petitioner,

and

RUBY BRISELDA ESCOBAR and AMER TOMA,

Plaintiff-Intervenors,

- 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,

Respondents.

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

DECLARATION OF DORA SCHRIRO

I, Dora Schriro, declare as follows:

Background and Qualifications

1. I am a career public servant who has served as an executive-level administrator, policy maker, and homeland security advisor. I was appointed to lead a number of city and state agencies and a federal office.

2. I was the Commissioner of the Connecticut Department of Emergency Services and Public Protection encompassing six state agencies including the Connecticut State Police and Homeland Security and Emergency Management, from 2014 through 2018. I served concurrently as Connecticut's Homeland Security Advisor from 2016 through 2018. My Department of Homeland Security (DHS) security clearance was Top Secret. During my tenure as Director, we grappled with Ebola and through our Division of Emergency Management and Homeland Security, developed a protocol specifically for first responders – including the Connecticut State Police, all the state's local Police Departments, career and volunteer fire fighters and other first responders, all of whom we served through the Department's six divisions including the Connecticut State Police, Police Officer Standards and Training (POST), the Connecticut Fire Academy, Emergency Management and Homeland Security, Scientific Services (the state's crime lab), and Statewide Telecommunications. Additionally, as the state's Homeland Security Advisor, I interfaced with many of the DHS offices and agencies on an ongoing basis including the Federal Emergency Management Agency with which we had an active and ongoing partnership.

3. I was Senior Advisor to DHS Secretary Janet Napolitano on U.S. Immigration and Customs Enforcement (ICE) Detention and Removal, and the founding Director of the ICE Office of Detention Policy and Planning in 2009. During my tenure, I authored the report Immigration Detention Overview and Recommendations, DHS' template for immigration detention reform. My report included a number of recommendations specific to risk assessments, the continuum of control, pre-release planning, alternatives to detention, and healthcare. Specific to healthcare, I found the assessment, treatment, and management of pandemic and contagious diseases was inconsistent across Division of Immigration Health Services (DIHS)-staffed and non-dedicated Intergovernmental Service Agreement (IGSA) facilities and recommended improvements should be made to ensure that all facilities are capable of managing large-scale outbreaks. Unfortunately, these

findings have recency today.[1] At the invitation of DHS Secretary Jeh Johnson, I also served in 2015 and 2016 as a member of the DHS Advisory Committee on Family Residential Facilities and co-authored its report.

4. I was the Commissioner of two city jail systems: the St. Louis City Division of Corrections, which included the St. Louis Police Department Prison Intake Facility, from 2001 to 2003; and the New York City (NYC) Department of Correction from 2009 to 2014. I was also the Warden of the Medium Security Institution, a jail in St. Louis City, Missouri, from 1989 to 1993. During my tenure as Warden, I routinely released pretrial inmates, conditioned upon daily check-in and random drug testing, to comply with a court-ordered facility population cap. During my tenure as Commissioner of the NYC Department of Correction, I opened NYC's first centralized reception and diagnostic facility in which comprehensive risk assessment, custody classification, and gang identification were completed, and discharge planning was initiated. I also created pre-trial and post-plea diversion opportunities for the mentally ill and seriously mentally ill jail population and special housing for the young adult population. During an earlier appointment to the NYC Department of Correction as Assistant Commissioner for Programs Services from 1985 to 1989, I also oversaw the city's work release program for pre-trial and city-sentenced inmates.

5. I was the Director of two state correctional systems: the Missouri Department of Corrections, which encompasses state prisons, probation, and parole, from 1993 to 2001; and the Arizona Department of Corrections, which encompasses state prisons and parole, from 2003 to 2009. During my tenure as Director of the Arizona Department of Corrections, the department was the first correctional system to be selected Winner of the Innovations in American Government awards program, for a prison-based reform we named Parallel Universe—pre-release preparation in which all inmates participated from the first to the last day of their incarceration guided by norms and values closely mirroring those of the community. As Director of the Missouri Department of Corrections, I also served on the state's Sentencing Commission.

6. I was a member of the adjunct faculties of University of Missouri-St. Louis Department of Criminology from 1990 to 1998, St. Louis University School of Law from 2000 to 2002, and Arizona State University Sandra Day O'Connor

[1] DORA SCHRIRO, IMMIGRATION DETENTION OVERVIEW AND RECOMMENDATIONS (2009), *available at* https://www.ice.gov/doclib/about/offices/odpp/pdf/ice-detention-rpt.pdf.

School of Law from 2005 to 2008, during which time I taught graduate-level Criminology and Correctional Law courses and led Sentencing Seminars.

7. I have served continuously on the Women's Refugee Commission since 2012, and the American Bar Association (ABA) Commission on Immigration since 2014.

8. I am knowledgeable about both the American Correction Association and ICE Performance-Based and National Detention Standards, including Medical Care, Disability Identification, Assessment and Accommodations, and Classification Systems, which is premised on objective, evidence-based risk assessments and the least restrictive housing and community-based assignments consistent with those assessments. I have also participated in the development of ABA professional standards for both correctional systems and ICE detention facilities. I am familiar with the California Board of State and Community Corrections Title 15 Minimum Standards for Local Detention Facilities. I am also familiar with bond procedures in state, federal, and immigration courts.

9. I am knowledgeable about the operation of civil detention and criminal pre-trial and sentenced correctional facilities, and the individuals in the custody of both systems.

10. I have served as a Corrections expert to the California Department of Justice, Disability Rights California, and the Hampton County, Massachusetts Sheriff's Department. I am currently engaged by the California Department of Justice, the American Civil Liberties Union, the Southern Poverty Justice Center, and the St. Louis University School of Law Legal Clinics.

11. A complete and correct Resume, which includes a list of my publications from the last ten years, is attached as Appendix A.

12. In the previous four years, I have testified as an expert at trial or by deposition in the following case: *Endicott v. Hurley*, No. 2:14-cv-107 DDN (E.D. Mo.).

Expert Assignment

13. Plaintiffs' counsel has asked me, based on my expertise in the operation of civil and criminal detention systems, including those used to house ICE detainees, to address whether conditions in immigration detention place detainees at risk of contracting COVID-19 and whether alternatives to detention

can be used to release medically vulnerable and low-risk individuals from immigration detention while maintaining public safety and ensuring compliance with court orders.

Findings and Conclusions

14. According to the World Health Organization, COVID-19 has reached pandemic status.[2] There is no vaccine to prevent transmission, and there is no cure for COVID-19.[3] The likelihood of its recurrence is great.[4] The World Health Organization, the Centers for Disease Control and Prevention, and other public health experts recommend the use of social distancing and other preventive strategies to control the virus.[5] The Vera Institute of Justice and Community-Oriented Correctional Health Services further recommend that authorities in correctional and immigration detention settings "[u]se their authority to release as many people from their custody as possible."[6]

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[2] European Regional Office, *WHO Announces COVID-19 Outbreak a Pandemic*, WHO (Mar. 12, 2020), http://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/news/news/2020/3/who-announces-covid-19-outbreak-a-pandemic.

[3] *Coronavirus Disease 2019 (COVID-19): Situation Summary*, CDC, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html (last updated Mar. 21, 2020).

[4] Ed Yong, *How the Pandemic Will End*, ATLANTIC (Mar. 25, 2020), https://www.theatlantic.com/health/archive/2020/03/how-will-coronavirus-end/608719/.

[5] *Coronavirus Disease Advice for the Public*, WHO, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public (last updated Mar. 18, 2020); *How to Protect Yourself*, CDC, https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html (last updated Mar. 18, 2020); Saralyn Cruickshank, *Now Is not the Time to Ease Social Distancing Measures, Experts Say*, HUB JOHNS HOPKINS U. (Mar. 24, 2020), https://hub.jhu.edu/2020/03/24/no-time-to-ease-social-distancing/.

[6] COMMUNITY-ORIENTED CORRECTIONAL HEALTH SERVICES & VERA INSTITUTE OF JUSTICE, GUIDANCE FOR PREVENTIVE AND RESPONSIVE MEASURES TO CORONAVIRUS FOR JAILS, PRISONS, IMMIGRATION DETENTION AND YOUTH FACILITIES 2 (Mar. 18, 2020), *available at* https://cochs.org/files/covid-19/covid-19-jails-prison-immigration.pdf.

15. I have reviewed the relevant guidance released by ICE and the CDC: The ICE Health Service Corps (IHSC) Interim Guidance, issued on March 6, 2020;[7] the updated ICE statement on changes to enforcement operations, issued on March 18, 2018;[8] the ICE memorandum on COVID-19, issued on March 27, 2020;[9] the ICE guidance on release of medically vulnerable individuals, issued on April 4, 2020;[10] the ICE Enforcement and Removal Operations COVID-19 Pandemic Response Requirements issued on April 10, 2020 ("ERO COVID-19 PRR");[11] and the CDC guidance on managing coronavirus disease 2019 in correctional and detention facilities, issued March 23, 2020.[12]

16. It is my opinion, based on years of my experience as Warden and then Commissioner of four correctional systems and Director of the ICE Office of Detention Policy and Planning, and my continuing oversight and assessments of correctional and immigration detention facilities in the capacity as an Expert, that the plans that ICE has put forth are insufficient to protect the detained population, detention staff, and the public at-large. ICE, a federal agency, requires a robust

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[7] ICE HEALTH SERVICE CORPS, INTERIM REFERENCE SHEET ON 2019-NOVEL CORONAVIRUS (COVID-19) (Mar. 6, 2020) [hereinafter IHSC Interim Reference Sheet].

[8] *Updated ICE Statement on COVID-19*, ICE NEWS RELEASES (Mar. 18, 2020), https://www.ice.gov/news/releases/updated-ice-statement-covid-19 [hereinafter March 18 ICE Statement].

[9] *See* ICE Enforcement and Removal Operations, *Memorandum on Coronavirus Disease 2019 (COVID-19) Action Plan, Revision 1*, ICE (Mar. 27, 2020), https://www.ice.gov/doclib/coronavirus/attF.pdf [hereinafter March 27 ICE Memorandum].

[10] Email from Peter B. Berg, Assistant Dir. of Field Operations, ICE, to Field Office Dirs. and Deputy Field Office Dirs., ICE (Apr. 4, 2020, 5:17 PM) (detailing ICE's protocols for the release of medically vulnerable detainees) [hereinafter ICE Release Guidance].

[11] IMMIGRATION AND CUSTOMS ENFORCEMENT, ENFORCEMENT AND REMOVAL OPERATIONS, COVID-19 PANDEMIC RESPONSE REQUIREMENTS 11 (Apr. 10, 2020) [hereinafter ERO COVID-19 PRR].

[12] Centers for Disease Control & Prevention, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, CDC (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html [hereinafter CDC, *Interim Guidance*].

national response to COVID-19, a plan that encompasses all detention facilities, is supported by a unified system of health care, one that meets all CDC requirements, and contemplates a continuum of control that includes alternatives to detention.

17. Jails, prisons, and immigration detention facilities are known notorious amplifiers of infectious disease.[13] A large number of state and local correctional systems recognizing the harm they can cause by failing to act timely and effectively, have taken affirmative actions to reduce the size of their systems to curb the spread of the coronavirus disease and are realizing positive results. ICE, which operates the largest system of incapacitation in the country, has lagged in its efforts to lower its census and to address conditions of detention for those detainees who remain in its custody.

18. These are the primary measures ICE has taken to date, and their outcomes.

19. The IHSC issued Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19), Version 6.0, March 6, 2020, informing its health care staff that revised CDC guidance expanded testing to a wider group of symptomatic patients. However, it directed that providers should use their judgement to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. They were strongly encouraged to test for other causes of respiratory illness including infection such as influenza.[14] The memorandum appeared to achieve its intended effect. In the same period of time that the Bureau of Prisons was testing extensively and reported 337 confirmed cases of COVID-19 and eight deaths,[15] the NYC Department of Correction, confirmed 287 cases,[16] and Cook County jails, over 350.[17] ICE has reported on April 18th that 124 detainees

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[13] Kelsey Kauffman, *Why Jails Are Key to "Flattening the Curve" of Coronavirus*, APPEAL (Mar. 13, 2020), https://theappeal.org/jails-coronavirus-covid-19-pandemic-flattening-curve/.

[14] IHSC Interim Reference Sheet, *supra* note 7.

[15] *COVID-19 Cases*, BOP, https://www.bop.gov/coronavirus/ (last updated Apr. 17, 2020).

[16] *Coronavirus in the U.S.: Latest Map and Case Count*, N.Y. TIMES, https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html (last updated Apr. 17, 2020, 8:24 AM).

[17] *Report: Cluster of COVID-19 Cases at Cook County Jail the Largest in Nation*, NBC CHI. (Apr. 7, 2020), https://www.nbcchicago.com/news/local/report-cluster-of-covid-19-cases-at-cook-county-jail-the-largest-in-the-nation/2252000/ (accessed Apr. 17, 2020).

have tested positive,[18] climbing from 89 cases reported on April 15th.[19] ICE has refused to provide confirmed cases of vendors and contractors.[20]

20. The ICE newsroom issued Updated Statement on COVID-19 on March 18, 2018. ICE Enforcement and Removal Operations (ERO) will focus enforcement on public safety risks and individuals subject to mandatory detention based on criminal grounds. ICE notified Congress that it will halt arrests except for those deemed "mission critical" to "maintain public safety and national security."[21,22] In essence, ICE has acknowledged its prosecutorial discretion and committed to exercise it. For those individuals who do not fall into those categories, ERO will exercise discretion to delay enforcement actions until after the crisis or utilize alternative to detention, as appropriate. Public safety risks casts a wide net and individuals subject to mandatory detention based on criminal grounds includes persons charged but not convicted, and persons who could have been charged.[23]

21. ERO issued a subsequent memorandum, COVID-19 Detained Docket Review, to Field Office Directors and Deputy Directors, on April 4, 2020, providing additional guidance on the release of medically vulnerable individuals pursuant to the March 18 announcement. The field was informed the categories of cases had been expanded and that the presence of a medical risk factor should be considered a "significant discretionary factor weighing in favor of release."

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[18] *ICE Guidance on COVID-19: Confirmed Cases*, ICE, https://www.ice.gov/coronavirus (last updated Apr. 17, 2020, 12:04 PM).

[19] Nina Shapiro, *ICE Releases Some Detainees from Tacoma Center, but Advocates Say Coronavirus Outbreak Is Inevitable*, SEATTLE TIMES (Apr. 16, 2020, 1:07 PM), https://www.seattletimes.com/seattle-news/immigrant-advocates-say-outbreak-at-northwest-detention-is-a-matter-of-time/.

[20] Monique O. Madan, *ICE Refuses to Say if its Contractors Have COVID-19. A Federal Judge Just Ordered it to*., MIAMI HERALD (Apr. 15, 2020), https://www.miamiherald.com/news/local/immigration/article242022731.html.

[21] Maria Sacchetti &Arelis R. Hernández, *ICE to Stop Most Immigration Enforcement Inside U.S., Will Focus on Criminals During Coronavirus Outbreak*, WASH. POST (Mar. 18, 2020), https://www.washingtonpost.com/national/ice-halting-most-immigration-enforcement/2020/03/18/d0516228-696c-11ea-abef-020f086a3fab_story.html.

[22] Ian Kullgren, *ICE to Scale Back Arrests During Coronavirus Pandemic*, POLITICO (Mar. 18, 2020), https://www.politico.com/news/2020/03/18/ice-to-scale-back-arrests-during-coronavirus-pandemic-136800.

[23] March 18 ICE Statement, *supra* note 8.

However, the guidance provides that risk factors may not always be determinative and detainees subject to mandatory detention shall not be released. On April 17, ICE's posture hardened. Acting Director Albence, acknowledging that only 400 detainees have been tested – of whom over 100 have tested positive for the coronavirus disease – asserted that continued detention during the pandemic is a necessary deterrent to avert a "rush at the borders."[24] Detention for the express purpose of deterrence for any reason is impermissible; to knowingly fail to protect at-risk individuals from contracting a deadly disease is unconscionable.

22. Based on my experience at DHS, ICE exercises discretion to release or decline to detain medically vulnerable individuals, even when those individuals are, per statute, mandatorily detained. Regardless of statute, ICE has the capacity to, and in fact does, release medically vulnerable individuals when necessary for public health. The recent memoranda released on March 18 and April 4 to field office directors and deputy field office directors regarding mandatory detention requirements are unnecessarily restrictive.[25]

23. ERO issued Memorandum on Coronavirus Disease 2019 (COVID-19), Action Plan, Revision 1, on March 27, 2020. The revision was applicable only to ICE's 42 IHSC-staffed and non-IHSC staffed, ICE-dedicated facilities.[26] With regards to the remaining 192 locations, all non-dedicated facilities, ICE deferred to local, state, tribal, territorial and federal public health authorities but recommended that actions contained in this memo be considered best practices.[27] The impact of differentiating expectations is significant. The conditions of detention for a detainee in a national system of incapacitation varies not by his or her assessed

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[24] U.S. House of Representatives, House Committee on Oversight and Reform, *DHS Officials Refuse to Release Asylum Seekers and Other Non-Violent Detainees Despite Spread of Coronavirus*, OVERSIGHT.HOUSE.GOV (Apr. 17, 2020), https://oversight.house.gov/news/press-releases/dhs-officials-refuse-to-release-asylum-seekers-and-other-non-violent-detainees [hereinafter *DHS Officials Refuse to Release Asylum Seekers*].

[25] ICE Release Guidance, *supra* note 10.

[26] A dedicated facility is an immigration detention center that houses only ICE detainees. A non-dedicated facility hosts more than one confined population. ICE utilizes 234 facilities to detain persons in its custody of which 42 are dedicated and 192 are non-dedicated. IHSC staffs 21 of the 42 dedicated detention facilities.

[27] March 27 ICE Memorandum, *supra* note 9.

needs or risk but by location, treating similarly situated detainees differently. Additionally, this Plan references the CDC Interim Guidance[28] but does not require its adoption by either the dedicated or non-dedicated facilities.

