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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE

FAOUR ABDALLAH FRAIHAT, *et al.*,

Plaintiffs,

v.

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, *et al.*,

Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

PLAINTIFFS' NOTICE OF MOTION AND EMERGENCY MOTION FOR PRELIMINARY INJUNCTION; MEMORANDUM OF POINTS AND AUTHORIES

ORAL ARGUMENT REQUESTED

Date: March 31, 2020

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NOTICE OF MOTION AND MOTION FOR PRELIMINARY INJUNCTION

TO THE HONORABLE COURT, ALL PARTIES, AND THEIR ATTORNEYS OF RECORD HEREIN:

NOTICE IS HEREBY GIVEN that on March 31, 2020 at 2:00 PM or at such other time as the Court may set the matter for hearing, Plaintiffs Faour Fraihat, Jimmy Sudney, Aristoteles Sanchez Martinez, Alex Hernandez, and Martin Munoz on behalf of themselves an all others similarly situated, will and hereby do move for an order granting a class-wide preliminary injunction[1] requiring Defendants to:

(i) identify all people in ICE custody with one or more Risk Factors as defined in Plaintiffs' motion;

(ii) conduct a comprehensive, evidence-based assessment of medically necessary precautions that should be implemented to ensure the health and safety of such persons during the COVID-19 pandemic, including assurance that all such persons have timely access to competent, sufficient, and appropriately qualified staffing, medical care, screening, social distancing measures, sanitation methods, education, equipment, hospitals and all other medically necessary protective measures;;

(iii) promptly (within 48 hours) effectuate the release of individuals with one or more Risk Factors if medically necessary safeguards cannot be immediately (within 24 hours) provided to ensure health and safety, and absent an individualized finding of dangerousness to community;

(iv) modify its existing COVID-19 protocols to remediate all Protocol

[1] Although Local Rule 7-3 does not require a meet and confer for motions for preliminary injunctions, Plaintiffs' counsel conferred with Defendants' counsel regarding this motion on March 23, 2020. *See* Declaration of Jared Davidson in Support of Plaintiffs' Motion for Leave to File Emergency Motion for Provisional Class Certification.

Deficiencies;

(v) the appointment of a Special Master to oversee this process.

Due to the rapidly evolving COVID-19 pandemic and the risk it poses to people in ICE custody with one or more Risk Factors, Plaintiffs, on behalf of themselves and all those similarly situated, respectfully request this Court to schedule a hearing as soon as possible, and no later than March 31, 2020, via teleconference.[2]

This Motion is based on this Notice of Motion, the accompanying Memorandum of Points and Authorities, the supporting declarations, proposed order, all pleadings and papers filed in this action, and such additional papers and arguments as may be presented at or in connection with the hearing.

Dated: March 24, 2020

Respectfully Submitted,

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[2] Notice from Clerk stating: "In civil cases, no hearings will go forward except for emergency time-sensitive matters, such as requests for temporary restraining orders and preliminary injunctions, as ordered by the assigned judicial officer. Any hearings on emergency civil matters will proceed telephonically only." Effective, March 23, 2020.

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Plaintiffs,

v.

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, *et al.*,

Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

PLAINTIFFS' MEMORANDUM IN SUPPORT OF EMERGENCY MOTION FOR PRELIMINARY INJUNCTION

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I. INTRODUCTION

The COVID-19 pandemic is a public health crisis unprecedented in modern history that has resulted in the infection of hundreds of thousands of people and the deaths of tens of thousands in just a few months. Without immediate and drastic public health measures, it could result in the death of as many as 2.2 million people in the United States alone.

Tens of thousands of people are currently subject to civil immigration detention in the United States. Immigration and Customs Enforcement ("ICE") imprisons them in close quarters in facilities with long track records of egregiously inadequate healthcare documented by the Department of Homeland Security's ("DHS") own Office of Inspector General ("OIG") and multiple other organizations, which ICE has failed to remediate. ICE knows of the acute and imminent threat COVID-19 poses to detained populations; two infectious disease experts retained by DHS itself recently advised that COVID-19 poses an "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."[1] Detained people with certain risk factors—including people who are older, pregnant, or who have underlying medical conditions (enumerated below and hereinafter referred to as "Risk Factors")—are at a heightened risk of serious illness, life-altering complications, and death from COVID-19.

Yet, ICE's response to the COVID-19 is alarmingly inadequate—particularly now that there is now at least one documented positive case of a person in ICE detention. Although ICE has issued some skeletal "guidance" on COVID-19, that guidance is dangerously deficient in numerous respects from any reasonable medical and public health perspective. For example, as detailed below,

[1] Letter from Dr. Scott Allen and Dr. Josiah Rich to Congressman Bennie Thompson et al. (Mar. 19, 2020) (the "Allen/Rich letter") (attached as Exhibit E to Seaborn Decl.).

ICE's policies and practices do not contemplate identifying persons with Risk Factors, much less taking the significant steps necessary to reduce the risk of contagion, illness, complications, and death in its already broken medical care system. ICE's approach is contrary to the recommendations of its own experts and is inconsistent with appropriate standards of care during this pandemic. In fact in recognition of "the rapidly escalating public health crisis, which public health authorities predict will especially impact immigration detention centers," the Ninth Circuit recently issued a published order requiring the release of a detained immigrant. *See Xochihua-Jaimes v. William P. Barr*, Case No. 18-71460 (9th Cir. March 23, 2020) (attached as Exhibit G to Declaration of Stuart Seaborn in Support of Plaintiffs' Motion for Class Certification and Emergency Motion for Preliminary Injunction ("Seaborn Decl.")).

As detailed below, Plaintiffs are highly likely to succeed on the merits of their claims that ICE's inadequate response to COVID-19 (1) violates the Due Process Clause by constituting objectively deliberate indifference to a substantial risk of harm and imposing punitive conditions, and (2) violates Section 504 of the Rehabilitation Act by failing to affirmatively identify and accommodate the needs of disabled people with Risk Factors and by subjecting them to unnecessarily restrictive placements. Moreover, Plaintiffs can show that, absent such emergency relief, the substantial—and lethal—risk of COVID-19 infection constitutes an irreparable harm as Plaintiffs' and other peoples' very lives hang in the balance. Given that ICE has access to multiple alternatives to detention and no legal interest in punishing people with Risk Factors by subjecting them to a risk of COVID-19 infection, the balance of equities tip sharply in favor of Plaintiffs. Finally, minimizing COVID-19 transmission in a carceral setting is inarguably in the public interest, as the risk of infection also includes staff and community members.

Accordingly, ICE must take immediate and significant measures to protect people with Risk Factors, or, if those measures cannot be immediately implemented, release those people absent a showing of dangerousness. DHS's own experts have urged ICE to release people with Risk Factors,[2] as have 3000 medical professionals.[3] This is in accord with a growing number of jails across the country that are releasing medically vulnerable people.

On behalf of two subclasses of people with Risk Factors in ICE custody, Plaintiffs seek a preliminary injunction requiring ICE to immediately (i) identify all people in ICE custody with one or more Risk Factors; (ii) conduct a comprehensive, evidence-based assessment of medically necessary precautions that should be implemented to ensure the health and safety of such persons during the COVID-19 pandemic, including assurance that all such persons have timely access to competent, sufficient, and appropriately qualified staffing, medical care, screening, social distancing measures, sanitation methods, education, equipment, hospitals, and all other medically necessary protective measures; (iii) promptly (within 48 hours) effectuate the release of individuals with one or more Risk Factors if such medically necessary safeguards cannot be immediately (within 24 hours) provided to ensure health and safety, and absent an individualized finding of dangerousness to community; and (iv) modify its existing COVID-19 protocols to remediate all Protocol Deficiencies.[4] Plaintiffs also seek the immediate appointment of a Special Master to oversee this process.

---

[2] Allen/Rich letter.

[3] Letter from Dr. Nathaniel Kratz et al., to Matthew T. Albence, Acting Dir., U.S. Immigr. and Customs Enf't (Mar. 2020) ("Medical Professionals Letter") (attached as exhibit []).

[4] The Protocol Deficiencies are identified in paragraph 14 of the Declaration of Homer Venters in Support of Motion for Preliminary Injunction and Class

II. FACTS

A. COVID-19 Poses an Extraordinary Risk to People in Detention Centers With Risk Factors.

COVID-19, a disease caused by the novel coronavirus, has reached pandemic status. Almost 400,000 people worldwide have been diagnosed with COVID-19, and over 18,000 people have died as a result.[5] In the United States, over 46,000 people have been diagnosed with COVID-19, of whom almost 600 have died.[6] The transmission of COVID-19 is expected to grow exponentially. Decl. of Carlos Franco-Paredes in Supp. of Mot. for Prelim. Inj. and Class Certification ("Franco-Paredes Decl.") ¶ 1.