24. ERO issued COVID-19 Pandemic Response Requirements, Version 1.0, on April 10, 2020. The Pandemic Response Requirements (PPR) reaffirmed ICE's different performance expectations for dedicated and non-dedicated facilities but it also directed all detention facilities to comply with the CDC's guidance some of which is contrary to or omitted in the instructions issued by ICE. These inconsistencies are significant and impede compliance. ICE headquarters failed to produce one complete and accurate set of instructions. It is unrealistic to expect that the field has the time or expertise to recognize and reconcile the many substantive differences.

a. *Intake screening*. The CDC requires a screening at intake for signs and symptoms, whereas ICE directs a verbal screening, basically, several questions concerning recent travel and contact. ICE makes no mention of taking the detainee's temperature although it directed that the facilities take that of their staff at the beginning of each shift. The CDC also believes screening should be ongoing whereas ICE expects it would occur at intake only. With an average length of stay of 56 days this year to date, ICE overlooked the majority of the population.

b. *Monitoring and management, suspected exposures*. ICE directs monitoring occur in a single cell "depending on the space available" and otherwise in a unit with others,[29] which is most frequently the case. It is unclear whether ICE issues masks.

c. *Social distancing*. The facilities are densely populated. The housing units usually have 50 to 100 or more beds. The population eats, sleeps, and recreates in large groups. Detainees are shackled to one another during transports and sit or stand shoulder to shoulder on benches in Intake and the medical unit, and the pill line. ERO's PRR acknowledges that "strict social distancing may not be possible in

[28] CDC, *Interim Guidance*, *supra* note 12.
[29] ERO COVID-19 PRR, *supra* note 11, at 15.

congregate settings such as detention facilities," and requires facilities to implement suggested measures to enhance social distancing only "to the extent practicable."[30]

d. *Intra- and inter-facility movement*. The CDC addressed limiting transmission between facilities as well as within by restricting transfers unless absolutely necessary. The DOJ Bureau of Prisons limited its inter-facility transfers on March 13;[31] ICE adopted its own restriction on April 14 but with latitude for unspecified security considerations.

e. *Cleaning and sanitation*. CDC guidelines provide clear details about the types of cleaning agents and applications that should be adopted; ICE has none. That is unfortunate. Detainees are responsible for cleaning their own living area and are "employed" by the facility as porters to clean common areas in their housing units and throughout the facility. Most often, they perform these duties without any training and only limited supervision and cleaning supplies and no protective gloves, glasses, and gowns or coveralls. The facilities also rely on detainees to perform most of the food preparation and cooking as well as the laundry and sanitation, but there is no universal health screening protocol to ensure that everyone preparing and serving the meals and laundering the clothes and bedding as well as cleaning the facility are not sick or symptomatic.

f. *Focus and Press*. ICE is an enforcement agency that promulgated requirements to address a pandemic disease that threatens its workforce, all the persons in its custody, and the communities to which they return at the end of their shifts or upon their release from custody. Some requirements are conditioned "as practicable," for example, offering "the seasonal influenza vaccine to all detained

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[30] *Id.* at 13.

[31] *Federal Bureau of Prisons COVID-19 Action Plan: Agency-Wide Modified Operations*, BOP (Mar. 13, 2020), https://www.bop.gov/resources/news/20200313_covid-19.jsp.

persons . . . throughout the influenza season, where possible."[32] Other recommendations are couched as "make an effort to," notably, to reduce number of persons systemwide who are detained.[33] There is no clear path to compliance; for example, the circumstances under which detainees can expect to be tested for COVID-19 remains unclear. The guidance continues to rely on the quarantine of persons who may have been exposed or evidence symptoms. Also, troubling there is no assurance of quarantine in a single cell; most are quarantined as a group, increasing the likelihood of their exposure. Flattening the curve is an undertaking which ERO, a network of over 200 detention facilities, an average daily population of 33,000 and year-to-date admissions approaching 140,000, must succeed. It is my opinion, the equivocation expressed throughout the PRR and preceding instruction, about most matters but mandatory detention, conveys a lack of urgency when nothing is needed more than to focus and press quickly and comprehensively towards full implementation.

Conditions in Immigration Detention

25. As a matter of law, immigration detention is unlike criminal incarceration. Yet immigration detainees and pre-trial inmates and sentenced prisoners tend to be seen by the public as comparable which is to say, dangerous, and both confined populations are typically managed in similar ways, as if they are dangerous.[34] All three categories of confined people are ordinarily assigned to secure facilities with hardened perimeters in remote locations at considerable distances from counsel and their families as well as a hospital with an emergency room or intensive care beds. With just a few exceptions, the facilities that ICE uses to detain immigrants were originally built, and currently operate, as jails and prisons to confine pre-trial and sentenced prisoners. Their design, construction, staffing plans, and population management strategies are based largely upon the principles of command and control. Additionally, ICE adopted detention standards based on corrections law, which are largely not applicable to immigration detainees and which were promulgated by a correctional organization, the

[32] ERO COVID-19 PRR, *supra* note 11, at 6, 8.
[33] *Id.* at 13.
[34] Zadvydas v. Davis, 533 U.S. 678, 609 (2001).

American Correctional Association, to guide the operation of correctional facilities.[35]

26. Based on my years of experience overseeing and managing secure facilities, conditions in immigration detention facilities place people in close contact with one another and allow disease to spread freely. The facilities to which ICE detainees are assigned vary in age and architecture. Most are premised upon restricted movement and management by groups. Quite a few do not have windows that open and ventilation is poor. The housing units consist of single and double cells, cells with as many as four or five bunkbeds, or dormitories of varying size, usually 50 to 100 beds or more in size. Even to the extent that facilities are able to reduce population sizes to 75 percent capacity, as ICE recommends, individuals must still come into frequent contact and are still likely to live and sleep in multi-person dorms or cells.

27. Detainees spend the majority of time in their housing area. A recreation deck is often adjacent to the housing unit in facilities built in the past 25 years, while older facilities utilize a yard. Detainees access the recreation yard, religious services, the law library, and visitation under officer escort. In the course of a day, they can be staged in multi-person holding tanks and waiting rooms in Intake, the Medical Unit, and other areas, escorted as whole housing units, and transported en masse in buses shackled to one another, and they routinely eat their meals together. None of these circumstances permit detained people to maintain social distancing of at least six feet, as recommended by public health experts. Staggering meal and recreation times, as suggested by ICE and CDC guidance,[36] would be useful in limiting the number of people in each area but doing so would require greater staffing and therefore is not generally feasible. Doing so also would not ensure that people are able to keep six feet apart in cafeterias or recreation rooms in which tables and chairs are bolted down close together and people may have to line up to get trays or equipment or use the restroom. Extended hours may also impact turnout with fewer detainees rising for breakfast before sunrise or outdoor recreation after dark.

28. Segregation cells intended for disciplinary and administrative purposes are frequently used to detain special populations whose unique medical,

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[35] AM. CORR. ASS'N, PERFORMANCE-BASED STANDARDS FOR ADULT LOCAL DETENTION FACILITIES (4th ed. 2004); AM. CORR. ASS'N, 2016 STANDARDS SUPPLEMENT (2016).

[36] *Id.* at 13; CDC, *Interim Guidance*, *supra* note 12.

mental health, and protective custody requirements cannot be accommodated in general population housing including medical isolation.

29. It is also important to note that the demeanor of the immigration detention population is distinct from the criminally incarcerated population. Despite the characterization by ICE that the majority are criminal aliens, that term has changed over the past several years to include persons charged but not pled or proven guilty and persons who may have been charged but were not. The majority of the population is eligible for housing in a dormitory, signifying a low propensity for violence.

30. It is my experience that the majority of detainees are motivated by the desire for repatriation or relief, and exercise exceptional restraint under the most difficult of circumstances in custody as well as the community on their recognizance, bond, or community supervision. While working at ICE and having reviewed hundreds of detainee institutional files since then, only a few detainees file grievances, and fewer are disciplined for an infraction, particularly any serious infraction.

31. It is also my experience that many detainees are fearful for their health and well-being in the custody of ICE. Under ordinary circumstances, they have difficulty accessing healthcare. They often wait days for appointments for emergent and urgent matters. The formulary is limited, and all off-site specialty services must be pre-approved by IHSC. Once a prescription is ordered, it can take days before it is filled and is often discontinued without notice. Health care consistent with community expectations such as prescription glasses, dental cleanings, and filling cavities is frequently denied.

32. Sanitation practices at immigration detention facilities generally do little to curb the spread of illness. Issuance of cleaned clothing, sheets, towels, and blankets are regulated, and the quantity of each item in a detainee's possession at any time limited in number. As a rule, the beds, mattresses, and personal property containers are not sanitized between detainees' assignments. Detainees are responsible for cleaning their own living areas. They are also employed by the facility as porters to clean common areas including their dayrooms and restrooms, facility corridors, the medical unit, recreation areas, kitchen, and mess hall. In either instance, they usually perform these duties without any training, and are

provided only limited supervision, cleaning materials and supplies, and no protective gloves, glasses, and gowns or coveralls as recommended by the CDC.[37]

33. Objects with which many detainees come in contact frequently—notably, the phones, tables and chairs, paperback books, decks of cards and board games, the boxes in which they deposit kites to staff members, and other high-touch surfaces in the housing units—are not sanitized or replaced routinely. Similarly, the equipment issued in recreation areas, the kiosks and other furnishing and equipment in the law library, and the various staging and holding areas in Intake and Medical Unit, as well as the courtrooms and attorney and regular visit areas, receive limited attention.

34. Under ordinary circumstances, little to no instruction regarding sanitation is provided to the population at large or to detainees with work assignments. Instruction when given on any subject is most often in English and sometimes Spanish, and far less frequently in any other of detainees' native languages.

35. In general, tissues are not provided, handkerchiefs are unauthorized articles of clothing, and access to toilet paper and paper towel is limited, leaving detainees with nowhere to sneeze, cough, or wipe their noses other than into their own clothes, sheets, blankets, or towels, none of which is replaced daily. Additionally, detainees' access to hand soap, toothpaste and toothbrushes, and shampoo is limited, particularly for the indigent who are dependent upon the facility for their replenishment. A minority of detainees have an institutional job and most of them earn a dollar a day. Most of the items sold including hygiene products, are marked up. A bar of soap can cost as much as two dollars.

36. Also of concern, ICE facilities often rely on detainees to perform most of the cooking and cleaning in the facility, but neither ICE nor the ICE Health Service Corps (IHSC) has a universal health screening protocol to ensure that all the persons preparing and serving meals and cleaning the area are not sick or symptomatic. Some facilities also utilize detainees to distribute meal trays that are delivered to the housing units. In these locations, disposable plastic gloves are sometimes available but not hairnets or masks. It does not appear that practices employed in the kitchen and mess hall carry over to meal service in the dayrooms.

[37] CDC, *Interim Guidance*, *supra* note 12.

37. It is also my experience that the population is especially alarmed about the spread of the coronavirus to and through the facilities to which they are confined. Hotlines are fielding calls from detainees who have underlying health conditions including diabetes, cancer, kidney issues, asthma, or are otherwise medically vulnerable especially the elderly, mentally ill and transgender persons. One recent caller, who has asthma and reported a fever and serious cough, told the ABA hotline that the facility tested him for tuberculosis but not for COVID-19 and released him back to his pod. Many have expressed concern about their inability to stay physically distant from one another, the lack of precautions being taken by their facilities, the frequency with which detainees are being transferred in from other facilities, the lack of personal protection equipment (PPE) for them and facility staff, and that as the census drops the facility is closing housing units not, spreading out the remaining detainees to every other bed or more. The hotline has also received reports that detainees are being told to clean their housing units, but they are not being given cleaning solutions or are permitted to clean more frequently than once a day and that they have not been issued hand soap or hand sanitizer.

38. There are other disparities that are imbedded in ICE's site and facility selection process including whether there is a hospital nearby the detention facility and if it has any intensive care beds. Presently, about a third of all detainees are housed in a facility outside a 25- mile radius of hospital with an ICU bed.[38]

39. It is my opinion that the detainees' concerns are real, and their reports are credible. Any one of these circumstances, make it more likely that respiratory diseases such as COVID-19 will spread quickly once they are introduced into any of ICE's detention facilities.

40. It is also my opinion that ERO's Pandemic Response Requirements, its plan to protect the population and the public, will not suffice. Basically, ICE proposes "[e]fforts should be made to reduce the detained population to approximately 75% of capacity" and for all those who remain detained, "[w]henever possible, all staff and detainees should maintain a distance of six feet from one another" and otherwise adhere to CDC guidelines, where practicable.[39]

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[38] Kristina Cooke, Mica Rosenberg & Ryan McNeil, *As Pandemic Rages, US Immigrants Detained in Areas with Few Hospitals*, REUTERS (Apr. 3, 2020), https://www.reuters.com/article/us-health-coronavirus-usa-detention-insi/as-pandemic-rages-u-s-immigrants-detained-in-areas-with-few-hospitals-idUSKBN21L1E4.

[39] ERO COVID-19 PRR, *supra* note 11, at 13-14.

41. It is now clear that ICE is unwilling to identify infected individuals and refused to release to release asylum seekers and other non-violent detainees despite the spread of coronavirus through its detention facilities.[40] In stark contrast, best correctional and correctional health care practice requires, at a minimum, the preemptive release of individuals who are at-risk of serious illness or death if they become infected with COVID-19. As Dr. Scott Allen and Dr. Josiah Rich, medical experts to the Department of Homeland Security, recommended in their recent letter to Congress on the pandemic, "[m]inimally, DHS should consider releasing all detainees in high risk medical groups such as older people and those with chronic diseases." Dr. Allen and Dr. Rich concluded that "acting immediately will save lives not of only those detained, but also detention staff and their families, and the community-at-large."[41]

Alternatives to Detention

42. Initally, ICE proposed only one population, persons medically vulnerable primarily due to age or other infirmity and not subject to mandatory detention, for consideration for release. Now, ICE will no longer consider any detainees for release whether to protect those who are medically vulnerable or to lower the census to prevent the spread of the coronavirus through the facilities and into the community. This posture can have a devasting effect nationwide. To protect medically vulnerable persons who are detained today, and to reduce the likelihood of infecting others in the weeks and months to come, ICE should reduce the census as quickly as possible and then, sustain it. The most effective way in which to accomplish this is by enlarging not shrinking the pool, which in this instance should include those who are medically vulnerable as well and other, low-risk individuals who would be successful on community supervision.

43. Based on my experience operating state and local correctional systems that included probation and parole departments and working in various capacities within DHS including to make an assessment of ICE's alternative to detention program, it is my opinion that alternatives to detention can be used effectively and safely to ensure that immigrant detainees are not subjected to unnecessary risk

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[40] *DHS Officials Refuse to Release Asylum Seekers*, *supra* note 24.

[41] *See* Letter from Scott A. Allen, MD, FACP, Professor Emeritus, Univ. of Cal. Riverside Sch. of Med., & Josiah Rich, MD, MPH, Professor, Brown Univ, to House and Senate Comms. on Homeland Sec. (Mar. 19, 2020), https://whistleblower.org/wp-content/uploads/2020/03/Drs.-Allen-and-Rich-3.20.2020-Letter-to-Congress.pdf [hereinafter Allen & Rich].

from COVID-19 while ensuring public safety and appearance for court hearings and other appointments.

44. The research literature and government oversight agencies concur. Alternatives to detention, including supervised release, informed by individualized risk assessment, are a highly effective method of managing immigration cases without either unnecessary pretrial detention or risk to public safety or risk of failure to appear for court hearings. Compliance rates with supervised release are extremely high; for example, a recent Government Accountability Office report found that 99 percent of immigrant participants in ICE's alternative to detention program appeared at scheduled court hearings.[42] ICE also operated a very successful Family Case Management Program until recently.[43] According to the DHS Inspector General report, overall compliance was 99 percent for ICE check-ins and appointments, and 100 percent for attendance in court hearings.[44] Two percent of participants absconded during the process.[45]

45. Doctors serving as subject matter experts for DHS agree that ICE should release at least medically vulnerable people in light of the current COVID-19 pandemic.[46]

46. However, small and incremental changes in admissions or releases do not fully protect currently detained people from contracting or spreading COVID-19—and especially those who are at-risk of serious illness or death. Instead, ICE can ensure their safety by making full use of its alternatives to detention program. Alternatives to detention include release on personal recognizance, and release on conditions such as phone call check-ins or, when absolutely necessary, electronic surveillance. These alternatives also include the Intensive Supervision Appearance

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[42] U.S. GOV'T ACCOUNTABILITY OFF., GAO-15-26, *ALTERNATIVE TO DETENTION; IMPROVED DATA AND COLLECTION AND ANALYSIS NEEDED TO BETTER ASSESS PROGRAM EFFECTIVENESS* 30 (2014).

[43] Frank Bajak, *ICE Shutters Helpful Family Management Program Amid Budget Cuts*, ASSOCIATED PRESS (June 9, 2017), https://www.csmonitor.com/USA/Foreign-Policy/2017/0609/ICE-shutters-helpful-family-management-program-amid-budget-cuts.

[44] DHS OFFICE OF INSPECTOR GEN., U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT'S AWARD OF THE FAMILY CASE MANAGEMENT PROGRAM CONTRACT (REDACTED) 5 (2017), *available at* https://www.oig.dhs.gov/sites/default/files/assets/2017-12/OIG-18-22-Nov17.pdf.

[45] *Id.*

[46] Allen & Rich, *supra* note 41.

Program (ISAP), in which staff maintains contact with participants with reminder calls and letters and coaching towards meeting all the upcoming reporting requirements and follows up within 48 hours after each court appearance. Under ISAP, when a participant, or the government, files an appeal in the person's removal case and while that appeal is pending, monitoring is modified as necessary to include the addition or removal of GPS or Voice-ID technology, and to increase or decrease in-office and home visit frequency. And if reinstated, alternatives to detention could include a program modeled on ICE's Family Case Management Program, offering orientation and education for participants about their legal rights and responsibilities; individualized service plans; assistance with transportation logistics; tracking and monitoring of immigration obligations (to include ICE check-ins, attendance at immigration court hearings); and safe repatriation and reintegration planning for participants who are returning to their home countries.[47]

47. GPS monitoring when recommended, requires minimal physical contact and does not pose risk to the officer or the detainee taking routine precautions. The contact necessary to place an ankle monitor on an individual is minimal, and necessary precautions to avoid spread of COVID-19 are easily implemented and commonly done. Moreover, after initial installation there is little need for future physical contact. On-going communication by phone is routine. In my opinion, supervision by means of GPS affords appreciably more social distancing for persons in ICE's custody and ICE personnel than does any interaction between a detainee and detention officer in the confines of detention setting.

48. Alternatives to detention are effective because they are tailored to an individual depending on their levels of need and risk in the community. Such tailored alternatives maximize medically vulnerable and low-risk people's ability to remain healthy in the community while protecting public safety and the integrity of court proceedings and other legal requirements. When there is a threat to our health and well-being, especially one as serious as COVID-19, we count on the government to protect us from undue harm. The government assumes the same responsibility for those in its custody who lack the autonomy to care for themselves. Today, "flattening the curve" so that the infection rate for COVID-19 stays below the healthcare system capacity is key both to controlling the pandemic in the United States and to preventing undue harm to those of us in custody. As

[47] U.S. IMMIGRATIONS AND CUSTOM ENF'T, FACT SHEET: STAKEHOLDER REFERRALS TO THE ICE/ERO FAMILY CASE MANAGEMENT PROGRAM 1 (2016), *available at* https://www.aila.org/infonet/ice-fact-sheet-family-case-management-program.

individuals, our responsibility to ourselves and others is to limit our social interactions and maintain rigorous personal hygiene practices. For government and institutions, "flattening the curve" requires focusing on densely populated places in which its inhabitants cannot isolate themselves. That is why increasingly more governors have closed all but the essential governmental agencies and businesses and are focusing now on jails and prisons, widely recognized by the healthcare community to be "amplifiers of infectious diseases" such as COVID-19.[48] They do so because they recognize the conditions that can keep diseases from spreading—such as social distancing and rigorous sanitation—are nearly impossible to achieve in correctional and immigration detention facilities.

49. Numerous state and local systems have acted to reduce detention in light of COVID-19, both by decreasing pretrial detention and by releasing detained and sentenced individuals. These measures demonstrate that people can be protected from COVID-19 consistent with public safety needs.

50. At the local level, leaders have been swift to act:

- District attorneys in San Francisco, California[49] and Boulder, Colorado[50] have taken steps to release people held pretrial, with limited time left on their sentence, and charged with non-violent offenses.
- Ohio courts in Cuyahoga County[51] and Hamilton County[52] have begun to issue court orders and conduct special hearings to increase the number of

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[48] *Responses to the COVID-19*, PRISON POL'Y INITIATIVE (Mar. 26, 2020), https://www.prisonpolicy.org/virus/virusresponse.html.