People are able to transmit the disease even before they exhibit any symptoms, and for weeks after those symptoms have resolved. Decl. of Jaimie Meyer is Supp. of Mot. for Prelim. Inj. and Class Certification ("Meyer Decl.") ¶ 20. In China, the average infected person passed the virus on to 2-3 other people, and transmission occurred at a distance of 3-6 feet. *Id.*

Because humans have never been exposed to this virus, they have not developed any immunities or protective responses, and thus everyone is at risk of infection. *Id.* Further, there is no vaccine currently available, and there is unlikely to be a vaccine for at least a year. *Id.* The only prevention strategies are social distancing, and containment practices such as intensive handwashing, decontamination, and aggressive cleaning of surfaces. *Id.* ¶ 23.

Certification. Those deficiencies may change as the ICE Protocols are modified.

[5] Ciara Linnane, *Coronavirus update: 407,405 cases, 18,227 deaths, Italy shows glimmer of hope and NYC remains U.S. epicenter*, MARKETWATCH (Mar. 24, 2020), https://www.marketwatch.com/story/coronavirus-update-392870-cases-globally-17159-deaths-italy-shows-glimmer-of-hope-and-nyc-remains-us-epicenter-2020-03-24.

[6] *Coronavirus COVID-19 Global Cases by the Ctr. for Sys. Sci. and Eng'g (CSSE) at John Hopkins Univ.*, JOHN HOPKINS UNIV. & MED. (Mar. 24, 2020), https://coronavirus.jhu.edu/map.html

B. COVID-19 Has Already Begun Infecting People in Detention Centers.

There is now at least one person in ICE detention who has tested positive for COVID-19.[7] This comes as no surprise: ICE employees have already tested positive,[8] and it is clear that guards and other detention facility staff will continue to spread the virus throughout ICE's detention system. Allen/Rich letter at 3; Venters Decl. ¶ 8. According to an expert in infectious diseases in congregate settings, "ICE will not be able to stop the entry of COVID-19 into ICE facilities, and the reality is that the infection is likely inside multiple facilities already." Decl. of Homer Venters in Supp. of Mot. for Prelim. Inj. and Class Certification ("Venters Decl.") ¶ 7. DHS's own infectious disease experts share this view. On March 19, 2020, Dr. Scott Allen and Dr. Josiah Rich—both medical experts for DHS's Office of Civil Rights and Civil Liberties who are experts in the field of detention health, infectious disease, and public health—wrote a letter (attached as Exhibit E to the Seaborn Decl.) to members of Congress. In that letter, these experts warned of the "imminent risk to the health and safety of immigrant detainees" posed by COVID-19. Allen/Rich letter at 3.

Once COVID-19 is in a facility, "ICE will be unable to stop the spread of the virus throughout the facility." Venters Decl. ¶ 8; *see generally* Meyer Decl. ¶¶ 7-19. There are numerous reasons for this, including: social distancing, essential to slowing the spread of COVID-19, is an "oxymoron in congregant settings" (Allen/Rich letter at 4); the virus will spread as people are transferred among

[7] Hamed Aleaziz, *An Ice Detainee Has Become the First to Test Positive for the Coronavirus*, BUZZFEED NEWS (Mar. 24, 2020, 3:36 P.M. EST), https://www.buzzfeednews.com/article/hamedaleaziz/immigrant-ice-detention-facility-coronavirus-test; Ken Klippenstein, *Exlcusive: ICE Detainees Are Being Quarantined* (Mar. 24, 2020, 2:48 P.M. EST), https://www.thenation.com/article/society/corona-covid-immigration-detention/.

[8] Emily Kassie, *First ICE Emp. Tests Positive for Coronavirus*, THE MARSHALL PROJECT (Mar. 19, 8:15 PM), https://www.themarshallproject.org/2020/03/19/first-ice-employee-tests-positive-for-coronavirus

detention centers, people move within detention centers, and staff bring the virus in from the community (Allen/Rich letter at 3; Venters Decl. ¶ 8); and many detention centers are in remote areas with limited access to hospitals and qualified staff (Allen/Rich letter at 4).

C. People With Risk Factors Are at Significantly Increased Risk of Significant Harm, Complications or Death If They Are Infected.

Certain characteristics put people at higher risk of death or serious illness from COVID-19. These characteristics ("Risk Factors") include: people who are age 55 or older; people who are pregnant; and people who have underlying chronic conditions.[9] Each of the named Plaintiffs have such Risk Factors making them highly vulnerable, such as being 55 or older and having conditions such as diabetes, asthma, and hypertension.[10] Preliminary data show that 15 percent of people in high-risk categories who have contracted COVID-19 have died. Franco-Paredes Decl. at 4. In addition, people with Risk Factors are at significantly increased risk of serious harm from COVID-19. For example, people with Risk Factors can suffer severely damaged lung tissue requiring extensive periods of rehabilitation and, in some cases, permanent loss of respiratory capacity, heart

[9] These include: cardiovascular disease (congestive heart failure, history of myocardial infarction, history of cardiac surgery); high blood pressure; chronic respiratory disease (asthma, chronic obstructive pulmonary disease including chronic bronchitis or emphysema, or other pulmonary diseases); diabetes; cancer; liver disease; kidney disease; autoimmune diseases (psoriasis, rheumatoid arthritis, systemic lupus erythematosus); severe psychiatric illness; history of transplantation or HIV/AIDS.

[10] Venters Decl. ¶ 21; Decl. of Alex Hernandez in Supp. of Mot. for Prelim. Inj. and Class Certification ("Hernandez Decl.") ¶ 2; Decl. of Faour Fraihat in Supp. of Mot. for Prelim. Inj. and Class Certification ("Fraihat Decl.") ¶ 3-5; Decl. of Jimmy Sudney in Supp. of Mot. for Prelim. Inj. and Class Certification ("Sudney Decl.") ¶ 3-7; Decl. of Martin Munoz in Supp. of Mot. for Prelim. Inj. and Class Certification (Munoz Decl.) ¶ 2; Declaration of Aristoteles Sanchez Martinez in Supp. of Mot. for Prelim. Inj. and Class Certification ("Sanchez Martinez Decl.") ¶ 2-4.

damage, or damage to other organs. Franco-Paredes Decl. at 4-5. Most people with Risk Factors who develop even mild symptoms require close monitoring, and if they develop moderate or severe symptoms, they require advanced support. Meyer Decl. ¶ 22. This level of supportive care requires highly specialized equipment in limited supply, and a team of care providers, including 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. Franco-Paredes Decl. at ¶¶ 6-7.

D. ICE's Responses to COVID-19 and Its Inadequate Healthcare System Will Not Protect People With Risk Factors.

ICE issued an "Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19)" and has established a webpage entitled "ICE Guidance on COVID-19," which are attached as Exhibit H and I to the Seaborn Decl. These documents (collectively the "ICE Protocols") will not protect people with Risk Factors. As detailed in Dr. Venters's declaration, the ICE Protocols do not: identify the Risk Factors; include any procedures during intake or otherwise to identify people with those Risk Factors; or describe any steps to provide increased protections for people with Risk Factors. Venters Decl. ¶¶ 14, 20-21. The protocols also do not address: imminent shortages of medical supplies and staffing or education of detained people and staff about the virus, amongst other critical issues as outlined in Dr. Venters' report.[11]

Further, as detailed in the attached declarations, there is substantial evidence that ICE's COVID-19 protocols are not being followed in detention centers throughout the country, and that ICE is otherwise failing to provide an adequate response, which exacerbates the risk of harm to the subclass.[12]

[11] *See generally* Venters Decl.

[12] *See generally* Decl. of Andrea Saenz ("Saenz Decl."); Decl. of Laura G. Rivera in Supp. of Mot. for Prelim. Inj. and Class Certification ("Rivera Decl."); Decl. of Anne Rios in Supp. of Motion for Prelim. Inj. and Class Certification ("Rios Decl."); Decl. of Elissa Steglich in Supp. of Mot. for Prelim. Inj. and Class

Finally, the COVID-19 pandemic will place an enormous burden on an already broken system and therefore make it functionally impossible to provide adequate care. As detailed below, ICE's healthcare system already failed to provide adequate care prior to the pandemic. COVID-19 will make these conditions much worse—and virtually impossible to respond consistent with governing standards of care.