[49] Darwin Bond Graham, *San Francisco Officials Push to Reduce Jail Population to Prevent Coronavirus Outbreak*, APPEAL (Mar. 11, 2020), https://theappeal.org/coronavirus-san-francisco-reduce-jail-population/.

[50] Elise Schmelzer, *Denver, Boulder Law Enforcement Arresting Fewer People to Avoid Introducing Coronavirus to Jails*, DENVER POST (Mar. 16, 2020), https://www.denverpost.com/2020/03/16/colorado-coronavirus-jails-arrests/.

[51] Kevin Freeman, *Cuyahoga County Jail Releasing Some Inmates Early to Help Minimize Potential Coronavirus Outbreak*, FOX 8 (Mar. 14, 2020), https://fox8.com/news/coronavirus/cuyahoga-county-jail-releasing-some-inmates-early-to-help-minimize-potential-coronavirus-outbreak/.

[52] Kevin Grasha, *Order to Authorize Hamilton County Sheriff to Release Low-Risk, Nonviolent Jail Inmates*, CINCINNATI ENQUIRER (Mar. 16, 2020), https://www.cincinnati.com/story/news/crime/crime-and-

people released from local jails. On a single day, judges released 38 people from the Cuyahoga County Jail, and they hope to release at least 200 more people charged with low-level, non-violent crimes.

- The Los Angeles County Sheriff's Department[53] has reduced their jail population by 10% in the past month to mitigate the risk of virus transmission in crowded jails. To reduce the jail population by 1,700 people, the Sheriff reports releasing people with less than 30 days left on their sentences and is considering releasing pregnant people and older adults at high risk.
- In Travis County, Texas,[54] judges have begun to release more people from local jails on personal bonds (about 50% more often than usual), focusing on preventing people with health issues who are charged with non-violent offenses from going into the jail system.
- Court orders in Spokane, Washington[55] and in three counties in Alabama[56] have authorized the release of people being held pretrial and some people serving sentences for "low-level" misdemeanor offenses.

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courts/2020/03/16/coronavirus-hamilton-county-sheriff-release-low-risk-inmates/5062700002/.

[53] Justin Carissimo, *1,700 Inmates Released from Los Angeles County in Response to Coronavirus Outbreak*, CBS NEWS (Mar. 24, 2020), https://www.cbsnews.com/news/inmates-released-los-angeles-county-coronavirus-response-2020-03-24/.

[54] Ryan Autullo, *Travis County Judges Releasing Inmates to Limit Coronavirus Spread*, STATESMAN (Mar. 16, 2020), https://www.statesman.com/news/20200316/travis-county-judges-releasing-inmates-to-limit-coronavirus-spread?fbclid=IwAR3VKawwn3bwSLSO9jXBxXNRuaWd1DRLsCBFc-ZkPN1INWW8xnzLPvZYNO4.

[55] Chad Sokol, *Dozens Released from Spokane County Custody Following Municipal Court Emergency Order*, SPOKESMAN (Mar. 17, 2020), http://www.courts.wa.gov/content/publicupload/eclips/2020%2003%2018%20Dozens%20released%20from%20Spokane%20County%20custody%20following%20Municipal%20Court%20emergency%20order.pdf.

[56] Marty Roney, *Coronavirus: County Jail Inmates Ordered Released in Autauga, Elmore, Chilton Counties,* MONTGOMERY ADVERTISER (Mar. 18, 2020), https://www.montgomeryadvertiser.com/story/news/crime/2020/03/18/county-jail-inmates-ordered-released-autauga-elmore-chilton-counties/2871087001/.

- In Hillsborough County, Florida,[57] over 160 people were released following authorization via administrative order for people accused of ordinance violations, misdemeanors, traffic offenses, and third-degree felonies.
- In Arizona, the Coconino County[58] court system and jail have released around 50 people who were held in the county jail on non-violent charges.
- In Salt Lake County, Utah,[59] the District Attorney reported that the county jail plans to release at least 90 people this week and to conduct another set of releases of up to 100 more people the following week.
- The New Jersey Chief Justice signed an order calling for the temporary release of 1,000 people from jails (almost a tenth of the entire state's county jail population) across the state of New Jersey[60] who are serving county jail sentences for probation violations, municipal court convictions, "low-level indictable crimes," and "disorderly persons offenses.
- The New York City Department of Correction has released approximately 1,600 people from its jails.[61]

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[57] WFTS Digital Staff, *164 "Low Level, Nonviolent" Offenders Being Released from Hillsborough County Jails*, ABC NEWS (Mar. 19, 2020), https://www.abcactionnews.com/news/region-hillsborough/164-low-level-nonviolent-offenders-being-released-from-hillsborough-county-jails.

[58] Scott Buffon, *Coconino County Jail Releases Nonviolent Inmates in Light of Coronavirus Concerns*, ARIZONA DAILY SUN (Mar. 20, 2020), https://azdailysun.com/news/local/coconino-county-jail-releases-nonviolent-inmates-in-light-of-coronavirus/article_a6046904-18ff-532a-9dba-54a58862c50b.html.

[59] Jessica Miller, *Hundreds of Utah Inmates Will Soon Be Released in Response to Coronavirus*, SALT LAKE CITY TRIBUNE (Mar. 20, 2020), https://www.sltrib.com/news/2020/03/21/hundreds-utah-inmates/?fbclid=IwAR3r8BcHeEkoAOcyP3pmBu9XWkEj4MMsDC_LUH4YZn2QGd18hALk4vM9X1c.

[60] Kathleen Hopkins, *Coronavirus in NJ: Up to 1,000 Inmates to Be Released from Jails*, ASBURY PARK PRESS (Mar. 23, 2020), https://www.app.com/story/news/2020/03/23/nj-coronavirus-up-1-000-inmates-released-jails/2897439001/.

[61] CITY OF N.Y., NEW YORK CITY JAIL POPULATION REDUCTION IN THE TIME OF COVID-19 2 (2020), *available at* http://criminaljustice.cityofnewyork.us/wp-content/uploads/2020/04/MOCJ-COVID-19-Jail-Reduction.pdf.

51. At the state level, state correctional systems are also taking steps to reduce the prison population in the face of the pandemic:

- The North Dakota parole board[62] granted early release dates to 56 people held in state prison with expected release dates later in March and early April.
- The director of the Iowa Department of Corrections[63] reported the planned, expedited release of about 700 incarcerated people who have been determined eligible for release by the Iowa Board of Parole.
- In Illinois,[64] the governor signed an executive order that eases the restrictions on early prison releases for "good behavior" by waiving the required 14-day notification to the State Attorney's office. The executive order explicitly states that this is an effort to reduce the prison population, which is particularly vulnerable to the COVID-19 outbreak.
- Illinois' governor signed a second executive order suspended all admissions to the Illinois Department of Corrections ("IDOC") from Illinois county jails, with exceptions solely authorized by the IDOC Director.[65]
- The CA Department of Corrections & Rehabilitation released to parole 3,500 nonviolent offenders with 60 days or less left on their sentences.[66]

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[62] Arielle Zionts, *DOC, Gov. Noem Not Planning Special Coronavirus Releases from Prisons*, RAPID CITY J. (Mar. 21, 2020), https://rapidcityjournal.com/news/local/crime-and-courts/doc-noem-not-planning-special-coronavirus-releases-from-prisons/article_d999f510-7c7c-5d19-ab3a-77176002ef99.html.

[63] Linh Ta, *Iowa's Prisons Will Accelerate Release of Approved Inmates to Mitigate COVID-19*, TIMES-REPUBLICAN (Mar. 23, 2020), https://www.timesrepublican.com/news/todays-news/2020/03/iowas-prisons-will-accelerate-release-of-approved-inmates-to-mitigate-covid-19/.

[64] Rylee Tan, *Illinois Reaches 1,285 COVID-19 Cases, Gov. Pritzker Eases Restrictions on Prison Release*, LOYOLA-PHOENIX (Mar. 23, 2020), http://loyolaphoenix.com/2020/03/illinois-reaches-1285-covid-19-cases-gov-pritzker-eases-restrictions-on-prison-release/.

[65] Ill. Exec. Order No. 2020-13 (Mar. 26, 2020), *available at* https://www2.illinois.gov/Pages/Executive-Orders/ExecutiveOrder2020-13.aspx.

[66] Justin Wise, *California to Release up to 3,500 Non-Violent Inmates Amid Coronavirus Outbreak*, HILL (Mar. 31, 2020), https://thehill.com/homenews/state-

- Kentucky's governor commuted 186 sentences and released 743 inmates within 6 months of completing their sentences.[67]
- New Jersey's governor signed an executive order to temporarily release nonviolent offenders.[68]

52. In addition to releasing people from jail and prison, jurisdictions are reducing jail admissions, contributing to the reduction in average daily populations, alleviating overcrowding and reducing density.

- In Bexar County, Texas,[69] the Sheriff released a COVID-19 mitigation plan that includes encouraging the use of cite and release and "filing non-violent offenses at large," rather than locking more people up during this pandemic.
- The Baltimore, Maryland State's Attorney[70] will dismiss pending criminal charges against anyone arrested for drug offenses, trespassing, and minor traffic offenses, among other nonviolent offenses.

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watch/490498-california-to-release-3500-non-violent-inmates-amid-coronavirus-outbreak.

[67] *Kentucky Plans to Release More Than 900 Prisoners Because of the COVID-19 Outbreak*, WDRB.COM (Apr. 2, 2020), https://www.wdrb.com/news/kentucky-plans-to-release-more-than-900-prisoners-because-of-the-covid-19-outbreak/article_aef84282-7541-11ea-8a18-efe5a8cf107d.html?eType=EmailBlastContent&eId=14e33471-26cd-4585-b9b6-e1e52182b91c.

[68] N.J. Exec. Order No. 124 (Apr. 10, 2020), *available at* http://d31hzlhk6di2h5.cloudfront.net/20200410/c0/64/ce/2c/0ef068b5d2c6459546c33a46/EO-124.pdf.

[69] Courtney Friedman, *Bexar County Sheriff Announces COVID-19 Prevention Plan for Jail Inmates, Deputies*, KSAT.COM (Mar. 14, 2020), https://www.ksat.com/news/local/2020/03/15/bexar-county-sheriff-announces-covid-19-prevention-plan-for-jail-inmates-deputies/.

[70] Tim Prudente & Phillip Jackson, *Baltimore State's Attorney Mosby to Stop Prosecuting Drug Possession, Prostitution, Other Crimes Amid Coronavirus*, BALT. SUN (Mar. 18, 2020), https://www.baltimoresun.com/coronavirus/bs-md-ci-cr-mosby-prisoner-release-20200318-u7knneb6o5gqvnqmtpejftavia-story.html.

- District attorneys in Brooklyn, New York[71] and Philadelphia, Pennsylvania,[72] have taken steps to reduce jail admissions by releasing people charged with non-violent offenses and not actively prosecuting low-level, non-violent offenses.
- Police departments in Los Angeles County, California,[73] Denver, Colorado,[74] and Philadelphia, Pennsylvania[75] are reducing arrests by using cite and release practices, delaying arrests, and issuing summons. In Los Angeles County, the number of arrests has decreased from an average of 300 per day to about 60 per day.
- The state of Maine[76] vacated all outstanding bench warrants (for over 12,000 people) for unpaid court fines and fees and for failure to appear for hearings in an effort to reduce jail admissions.
- State and federal courts in Connecticut have begun releasing sentenced prison and jail inmates vulnerable to complications from COVID-19 as well.[77]

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[71] Andrew Denney & Larry Celona, *Coronavirus In NY: Brooklyn DA to Stop Prosecuting "Low-Level" Offenses*, N.Y. POST (Mar. 17, 2020), https://nypost.com/2020/03/17/coronavirus-in-ny-brooklyn-da-to-stop-prosecuting-low-level-offenses/.

[72] Samantha Melamed & Mike Newall, *With Courts Closed by Pandemic, Philly Police Stop Low-Level Arrests to Manage Jail Crowding*, PHILA. INQUIRER (Mar. 18, 2020), https://www.inquirer.com/health/coronavirus/philadelphia-police-coronavirus-covid-pandemic-arrests-jail-overcrowding-larry-krasner-20200317.html.

[73] Salvador Hernandez, *Los Angeles Is Releasing Inmates Early and Arresting Fewer People over Fears oftThe Coronavirus in Jails*, BUZZFEED NEWS (Mar. 16, 2020), https://www.buzzfeednews.com/article/salvadorhernandez/los-angeles-coronavirus-inmates-early-release.

[74] Schmelzer, *supra* note 50.

[75] Melamed & Newall, *supra* note 72.

[76] Judy Harrison, *Maine Courts Vacate Warrants for Unpaid Fines and Fees*, BANGOR DAILY NEWS (Mar. 16, 2020), https://bangordailynews.com/2020/03/16/news/state/maine-courts-vacate-warrants-for-unpaid-fines-and-fees.

[77] Edmund H. Mahony, *Courts Ponder the Release of Low-Risk Inmates in an Effort to Block the Spread of COVID-19 to the Prison System*, HARTFORD COURANT (Mar. 24, 2020), https://www.courant.com/coronavirus/hc-news-covid-inmate-releases-20200323-20200324-oreyf4kbdfbe3adv6u6ajsj57u-story.html.

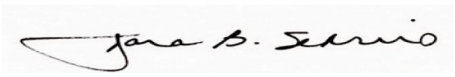
- In response to the Oklahoma Department of Corrections' decision not to admit any new people to state prisons, Tulsa and Oklahoma counties are trying to keep their jail population down by not arresting people for misdemeanor offenses and warrants, and by releasing 130 people this past week through accelerated bond reviews and plea agreements.
- In King County, Washington, Seattle jails are no longer accepting people booked for misdemeanor charges that do not present a public safety concern or people who are arrested for violating terms of community supervision. The Department of Adult and Juvenile Detention is also delaying all misdemeanor "commitment sentences" (court orders requiring someone to report to a jail at a later date to serve their sentence).

53. Individuals with medical vulnerability to COVID-19 face irreparable harm if they continue to be detained and are unlikely to pose significant flight or public safety threats if they were released under conditions consistent with objective assessments of risk. The government, including local and federal officials responsible for ICE detainees, should release as many of these vulnerable individuals as possible, as quickly as possible, with only those conditions that are necessary to ensure participation in court proceedings or other appointments.

54. Given the severity of COVID-19 and the rapidly escalating rate of infection and death in the United States, as well as the increased risks in facilities housing ICE detainees, I also recommend that any other individuals deemed likely to comply on appropriate conditions of supervision where necessary be released immediately, to protect themselves, other detainees, correctional and medical staff, and the general public, without impeding immigration court proceedings or other legally-required appointments.

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

Executed this 20th day in April 2020, in New York City, NY.



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Dora Schriro

Appendix A

DORA B. SCHRIRO, Ed.D. J.D.
EXECUTIVE EXPERIENCE

State of Connecticut, Middletown CT (2014–2018)
CT Homeland Security Advisor (2016–2018), DHS clearance, Top Secret, appointed by Gov. Dannel Malloy
Commissioner, Department of Emergency Services & Public Protection (2014–2018), appt. by Gov. Malloy

- Responsible for CT State Police, Emergency Management & Homeland Security, Scientific Services, Fire Prevention & Control, Police Officer Standards & Training, Statewide Telecommunications.
- FY2018 operating budget, $185M; federal grants, $348M; bond funding, $79M; 1817 employees
- Public Safety & Service, Homeland Security, and Emergency Response, Recovery & Resiliency
- Accomplishments: 1. Comprehensive procedural justice effort with body-worn cameras, all state police on patrol, civilian complaint process, 21st century curricula for state & local law enforcement, an investigative protocol for officer-involved shootings, annual reports of uses of force, traffic stops & police pursuits, mandatory police agency accreditation, and ICE-interface protocol; 2. Drug intervention & enforcement including a dark-web opioid taskforce, equipping all troopers and training first responders to administer naloxone; 3. Other harm reduction efforts including a multi-jurisdictional cybersecurity investigative unit, comprehensive gun control, community-focused active shooter preparedness, wrap-around DV safety & support, K-12 & post-secondary school safety planning, and Ebola & Zika first responder protocols

City of New York, New York, New York (2009–2014)
Commissioner, New York City Department of Correction, appointed by Mayor Michael Bloomberg

- Responsible for adult detention, prisoner processing, and operation of criminal court pens, an average of 12,000 inmates daily and 100,000 pretrial and city-sentenced inmate admissions annually
- FY2014 operating budget, $1.065B, capital budget, $691.9M; 10,440 employees
- Focus: Special Populations; Intake, Classification and Discharge Planning; Staff Accountability; Alternatives to Disciplinary Segregation; Alternatives to Detention
- Accomplishments: 1st U.S. Social Impact Bond funded program, adolescent pre-release initiative; Justice Reinvestment funded pre-release preparation for adults; pre-trial & post-plea diversion for the mentally ill; comprehensive reform of disciplinary segregation with clinical alternatives for special populations; centralized intake with risk & needs classification, gang identification, and discharge planning

US Department of Homeland Security, Washington DC (2009–2009)
Senior Advisor to Secretary on ICE Detention and Removal, appointed by DHS Sec. Janet Napolitano
Director, ICE Office of Detention Policy and Planning, appointed by ICE Asst. Sec. John Morton

- Focus: Design a civil detention system satisfying all safety and security needs and legal requirements
- Authored, *2009 Report on ICE Detention Policies and Practices: A Recommended Course of Action for Systems Reform*, DHS' adopted template for improving the operation of immigration detention
- Improved the efficiency and effectiveness and increased the transparency of ICE detention operations

State of Arizona, Phoenix, Arizona (2003–2009)
Department Director, Arizona Department of Corrections, appointed by Gov. Janet Napolitano

- Responsible for adult corrections and community supervision including 39,000 inmates and 7,200 parolees daily and 55,000 felons annually (21,000 admissions/11,500 case openings)
- FY2009 operating budget, $1.23B; 9,750 employees
- Focus: Systems reform, re-entry, victim services, strategic planning, privatization oversight
- Winner, 2008 Innovations in American Government, and first prison-based reform awards recipient

City of St. Louis, St. Louis, Missouri (2001–2003)

Commissioner of Corrections, St. Louis City Division of Corrections, appointed by Mayor Francis Slay

- Responsible for adult detention, prisoner processing, and city probation and parole including 1,500 jail inmates and 2,000 offenders on supervision daily (9,000 admissions/63,000 bookings annually)
- FY2003 operating budget, $68M; 615 employees
- Focus: Population management, alternative sentencing initiatives, staff development
- Opened and operated the city's first combined police prisoner processing and detention center

State of Missouri, Jefferson City, Missouri (1993–2001)

Department Director, Missouri Department of Corrections, appointed by Gov. Mel Carnahan

- Responsible for adult corrections and probation and parole services including 28,000 prisoners and 65,000 offenders on community supervision daily, 35,000 admissions/72,000 case openings annually
- FY2002 operating budget, $500M; 11,000 employees
- Focus: Systems and sentencing reform, litigation reduction, restorative justice, capital construction
- Winner, Council of State Governments Innovations award program; four-time Innovations in American Government Finalist and Semi-Finalist

City of St. Louis, St. Louis Missouri (1989–1993)

Correctional Superintendent, St. Louis City Division of Correction, appointed by Mayor Vince Schoemehl

- Responsible for 600 pre-trial and city sentenced inmates, 4,000 admissions annually
- FY1993 operating budget, $26M; 210 employees
- Focus: Court oversight, overcrowding, certified juveniles, community relations

City of New York, New York, New York (1984–1989)

Assistant Commissioner, New York City Department of Correction, appointed by Mayor Ed Koch

- Responsible for design and delivery of inmate programs services, programs development, grants
- Services provided to 100,000 pre-trial and city sentenced inmates annually by 200 employees
- Focus: Public-funded and accredited education, school-aged inmates; contracts management

Assistant Deputy Director, Office of the Mayor, Coordinator of Criminal Justice

- Grants administration, federal and state funded systems reforms, $189M annually
- Focus: Alternatives to detention, intermediate sanctions, policy analysis, applied research

CONSULTING SERVICES

Dora B. Schriro Consulting Services, LLC (est. 2013)

EDUCATION

St. Louis University, St. Louis, Missouri, Juris Doctorate, School of Law (2002)
Columbia University, New York, New York, Doctor of Education, Teachers College (1984)
University of Massachusetts at Boston, Massachusetts, Master of Education (1980)
Northeastern University, Boston, Massachusetts, Bachelor of Arts cum laude (1972)

MANAGERIAL PROGRAMS

Council of State Governments, Toll Fellowship (2018)
Harvard University, JFK School of Government, Innovations in Governance (2005)
Harvard University, JFK School of Government, Strategic Public Sector Negotiations (1996)
Harvard University, JFK School of Government, Senior Executives in State and Local Government (1992)

HONORS AND AWARDS, INNOVATIONS

Innovations in American Government, 2008 Winner, Getting Ready: Keeping Communities Safe
Innovations in American Government, 2000 Semi-finalist, Correcting Corrections
Innovations in American Government, 1999 Semi-finalist, Constituent Services
Innovations in American Government, 1998 Semi-finalist, Pre-Promotional Training
Innovations in American Government, 1997 Finalist, Constituent Services
Council of State Governments, 1998 Innovations Award Winner, Waste Tire to Energy
Council of State Governments, 1997 Innovations Award Regional Finalist, Pre-Promotional Training
Council of State Governments, 1996 Innovations Award Finalist, Constituent Services

OTHER HONORS AND AWARDS

U.S. Department of Justice, Office for Victims of Crime, Allied Professional Award, 2012
Florida Immigrant Advocacy Center, American Justice Award, 2011
Hofstra University (Hempstead, New York) Presidential Medal, 2010
National Governors Association, Distinguished Service to State Government Award, 2006
Arizona Parents of Murdered Children, Filling Empty Shoes, 2006 Honoree
Farmingdale Public Schools (Farmingdale, New York), Wall of Fame, 2001 Inductee
St. Louis Forum, Trailblazer Award, 2000
Association of Correctional Administrators, Michael Francke Award for Outstanding Leadership, 1999
Jefferson City (Missouri) Ten Most Influential Women, 1998
Missouri Governor Award for Quality and Productivity, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000
Missouri Governor Torch of Excellence Gold Award, 1999
Missouri Governor Torch of Excellence Award, 1997
International Association of Correctional Training Personnel Award, Pre-Promotional Training, 1996
Women's Self-Help Center, Twenty Distinguished Women, 1996
St. Louis (Missouri) YWCA Special Leadership Award for a Government Official, 1995
Jefferson City (Missouri) News Tribune Statesman of the Month, June 1995

PUBLICATIONS, IMMIGRATION DETENTION REFORM

Weeping in the Playtime of Others: The Obama Administration's Failed Reform of ICE Family Detention Practices, in Journal on Migration and Human Security, The Law that Begot the Modern U.S. immigration Enforcement System: IIRIRA 20 Years Later (December 2018)
Women and Children First: An Inside Look at the Impediments to Reforming Family Detention in the U.S., in Challenging Immigration Detention, ed. by Flynn and Flynn. Edward Elgar Publishing (September 2017)
Afterword, Intimate Economies, Anomie and Moral Ambiguity, in Intimate Economies of Immigration Detention: Critical Perspectives, ed. by Conlon and Hiemstra. Routledge Publishers (2016)
Improving Conditions of Confinement for Immigrant Detainees: Guideposts toward a Civil System of Civil Detention in The New Deportation Delirium, ed. by Kanstroom and Lykes. NYU Press (2015)
Family Immigration Detention: The Past Cannot be Prologue, co-author, ABA Commission on Immigration (2015)
Envisioning a Civil System of Civil Detention: Our Opportunity, Our Challenge (Foreword), in Outside Justice, ed. by Brotherton, Stageman and Leyro. Springer Press (2013)
Improving Conditions of Confinement for Criminal Inmates and Immigrant Detainees, American Criminal Law Review, Georgetown University Law Center (Fall 2010)
The 2009 Report on ICE Detention Policies and Practices: A Recommended Course of Action for Systems Reform, U.S. Department of Homeland Security (October 2009)
Rethinking Civil Detention and Supervision, Arizona Attorney (July–August 2009)

PUBLICATIONS, CORRECTIONS REFORM

Smart and Safe: Making the Most of Adolescents' Time in Detention, the Physical Plant, Our Workforce, and the "What Works' Literature, in The State of Criminal Justice, American Bar Association (2013)
Corrections: The Justice-Involved Mentally Ill, A Practitioner's Perspective, in The State of Criminal Justice, American Bar Association (2012)
Good Science, Good Sense: Making Meaningful Change Happen – A Practitioner's Perspective, Criminology & Public Policy, Vol. 11, No. 1, Special Issue (February 2012)
Is Good Time a Good Idea? Federal Sentencing Reporter, Vol. 21, No. 3 (February 2009)
Correcting Corrections: The Arizona Plan: Creating Conditions for Positive Change in Corrections, Confronting Confinement: A Report of the Commission on Safety and Abuse in American Prisons (2006)
Missouri's Parallel Universe: Blueprint for Effective Prison Management, Corrections Today (April 2001)
Correcting Corrections: Missouri's Parallel Universe, Papers from the Executive Sessions on Sentencing and Corrections, U.S. Department of Justice, Office of Justice Programs (May 2000)
Avoiding Inmate Litigation: The 'Show-Me' State Shows How, Sheriff's Magazine, (March–April 1999)
Best Practices: Excellence in Corrections, American Correctional Association (August 1998)
Reducing Inmate Litigation, Corrections Today (August 1998)
Corrections Management Quarterly, Issue Editor, Aspen Publications (1997)
Currents, Leadership St. Louis, Danforth Foundation (1992)
What Makes Correctional Education Educational, Journal of Correctional Education (September 1986)
Safe Schools, Sound Schools, ERIC Clearinghouse on Urban Education (January 1985)
What Works with Serious Juvenile Offenders: US Experience, Juvenile Delinquency in Australia (1984)
What Makes Correctional Education Educational: Ethnography of an Instructionally Effective School, University Microfilm (1983)

STANDARDS, SENTENCING AND RELATED CIVIL-CRIMINAL JUSTICE REFORM ACTIVITIES

Women's Refugee Commission, Commissioner (2012–2020)
American Bar Association, Commission on Immigration, Special Advisor (2019–2020)
American Bar Association, Commission on Immigration, Advisory Board Member (2017–2019)
American Bar Association, Commission on Immigration, Standards for the Custody, Placement and Care; Legal Representation, and Adjudication of Unaccompanied Alien Children in the United States (2018)
U.S. Dept. of Homeland Security, DHS Family Residential Ctr. Advisory Committee, member (2015–2016)
American Bar Association, Commission on Immigration, Commissioner (2014–2016)
American Bar Association, Commission on Immigration, Co-chair, Standing Subcommittee on Punitive Segregation, (2012–2014)
American Bar Association, Commission on Immigration, Civil Detention Standards Task Force (2011–2012)
American Bar Association, Criminal Justice Standards Subcommittee, ACA representative (2005–2008)
Arizona State University School of Law, Sentencing Policy Seminar (2004–2005)
Arizona Attorney General Sentencing Advisory Committee (2004–2008)
St. Louis University School of Law, Instructor, Sentencing Policy Seminar (2000–2002)
Missouri Sentencing Advisory Commission, Vice Chair (1994–2001)
U.S. Department of Justice Executive Sessions on Sentencing and Corrections, in conjunction with Harvard University JFK School of Government and University of Minnesota Law School (1997–2000)
Partnership for Criminal Justice Workshop, Institute on Criminal Justice, University of Minnesota Law School, State Partner (1997–2000)
State Sentencing and Corrections Program, Vera Institute of Justice, National Associate (1999–2002)
U.S. Dept. of Justice, Bureau of Justice Assist., Discretionary Grant Program, Peer Reviewer (1994–2002)

PRE-DOCTORAL EMPLOYMENT, LECTURING AND RELATED EXPERIENCE

Employment

- Executive Director, Planned Parenthood of Bergen County, Hackensack, New Jersey (1983–1984)
- Director, Correctional Education Consortium, Long Island City, New York (1982–1983)
- Supervising Social Worker, Franklin Public Schools, Franklin, Massachusetts (1978–1981)
- Director, Adult and Continuing Education, Franklin Public Schools, Franklin, MA (1978–1981)
- Director, Staff Development, Wrentham State School, Wrentham, Massachusetts (1977–1978)
- Program Administrator, Medfield-Norfolk Prison Project, Medfield, Massachusetts (1974–1976)

Academic Experience

- Instructor, Arizona State University School of Law, Corrections Law Seminar (2005–2008)
- Instructor, St. Louis University School of Law, Sentencing Policy (2000–2002)
- Senior Policy Fellow, Public Policy Research Center, University of Missouri-St. Louis (2001)
- Visiting Lecturer, Strategic Planning, National Institute of Corrections (1998–2002)
- Adjunct Professor, Criminal Justice, University of Missouri-St. Louis (1990–1998)
- Adjunct Professor, Criminal Justice, Long Island University at CW Post (1986–1988)
- Instructor, Innovation, Open Center of New York City (1987)
- Teaching Assistant, Field Research Methodology, Administrative Intern to the School Superintendent, Franklin Public Schools, Franklin, Massachusetts (1979)
- Visiting Lecturer, Special Education, Framingham State College, Framingham, Massachusetts (1979)
- Adjunct Professor, Psychology, Fischer Junior College, Boston, Massachusetts (1978)

Related Activities

- Institutional Research Board, St. Louis University (2002–2003)
- Institutional Research Board, University of Missouri-St. Louis (2001–2003)

Contact information:

611 King Avenue
City Island, NY 10464
917-710-7029
dora.schriro@gmail.com

Professional References available upon request

DECLARATION OF MY KHANH NGO, ESQ.
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	Elena Durnbaugh, *2 Probable Coronavirus Cases Identified at Calhoun County Jail*, Battle Creek Enquirer (Apr. 24, 2020), https://www.battlecreekenquirer.com/story/news/2020/04/24/2-probable-coronavirus-covid-19-cases-calhoun-county-jail/3018764001/.
B	Coronavirus disease 2019 (COVID-19) Situation Report – 97, World Health Organization (Apr. 26, 2020), https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200426-sitrep-97-covid-19.pdf?sfvrsn=d1c3e800_2.
C	U.S. Immigration & Customs Enforcement, ICE Guidance on COVID-19: Confirmed Cases (updated Apr. 7, 2020), https://www.ice.gov/coronavirus.
D	U.S. Immigration & Customs Enforcement, ICE Guidance on COVID-19: Confirmed Cases (updated Apr. 24, 2020), https://www.ice.gov/coronavirus.
E	Monique O. Madan, *ICE Has Tested A Tiny Fraction of Its Detainees for COVID-19. Most of Them Were Positive*, Miami Herald (Apr. 22, 2020), https://www.miamiherald.com/news/local/immigration/article242203726.html.
F	Ken Klippenstein, *Exclusive: ICE Detainees Are Being Quarantined*, The Nation (Mar. 24, 2020), https://www.thenation.com/article/society/corona-covid-immigration-detention/.

G	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.
H	Letter from Bd. of Correction of the City of New York to Criminal Justice Leaders (Mar. 21, 2020).
I	News Release, *California Chief Justice Issues Second Advisory on Emergency Relief Measures* (Mar. 20, 2020).
J	Linh Ta, *Iowa's Prisons Will Accelerate Release of Approved Inmates To Mitigate COVID-19*, Times Republican (Mar. 23, 2020), https://www.timesrepublican.com/news/todays-news/2020/03/iowas-prisons-will-accelerate-release-of-approved-inmates-to-mitigate-covid-19/.
K	Frank Fernandez, *Coronavirus Preparation Prompts Volusia Jail to Release Some Non-Violent Offenders*, The Daytona Beach News-Journal (Mar. 20, 2020).
L	BBC News, *US Jails Begin Releasing Prisoners to Stem Covid-19 Infections* (Mar. 19, 2020).
M	Mich. Exec. Order No. 2020-29 (Apr. 26, 2020), https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-523422--,00.html.
N	Chief Justice Bridget M. McCormack, Michigan Supreme Court Sheriff Matt Saxton (ret.), Executive Director, Michigan Sheriffs' Association Joint Statement (Mar. 26, 2020), https://courts.michigan.gov/News-Events/press_releases/Documents/CJ%20and%20MSA%20Joint%20Statement%20draft%202%20%28003%29.pdf.
O	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/.

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 26th 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 20, 2020 Elena Durnbaugh,
2 Probable Coronavirus Cases
Identified at Calhoun County Jail,
Battle Creek Enquirer

2 probable coronavirus cases identified at Calhoun County Jail

Elena Durnbaugh, Battle Creek Enquirer Published 10:54 a.m. ET April 24, 2020 | **Updated 11:16 a.m. ET April 24, 2020**

Two probable cases of COVID-19 have been identified at the Calhoun County Jail, according to the Calhoun County Joint Operations Center.

The Calhoun County Sheriff's Office and Public Health Department were notified on Thursday that a corrections staff member showed symptoms of COVID-19.

The staff member went to a personal doctor and tested negative for the coronavirus, according to Sheriff Steve Hinkley, but the individual was told that the symptoms were consistent with COVID-19 and is considered a probable patient.

The corrections deputy does not have responsibilities that involve direct contact with inmates and is self-isolating at home.

The second probable case is an inmate admitted to the jail on Thursday, according to the Joint Operations Center. The person came into the jail with COVID-19 symptoms, including an elevated temperature.

The symptoms were identified during the intake process and precautions were put in place, including putting the person in a negative pressure medical isolation cell.

The individual was tested for COVID-19, and the results are pending.

There is no connection between the two probable cases, according to the Joint Operations Center.

The Calhoun County Jail is working closely with the Public Health Department to mitigate the spread of COVID-19 and is working diligently to protect the health of both corrections staff and inmates.

Calhoun County continues to provide regular updates on its response to COVID-19, including daily case counts, on its website.

Trace Christenson contributed to reporting.

Contact Elena Durnbaugh at (269) 243-5938 or edurnbaugh@battlecreekenquirer.com. Follow her on Twitter at @ElenaDurnbaugh.

Exhibit B

April 26, 2020 Coronavirus disease 2019 (COVID-19) Situation Report – 97, World Health Organization

Coronavirus disease 2019 (COVID-19) Situation Report – 97

Data as received by WHO from national authorities by 10:00 CEST, 26 April 2020

HIGHLIGHTS

- Public health systems are coming under severe strain as the COVID-19 pandemic continues. Countries must also continue to focus on other health emergencies and make progress against diseases such as malaria or poliomyelitis (polio). A new analysis on malaria supports the call to minimize disruptions to malaria prevention and treatment services during the COVID-19 pandemic. More information is available in the statement from the WHO Regional Office for Africa, the statement from the WHO Regional Office for the Americas and in details on the analysis.

- The WHO Regional Office for the Americas urges countries to strengthen vaccination against seasonal influenza and measles to prevent respiratory illness and vaccine-preventable disease outbreaks during the COVID-19 pandemic. More information is available here.

- The core protocol for therapeutics against COVID-19 has been published by the WHO R&D Blueprint Working Group. More information is available here.

- The WHO Regional Director for Europe has emphasized the need to build sustainable people-centred long-term care in the wake of COVID-19. More information is available here.

- The WHO Regional Office for Europe has published key considerations for the gradual easing of the lockdown restrictions introduced by many countries in response to the spread of COVID-19 across the European Region. More information is available here.

SITUATION IN NUMBERS

total (new cases in last 24 hours)

Globally
2 804 796 confirmed (84 900)
193 722 deaths (6018)

European Region
1 341 851 confirmed (27 185)
122 218 deaths (2756)

Region of the Americas
1 094 846 confirmed (47 338)
56 063 deaths (2960)

Eastern Mediterranean Region
160 586 confirmed (5615)
6899 deaths (149)

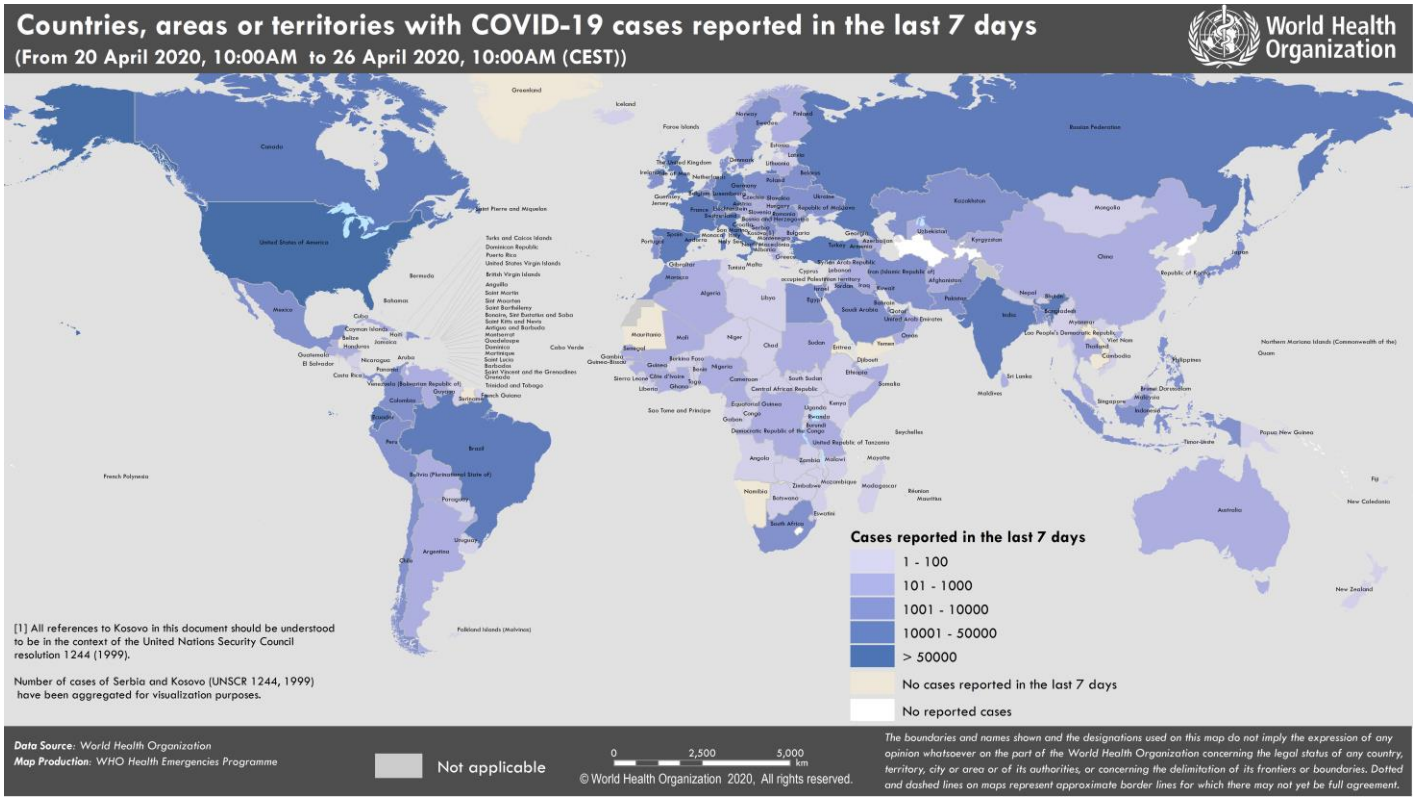
Western Pacific Region
142 639 confirmed (1170)
5943 deaths (37)