III. ARGUMENT

"A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Arroyo v. U.S. Dep't of Homeland Sec.*, Case No. SACV 19-815 JGB (SHKx), 2019 WL 2912848, at *6 (C.D. Cal. June 20, 2019) (citation omitted). Plaintiffs meet each of these requirements.[13]

Certification ("Steglich Decl."); Decl. of Keren Swick in Supp. of Mot. for Prelim. Inj. and Class Certification ("Zwick Decl."); Decl. of Linda Corchado in Supp. of Mot. for Prelim. Inj. and Class Certification ("Corchado Decl.");Hernandez Decl.; Fraihat Decl.; Sudney Decl.; Munoz Decl.; Decl. of Mikhail Solomonov in Supp. of Mot. for Prelim. Inj. and Class Certification ("Solomonov Decl."); Decl. of Francis L. Conlin in Supp. of Mot. for Prelim. Inj. and Class Certification ("Conlin Decl.").

[13] Mandatory injunctions are appropriate when extreme or very serious damage will result if the mandatory injunction is not granted. *Anderson v. United States* 612 F.2d 1112 (9th Cir. 1979); *see also J.P. v. Sessions*, Case No. LA CV18-06081 JAK (SKx), 2019 WL 6723686 (C.D. Cal. Nov. 5, 2019) (holding that severe trauma due to family separation constitutes extreme or very serious damage justifying a mandatory injunction); *Hernandez v. Sessions*, 872 F.3d 976 (9th Cir. 2017) (holding that unlawful detention constitutes extreme or very serious damage); *Saravia v. Sessions*, 280 F. Supp. 3d 1168 (N.D. Cal. 2017) (holding that detention of minors without due process results in extreme or very serious damage).

A. Plaintiffs are likely to succeed on their two Fifth Amendment claims.

1. ICE's COVID-19 Policies and Practices Demonstrate Objective Deliberate Indifference to People with Risk Factors.

People in immigration detention establish a due process violation warranting injunctive relief by showing that Defendants' policies and practices concerning medical care—in their totality—constitute objective deliberate indifference to a substantial risk of suffering serious harm. *Gordon v. County of Orange*, 888 F.3d 1118, 1124-25 (9th Cir. 2018).[14] In systemic cases, such as here, deliberate indifference is shown by, *inter alia*, evidence of "systematic or gross deficiencies in staffing, facilities, equipment, or procedures." *Hernandez v. County of Monterey*, 305 F.R.D. 132, 152-53, 155 n. 138 (N.D. Cal. 2015). Importantly, the key question in systemic cases focuses not on individual circumstances but rather on whether systemic deficiencies "taken as whole" subject people to a "substantial risk of serious harm." *See Brown v. Plata*, 563 U.S. 493, 505 n.3 (2011).

Here, the evidence establishes not only that COVID-19 poses a substantial risk of serious harm to the subclass but also that Defendants' response to that imminent risk—viewed in its totality and in relation to Defendants' already inadequate healthcare system—constitutes objective deliberate indifference.

First, there is no serious dispute that people with Risk Factors in detention face a substantial risk of serious harm from the COVID-19 pandemic. Numerous experts—including medical experts retained by DHS—have concluded that COVID-19 poses a substantial risk of harm to all people in detention given the

[14] The plaintiff in *Gordon* was in pretrial criminal detention, whereas Plaintiffs and the putative subclass members in this case are in civil detention. People in civil detention are entitled to greater constitutional protections than people in pretrial criminal detention. *Jones v. Blanas*, 393 F.3d 918, 934 (9th Cir. 2004). Thus, Plaintiffs and the class may be entitled to even more protection than the *Gordon* standard. Because Plaintiffs easily meet the *Gordon* standard, they do not propose a less stringent one for purposes of this motion.

nature of both detention and the disease itself.[15] That substantial risk is exponentially magnified for Plaintiffs and other people with Risk Factors whose healthcare conditions and/or age place them at heightened risk of illness, serious complications, and even death.[16]

Second, the evidence overwhelmingly shows that—on a systematic scale—Defendants have been objectively deliberately indifferent to the medical needs of the people with Risk Factors during the COVID-19 pandemic. That evidence shows that Defendants have failed to promulgate and implement medically necessary protocols and practices to protect medically vulnerable people. As detailed in the attached report of Dr. Homer Venters, a nationally recognized expert on correctional healthcare, ICE's response to COVID-19 contains serious defects, including: failures to screen medically vulnerable people and implement corresponding precautions; inadequate screening mechanisms; inadequate infection control procedures; inadequate guidance to clinicians on when to test and hospitalize; failure to account for infection surge and corresponding impact on pre-existing inadequacies of facility, equipment, and staffing capabilities; failures to consider the medical necessity of release; amongst other defects.[17]

Further, ICE's response to COVID-19 contradicts important provisions in the recently-issued guidelines from the Center for Disease Control ("CDC") addressing COVID-19 in correctional and detention facilities.[18] For example, contrary to the CDC Guidelines, the ICE Protocols: (1) do not discuss staffing shortages that will result from the pandemic, or provide guidance to detention

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[15] Allen/Rich Letter; Medical Professionals Letter.

[16] Venters Decl. at ¶¶ 21-22 .

[17] *See generally* Venters Decl.

[18] *Interim Guidance on Mgmt. of Coronavirus Disease 2019 (COVID-19) in Corr. and Det. Facilities*, CDC (March 23, 2020) https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

center staff on how to address staffing shortages as the level of medical encounters increase, and as increased staffing becomes necessary to provide infection control measures while transporting patients; (2) fail to include basic infection control measures, including use of masks for anyone with a cough; and (3) do not require social distancing to prevent the spread of infection, including maintaining 6 feet of separation between people, a measure that is impossible to achieve in the limited space available in detention centers. *See generally* Venters Decl. ¶¶ 11-12, 14.

The evidence further establishes that these serious defects are far from anomalous, but rather systemic in nature. Indeed, the attached declarations paint an alarming picture of ICE's inadequate responses to COVID-19 across the entire country, including failures to: test for COVID-19,[19] provide basic and necessary sanitation supplies such as hand sanitizer,[20] check symptoms, provide necessary education about COVID-19 to detained people and staff,[21] provide people with protective gear (e.g., masks),[22] increase medical staffing,[23] respond to sick calls,[24] and assess medically vulnerable detained people and increase precautionary measures.[25] As a direct consequence, medically vulnerable people feel like they are "sitting ducks"[26] and are "scared for [their] life."[27]

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[19] Solomonov Decl. at ¶ 7; Munoz Decl. ¶ 5.

[20] Hernandez Decl. ¶ 4; Sudney Decl. ¶ 11; Solomonov Decl. ¶7.

[21] *See*, *e.g.*, Steglich Decl. at ¶ 6; Zwick Decl. at ¶¶ 9-14; Rivera Declaration at ¶ 12; Corchado Decl. at ¶ 16; Hernandez Decl. ¶ 3; Fraihat Decl. ¶ 6; Sudney Decl. ¶ 8; Munoz Decl. ¶3

[22] Rios Decl. at ¶ 23; Fraihat Decl. ¶ 9; Sudney Decl. ¶ 11; Munoz Decl. ¶ 7; Solomonov Decl. ¶ 7.

[23] Zwick Decl. at ¶ 16; Hernandez Decl. ¶ 4; Fraihat Decl. ¶ 9; Sudney Decl. ¶ 11; Munoz Decl. ¶ 7.

[24] *See* Saenz Decl. at ¶ 8; Munoz Decl. ¶¶ 8-9.

[25] Hernandez Decl. ¶ 8; Fraihat Decl. ¶ 10; Sudney Decl. ¶ 12; Munoz Decl. ¶ 11; Solomonov Decl. at ¶ 10.

[26] Rios Decl. at ¶ 13.

[27] Hernandez Decl. at ¶ 8; Munoz Decl. at ¶ 11; Fraihat Decl. at ¶ 10.

Importantly, the COVID-19 pandemic—and ICE's unreasonable response to it—will significantly strain ICE's already broken medical care system. Long before the COVID-19 outbreak, numerous reports (including by DHS itself) have identified serious and substantial flaws in ICE's medical care system. For example, a 2017 OIG report that assessed care at certain ICE facilities identified "long waits for the provision of medical care[.]"[28] Other reports echo these alarming findings about substandard medical care in ICE facilities.[29] These pre-existing and well-known inadequacies to ICE's medical care system[30]—when viewed in their totality and in relation to ICE's COVID-19 response—further evince objective deliberate indifference to the critical healthcare needs of people with Risk Factors. *See, e.g.*, *Brown*, 563 U.S. at 505 n.3; Pl.'s Compl. at 12-13 (collecting cases).