South-East Asia Region
43 846 confirmed (2773)
1747 deaths (89)

African Region
20 316 confirmed (819)
839 deaths (27)

WHO RISK ASSESSMENT
Global Level Very High

Figure 1. Countries, territories or areas with reported confirmed cases of COVID-19, 26 April 2020



SURVEILLANCE

Table 1. Countries, territories or areas with reported laboratory-confirmed COVID-19 cases and deaths, by WHO region.* Data as of 26 April 2020

Reporting Country/ Territory/Area†	Total confirmed‡ cases	New confirmed cases	Total deaths	New deaths	Transmission classification§	Days since last reported case
Western Pacific Region						
China	84338	14	4642	0	Clusters of cases	0
Japan	13182	353	348	14	Clusters of cases	0
Singapore	12693	618	12	0	Clusters of cases	0
Republic of Korea	10728	10	242	2	Clusters of cases	0
Philippines	7294	102	494	17	Clusters of cases	0
Australia	6703	16	81	2	Clusters of cases	0
Malaysia	5742	51	98	2	Clusters of cases	0
New Zealand	1121	4	18	0	Clusters of cases	0
Viet Nam	270	0	0	0	Clusters of cases	1
Brunei Darussalam	138	0	1	0	Sporadic cases	6
Cambodia	122	0	0	0	Sporadic cases	14
Mongolia	37	1	0	0	Sporadic cases	0
Lao People's Democratic Republic	19	0	0	0	Sporadic cases	13
Fiji	18	0	0	0	Sporadic cases	5
Papua New Guinea	8	0	0	0	Sporadic cases	3
Guam	137	1	5	0	Clusters of cases	0
French Polynesia	57	0	0	0	Sporadic cases	4
New Caledonia	18	0	0	0	Sporadic cases	23
Northern Mariana Islands (Commonwealth of the)	14	0	2	0	Pending	8
Spain	219764	0	22524	0	Pending	1
Italy	195351	2357	26384	415	Community transmission	0
Germany	154175	1737	5640	140	Community transmission	0
The United Kingdom	148381	4913	20319	813	Community transmission	0
France	122875	1537	22580	368	Community transmission	0
Turkey	107773	2861	2706	106	Community transmission	0
Russian Federation	74588	5966	681	66	Clusters of cases	0
Belgium	45325	1032	6917	238	Community transmission	0
Netherlands	37190	655	4409	120	Community transmission	0

Switzerland	28978	383	1336	28	Community transmission	0
Portugal	23392	595	880	26	Pending	0
Ireland	18561	377	1063	234	Pending	0
Sweden	18177	610	2192	40	Community transmission	0
Israel	15398	370	199	5	Pending	0
Austria	15134	66	536	23	Pending	0
Poland	11273	381	524	30	Pending	0
Romania	10635	218	575	23	Community transmission	0
Belarus	9590	817	67	4	Clusters of cases	0
Ukraine	8617	492	209	8	Community transmission	0
Denmark	8445	235	418	15	Pending	0
Serbia	7779	296	151	7	Pending	0
Norway	7467	59	193	2	Pending	0
Czechia	7352	79	218	3	Community transmission	0
Finland	4475	80	186	9	Pending	0
Luxembourg	3711	16	85	0	Pending	0
Republic of Moldova	3304	194	94	7	Pending	0
Kazakhstan	2601	185	25	0	Pending	0
Greece	2506	16	130	0	Pending	0
Hungary	2500	57	272	10	Clusters of cases	0
Croatia	2016	7	54	3	Community transmission	0
Uzbekistan	1865	29	8	0	Clusters of cases	0
Iceland	1790	1	10	0	Community transmission	0
Armenia	1746	150	28	1	Clusters of cases	0
Estonia	1635	30	46	0	Pending	0
Azerbaijan	1617	25	21	0	Clusters of cases	0
Bosnia and Herzegovina	1485	57	56	2	Community transmission	0
Lithuania	1438	28	41	1	Pending	0
Slovenia	1388	15	81	1	Community transmission	0
Slovakia	1373	13	17	0	Clusters of cases	0
North Macedonia	1367	41	59	2	Clusters of cases	0
Bulgaria	1247	59	55	1	Pending	0
Cyprus	810	6	17	0	Clusters of cases	0
Latvia	804	20	12	0	Pending	0
Andorra	738	5	40	0	Community transmission	0
Albania	712	34	27	0	Clusters of cases	0
Kyrgyzstan	682	17	8	0	Pending	0
San Marino	513	0	40	0	Community transmission	1
Georgia	485	29	5	0	Community transmission	0

Malta	448	1	4	1	Pending	0
Montenegro	319	0	6	1	Clusters of cases	1
Liechtenstein	83	1	1	0	Pending	0
Monaco	68	0	1	0	Sporadic cases	12
Holy See	9	0	0	0	Sporadic cases	5
Kosovo[1]	731	28	20	1	Community transmission	0
Isle of Man	308	0	18	1	Pending	1
Jersey	278	2	19	0	Pending	0
Guernsey	245	0	11	1	Community transmission	1
Faroe Islands	187	0	0	0	Pending	2
Gibraltar	136	3	0	0	Clusters of cases	0
Greenland	11	0	0	0	Pending	20
India	26496	1990	824	49	Clusters of cases	0
Indonesia	8607	396	720	31	Community transmission	0
Bangladesh	4998	309	140	9	Pending	0
Thailand	2922	15	51	0	Pending	0
Sri Lanka	460	40	7	0	Clusters of cases	0
Myanmar	146	2	5	0	Clusters of cases	0
Maldives	137	21	0	0	Clusters of cases	0
Nepal	49	0	0	0	Sporadic cases	1
Timor-Leste	24	0	0	0	Clusters of cases	2
Bhutan	7	0	0	0	Sporadic cases	3
Iran (Islamic Republic of)	89328	1134	5650	76	Community transmission	0
Saudi Arabia	16299	1197	136	9	Clusters of cases	0
Pakistan	12723	783	269	16	Clusters of cases	0
United Arab Emirates	9813	532	71	7	Pending	0
Qatar	9358	833	10	0	Pending	0
Egypt	4319	227	307	13	Clusters of cases	0
Morocco	3897	139	159	1	Clusters of cases	0
Kuwait	2892	278	19	4	Clusters of cases	0
Bahrain	2589	71	20	12	Clusters of cases	0
Oman	1998	93	10	0	Clusters of cases	0
Iraq	1763	55	86	0	Clusters of cases	0
Afghanistan	1463	133	49	6	Clusters of cases	0
Djibouti	1008	9	2	0	Clusters of cases	0
Tunisia	939	17	38	0	Community transmission	0
Lebanon	704	8	24	2	Clusters of cases	0
Jordan	444	3	7	0	Clusters of cases	0
Somalia	390	62	18	2	Sporadic cases	0
Sudan	213	39	17	1	Sporadic cases	0
Libya	61	0	2	0	Clusters of cases	1

Syrian Arab Republic	42	0	3	0	Community transmission	4
Yemen	1	0	0	0	Pending	15
occupied Palestinian territory	342	2	2	0	Clusters of cases	0
United States of America	899281	38509	46204	2151	Community transmission	0
Brazil	52995	3503	3670	357	Community transmission	0
Canada	44353	1614	2350	153	Community transmission	0
Ecuador	22719	0	576	0	Community transmission	1
Peru	21648	734	634	62	Community transmission	0
Mexico	12872	1239	1221	152	Community transmission	0
Chile	12858	552	181	7	Community transmission	0
Dominican Republic	5926	177	273	6	Community transmission	0
Panama	5338	172	154	8	Community transmission	0
Colombia	4881	320	225	10	Community transmission	0
Argentina	3701	222	179	12	Community transmission	0
Cuba	1337	52	51	2	Clusters of cases	0
Bolivia (Plurinational State of)	807	104	44	1	Clusters of cases	0
Costa Rica	687	1	6	0	Clusters of cases	0
Honduras	591	29	55	8	Clusters of cases	0
Uruguay	563	6	12	0	Clusters of cases	0
Guatemala	430	46	13	2	Clusters of cases	0
Venezuela (Bolivarian Republic of)	318	0	10	0	Clusters of cases	1
Jamaica	288	31	7	0	Clusters of cases	0
El Salvador	274	13	8	0	Clusters of cases	0
Paraguay	223	3	9	0	Community transmission	0
Trinidad and Tobago	115	0	8	0	Sporadic cases	3
Barbados	77	1	6	0	Clusters of cases	0
Guyana	73	3	7	0	Clusters of cases	0
Bahamas	72	0	11	0	Clusters of cases	1
Haiti	72	0	6	1	Clusters of cases	1
Antigua and Barbuda	24	0	3	0	Clusters of cases	3
Belize	18	0	2	0	Sporadic cases	11
Dominica	16	0	0	0	Clusters of cases	15
Grenada	15	0	0	0	Clusters of cases	2
Saint Kitts and Nevis	15	0	0	0	Sporadic cases	5
Saint Lucia	15	0	0	0	Sporadic cases	14

Saint Vincent and the Grenadines	14	0	0	0	Sporadic cases	1
Nicaragua	11	0	3	0	Pending	1
Suriname	10	0	1	0	Sporadic cases	22
Puerto Rico	1276	0	77	26	Clusters of cases	4
Martinique	170	0	14	0	Clusters of cases	2
Guadeloupe	149	0	12	0	Clusters of cases	1
French Guiana	109	0	1	0	Clusters of cases	1
Aruba	100	0	2	0	Clusters of cases	3
Bermuda	99	0	5	0	Clusters of cases	2
Sint Maarten	73	0	12	0	Clusters of cases	2
Cayman Islands	70	4	1	0	Clusters of cases	0
United States Virgin Islands	55	1	3	0	Clusters of cases	0
Saint Martin	38	0	3	1	Sporadic cases	3
Curaçao	14	0	1	0	Sporadic cases	17
Falkland Islands (Malvinas)	13	1	0	0	Clusters of cases	0
Montserrat	11	0	1	1	Sporadic cases	12
Turks and Caicos Islands	11	0	1	0	Sporadic cases	9
British Virgin Islands	6	1	1	0	Sporadic cases	0
Saint Barthélemy	6	0	0	0	Sporadic cases	26
Bonaire, Sint Eustatius and Saba	5	0	0	0	Sporadic cases	8
Anguilla	3	0	0	0	Sporadic cases	22
Saint Pierre and Miquelon	1	0	0	0	Sporadic cases	18
South Africa	4361	141	86	7	Community transmission	0
Algeria	3256	129	419	4	Community transmission	0
Cameroon	1518	115	53	4	Clusters of cases	0
Ghana	1279	0	10	0	Clusters of cases	1
Nigeria	1182	87	35	3	Community transmission	0
Côte d'Ivoire	1111	34	14	0	Clusters of cases	0
Guinea	996	42	7	1	Community transmission	0
Niger	684	3	27	3	Clusters of cases	0
Burkina Faso	629	13	41	0	Community transmission	0
Senegal	614	69	7	0	Clusters of cases	0
Democratic Republic of the Congo	442	26	28	0	Clusters of cases	0
Mali	370	45	21	0	Clusters of cases	0
Kenya	343	7	14	0	Clusters of cases	0
Mauritius	331	0	9	0	Community transmission	2

United Republic of Tanzania	300	0	10	0	Clusters of cases	1
Equatorial Guinea	258	46	1	0	Clusters of cases	0
Congo	200	0	8	2	Clusters of cases	1
Rwanda	183	7	0	0	Clusters of cases	0
Gabon	176	4	3	0	Clusters of cases	0
Madagascar	124	2	0	0	Clusters of cases	0
Ethiopia	122	5	3	0	Clusters of cases	0
Liberia	120	3	11	3	Clusters of cases	0
Togo	96	6	6	0	Clusters of cases	0
Cabo Verde	90	2	1	0	Sporadic cases	0
Sierra Leone	86	4	3	0	Clusters of cases	0
Zambia	84	0	3	0	Sporadic cases	1
Uganda	75	0	0	0	Sporadic cases	1
Mozambique	70	5	0	0	Sporadic cases	0
Benin	58	0	1	0	Sporadic cases	2
Eswatini	56	16	1	0	Sporadic cases	0
Guinea-Bissau	52	0	0	0	Sporadic cases	2
Chad	46	6	0	0	Sporadic cases	0
Eritrea	39	0	0	0	Sporadic cases	7
Malawi	33	0	3	0	Sporadic cases	2
Zimbabwe	31	2	4	0	Sporadic cases	0
Angola	25	0	2	0	Sporadic cases	2
Botswana	22	0	1	0	Sporadic cases	3
Central African Republic	19	0	0	0	Sporadic cases	1
Namibia	16	0	0	0	Sporadic cases	20
Burundi	12	0	1	0	Sporadic cases	1
Seychelles	11	0	0	0	Sporadic cases	19
Gambia	10	0	1	0	Sporadic cases	5
São Tomé and Príncipe	8	0	0	0	Sporadic cases	2
Mauritania	7	0	1	0	Sporadic cases	15
South Sudan	5	0	0	0	Sporadic cases	1
Réunion	412	0	0	0	Clusters of cases	2
Mayotte	354	0	4	0	Clusters of cases	1
Subtotal for all Regions	**2804084**	**84900**	**193709**	**6018**		
International conveyance (Diamond Princess)	712	0	13	0	Not Applicable[††]	41
Grand total	**2804796**	**84900**	**193722**	**6018**		

[*]Countries are arranged by official WHO regions, in descending order by the number of total confirmed cases. Overseas territories[**] are listed under the WHO region that administers them.

[†]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 a process of country/territory/area self-reporting. Classifications are reviewed on a weekly basis and may be upgraded or downgraded as new information becomes available. Not all locations within a given country/territory/area are equally affected; countries/territories/areas experiencing multiple types of transmission are classified in the highest category reported. Within a given transmission category, different countries/territories/areas may have differing degrees of transmission as indicated by the differing numbers of

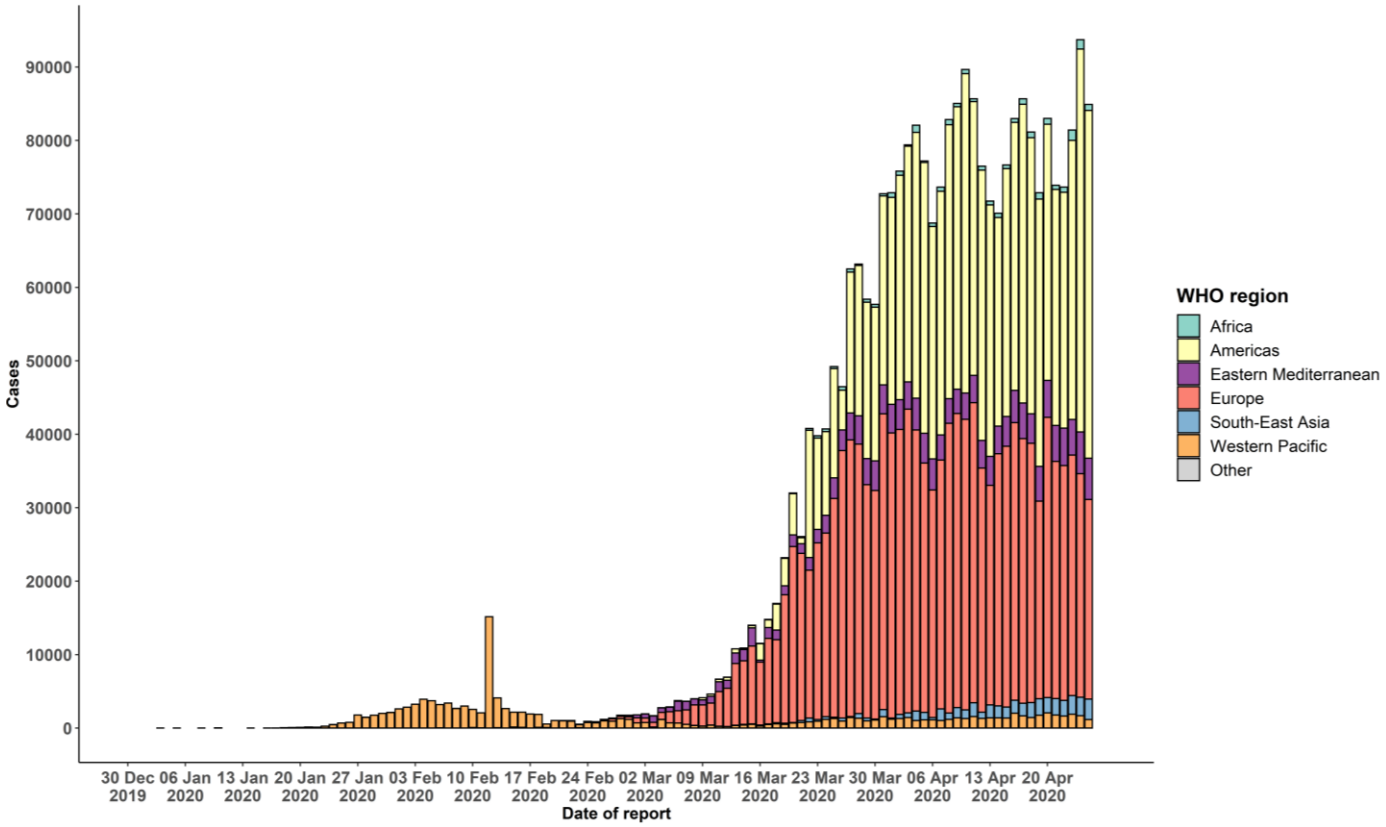
cases, recency of cases, and other factors.
Terms:

- **No cases**: Countries/territories/areas with no confirmed cases (not shown in table)
- **Sporadic cases**: Countries/territories/areas with one or more cases, imported or locally detected
- **Clusters of cases**: Countries/territories/areas experiencing cases, clustered in time, geographic location and/or by common exposures
- **Community transmission**: Countries/area/territories experiencing larger outbreaks of local transmission defined through an assessment of factors including, but not limited to:
    - Large numbers of cases not linkable to transmission chains
    - Large numbers of cases from sentinel lab surveillance
    - Multiple unrelated clusters in several areas of the country/territory/area

** "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).
†† As the international conveyance (Diamond Princess) is no longer occupied, transmission classification cannot be applied.

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.

Figure 2. Epidemic curve of confirmed COVID-19, by date of report and WHO region through 26 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 COVID-19 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 COVID-19.
- 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 COVID-19.
- WHO has provided recommendations to reduce risk of transmission from animals to humans.
- WHO has published an updated recommendations for international traffic in relation to COVID-19 outbreak .
- WHO has activated the R&D blueprint to accelerate diagnostics, vaccines, and therapeutics.
- OpenWHO is an interactive, web-based, knowledge-transfer platform offering free online courses to improve the response to health emergencies. COVID-19 resources are hosted on 2 learning channels: one for courses in official WHO languages here and a second for courses in additional national languages here.
    - There are more than 1.5 million enrolments in the platform's courses to support the COVID-19 response. Specifically, WHO has developed courses on the following topics:
    - A general introduction to emerging respiratory viruses, including novel coronaviruses (available in Arabic, Chinese, English, French, Russian, Spanish, Bengali, Hindi, Hungarian, Indian Sign Language, Indonesian, Macedonian, Persian, Portuguese, Serbian, Turkish and Vietnamese);

  - Clinical care for Severe Acute Respiratory Infection (SARI) (available in English, French, Russian, Spanish, Indonesian, Portuguese and Vietnamese);
  - Health and safety briefing for respiratory diseases – ePROTECT (available in Arabic, Chinese, English, French, Russian, Spanish, Indonesian and Portuguese);
  - Infection Prevention and Control for COVID-19 (available in Chinese, English, French, Russian, Spanish, Indonesian, Italian, Japanese, Macedonian, Portuguese, Serbian and Turkish);
  - COVID-19 operational planning guidelines and partners platform to support country preparedness and response (available in Chinese, English, French, Russian, Indonesian and Portuguese);
  - SARI treatment facility design (available in Arabic, English, Italian and Portuguese);
  - An introduction to Go.Data – field data collection, chains of transmission and contact follow-up (available in English and coming soon in additional languages);
  - How to put on and remove personal protective equipment (PPE) for COVID-19 (available in English and coming soon in additional languages); and
  - Standard precautions for hand hygiene (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.

Definition of COVID-19 death

COVID-19 death is defined for surveillance purposes as a death resulting from a clinically compatible illness in a probable or confirmed COVID-19 case, unless there is a clear alternative cause of death that cannot be related to COVID disease (e.g. trauma). There should be no period of complete recovery between the illness and death.

Further guidance for certification and classification (coding) of COVID-19 as cause of death is available here.

[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 C

April 7, 2020 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

DETAINEES

19

There have been 19 confirmed cases of COVID-19 among those in ICE custody*.

- 2 detainees in Bergen County Jail (Hackensack, NJ)
- 2 detainees in Essex County Correctional Facility (Newark, NJ)
- 2 detainees in Hudson County Jail (Kearny, NJ)
- 2 detainees in La Palma Correctional Facility (Eloy, AZ)
- 1 detainee in LaSalle Correctional Center (Olla, LA)
- 5 detainees in Pike County Correctional Facility (Hawley, PA)
- 1 detainee in Pine Prairie ICE Processing Center (Pine Prairie, LA)
- 1 detainee in St. Clair County Jail (Huron, MI)
- 1 detainee in York County Prison (York, PA)
- 1 detainee in Otay Mesa Detention Center (San Diego, CA)

*Some detainees may no longer be in ICE custody.

Updated 04/07/2020 4:05pm

DETENTION FACILITY EMPLOYEES & PERSONNEL

7

There have been 7 confirmed cases of COVID-19 among ICE employees and personnel working in ICE detention facilities.

- 2 ICE personnel in Aurora Contract Detention Facility (Aurora, CO)
- 1 ICE personnel in Elizabeth Contract Detention Facility (Elizabeth, NJ)
- 1 ICE personnel in Houston Contract Detention Facility (Houston, TX)
- 1 ICE personnel in Hudson County Jail (Kearny, NJ)
- 2 ICE personnel in Alexandria Staging Facility (Alexandria, LA)

Updated 04/04/2020 8:00pm

ICE

There have been 48 confirmed cases of COVID-19 among ICE employees

EMPLOYEES not assigned to detention facilities.

48

Updated 04/04/2020 8:00pm

Last Reviewed/Updated: 04/07/2020

Exhibit D

April 24, 2020 U.S. Immigration & Customs Enforcement, ICE Guidance on COVID-19: Confirmed Cases

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

DETAINEES

317

There have been 317 confirmed cases of COVID-19 among those in ICE custody*.

- 9 detainees in Adams County Correctional Center (Natchez, MS)
- 2 detainees in Bergen County Jail (Hackensack, NJ)
- 1 detainee in Bluebonnet Detention Facility (Anson, TX)
- 49 detainees in Buffalo Federal Detention Facility (Batavia, NY)
- 2 detainees in Caroline Detention Facility (Bowling Green, VA)
- 1 detainee in Catahoula Correctional Center (Harrisonburg, LA)
- 5 detainees in El Paso Processing Center (El Paso, TX)
- 13 detainees in Elizabeth Detention Center (Elizabeth, NJ)
- 2 detainees in Essex County Correctional Facility (Newark, NJ)
- 10 detainees in Florence Detention Center (Florence, AZ)
- 8 detainees in Hudson County Jail (Kearny, NJ)
- 1 detainee in IAH Secure Adult Detention Facility (Livingston, TX)
- 1 detainee in Irwin County Detention Center (Ocilla, GA)
- 2 detainees in Krome Detention Center (Miami, FL)
- 18 detainees in La Palma Correctional Facility (Eloy, AZ)
- 20 detainees in LaSalle ICE Processing Center (Jena, LA)
- 3 detainees in Montgomery Processing Center (Conroe, TX)
- 57 detainees in Otay Mesa Detention Center (San Diego, CA)
- 2 detainees in Otero County Processing Center (Chaparral, NM)
- 35 detainees in Prairieland Detention Center (Alvarado, TX)
- 14 detainees in Pike County Correctional Facility (Hawley, PA)
- 15 detainees in Pine Prairie ICE Processing Center (Pine Prairie, LA)
- 9 detainees in Pulaski County Detention Center (Ullin, IL)
- 32 detainees in Richwood Correctional Center (Monroe, LA)
- 2 detainees in River Correctional Center (Ferriday, LA)

- 2 detainees in South Texas ICE Processing Center (Pearsall, TX)
- 5 detainees in St. Clair County Jail (Huron, MI)
- 9 detainees in Stewart Detention Center (Lumpkin, GA)
- 2 detainees in Winn Correctional Center (Winnfield, LA)
- 1 detainee in York County Prison (York, PA)

*Some detainees may no longer be in ICE custody.

Updated 04/24/2020 5:00pm

ICE EMPLOYEES AT DETENTION CENTERS

35

There have been 35 confirmed cases of COVID-19 among ICE employees working in ICE detention facilities.

- 14 at Alexandria Staging Facility (Alexandria, LA)
- 2 at Aurora Contract Detention Facility (Aurora, CO)
- 1 in Bergen County Jail (Hackensack, NJ)
- 1 at Butler County Jail (Hamilton, OH)
- 2 at Elizabeth Contract Detention Facility (Elizabeth, NJ)
- 1 at Essex County Correctional Facility (Newark, NJ)
- 1 at Florence Correctional Center (Florence, AZ)
- 2 at Houston Contract Detention Facility (Houston, TX)
- 1 at Hudson County Jail (Kearny, NJ)
- 8 at Otay Mesa Detention Center (San Diego, CA)
- 1 at Stewart Detention Center (Lumpkin, GA)

Updated 04/24/2020 5:00pm

ICE EMPLOYEES

89

There have been 88 confirmed cases of COVID-19 among ICE employees not assigned to detention facilities.

Updated 04/24/2020 5:00pm

Last Reviewed/Updated: 04/24/2020

Exhibit E

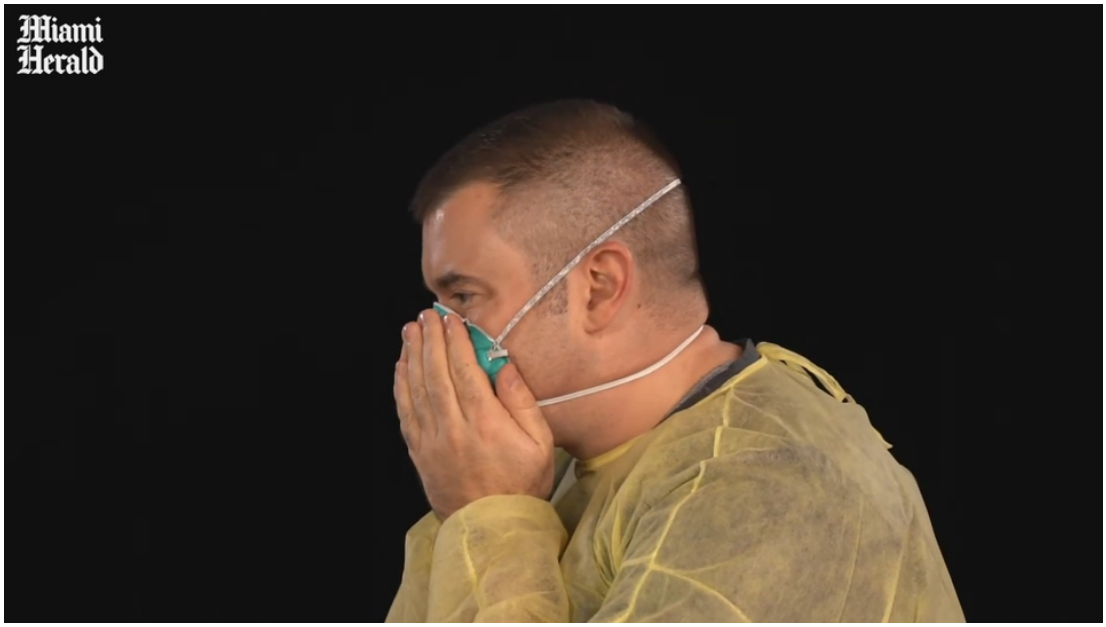
April 22, 2020 Monique O. Madan, ICE has tested a tiny fraction of its detainees for COVID-19. Most of them were positive.

IMMIGRATION

ICE has tested a tiny fraction of its detainees for COVID-19. Most of them were positive

BY MONIQUE O. MADAN

APRIL 22, 2020 02:48 PM, UPDATED APRIL 22, 2020 07:20 PM



This video demonstrates the recommendations by the CDC for putting on and taking off N95 and surgical masks. BY MARTA OLIVER CRAVIOTTO | CENTERS FOR DISEASE CONTROL AND PREVENTION

At least 60% of immigration detainees who have been tested nationwide have the virus that causes COVID-19, according to federal data.

According to U.S. Immigration and Customs Enforcement, 425 of its 32,309 detainees have been tested for the new coronavirus as of Tuesday.

The numbers from ICE reveal that only 1.32% of its detainees have been tested. Out of those 425 tests, the agency says on its website that 253 people tested positive as of Wednesday, meaning that 59.5% of people who were tested have the virus.

That number could be higher because ICE does not update its website in real time. In the past few weeks, officials have delayed by up to a week in posting the number of confirmed cases on its COVID-19 webpage.

ICE does not report on its site how many tests have been administered. The Miami Herald obtained those numbers from an agency official on Wednesday.

"One of U.S. Immigration and Customs Enforcement's (ICE) highest priorities is the health and safety of those in our custody," ICE said in a statement on Wednesday. "Detainees are being monitored and tested for COVID-19 in line with CDC guidance, and in conjunction with the recommendations of state and local health partners."

Last week, a federal lawsuit was filed in Miami federal court citing national health experts who said the opposite.

According to the sworn statements, health experts say U.S. immigration officials are violating federal guidelines by grouping inmates together by the hundreds if they have COVID-19 symptoms

or have been exposed to the coronavirus, a measure that the agency calls "cohorting."

ICE "directly contradicts [Centers for Disease Control and Prevention] guidance in several ways, including, most critically, that ICE officials describe cohorting as the planned response to a known COVID-19 exposure, not a practice of last resort," said Joseph Shin, an assistant professor of medicine at Weill Cornell Medicine, a founding member of the Cornell Center for Health Equity, and past medical director for the Weill Cornell Center for Human Rights, in a sworn statement that is part of the lawsuit.

On Tuesday, ICE told a federal judge that 350 detainees — more than half of the detainees inside Krome, an immigration detention center in southwest Miami-Dade County — have been exposed to COVID-19.

But those numbers are "likely to be much greater," experts say, due to a lack of testing and the agency's transfer practices. A recent example includes at least 50 Guatemalans being transferred between an airport and detention centers at least 13 times within the last eight days. ICE is also not testing people who have shown serious symptoms, federal sources inside detention centers say.

"If people are coming and going, and leaving and then coming in, then the number of people that have actually been exposed is way more than 350," Dr. Ashish Jha, director of Harvard's Global Health Institute, told the Miami Herald.

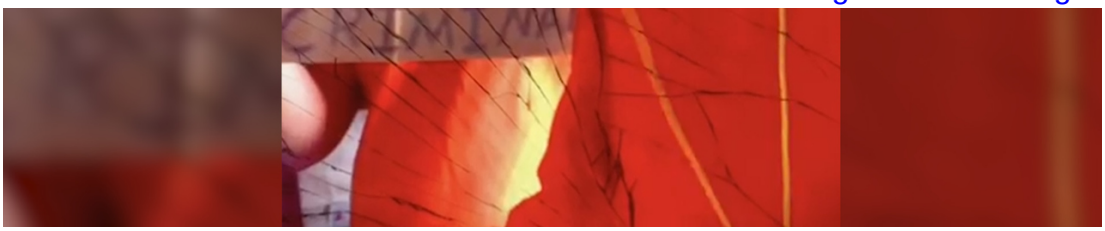
"The idea that you have all these transfers from center to center or to airports, each one of them requires officers and a number of people that you have to interact with," Jha added. "It's very risky under the context of coronavirus. So by cohorting people, all you are doing is spreading it among everyone, including people that may not have it. And because we are not testing, there is no way of knowing."

MONIQUE O. MADAN

305-376-2108

Monique O. Madan covers immigration and enterprise; she previously covered breaking news and local government. Her work has appeared in The New York Times, The Boston Globe, The Boston Herald and The Dallas Morning News. She is currently a Reveal Fellow at the Center for Investigative Reporting. She graduated from Miami Dade College and Emerson College in Boston. A note to tipsters: If you want to send Monique confidential information, her email and mailbox are open. The address is 3511 NW 91st Ave, Doral, FL 33172. You can also direct message her on social media and she'll provide encrypted Signal details.

COMMENTS



Immigration inmates say they have no access to masks, gloves amid coronavirus

COVID-19 stranded these Argentine tourists, now they're living in Liberty City with no way back home

VIEW MORE VIDEO →

TRENDING STORIES

More coronavirus cases reported at 24 South Florida grocery stores, including Publix

UPDATED APRIL 24, 2020 11:14 PM

Miami-Dade has tens of thousands of missed coronavirus infections, UM survey finds

UPDATED APRIL 24, 2020 03:49 PM

Florida sees steepest decline in new daily coronavirus cases, deaths. This may be an anomaly

UPDATED APRIL 25, 2020 09:46 PM

'I'm not in a rush.' DeSantis says no theaters or sports venues yet. Florida will reopen in phases

UPDATED APRIL 25, 2020 06:09 PM

NFL draft's second day begins with a bang for Miami Dolphins but ends without sizzle

UPDATED APRIL 25, 2020 11:25 AM

MORE IMMIGRATION

HAITI

ICE plans to increase COVID-19 testing as Haiti commission calls for pause in deportations

UPDATED APRIL 24, 2020 06:11 PM

IMMIGRATION

ICE may start testing deportees pending results of coronavirus checks by CDC in Guatemala

UPDATED APRIL 23, 2020 08:02 PM

IMMIGRATION

Judge says ICE should 'substantially' cut detention center populations, give detainees masks

UPDATED APRIL 22, 2020 08:05 PM

IMMIGRATION

More than half of Krome detainees have been exposed to the coronavirus

UPDATED APRIL 21, 2020 05:15 PM

IMMIGRATION

Trump to sign executive order to 'suspend immigration' amid coronavirus pandemic

UPDATED APRIL 21, 2020 11:27 AM

IMMIGRATION

Miami airport spokesman who said flights were chartered by ICE says he made a 'mistake'

UPDATED APRIL 20, 2020 05:52 PM

Exhibit F

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

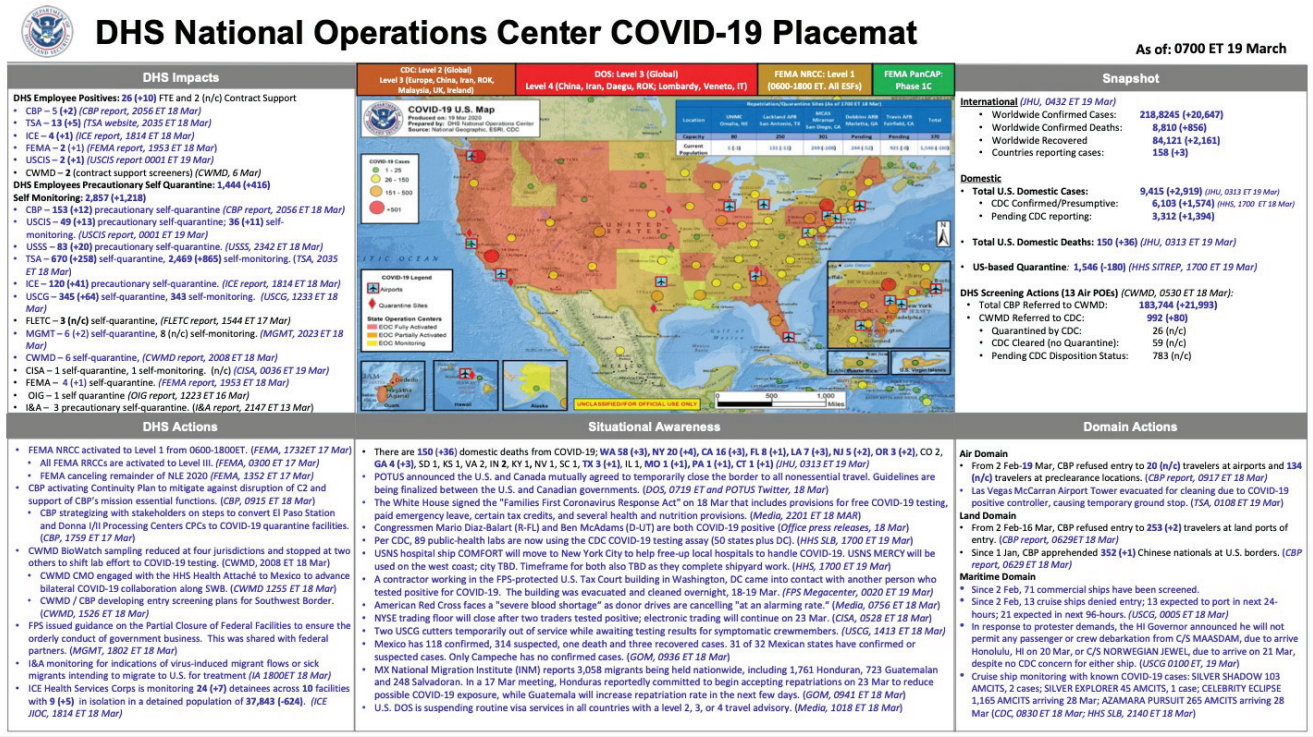
March 24, 2020

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 *(IHU, 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)** *(IHU, 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)** *(IHU, 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)** *(IHU, 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

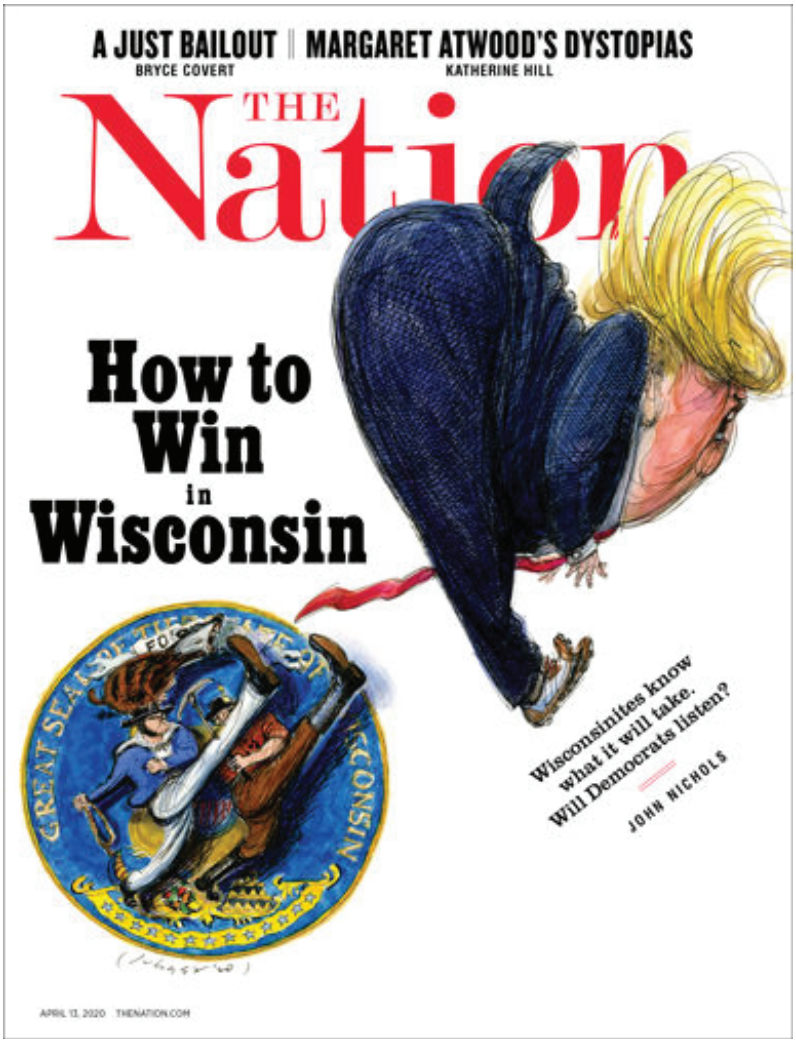
Peter Kornbluh

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 G

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,
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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 H

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 I

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.