ICE's inadequate COVID-19 response will be further exacerbated by its pre-existing, systemic, and long-entrenched failures to conduct meaningful oversight. Indeed, numerous reports—including those by DHS itself—have concluded that

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[28] Off. of Inspector Gen., Off. of Homeland Sec., *OIG-18-32: Concerns About ICE Detainee Treatment and Care at Detention Facilities*, at 7 (Dec. 11, 2017), https://www.oig.dhs.gov/sites/default/files/assets/2017-12/OIG-18-32-Dec17.pdf.

[29] *See, e.g.*, U.S. Gov't Accountability Off. *GAO-16-23: Additional Actions Needed to Strengthen Mgmt. and Oversight of Detainee Med. Care* (Feb. 2016), https://www.gao.gov/assets/680/675484.pdf; Human Rts. Watch, Am. Civil Liberties Union, Nat'l Immigr. Just. Ctr. & Det. Watch Network, *Code Red: The Fatal Consequences of Dangerously Substandard Med. Care in Immigr. Det,* at 15, 19, 25, 46 (June 2018), https://www.hrw.org/sites/default/files/report_pdf/us0618_immigration_web2.pdf; Human Rts. First, *Prisons and Punishment: Immigr. Det. inCal.*, at 10-13 (Jan. 2019), https://www.humanrightsfirst.org/sites/default/files/Prisons_and_Punishment.pdf; J. David McSwane, *ICE Has Repeatedly Failed to Contain Contagious Diseases, Our Analysis Shows. It's a Danger to the Pub.*, PROPUBLICA (Mar. 20, 2020), available at https://www.propublica.org/article/ice-has-repeatedly-failed-to-contain-contagious-diseases-our-analysis-shows-its-a-danger-to-the-public (analysis of DDRs demonstrates that ICE facilities have "long histories of mishandling infectious diseases that can rapidly spread outside their walls.").

[30] Venters Dec. ¶ 8.

ICE fails to effectively oversee the detention facilities holding people in its custody.[31] These ongoing oversight failures almost certainly guarantee that ICE will at best be unable—or, at worst, unwilling—to meaningfully oversee medical care during the COVID-19 pandemic in the over 100 detention facilities across the country. For these reasons, a Special Master is necessary to ensure that necessary protocols implemented to protect people with Risk Factors.

ICE's deliberate indifference to the serious medical needs of people with Risk Factors during the COVID-19 pandemic is itself a cognizable constitutional injury making injunctive relief appropriate. *See, e.g., Helling v. McKinney*, 509 U.S. 25, 33 (1993) (holding that it "would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening condition in their prison on the ground that nothing yet had happened to them"); *Parsons v. Ryan* , 754 F.3d 657, 680 (9th Cir. 2014) (exposure to a substantial risk of serious harm is, "in its own right, a constitutional injury"). To abate this risk of harm, ICE must immediately identify all people with Risk Factors and implement medically necessary precautions to ensure that they are protected from COVID-19. Absent immediate implementation of such precautionary measures, release is the only medically appropriate way to protect people with Risk Factors.[32] Such measures are consistent with the recommendations of DHS's own experts who have urged ICE

[31] *See, e.g.*, Off. of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG-19-18: ICE Does Not Fully Use Contracting Tools to Hold Det. Facility Contractors Accountable for Failing to Meet Performance Standards*, at 5 (Jan. 29, 2019), https://www.oig.dhs.gov/sites/default/files/assets/2019-02/OIG-19-18-Jan19.pdf; Off. of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG-18-55: Immigr. and Customs Enf't Did Not Follow Fed. Procurement Guidelines When Contracting for Det. Servs.*, at 19 (Feb. 21, 2018), https://www.oig.dhs.gov/sites/default/files/assets/2018-02/OIG-18-53-Feb18.pdf.

[32] *See* Venters Decl. ¶ 23.

to release detainees with Risk Factors,[33] as well as the recommendations of 3000 medical professionals.[34]

Both ICE and this Court are empowered to release medically vulnerable people during the COVID-19 pandemic. First, ICE has long maintained discretion to release medically vulnerable people from detention so that they may simultaneously adjudicate their removal cases while ensuring that they can seek necessary medical care outside detention.[35] There has been no intervening change of law that prohibits ICE from releasing people.[36]

Second, and crucially, this Court maintains inherent and broad authority to cure constitutional injuries irrespective of ICE's decision to exercise its powers to release. *See*, *e.g.*, *Brown v. Plata*, 563 U.S. at 503 ("[w]ithout a reduction in overcrowding, there will be no efficacious remedy for the unconstitutional care of the sick and mentally ill in California's prisons."); *Hutto v. Finney*, 437 U.S. 678, 687-88 (1978) (finding "a 30-day limitation on sentences to punitive isolation" an appropriate remedy to unconstitutional prison conditions). Indeed, the Ninth Circuit recently issued a published order requiring the release of a detained immigrant, holding that "in light of the rapidly escalating public health crisis, which public health authorities predict will especially impact immigration detention centers, the court *sua sponte* orders that Petitioner be immediately released from detention and that removal of Petitioner be stayed pending final

[33] Allen/Rich Letter.

[34] Medical Professionals Letter.

[35] *See*, e.g., Decl. of Andrew Lorenzen-Strait in Supp. of Mot. for Prelim. Inj. and Class Certification ("Lorenzen-Strait Decl."); Decl. of Maureen Sweeney ("Sweeny Decl.").

[36] *Id.*

disposition by this court."[37] *See Xochihua-Jaimes v. William P. Barr*, Case No. 18-71460 (9th Cir. March 23, 2020).

2. Defendants' COVID-19 Response Subjects Plaintiffs and Similarly Situated People with Risk Factors to Punitive Conditions in Violation of the Fifth Amendment.

Defendants' policies and practices concerning the custody and care of people with Risk Factors during the COVID-19 pandemic are more restrictive and—in many cases—more dangerous than conditions in criminal detention and therefore constitute punishment in violation of the Fifth Amendment.

People in civil detention are entitled to "more considerate treatment" than individuals detained pursuant to criminal process and may not be subjected to punitive conditions. *See Jones*, 393 F.3d at 931 (citing *Youngberg v. Romeo*, 457 U.S. 307, 321-22 (1982)). A rebuttable presumption of punitiveness arises in two circumstances: (1) "where the individual is detained under conditions identical to, similar to, or more restrictive than those under which pretrial criminal detainees are held," *id*. at 934, or (2) where those conditions "are employed to achieve objectives that could be accomplished in so many alternative and less harsh methods," *id*. at 932. If Plaintiffs establish even one of these presumptions, "the burden shifts to the defendant to show (1) legitimate, non-punitive interests justifying the conditions of [the detained person's] confinement and (2) that the restrictions imposed . . . [are] not excessive in relation to these interests." *King v. County of Los Angeles*, 885 F.3d 548, 557 (9th Cir. 2018) (internal quotation marks omitted).

[37] The district court's recent and non-binding decision in *Dawson v. Asher*, No. C20-0409-JLR-MAT, 2020 WL 1304557 (W.D. Wash. Mar. 19, 2020), has no bearing on the issues presented here. First, Plaintiffs in *Dawson* provided no evidence—much less the substantial evidence marshalled here—evincing the deficiencies in ICE's policies and other responses to COVID-19. *Second*, the court's ruling in *Dawson* suggesting that a detained person cannot seek injunctive relief until after someone is infected in the facility is contrary to binding Supreme Court precedent making clear that detained people need not await actual harm to seek an injunction to abate that harm. *See Helling*, 509 U.S. at 33 .