CALIFORNIA COURTS
THE JUDICIAL BRANCH OF CALIFORNIA

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.

CALIFORNIA COURTS
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 J

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 K

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

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

NJ news-journalonline.com/news/20200320/coronavirus-preparation-prompts-volusia-jail-to-release-some-non-violent-offenders

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.

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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.

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Exhibit L

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

bbc.com/news/world-us-canada-51947802

Image copyright Getty Images
Image caption New York is to release prisoners who are most vulnerable to coronavirus infection

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.

More about coronavirus

- 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.

Media playback is unsupported on your device
Media captionCoronavirus: Trump blames media for virus spread

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.

Exhibit M

April 26, 2020
Mich. Exec. Order No. 2020-29

Executive Order 2020-29 (COVID-19)

michigan.gov/whitmer/0,9309,7-387-90499_90705-523422--,00.html

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:

1. 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.

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

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

4. 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.

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

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

7. 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.

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

1. Ensuring that protective laundering protocols are in place.

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

11. 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:

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

2. Anyone who is incarcerated for a traffic violation.

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

4. 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:

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

2. 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.

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

4. 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 N

March 26, 2020 Chief Justice Bridget M. McCormack, Michigan Supreme Court Sheriff Matt Saxton (ret.), Executive Director, Michigan Sheriffs' Association Joint Statement

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.

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Exhibit O

March 22, 2020 John Sandweg, I Used to Run ICE. We Need to Release the Nonviolent Detainees, The Atlantic

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

theatlantic.com/ideas/archive/2020/03/release-ice-detainees/608536/

John Sandweg Former acting director of Immigration and Customs Enforcement

March 22, 2020

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.

John Sandweg is the former acting director of Immigration and Customs Enforcement.

DECLARATION OF HEATHER GARVOCK, ESQ.
REGARDING QAID AHMED ALHALMI

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

1. My name is Heather Garvock. I make these statements based upon my personal knowledge after having spoken with my client and reviewing his immigration records.
2. I am an attorney with Ellis Porter, PLC. I represent Qaid Ahmed Alhalmi, a 58-year-old Yemeni national who has been in civil immigration detention at Calhoun County Correctional Facility ("Calhoun") since September 2019 based on an old final removal order, which I describe further below. I began representing Mr. Alhalmi on March 23, 2020 and have spoken to him anywhere between one and four times per week via phone and video visitation over the past month.
3. In my conversations with Mr. Alhami, and my review of his immigration file, I have learned the following:
    a. Mr. Alhalmi entered the United States twice, first on May 29, 1992 as a nonimmigrant visitor, and then on July 27, 1995, also as a nonimmigrant visitor. He has remained in the United States ever since.
    b. Mr. Alhalmi has a history of serious medical conditions:

i. Mr. Alhalmi suffers from hypertension, which creates a high risk of heart attack, stroke, or other serious complications.

ii. Mr. Alhalmi also suffers from type 2 diabetes. His condition was previously managed with diet and medication. Since coming to Calhoun, Mr. Alhalmi's blood sugar has increased and he has become insulin dependent.

iii. For the last three weeks, Mr. Alhalmi has been experiencing chest pain upon exertion and shortness of breath. Patients with type 2 diabetes are prone to "silent heart attacks" the symptoms of which include periodic chest pains upon exertion and shortness of breath. Mr. Alhalmi requested a medical exam, and Calhoun performed an x-ray, but did not provide adequate screening to evaluate whether a cardiac event had occurred, such as blood work, an EKG or stress test, or an echocardiogram. Mr. Alhalmi's son-in-law, also a physician, shared his concerns with a Calhoun staff member who denied his request and claimed that Calhoun

would determine what testing Mr. Alhalmi should receive. Mr. Alhalmi continues to have chest pains but has not received further testing or even seen a doctor.

iv. U.S. Immigration and Customs Enforcement ("ICE") is aware of Mr. Alhalmi's medical conditions. During his initial health screening, Calhoun learned that he had hypertension, that his blood sugar was too high, and that he had extreme chest pain.

v. Because of his pre-existing medical conditions, Mr. Alhalmi is very worried about his risk of being infected with COVID-19 at Calhoun. Additionally, based on the experience he has had related to his chest pain, he fears that if he is infected he will not receive adequate testing and care to ensure that he does not experience the most severe symptoms of the disease.

4. Throughout the course of my representation of Mr. Alhalmi, I have also learned the following about conditions in Calhoun:

a. Mr. Alhalmi is housed in a small, which he estimates to be approximately seven by five feet cell, with one other detainee.

Mr. Alhalmi's cell contains a bunk bed, toilet, sink, and bar of soap, all of which he shares with his cellmate.

b. Mr. Alhalmi's cell is located in Pod B, which contains approximately 58 detainees and includes detainees serving criminal sentences. There are no windows in the Pod. All detainees in Pod B share four showers that are cleaned once a week. They also share two common bathrooms. The bathrooms contain sinks, but there is often no soap available for handwashing. The detainees do not have access to hand sanitizer.

c. Detainees are constantly moved in and out of Mr. Alhalmi's small cell. He has shared a cell with five different cellmates in the last two weeks. The cells are not cleaned before new cellmates arrive or after old cellmates leave.

d. Calhoun does not provide detainees with gloves or masks. Mr. Alhalmi has only seen medical caretakers wearing masks. However, Mr. Alhalmi saw a maskless nurse caring for another inmate, while Mr. Alhalmi was waiting to be seen in the medical area.

e. At least seven detainees housed in the same Pod as Mr. Alhalmi are exhibiting symptoms consistent with COVID-19, including a cough and sore throat. Mr. Alhalmi does not believe that they have been tested for the virus, despite having requested testing.

f. Detainees in Pod A may have contracted COVID-19. Mr. Alhalmi was transferred from Pod A to Pod B approximately two weeks ago, and was told by Deputy Green, a male deputy for the Calhoun County Sheriff's Department, that the transfer was due to recent cases of "disease" in Pod A.

g. Detainees are unable to effectively practice social distancing by remaining six feet apart. At least four times per day all detainees are locked down and must stand next to each other by their bunk beds. While detainees eat, they all sit within arm's reach of one another. Calhoun staff have not discussed social distancing with the detainees, who continue to trade and share food with one another and generally remain in close proximity to one another.

h. While on video calls with my client, I have observed detainees milling around my client, frequently standing close enough to touch one another, and at times passing within a few feet of my client as he speaks to me on the phone.

5. Mr. Alhalmi was detained on or around September 17, 2019, during one of his standard Order of Supervision appointments. Mr. Alhalmi had been living in the community and complied with his order of supervision for 17 years without any issues since receiving a final removal order in 2002.
6. Mr. Alhalmi has never been convicted of a felony in the United States. In 2009, in Louisiana, he was charged with obscenity for failing to request a minor's identification when selling a pornographic video as a video store clerk. However, the charge was dismissed after he completed classes through the District Attorney's Diversion Program.
7. Mr. Alhalmi's final order of removal to Yemen was issued on August 8, 2002, in Detroit, Michigan. The Board of Immigration Appeals ("BIA") dismissed his appeal on December 15, 2003. On February 27, 2020, the BIA denied his Motion to Reopen. Mr. Alhalmi filed a Motion to Reconsider with the Board of Immigration Appeals on March 27, 2020,which is currently pending with the BIA. He has also filed an appeal of the BIA's dismissal with the Sixth Circuit.
8. I believe Mr. Alhalmi has not been removed, despite his order of removal, due to the ongoing civil war in Yemen which has made it difficult, if not impossible, to remove individuals to Yemen.

9. Before being detained, Mr. Alhalmi lived in Michigan with his wife of thirteen years. He has six children, three of whom are in the United States. Of his children in the United States, two are U.S. citizens, and the third is a lawful permanent resident. Prior to being detained, Mr. Alhalmi worked as a businessman, owning convenience stores in the Louisiana and Michigan areas.

10. If released, Mr. Alhalmi will live in his home in Dearborn, Michigan. At his home, Mr. Alhalmi will be able to get medical treatment for his pre-existing medical conditions while maintaining a safe distance from others and quarantining as necessary. Mr. Alhalmi is willing to comply with conditions of release like check-ins, as he did prior to being detained. His wife, Kelly Saleh, who is a U.S. citizen, would be able to pick him up from Calhoun.

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 26th day of April 2020.

/s/ Heather Garvock

Heather Garvock, Esq.
Ellis Porter, PLC
2211 Old Earhart Road, Suite 160
Ann Arbor, MI 48105

DECLARATION OF RICHARD KESSLER

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

1. My name is Richard Kessler. I make these statements based upon my personal knowledge.
2. I am an immigration attorney. I have practiced immigration law for over 38 years.
3. I represent Tomas Cardona Ramirez, a 38 year-old Guatemalan national, who has been detained in the Calhoun County Correctional Center ("Calhoun") in Battle Creek, Michigan since February 2020.
4. Mr. Cardona Ramirez came to the United States in 2004. The Detroit Immigration Court granted voluntary departure on April 24, 2020.
5. Mr. Cardona Ramirez is worried about exposure to COVID-19 due to a number of serious, pre-existing medical issues.
    a. Mr. Cardona Ramirez suffers from Type 2 diabetes. He was prescribed insulin and other medication to regulate his blood sugar and has continued to receive treatment while detained at Calhoun.
    b. Mr. Cardona Ramirez also has high blood pressure and hypertension. On July 29, Mr. Cardona Ramirez's blood

pressure was 153/92 and he was diagnosed with hypertension. He was prescribed medication to lower his blood pressure, including Lisinopril, an ACE inhibitor used to treat high blood pressure.

6. I last spoke with Mr. Cardona Ramirez on April 24, 2020. Through the course of my representation of Mr. Cardona Ramirez and other detainees in the same unit at Calhoun, I have also learned the following about conditions in Calhoun:

    a. Mr. Cardona Ramirez is housed in the B-unit. His unit has around 60 detainees who sleep in 27 two-person cells on two floors. The first floor has a common area where they eat their meals and spend most of their times. There are small tables with four seats each, which are about one to two feet apart. When the detainees are allowed to go outside, all 60 detainees go at the same time They are not able to stay six feet apart. As a result, it is impossible to practice adequate social distancing at Calhoun at all times.

    b. Inmates receive a small amount of soap for free, but have to purchase additional soap if they run out. The detainees have not been given gloves, masks or hand sanitizer. The staff

provides two bottles of disinfectant spray each day for the full unit of about 60 detainees. The detainees frequently run out before everyone is able to clean their cells, and additional cleaning product is typically not provided.

c. Some guards wear masks and gloves, but not all. The next unit over, Unit A, is a quarantine unit. The detainees believe staff members go in and out of Units A and B.

d. There are no windows in the dormitory and there is no natural light.

e. Detainees do not have access to tests for COVID-19. At least two detainees, who had trouble breathing and had chest pain, were not tested. Both were returned to the unit after their medical appointments.

7. If released, Mr. Cardona Ramirez will stay with his significant other and their children in Grand Rapids, Michigan. His significant other would be able to arrange to pick him up at Calhoun. Mr. Cardona Ramirez would maintain a safe distance from others and/or quarantine as necessary. He would also have access to treatment for his medical conditions.

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 26th day of April 2020, in Grand Rapids, Michigan.

/s/ Richard Kessler

Richard Kessler
Law Office of Richard Kessler, P.C.
4145 Kalamazoo Ave SE
Grand Rapids, MI 49508

DECLARATION OF JONATHAN CONTRERAS

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

1. My name is Jonathan Contreras. I make these statements based upon my personal knowledge.
2. I am an attorney with Merced Law, PLLC, a firm specializing in immigration matters. I have practiced immigration law for approximately three years.
3. I represent Julio Fernando Medina Euceda, a 54-year-old Honduran national, who has been detained in Calhoun County Correctional Center ("Calhoun") in Battle Creek, Michigan, since January 24, 2020. On February 25, 2020, the Detroit Immigration Court denied Mr. Medina Euceda's request for bond.
4. Mr. Medina Euceda entered the United States in 1991. He obtained lawful permanent residency in 2006. ICE claims that he was previously removed under a different name and did not disclose this removal on his application for lawful permanent residency. Mr. Medina Euceda requested voluntary departure, which the Detroit Immigration Court denied and ordered Mr. Medina Euceda removed on April 13, 2020.

5. Mr. Medina Euceda has not had any criminal convictions in approximately fifteen years. Between 1999 and 2005, he had three DUI convictions and one conviction for driving with a suspended license. Since 2005, Mr. Medina Euceda has stopped drinking.
6. Mr. Medina Euceda is worried about exposure to COVID-19, particularly in light of his age.
7. I last spoke with Mr. Medina Euceda on April 20, 2020. Through the course of my representation of Mr. Medina Euceda, I have also learned the following about conditions in Calhoun:
    a. No one in Calhoun is able to practice social distancing. Mr. Medina Euceda sleeps in a dorm with 30 bunk beds. In addition, the detainees at Calhoun eat together in a communal space.
    b. Outside of the two quarantined units, the guards do not wear masks or gloves. The detainees have not been given masks or any other personal protective equipment. The detainees have not been given any cleaning supplies.
8. If released, Mr. Medina Euceda will be able to return to the home he shares with the mother of his children in Detroit, Michigan. His family would be able to pick him up from Calhoun. Residing at

home, he will be able to get medical treatment if necessary and maintain a safe distance from others and/or quarantine as necessary. Mr. Medina Euceda has informed me that he is willing to abide by any reasonable conditions set for his release including cooperating with ICE should his removal to Honduras be scheduled.

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 26th day of April 2020, in Detroit, Michigan.

/s/ Jonathan Contreras
Jonathan Contreras
Merced Law, PLLC
1981 Scotten Avenue
Detroit, Michigan 48209

DECLARATION OF JOSEPH S. HUGHES IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER

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

1. My name is Joseph S. Hughes. I make these statements based upon my personal knowledge after having spoken with my client, Damary Rodriguez Salabarria.

2. I am an attorney with the Law Office of Joseph S. Hughes, a firm specializing in immigration matters. I have practiced immigration law for approximately 26 years.

3. I represent Damary Rodriguez Salabarria, a 46 year-old Cuban national presently detained at Calhoun County Correctional Center ("Calhoun") in Battle Creek, Michigan, where she has been held since August 10, 2019.

4. Ms. Rodriguez Salabarria entered the United States on August 1, 2019. Immigration and Customs Enforcement ("ICE") first detained her in McAllen, Texas, and subsequently transferred her to Calhoun on August 10, 2019. Upon her entry, she sought out Customs and Border Protection agents to request asylum, and passed a credible fear interview shortly thereafter.

5. Ms. Rodriguez Salabarria was ordered released on a $40,000 bond, but remains in custody because of her inability to pay. Her husband, Juan Agete Perez, was also granted bond and is currently living in Baytown, Texas.

6. Ms. Rodriguez Salabarria represented herself pro se before the Detroit Immigration Court. After her asylum claim was denied, I represented her in her appeal to the Board of Immigration Appeals ("BIA"). The BIA dismissed her appeal approximately two weeks ago. I have prepared and intend to file in the coming weeks a petition for review to the Sixth Circuit Court of Appeals.

7. Ms. Rodriguez Salabarria is worried about exposure to COVID-19 due to a number of serious, pre-existing medical issues.

a. Ms. Rodriguez Salabarria suffers from hypertension, chronic gastritis, and a peptic ulcer, as well as gastroesophageal reflux. She takes daily medication for all of these conditions. Although she has had her blood pressure checked while in custody, the nurse doing the reading did not communicate the results. Ms. Rodriguez tells me that either she was told her results in English, a language she does not speak, or was not told at all.

b. Prior to entering the United States, Ms. Rodriguez Salabarria had twice been admitted to a hospital intensive care unit due to acute pancreatitis, and has suffered from kidney infections. She has also undergone both an appendectomy and a cholecystectomy (gallbladder removal). Ms. Rodriguez Salabarria fears that her pre-existing medical conditions would significantly raise her chances of serious injury or death if she is infected with COVID-19.

8. I last spoke with Ms. Rodriguez Salabarria on April 24, 2020. Ms. Rodriguez Salabarria reports that correctional staff do not wear masks or gloves, nor are inmates given access to masks or gloves. Soap is not consistently provided, so inmates are sometimes required to buy their own. While there are sinks provided in the bathrooms, inmates are not always given enough time to properly wash up. Ms. Rodriguez Salabarria reports that other inmates appear to be ill. The only information she has been given about the coronavirus and COVID-19 was a presentation by a nurse approximately two months ago. However, the nurse presented in English and Ms. Rodriguez Salabarrria speaks and understands only Spanish.

9. No one in Calhoun is able to practice social distancing. Ms. Rodriguez Salabarria shares a cell with five other inmates. These inmates change frequently: Ms. Rodriguez Salabarria has shared a cell with ten different inmates in the previous two weeks. The cell contains four twin-sized bunkbeds. As a result, she is not able to maintain six feet of distance between herself and other inmates. Correctional staff serve meals to the inmates, but do not wear masks or gloves while doing so. Inmates continue to eat communally at tables of four to eight people. Tables are cleaned only after the inmates have eaten.