Here, the Plaintiffs with Risk Factors establish both presumptions of punitive conditions. First, by systemically failing to implement protocols to assess the propriety of continued detention for people with Risk Factors during the COVID-19 pandemic, ICE subjects Plaintiffs and the subclass to conditions that are "more restrictive than those under which pretrial criminal detainees are held." *See Jones*, 393 F.3d at 934. Indeed, throughout the country, sheriffs and other entities with jail oversight have taken steps to both assess and abate the significant risks to medically vulnerable people during the COVID-19 outbreak.[38] In sharp contrast, ICE has systemically failed to administer such protective measures to screen people with Risk Factors in order to assess the risks of their continued detention and/or to identify additional precautionary measures that should be implemented to protect them in light of their medical vulnerability.[39] As a result,

[38] *See, e.g.*, BBC NEWS, *US Jails Begin Releasing Prisoners to Stem COVID-19 Infections* (Mar. 19, 2020), https://www.bbc.com/news/world-us-canada-51947802; Salvador Hernandez, *Los Angeles is Releasing Inmates Early and Arresting Fewer People Over Fears of the Coronavirus in Jails*, BUZZFEED NEWS (Mar. 16, 2020, 4:39 PM), https://www.buzzfeednews.com/article/salvadorhernandez/los-angeles-coronavirus-inmates-early-release; Julia Marsh and Ben Feuerherd, NYC to release 40 coronavirus-prone inmates from Rikers as early as today, NEW YORK POST (Mar. 19, 2020) https://nypost.com/2020/03/19/nyc-to-release-40-coronavirus-prone-inmates-from-rikers-as-early-as-today/; Ryan Autullo, Travis County Judges Releasing Inmates to Limit Coronavirus Spread, STATESMAN (Mar. 16, 2020, 6:12 PM), https://www.statesman.com/news/20200316/travis-county-judges-releasing-inmates-to-limit-coronavirus-spread?fbclid=IwAR3VKawwn3bwSLSO9jXBxXNRuaWd1DRLsCBFc-ZkPN1INWW8xnzLPvZYNO4; CBS News 8, *San Diego & Sheriff to Release Inmates to Reduce Vulnerable Jail Population*, (Mar. 21, 2020, 11:33 AM), https://www.cbs8.com/article/news/health/coronavirus/san-diego-da-sheriff-to-release-inmates-to-reduce-vulnerable-jail-population/509-75730ca5-445a-4811-9024-6aeb1d9c2777; Letter from Mike McGrath, Chief Just., Sup. Ct. of Mont., to Mont. Dist. Ct. Judges (Mar. 20, 2020), https://courts.mt.gov/Portals/189/virus/Ltr%20to%20COLJ%20Judges%20re%20COVID-19%20032020.pdf?ver=2020-03-20-115517-333; https://www.pghcitypaper.com/pittsburgh/allegheny-county-jail-plans-to-release-some-medically-vulnerable-inmates-but-advocacy-groups-say-its-not-enough/Content?oid=16978582; https://www.nbcchicago.com/news/local/cook-county-jail-releases-detainees-highly-vulnerable-to-coronavirus/2238813/

[39] *See generally* Venters Decl.; *see also* note 9 *supra*.

people with Risk Factors in ICE custody face even worse—and more dangerous—conditions than they would in many jails during the COVID-19 pandemic.

Second, Plaintiffs and the putative subclass also satisfy *Jones*'s alternative test for establishing unconstitutionally punitive conditions, because the "restrictions [imposed on them during the COVID-19 outbreak] are 'employed to achieve objectives that could be accomplished in so many alternative and less harsh methods.'" *See Torres v. U.S. Dep't of Homeland Sec.*, 411 F. Supp. 3d 1036, 1065 (C.D. Cal. 2019) (quoting *Jones*, 393 F.3d at 932). As detailed above, ICE has discretion to release medically vulnerable people during the COVID-19 pandemic.[40] Moreover, Defendants also fail to implement medically necessary precautionary measures—short of release—to protect people with Risk Factors from the lethal harms of COVID-19. Such measures include: providing necessary education about COVID-19; ensuring conditions of confinement do not promote the spread of the virus; increasing medical staff; and conducting adequate screening procedures; amongst other protective measures.[41] Yet, as reflected in the attached declarations, Defendants' policies and practices fail to provide such less harsh and dangerous measures and thereby subject the subclass to unnecessarily punitive conditions.

B. Plaintiffs Are Likely to Prevail on Their Section 504 Claims.

1. Defendants' Failure to Protect Persons with Chronic Health Conditions from COVID-19 Denies them Meaningful Access to Defendants' Programs and Activities

Section 504 of the Rehabilitation Act prohibits Executive Agencies such as ICE and DHS from denying persons with disabilities the benefits of their programs and activities solely on the basis of disability. *See* 29 U.S.C. § 794 (a). Persons

[40] *See*, e.g., Lorenzen-Strait Decl.; Sweeney Decl.; Decl. of Laura Rivera at ¶¶ 14-16.

[41] Venters Decl. ¶ 20.

with the chronic health conditions that place them at risk of severe illness or death if exposed to COVID 19[42] are persons with disabilities under Section 504.[43]

In the context of detention facilities, Section 504 requires covered entities to take affirmative steps—including identifying, tracking and accommodating disability-related needs—to ensure that people with disabilities have meaningful access to the benefits of their programs and activities. *See Armstrong v. Brown*, 732 F.3d 955, 958-62 (9th Cir. 2013) (affirming order requiring DOC to ensure county facilities affirmatively track and accommodate the needs of people in detention with disabilities, including within 24 hours of intake)*;see also Updike v. Multnomah County*, 870 F.3d 939, 949 (9th Cir. 2017) (citing *Duvall v. County of Kitsap*, 260 F.3d 1124, 1136 (9th Cir. 2001)); *Pierce v. District of Columbia*, 128 F. Supp. 3d 250, 266-69 (D.D.C. 2015).

Due to the unique nature of detention, in which facility staff control nearly all aspects of detained individuals' daily lives, "most everything provided" to detained individuals is a covered program or activity, including "sleeping, eating, showering, toileting, communicating with those outside the jail by mail and telephone, exercising, entertainment, safety and security, the jail's administrative, disciplinary, and classification proceedings, medical, mental health and dental services, the library, educational, vocational, substance abuse and anger

[42] These chronic health conditions include cardiovascular disease, including congestive heart failure, history of myocardial infarction, and history of cardiac surgery; high blood pressure; chronic respiratory disease, including asthma, chronic obstructive pulmonary disease including chronic bronchitis or emphysema, or other pulmonary diseases; diabetes; cancer; liver disease; kidney disease; autoimmune diseases, including psoriasis, rheumatoid arthritis, and systemic lupus erythematosus; severe psychiatric illness; history of transplantation; and HIV/AIDS; Meyer Decl. ¶ 13, Franco-Paredes Decl. at. ¶¶ 1-2; Venters Decl. at ¶ 13n.4-5)

[43] *See* 29 U.S.C. § 705(20)(B); 42 U.S.C. § 12102, defining disability as "a physical or mental impairment that substantially limits one or more major life activities of [an] individual." The listed conditions limit individuals by substantially limiting their ability to breathe, circulate their blood, and fight off infection, among other limitations.

management classes and discharge services." *Hernandez v. County of Monterey*, 110 F. Supp. 3d 929, 935–36 (N.D. Cal. 2015) (internal citations omitted).

Defendants have failed to affirmatively identify detained persons whose chronic health conditions place them at risk of severe illness or death if exposed to COVID-19, conduct evaluations to determine appropriate precautions to protect such persons from contracting the virus, and implement those precautions. The failure to identify and implement such needed precautions (which are the equivalent of disability-based reasonable modifications to a covered entity's programs and services) leaves persons with chronic health conditions at significant risk of severe illness. The threat of death and severe illness will undoubtedly result in isolation and severe limitations on daily life and access to activities—including access to nearly all of the activities the district court in *Hernandez* found to be covered and thus subject to the meaningful access requirements.

In sum, Defendants' failure to identify and implement appropriate precautions for detained persons with chronic health conditions in light of their Risk Factors will deny those persons meaningful access to Defendants' programs and activities, among other harms, in violation of Section 504. Plaintiffs are likely to prevail on the merits of their Section 504 claim as a result. *See Hernandez v. County of Monterey*, 110 F. Supp. 3d 929 (N.D. Cal. 2015) (court found that plaintiffs likely to succeed on the merits and a preliminary injunction was appropriate in part to control the spread of a tuberculosis, a communicable disease, within a jail facility).

(b) Defendants' Failure to Identify and Implement Necessary Precautions for Persons with Chronic Health Conditions Subjects Them to Unnecessarily Restrictive Placements in Violation of Section 504

As noted above, living in a congregate setting creates an elevated risk of contracting the virus. But the disability subclass members also have chronic health

conditions that create an even more elevated risk of contracting the virus, which will likely lead to medical isolation or segregation.[44] Because of this, Defendants have a duty under *Olmstead v. L.C. ex rel Zimring,* 527 U.S. 581 (1999) to assess whether this setting is truly appropriate to the subclass members' needs, and if not, take steps to provide them with an alternate placement with less restrictive consequences.