10. If Ms. Rodriguez Salabarria is released, volunteers from the Washtenaw Interfaith Coalition for Immigrant Rights would pick her up from Calhoun and facilitate transportation to Baytown, Texas, where she can rejoin her husband. In Texas, Ms. Rodriguez Salabarria will have a support network that can help her access any needed medical care. She will be able to practice social distancing and/or quarantine, if necessary.

11. Ms. Rodriguez Salabarria has informed me that she is willing to abide by any conditions set for her release, including home confinement and/or wearing an ankle monitor.

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 26th day of April 2020, in Berrien Springs, Michigan.

/s/ Joseph S. Hughes

Joseph S. Hughes
Law Office of Joseph S. Hughes
213 W. Ferry St.
P.O. Box 83
Berrien Springs, Michigan 49103

DECLARATION OF CATERINA AMARO-LUEDTKE, ESQ.
REGARDING EMANUEL ROSALES BORBOA

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

1. My name is Caterina Amaro-Luedtke. I make these statements based upon my personal knowledge after having spoken with my client, Emanuel Rosales Borboa.

2. I am an attorney with Amaro Immigration Law, PLLC. I have practiced immigration law for approximately 13 years.

3. I represent Emanuel Rosales Borboa, a 35-year-old Mexican national who has been detained at Calhoun County Correctional Facility ("Calhoun") in Battle Creek, Michigan since March 9, 2020. I began representing Mr. Rosales Borboa in May 2017 and have spoken with him many times, most recently on April 24, 2020.

4. On August 27, 1995, when he was ten years old, Mr. Rosales Borboa entered the United States with his parents on a B-2 visa, and has continuously resided in the United States ever since.

5. U.S. Immigration and Customs Enforcement ("ICE") first detained Mr. Rosales Borboa in April 2017 after Mr. Rosales Borboa failed to produce proof of legal U.S. residency to an ICE agent while at work in Woodhaven, Michigan. Following his failure to produce documentation, ICE detained Mr. Rosales Borboa, who was then released on bond in May 2017.

6. On March 7, 2020, Detroit police stopped and questioned Mr. Rosales Borboa when he was observed walking a female friend to her car after his evening shift at the Well Bar in Detroit, Michigan. According to the police report, Mr. Rosales Borboa had removed his jacket to offer it to his friend, which revealed a pistol in his waistband. A nearby officer allegedly noticed the firearm and asked to see Mr. Rosales Borboa's Concealed Pistol License, which he was unable to provide. The officer placed Mr. Rosales Borboa under arrest. Mr. Rosales Borboa was charged with carrying a concealed weapon.

7. On March 9, 2020, Mr. Rosales Borboa appeared before a 36th District Court Magistrate for an arraignment, and his bond was set at $1,000.00 personal. However, ICE placed a detention hold on Mr. Rosales Borboa, and on March

9, 2020 transferred him to Calhoun. Mr. Rosales Borboa intends to contest the charges.

8. It is my experience that Mr. Rosales Borboa is a man of good moral character who has not been convicted of a crime. He is currently scheduled for an individual hearing in his immigration case on May 18, 2020. Mr. Rosales Borboa is seeking Cancellation of Removal for Non-Lawful Permanent Residents.

9. Mr. Rosales Borboa is a diagnosed asthmatic. Approximately ten years ago, Mr. Rosales Borboa had an asthma attack while playing hockey and was hospitalized for two days. During his hospitalization, doctors performed numerous tests and diagnosed him with asthma, prescribing an Albuterol inhaler–which he has used multiple times per week ever since–as well as Prednisone, an immunosuppressant medication used to treat, among other things, breathing problems. Mr. Rosales Borboa informed Calhoun staff of his asthma during his intake.

10. Mr. Rosales Borboa's asthma can be exacerbated by certain activities or surrounding conditions. For example, he suffers complications during exercise or when the climate is warm or humid. Because of his asthma, Mr. Rosales Borboa is worried about his risk of being infected with COVID-19 while at Calhoun.

11. Throughout the course of my representation of Mr. Rosales Borboa, I have also learned the following about conditions in Calhoun:

    a) Mr. Rosales Borboa is housed in Cubicle 5 in Pod H, a unit for low-security detainees at Calhoun. During his time at Calhoun, there have been as many as 42 detainees housed in Pod H. There are currently 37 detainees housed there, including Mr. Rosales Borboa. Pod H houses both immigration detainees and criminal inmates.

    b) Mr. Rosales Borboa shares a 20 x 8 feet cubicle with seven other detainees, who share six bunk beds. These bunk beds are placed at most three-feet apart from each other. During "lockdowns" detainees are confined to their respective cubicle. Lockdowns occur from 6:45 a.m.–7:30 a.m., 11:45 a.m.–12:30 p.m., 5:45 p.m.–7:30 p.m., and 9:45 p.m.–5:00 a.m., which means that Mr. Rosales Borboa is confined to his cubicle within 6 feet of the 7 other detainees for approximately 9.5 hours each day.

c) The detainees are responsible for cleaning their cubicles and they are only provided a mop, bucket, and soap.

d) When not in lockdown, Mr. Rosales Borboa and the other detainees spend their time playing cards or watching television in the common area, which consists of eight round tables that fit four persons to a table at an arms-length distance. Mr. Rosales Borboa and the 36 other detainees share meals at these tables three times per day.

e) For meals, one detainee typically brings around a food cart with prepared trays of food and distributes individual trays to the detainees, who wait in line for a tray. Social distancing is not practiced at this time either. The detainees who deliver and distribute food trays to Pod H also deliver and distribute food trays to the pods holding quarantined detainees, and do not wear protective gear like masks or gloves when delivering and distributing the food.

f) Detainees in Pod H share two bathrooms that contain four toilets, three showers, and four sinks between both floors of the facility. When confined in their cubicles, there are only two soap dispensers for all 37 detainees in the Pod, one for hand washing and the other for showering. The soap frequently runs out, and is refilled only after repeated requests by the detainees. At one point, the detainees were without soap for two days.

g) Approximately two weeks into his detention, a fellow detainee in Pod H fell ill and was removed from Pod H because the inmate had been in contact with someone infected with COVID-19. Shortly after the detainee was removed, Mr. Rosales Borboa and the other detainees were moved to Pod M for two weeks. During this time a second detainee in Pod M also fell ill with a high fever and increased blood pressure. This detainee was also removed but returned to Pod M only six days after being quarantined, while the other detainee who had been removed from Pod H never returned.

h) After being returned to Pod H, Mr. Rosales Borboa fell ill for two days. His symptoms included pain in his chest and a fever with sweats. He reported these symptoms to an on-duty Jail guard, who assured Mr. Rosales Borboa that a medical professional would evaluate him. No medical professional ever evaluated him, and he

was never tested for COVID-19. Nor was Mr. Rosales Borboa ever quarantined from other inmates during his illness.

i) Currently, two detainees housed in the same cubicle as Mr. Rosales Borboa are exhibiting symptoms consistent with COVID-19, including persistent coughing and sneezing.

j) Calhoun does not provide detainees with masks, gloves, or hand sanitizer. Detainees in Pod H were given masks during the brief period in which detainees were moved from Pod H to Pod M because of the suspected case of COVID-19 in Pod H. After this incident these detainees, including Mr. Rosales Borboa, were required to dispose of their masks.

k) After discarding the masks, a female deputy told the Pod H detainees that if they were caught with a mask they would be issued a citation and thrown in the hole for 24 hours. Being thrown in the hole involves solitary confinement in a cell for 23 hours a day, with 1 hour of release for showering.

l) The staff at Calhoun do not consistently wear masks or gloves. My client shared that whether a staff member is wearing any PPE is "hit or miss."

12. Given these conditions, it is impossible for Mr. Rosales Borboa and the other detainees to practice social distancing. It is not possible to keep the recommended six feet of distance between detainees. There are times, for example, when using the phone to speak with family and his attorneys, Mr. Rosales Borboa is only twelve inches away from another person. Calhoun staff does not discuss social distancing with the detainees, who continue to use the same phones, TV remotes, books, and playing cards. Detainees also trade and share food with, and generally remain in close proximity to, one another.

13. If released, Mr. Rosales Borboa's siblings will transport him by car to his home in Allen Park, Michigan, where he has lived for the last five years with his mother and siblings. At home, Mr. Rosales Borboa will be able to get medical treatment for his asthma while maintaining 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 24th day of April 2020.

/s/ *Caterina Amaro Luedtke*

Caterina Amaro-Luedtke (P70629)
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DECLARATION OF KAI DE GRAAF

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

1. My name is Kai De Graaf. I make these statements based upon my personal knowledge.
2. I am an attorney specializing in immigration matters. I have practiced immigration law for over 25 years.
3. I represent Min Dan Zhang, a 50-year-old Chinese national who has been detained in Calhoun County Correctional Center ("Calhoun") in Battle Creek, Michigan since August 22, 2019. On April 20, 2020, the Detroit Immigration Court denied Ms. Zhang's second request for bond.
4. Ms. Zhang entered the United States in 2013. On January 31, 2020, the Detroit Immigration Court denied her application for political asylum, withholding of removal and Conventional Against Torture relief. She has appealed this denial, and the appeal is currently pending before the Board of Immigration Appeals.
5. Ms. Zhang is worried about exposure to COVID-19, particularly in light of her age.

6. I last spoke with Ms. Zhang on April 24, 2020. Through the course of my representation of Ms. Zhang, I have also learned the following about conditions in Calhoun:

   a. No one in Calhoun is able to practice social distancing. Ms. Zhang shares an overcrowded cell with four other people. The beds in each cell are only one to two feet apart.

   b. Ms. Zhang has not seen staff sanitizing the facility. Guards wear gloves but not masks. She does not see guards changing their gloves or washing or sanitizing their hands. The inmates have not been given face masks or any other personal protective equipment.

   c. The detainees have not received information about COVID-19. Staff has not provided any education or even instructed detainees to wash their hands frequently and for 20 seconds.

   d. Detainees do not have access to free soap. Any soap must be bought from the commissary. Many detainees cannot afford soap and are not provided with any.

   e. At least one detainee, a woman in Ms. Zhang's cell, was ill and was coughing. Ms. Zhang believes that this woman was released from Calhoun.

7. Ms. Zhang has no criminal history.

8. If released, Ms. Zhang would return to care for her ten-year-old son and stay with extended family in Brooklyn, New York. She would be able to get medical treatment if necessary and maintain a safe distance from others and/or quarantine. Her family would be able to arrange for her to travel by car from Calhoun to Brooklyn. Ms. Zhang would comply with any reasonable supervision conditions imposed including reporting as required.

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 26th day of April 2020, in Ada, Michigan.

Kai W. De Graaf
Law Offices of Kai W. De Graaf
64 Fulton Street, Suite 1006
New York, NY 10038

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

REYNALDO ALBINO-MARTINEZ, JOSE NICOLAS CHAVEZ-VARGAS, GENER ALEJANDRO CHINCHILLA-FLORES, CRAIG DOBLE, and MIGUEL ANGEL APARICIO NAVAS,

Petitioner-Plaintiffs,

- 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; and U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT,

Respondent-Defendants.

Case No. 2:20-CV-10893

Judge Stephen J. Murphy, III

DECLARATION OF REYNALDO ALBINO-MARTINEZ

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

1. My name is Reynaldo Albino-Martinez. I make these statements based upon my personal knowledge and experience.

2. I was born in Mexico, and came to the United States in 1989 when I was twenty-four years old and have lived in the United States for 31 years.

3. I was detained at St. Clair County Jail ("St. Clair") from February 5, 2020 until April 14, 2020.

4. On April 13, 2020 I was taken from St. Clair to the McLaren Port Huron hospital where I tested positive for COVID-19 and pneumonia. The hospital discharged me back to St. Clair, where I spent the night. The following day, April 14, 2020 I was released under an order of supervision.

General Conditions in St. Clair

5. While in detention, I was housed in a large Pod with dozens of people.

6. Upon arrival to St. Clair, detainees are given only one bar of soap and are not given any other hygiene products. I was never given any hand sanitizer nor did I know of anyone in the Pod who had any hand sanitizer. Detainees must purchase other products through commissary but only if they have sufficient funds in their account.

7. I had no prior knowledge about COVID-19, and I never received any information about it until other detainees started talking about it. Staff at St. Clair did not provide any announcements about COVID-19 or give any instructions or guidance about what precautions to take.

8. I first found out how serious of a health risk COVID-19 is when other detainees discussed a case of a Cuban national who had possibly contracted the virus.

9. I have many health issues that put me at high risk from a COVID-19 infection, including diabetes and coronary artery disease. I also suffer from posterior subcapsular polar cataracts, declining vision and bleeding behind my right eye, rotator cuff tears, depression, diabetic retinopathy, pterygium, astigmatism, myopia, presbyopia, diabetic peripheral neuropathy, hyperlipidemia, ulnar neuropathy in my right eye, and acid reflux disease.

10. While I was at St Clair, I did receive insulin to treat my diabetes but I was in constant pain nearly the entire time of my detention. My body ached more than normal and it was hard for me to fall asleep and walk around. My eyesight deteriorated to the point that I required the help of others detained with me to be able to do various basic tasks, including injecting insulin for my diabetes. When I needed to eat, others helped me to the table where we all ate, and someone brought the plate of food over to me.

11. Due to my severe vision impairment, when I needed to make a phone call while in detention, I needed another detainee to assist me by dialing the number and handing me the receiver. The phones were never cleaned while I was there, not even after information about COVID-19 was commonly discussed.

12. I was not given any protective masks or gloves and I am not aware of any detainee who had been given protective items. I did see several corrections officers wearing masks and gloves. Staff at St. Clair did not inform me of the reasons or purpose for corrections officers wearing masks and gloves.

13. The Pod I was housed in has only two bathrooms and two sinks and they are shared by all of the detainees. It also had two showers but during the time of my detention, only one shower was working. The only shower that was functional had a shower curtain that was never cleaned during my time there and it did not appear to have been cleaned for a long time prior to my arrival, if at all.

14. One detainee in our Pod was designated as a "trustee" who was in charge of cleaning the shared areas, but cleaning did not happen every day. On rare occasion, I saw that the trustee was given disinfectant but I did not see this often. When disinfectant was not available, I did not see anyone cleaning our shared spaces.

15. The Pod is not large enough for individuals to practice social distancing. The sleeping arrangements also made it impossible to be six feet away from other detainees. The room I slept in housed four people at a time and the beds were less than six feet apart from each other.

16. Detainees ate food in a communal setting and about four people sat together to eat at a time.

Health Issues in St. Clair

17. Within one week after my initial detention, I started to feel sick. It began with a cough and then a sharp pain on the left side of my body. The coughing was so intense that I thought I had broken my ribs.

18. As soon as the cough started, I begged corrections officers to please let me see a nurse, but they ignored me. A nurse did not see me until the following day when another detainee started asking corrections officers when I would be seen because my coughing had gotten so severe. The nurse told me I had pulled a muscle from coughing so intensely.

19. Around Mid-February 2020, I was transported to the McLaren Port Huron Hospital and hospitalized for pneumonia.

20. I was discharged from McLaren Port Huron Hospital around the beginning of March 2020 and immediately taken back to the St. Clair medical unit where I continued to receive antibiotics.

21. Near the end of March 2020, I was taken back into the previous Pod I was housed in. Shortly after that, I started to notice that many of the people around me were sick and seemed to be getting worse. Because there was no way of distancing myself from others in the Pod, I was afraid that I would quickly become sick too. I didn't notice new people coming into the pod but before I was hospitalized again, I saw a couple of men who looked sick get taken out of the Pod.

22. I still felt sick when I was taken back into the Pod. At that time, I had a sore throat, a constant cough, and I had trouble breathing. St. Clair staff still did not give me a mask or gloves when I was placed back into the Pod. Even after I expressed concerns to one of the corrections officers that I was just in the hospital and worried that this many sick people being around me would be dangerous to my health.

23. After I returned to the Pod, I also noticed another detainee with a constant cough throughout the day. A nurse never checked on the other detainee during this time despite showing clear symptoms of COVID-19.

Contracting COVID-19 at St. Clair

24. My health condition worsened by or about April 12, 2020. Every time I stood up, I felt dizzy and couldn't walk very well. I asked the corrections officer to let me speak to a nurse, but I was again told that someone would come see me when they were available. No medical staff came to see me that day.

25. The next day, on or about April 13, 2020, a nurse arrived and asked me to step out of my cell. She asked me a couple of questions but then told me to just go lay down. I pleaded with the nurse to please let the doctor know that I was feeling extremely ill, that the pain was terrible and was much worse than when I was hospitalized for pneumonia, and that something was wrong with me.

26. The last thing I remember was saying to the nurse "this is too much, I need help" before I fainted. I do not remember being taken to the hospital. The next thing I remember is waking up cuffed to a bed in a hospital. When I awoke, a nurse asked if I remembered what happened to me. I told her about my last visit to the hospital, how bad I was feeling, and that I fainted.

27. I was given many tests at the hospital but then that same day I was transferred back to St. Clair. This was when I was given a mask for the first time and I was placed in a cell by myself.

28. I did not understand what was going on until a nurse at St. Clair told me that I tested positive for COVID-19. I felt scared because I worried that I wouldn't get the proper care while detained. I was also terrified that I would die while in detention and I feared that my family couldn't be there or be able to see me if something even worse happened to me.

Post-Release from St. Clair

29. I was released from detention on April 14, 2020. My attorneys were able to arrange for me to be taken to my home in St. Clair by an ambulette service so that I would not risk exposing others. The person driving the ambulette had on what looked like an n95 mask and wore gloves. I also wore a mask the entire drive home so that I could be safely sent home.

30. If I had been released before I was infected, then I would have stayed with my long-term girlfriend and her daughters, whom I have known for about twelve years. I would have been able to quarantine in their home. Once infected, I could no longer stay with them because of her daughter's health conditions and because my girlfriend cannot work in her field if she is exposed to COVID-19.

31. After being released, I stayed at my apartment in Saginaw alone so that I would not expose anyone else.

32. However, by the time I got to my home, I was already quite ill with COVID-19 and was taken back to the hospital the night of April 16, 2020. I spent most of that night throwing up with a fever and chills and stayed at the hospital overnight.

33. The hospital discharged me but that very next day on April 17, 2020 I received a call from the hospital staff informing me that it was urgent that I be admitted to the hospital as soon as possible. The hospital staff explained that my blood work had come back and they sent an ambulance to pick me up.

34. I remain hospitalized and have been told by the hospital nurse that I would be here for a few days. I continue to have a lingering cough and have trouble breathing and can only speak for short periods of time until I need to take a break. I just recently started to be able to eat without vomiting. I am still not able to get up and walk on my own.

35. I am getting much better care here at the hospital than I received in St. Clair, where my medical needs were ignored. There is a nurse that comes in frequently to take my temperature and my blood sugar levels. I also have help with administering my insulin for my diabetes. I am also able to practice social distancing from others and have access to hygiene items.

36. My family has more peace of mind because they can reach me directly and find out how I am doing every day. Although I still feel sick, I am feeling more optimistic about my recovery. I believe that if I would have stayed in St. Clair, I would have died from COVID-19 and my family would not have been able to say goodbye.

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 20th day of April 2020, in Saginaw, Michigan.

/s/ Reynaldo Albino-Martinez
Reynaldo Albino-Martinez