The regulations promulgated pursuant to the ADA (parallel to the Rehabilitation Act) provide that "[a] public entity shall administer services, programs, and activities in the most integrated setting *appropriate to the needs* of qualified individuals with disabilities." 28 C.F.R. § 35.130(d) (emphasis added). The Supreme Court held in *Olmstead v. L.C. ex rel Zimring,* that "[u]njustified [institutional] isolation . . . is properly regarded as discrimination based on disability." 527 U.S. 581, 597, 600 (1999). DHS and ICE recognize that they must comply with *Olmstead*. DHS's regulations provide that "[t]he Department shall administer programs and activities in the most integrated setting *appropriate to the needs* of qualified individuals with a disability." 6 C.F.R. § 15.30(d) (emphasis added); *see also ICE National Detention Standards for Non-Dedicated Facilities* at 137 (2019) (Standard 4.7 provides that Facilities are required by the Rehabilitation Act to have an equal opportunity to participate in the facility's programs, services, and activities "in the least restrictive and most integrated setting possible").[45]

The federal agency's duty under *Olmstead* consists of two parts. First, the agency must assess the placement needs of qualified individuals. *Olmstead* makes clear that jurisdictions must provide non-institutional placement "when the State's

[44] Venters Decl. ¶¶ 16-17.

[45] https://www.ice.gov/doclib/detention-standards/2019/nds2019.pdf; ICE, *Performance-Based National Detention Standards 2011*, Standard 4.8 at 344 (rev. 2016), https://www.ice.gov/doclib/detention-standards/2011/pbnds2011r2016.pdf (same).

treatment professionals determine that such placement is appropriate." *Olmstead*, 527 U.S. at 607. Second, the agency must ensure that placement is actually made in the most integrated setting appropriate to those needs.

A covered entity violates *Olmstead* when it fails to make an assessment of what setting is most "appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). In 2003, the Department of Justice made findings that Laguna Honda Hospital in San Francisco had violated *Olmstead* by failing to "conduct[] meaningful assessments of most residents to determine whether the nursing home is the most integrated setting to meet their needs."[46]

Courts have held that the *Olmstead* duty of assessment and appropriate placement also applies to people with disabilities in jail environments. *See, e.g.*, *See Winters v. Ark. Dept. of Health & Human Servs.*, 491 F.3d 933, 936-37 (8th Cir. 2007); *Reaves v. Dep't of Corrs.*, 195 F. Supp. 3d 383, 422-23, 427 (D. Mass. 2016); *Black v. Wiggington*, 1:12–CV–03365, 2015 WL 468618 (N.D. Ga. Feb, 4, 2015). This duty of appropriate placement extends to release from jail into the community in appropriate prisoners' situations. *See McClendon v. City of Albuquerque*, Case No. 95 CV 24 JAP/KBM, 2016 WL 9818311, at *14 (D.N.M. Nov. 9, 2016) (holding that the *Olmstead* mandate applied to a jail where overcrowding violated the Eighth Amendment, and that the defendants could develop a community diversion program for prisoners with mental health and developmental disabilities in order to discharge their duties under *Olmstead*).

[46] U.S. Department of Justice Department of Civil Rights, *Investigation of Laguna Honda Hospital and Rehabilitation Center* at 9 (Apr. 1, 2003), https://www.ada.gov/olmstead/documents/laguna_findings2.pdf. Later, the Department of Justice also found that the State of California had also failed in its duty to make similar assessments under the Social Security Act. U.S. Department of Justice Department of Civil Rights, *Laguna Honda Hospital and Rehabilitation Center, San Francisco, California* (Aug. 3, 2004), https://www.ada.gov/olmstead/documents/laguna_findings3.pdf.

The same duty to assess the needs of people with disabilities applies here. Because members of the subclass have disabilities and are at heightened risk of isolation during the COVID-19 pandemic as result of those disabilities, Defendants have an affirmative duty under *Olmstead* to assess what setting is appropriate to their needs and to ensure that unnecessary isolation does not take place. As those assessments have not yet occurred, and no alteration has taken place, the subclass's *Olmstead* claim has a high likelihood of success on the merits.

C. Plaintiffs Satisfy the Remaining Preliminary Injunction Factors

Plaintiffs satisfy the other factors for issuance of a preliminary injunction.

1. The Subclass Will Suffer Irreparable Harm Absent Immediate Relief.

Plaintiffs will suffer irreparable harm absent an injunction. COVID-19 is associated with significant morbidity and mortality in individuals with certain disabilities and chronic medical conditions. Franco-Paredes Decl. at 2, 3-4; Meyer Decl. ¶ 21. The risk posed by COVID-19 is significantly higher in the detention context than in the community, "in terms of risk of transmission, exposure, and harm to individuals who become infected." Meyer Decl. ¶¶ 7, 13. The mortality rate amongst populations with the relevant Risk Factors is significantly higher. Franco-Paredes Decl. at 4, 6; Meyer Decl. ¶¶ 14-16. Further, there is evidence that people with disabilities that fall within the high-risk categories are significantly more likely to develop complications. Franco-Paredes Decl. at 5-6.

In addition, "[i]t is well-established that the deprivation of constitutional rights 'unquestionably constitutes irreparable injury.'" *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012) (quoting *Elrod v. Burns*, 427 U.S. 347, 373 (1976)). Irreparable harm is also established where a preliminary injunction is necessary to preserve the health of someone in a detention setting. *See, e.g., Jones v. Texas Dep't of Criminal Justice*, 880 F.3d 756, 759 (5th Cir. 2018). Here, detained people

with Risk Factors are at significant risk of serious illness, life-altering complications, and death and will thus suffer irreparable harm absent an injunction.

As noted above, the disability subclass members are also subject to a greater likelihood of contracting the virus; complications and/or death from the virus; and higher morbidity, mortality, and poor health outcomes due to their underlying medical and disability conditions when medical and other care in the facility is taxed by conditions relating to the virus. Meyer Dec. ¶¶ 28, 30, 32; Franco-Paredes Dec. at 6. If any of these risks materializes, subclass members could be subjected to isolation in the extreme,[47] denying them meaningful access to the Defendants' detention programs as result. Such exclusion of people with disabilities from programs or services provided by a covered entity has been found to constitute irreparable injury. *See Hernandez*, 110 F. Supp. 3d at 956-57 (irreparable harm found where jail facility failed to provide persons with disabilities access to its programs and activities); *D.R. v. Antelope Valley Union High Sch. Dist.*, 746 F. Supp. 2d 1132, 1145–46 (C.D. Cal. 2010) (student suffered irreparable harm by missing minutes of education classes per day because of structural barriers).

Further, the Ninth Circuit recognizes that a risk of a more restrictive placement "inflicts cognizable irreparable injury for purposes of a preliminary injunction." *See, e.g.*, *M.R. v. Dreyfus*, 663 F.3d 1100, 1111 (9th Cir. 2011), *amended on other grounds by and reh'd denied*, 697 F.3d 706 (9th Cir. 2012); *A.H.R. v. Wash. State Health Care Auth.*, No. C15-5701JLR, 2016 WL 98513, at *15 (W.D. Wash. Jan. 7, 2016) (collecting cases); *Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161, 1176-77 (N.D. Cal. 2009) (same).

[47] For example, detention facilities sometimes isolate medically sensitive people in solitary confinement, although this is both ineffective as to the virus and dangerous to mental health. [Meyer Dec. ¶ 10; Venters Dec. ¶¶ 10, 16-17.]

2. The Balance of Hardships Tips Decidedly in Plaintiffs' Favor

The balance of equities favors Plaintiffs. Courts "'must balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief.'" *Winter v. Natural Resources Def. Council, Inc.*, 555 U.S. 7, 24 (2008) (*quoting Amoco Prod. Co. v. Gambell*, 480 U.S. 531, 542 (1987)). The Ninth Circuit has held that the interest in protecting individuals from physical harm outweighs monetary costs to government entities. *See Harris v. Bd. of Supervisors, L.A. Cnty.*, 366 F.3d 754, 766 (9th Cir. 2004).

Plaintiffs' interests in preventing exposure to a deadly virus and obtaining adequate health care if exposed or infected is essentially an interest in survival and the preservation of their lives. Further, people with disabilities that place them at heightened risk of infection will continue to be denied meaningful access to programs provided by Defendants if they are sickened or killed by COVID-19.

In sharp contrast to Plaintiffs' hardships, Defendants will merely be required to devise a plan to review people with Risk Factors and release those they cannot adequately care for in light of the spread of COVID-19. Other, safer options are available. These other placements may include placement in the community, which is indisputably among the options legally available to ICE and which has proven successful in the past in ensuring that subject individuals appear in court. Moreover, requiring Defendants to review individual risk factors and release those who they may not adequately protect may result in reducing future costs. Franco-Paredes Decl. at 1 ("the attack rate inside these centers may take exponential proportions consuming significant medical care and financial resources").

3. A Preliminary Injunction is in the Public Interest

Protecting public health by minimizing risk of transmission of COVID-19 is inarguably in the public interest. Immediately implementing measures to protect the health of people with Risk Factors, and releasing those for which such

measures cannot be implemented and who do not pose a danger to the public, protects the health of those people, staff, and the public at large by mitigating or eliminating a situation in which detained people become infected by COVID-19 and must rely on hospitals and medical equipment. Meyer Decl. ¶ 8. Further, a preliminary injunction enjoining Defendants' violations of the Rehabilitation Act and *Olmstead* would serve the public's interest in enforcement of federal disability law and "in elimination of discrimination on the basis of disability." *Enyart v. Nat'l Conference of Bar Examiners, Inc.*, 630 F.3d 1153, 1167 (9th Cir. 2011).

IV. CONCLUSION

For these reasons, Plaintiffs respectfully request that the Court grant the requested preliminary injunction to abate the imminent harm of COVID-19.

Respectfully Submitted,

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Maria del Pilar Gonzalez Morales
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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE

FAOUR ABDALLAH FRAIHAT, *et al.*,

Plaintiffs,

v.

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, *et al.*,

Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

Declaration of Thomas Ragland in Support of Motion for Preliminary Injunction and Class Certification

Date: March 24, 2020

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**Pro Hac Vice Application Forthcoming

DECLARATION OF THOMAS RAGLAND

1. My name is Thomas K. Ragland. I am a Member in the Immigration Business Unit of Clark Hill PLC. I work at the firm's Washington, D.C. office which is located at 1001 Pennsylvania Avenue NW, Suite 1300 South, Washington, DC 20004. I have practiced immigration law for over 25 years, including as an attorney at the Department of Justice's Board of Immigration Appeals and in the Office of Immigration Litigation at the Civil Division.

2. I represent a 63-year-old asylum seeker who is currently detained at the Adelanto Detention Facility ("Adelanto") in Adelanto, California. My client was taken into custody by U.S. Immigration and Customs Enforcement ("ICE") in June 2019. He is not subject to mandatory detention. In July 2019, an Immigration Judge ("IJ") at the Adelanto Immigration Court denied my client's motion for release on bond under INA §236(a), despite finding that he poses no danger to the community, on the ground that he poses a flight risk. On behalf of my client, I filed a timely appeal with the Board of Immigration Appeals ("BIA"). In February 2020, the BIA sustained our appeal and remanded my client's case to the Adelanto Immigration Court for a new bond hearing.

3. On March 12, 2020, the Adelanto Immigration Court issued a notice informing me that my client had been scheduled for a bond hearing on March 19, 2020.

4. On March 13, 2020, following discussions with the ICE counsel assigned to my client's case, we agreed upon stipulated terms for my client's release from custody: posting of a $30,000 bond and GPS electronic monitoring via an ankle bracelet.

5. On March 19, 2020, I appeared for a telephonic bond hearing before the IJ. ICE counsel was also present. The IJ informed me that he could not proceed with my client's bond hearing because he did not have the case file. He stated further that my client had been quarantined, for a reason unknown to him, and therefore was not present in the court. He stated that the bond hearing would thus have to be rescheduled. According to the IJ, to his knowledge the reason for the quarantine was not suspected coronavirus exposure, but he did not know why my client had been quarantined.

6. I informed the IJ that we had reached an agreement with opposing counsel on stipulated terms for my client's release. The IJ said he understood, but would not render a bond decision – notwithstanding the parties' stipulated agreement – without first reviewing the bond file, which he did not have before him. He stated further that my client could not be released for at least 2 weeks or 30 days in any event, due to quarantine policy at the Adelanto Detention Center.

7. The IJ stated that the earliest date on which he could conduct a bond hearing, when my client would be eligible for release from quarantine, is April 14, 2020 at 1:00 p.m.

8. Alarmed at the prospect that my client would languish for nearly another month in detention, I implored the IJ to release my client on the terms that ICE counsel and I had agreed to. I alerted the IJ to my client's advanced age and stated my concern that he

would face grave risk if exposed to coronavirus and infected with COVID-19 in the contained environment of an ICE detention center.

9. The IJ was adamant that my client could not be released, as a matter of Adelanto Detention Facility policy, so long as he is in quarantine. The IJ remarked that my client "is probably safer in here than he would be on the outside."

10. On March 20, 2020, I spoke with my client by telephone and asked him about the quarantine. He stated that he himself is not ill. Rather, the quarantine was instituted because, to his knowledge, someone at the facility complained of stomach pains. He said that he is confined with a group of approximately 80 inmates—none of whom appear to my client to be ill—and they are not permitted to interact with other detainees. They are not permitted to use spaces that were previously considered common spaces, like the cafeteria. He stated that he is residing in close quarters with four other individuals. He also said that no nurses or doctors have visited the facility to perform check-ups on the individuals with whom he is quarantined.

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

Executed on: March 21, 2020 By: */s/ Thomas K. Ragland*
Thomas K. Ragland

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UNITED STATES DISTRICT COURT
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EASTERN DIVISION – RIVERSIDE

FAOUR ABDALLAH FRAIHAT, *et al.*,

Plaintiffs,

v.

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Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

Declaration of Mikhail Solomonov in Support of Motion for Preliminary Injunction and Class Certification

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**Pro Hac Vice Application Forthcoming

DECLARATION OF MIKHAIL SOLOMONOV

I, Mikhail Solomonov, declare the following under penalty of perjury pursuant to 28 U.S.C. § 1746 as follows:

1. I am over 18 years of age and am competent to make this Declaration. I make this Declaration based on personal knowledge. I read and write in English and Russian.
2. I am in the custody of Immigration and Customs Enforcement (ICE) and am currently being detained at Aurora Contract Detention Facility (Aurora). I have been at Aurora since January 2020.

Background

3. Prior to being detained, I was a medical doctor and practiced in New Jersey. I had medical licenses in New York and New Jersey and practiced anesthesiology and pain management.

Experiences at Aurora

4. We have been seeing information about novel COVID-19 on television for a few weeks. Aurora has taken no steps to prepare us except for distributing limited information. I am extremely worried about this. It's business as usual in here, and I am afraid for my life and that of other detained people.
5. A week ago, some GEO lieutenants came in to the dorm and gave us a little lecture on what they are doing to screen people, primarily taking their temperature, and telling us to wash our hands for 20 seconds. They gave us CDC printouts about handwashing in English and Spanish. The medical staff did not attend that meeting. In my opinion, based on my medical training, the screening process they described is insufficient because it does not account for asymptomatic people. I filed a grievance about this with GEO.
6. Aurora brought in five new people to my dorm yesterday, six new people the day before, and two people the day before that. To my knowledge, the new people were not tested for COVID-19. Some told me that they had come to a jail where someone had symptoms, but had not been tested. They had their

temperature taken and filled out a questionnaire. We are up to 80 people in a dorm with capacity of 82 people, and it is impossible to stay away from other people in here.

7. We do not have access to hand sanitizer. No one in my dorm has been tested for COVID-19. The process for cleaning our dorm has not changed, and earlier this week we did not have enough rags to clean all of the surfaces in the dorm, like the tables in the day room. We have no access to masks. We do not have enough disinfectant to clean our dorms ourselves any additional amount.

8. Aside from the sinks in our cells, there is only one sink for the entire dorm. The water pressure on these sinks is very low, and the water only stays on for a few seconds after you turn it on. It is very difficult under these circumstances to wash my hands for 20 seconds as health authorities recommend.

9. I have filed multiple complaints with GEO about the inadequate procedures and protections for COVID-19 based on my medical training and experiences. My most recent grievance was signed by 65 people in my dorm. I have spoken to the warden, and they tell me they will be bringing us more supplies, but nothing has been brought to us. They are doing nothing to ensure sanitation in our dorm, which is probably the most critical area of the facility to keep clean, given that we are in four- or eight-man cells in a dorm of 80 people and we cannot leave or spread out.

10. I am also worried that they are not taking any steps to protect people who are at elevated risk for a COVID-19 infection with serious adverse effects. For example, my bunkmate is very old and has clear breathing issues. They have not come to visit him or screened him in any way that I have observed.

11. On March 20, 2020, a lieutenant and male nurse came to see us again. They told us we have no coronavirus cases in the facility, told us to wash our hands, and told us about the booklet. I brought up that they brought in new people from a jail and that they should stop bringing in new people to the dorm. They told me that they were screening people by taking temperature

and doing a screening questionnaire. I reiterated my earlier complaint that this is not enough to protect us.

12. It would be my strong preference to be home with my family sheltering in place and practicing social distancing.

13. Aurora's lack of preparedness is making me extremely worried for my safety and that of other detained people.

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

15. I have authorized attorney Elizabeth Jordan to sign this declaration on my behalf after she reviewed it with me over the telephone given the difficulty of arranging visitation and travel due to the current COVID-19 pandemic. If required to do so, I will provide a signature when I am able to do so.

Signature:

Elizabeth Jordan for Mikhail Solomonov

Date: 3/21/2020

Location: Aurora, Colorado

I, Elizabeth Jordan, declare the following under penalty of perjury pursuant to 28 U.S.C. § 1746 as follows:

1. I am a licensed attorney in good standing in Louisiana and New York. I am an attorney of record in *Fraihat v. ICE*, Case 5:19-cv-01546 (C.D. Cal.).
2. I interviewed and prepared a declaration for declarant Mikhail Solomonov with the consent of his immigration attorney. Out of necessity in light of the COVID-19 pandemic, I signed the attached declaration on Mikhail Solomonov's behalf with his express consent.
3. ICE is now requiring legal visitors to provide and wear personal protective equipment, including disposable vinyl gloves, surgical masks, and eye protection while visiting any detention facility. These supplies are not easily accessible, given the increase in demand. Any available supplies are prioritized to hospitals and other medical facilities that are experiencing dangerous shortages. As such, it is nearly impossible to arrange an in-person legal visit while this policy is in effect.
4. There are documented cases of COVID-19 in all fifty U.S. states and most inhabited U.S. territories. The Center for Disease Control and Protection (CDC) issued statements warning that individuals are at a higher risk of infection when traveling. Mr. Solomonov is detained at the Aurora Detention Center, in Aurora, Colorado, while I live in Denver, Colorado. Colorado has been under a state of emergency since March 10 and recommends avoiding non-essential travel. Moreover, the Aurora Detention Center has restricted contact legal visits and locked at least 10 detained people into quarantine due to possible community exposure.

5. In light of the above, to protect public health, I am not able to travel to Aurora Detention Center to obtain Mr. Solomonov's signature.
6. I spoke with Mr. Solomonov over the phone, interviewed him for a declaration, prepared the declaration, and then read the declaration to him and confirmed the accuracy of the information therein. Mr. Solomonov has confirmed that I can sign on his behalf as reflected in his declaration.

I declare under penalty of perjury that the statements above are true and correct to the best of my knowledge and that this declaration was executed on March 22, 2020 in Denver, Colorado.

Elizabeth Jordan

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FAOUR ABDALLAH FRAIHAT, *et al.*,

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Declaration of Maureen A. Sweeney

Date: March 24, 2020

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*Admitted Pro Hac Vice
**Pro Hac Vice Application Forthcoming

DECLARATION OF MAUREEN A. SWEENEY, ESQ.

I, Maureen A. Sweeney, hereby declare:

1. I am a Law School Professor at the University of Maryland Carey School of Law, where I have taught Immigration Law, the Immigration Clinic, and other courses for sixteen years. I am also an attorney licensed to practice law in the state of Maryland. Prior to my work at the university, I practiced immigration law at Catholic Charities Immigration Legal Services and Lutheran Immigration and Refugee Services in Baltimore. My scholarly and practice areas of specialization are in immigration removal litigation, with particular specialty in the areas of asylum and the immigration consequences of criminal convictions. My curriculum vitae is attached as Exhibit A.

2. The Immigration and Nationality Act (INA) gives Immigration Customs Enforcement (ICE) the authority to exercise broad discretion over the decision of whether and on what conditions to detain an individual who is in removal proceedings before the Immigration Court or is awaiting removal. *See*, e.g., 8 U.S.C. §1226(a) (providing for discretionary detention allowing for release on bond or on conditional parole); 8 U.S.C. §1182(d)(5)(A) (providing for parole of inadmissible individuals "on a case-by-case basis for urgent humanitarian reasons or significant public benefit"). Federal regulations provide that:

> [t]he authority of the Secretary [of Homeland Security] to continue an alien in custody or grant parole under section 212(d)(5)(A) of the [INA] shall be exercised by [a range of ICE and Customs and Border Protection officers]. The Secretary or his designees may invoke, in the exercise of discretion, the authority under section 212(d)(5)(A) of the Act.").

8 C.F.R. §212.5(a). In exercising this discretion, ICE agents have historically considered a broad range of factors, including an individual's health, their potential for legal relief, their family and other ties to the community, their criminal history and even the availability of detention capacity. *See* 8 C.F.R. §212.5(b) (providing for case-by-case parole determinations for individuals who, among other things, "have serious medical conditions in which continued detention would not be appropriate" or whose continued detention would not be in the public interest).

3. The INA also provides for what is commonly known as "mandatory" detention for individuals with a history of certain criminal convictions. *See* 8 U.S.C. §1226(c)(1). Despite the nominally "mandatory" nature of this detention, however, ICE has always, in fact, exercised discretion over individuals in this category, even if rarely exercising that discretion to release individuals.

4. By way of but one example, several years ago, our clinic represented a client who was subject to "mandatory" detention under 8 U.S.C. §1226(c)(1) because of a theft conviction from many years prior. ICE agents detained our client when he appeared at his master calendar hearing, informing him and us that the client was subject to

mandatory detention. Our client did, in fact, fall within the terms of §1226(c), but after they detained him, ICE agents chose to exercise their discretion to release him for medical reasons. Our client suffered from a number of medical conditions, including high blood pressure, heart conditions, and depression, and he did not have any of his medications with him when he was detained. We provided the ICE agents with proof of these conditions, and our client, for his part, made it clear that he would refuse to take medication that had not been prescribed by his doctors. When the agents realized the seriousness of our client's medical conditions and the risk created by his detention, they decided to release him that same day on his own recognizance.

5. This case constituted an example exercise of the discretion that ICE clearly has – and has exercised historically – to release individuals for urgent medical reasons, even when they fall within the terms of the "mandatory" detention provision. Nothing has changed in the statute or regulations to alter this authority since the day our client was detained and released. ICE has this authority to this day.

6. Based on my legal scholarship as an expert in immigration law, as well as my experience as an immigration practitioner, it is soundly within ICE's authority to release individuals from detention based on, among other things, medical conditions that cannot be adequately managed in a custodial setting. In such cases, ICE retains jurisdiction over the prosecution of immigration proceedings and the enforcement of removal orders but adjudication occurs in non-detained settings, allowing individuals to shelter in place with family, friends, or service providers able to provide for their needs.

I, Maureen A. Sweeney, swear under the penalty of perjury pursuant to 28 U.S.C. § 1746, that the foregoing declaration is true and correct to the best of my knowledge and belief.

Executed on this 23rd day in March, 2020 at Baltimore, Maryland.

Maureen A. Sweeney, Esq.

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE

FAOUR ABDALLAH FRAIHAT, *et al.*,

Plaintiffs,

v.

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, *et al.*,

Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

Declaration of Linda Corchado in Support of Motion for Preliminary Injunction and Class Certification

Date: March 24, 2020

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*Admitted Pro Hac Vice
**Pro Hac Vice Application Forthcoming

DECLARATION OF LINDA CORCHADO, LEGAL DIRECTOR, LAS AMERICAS IMMIGRANT ADVOCACY CENTER

1. I, Linda Corchado, declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct. If called as a witness, I could and would testify as follows.

2. I am an attorney licensed to practice law in New York. Since May 2019, I have been the Legal Director at Las Americas Immigrant Advocacy Center ("Las Americas"). As Legal Director, I engage in direct representation of noncitizen clients and also supervise attorneys and other staff at Las Americas who represent individuals detained during immigration proceedings.

3. I have been practicing law since 2015. I have focused my practice on immigration law, with a particular focus on asylum and the detention of asylum seekers. Prior to joining Las Americas, I worked as a private immigration attorney for four years.

Las Americas' Mission and Scope

4. Las Americas is a nonprofit legal services organization based in El Paso, Texas, dedicated to serving the legal needs of low-income asylum seekers and other low-income noncitizens in West Texas and New Mexico.

5. Las Americas' legal staff consists of six attorneys, two non-attorney representatives accredited by the Board of Immigration Appeals to represent noncitizens in immigration matters before the Department of Homeland Security ("DHS") and in immigration court, and six paralegals.

6. A central part of Las Americas' mission is providing consultation and legal services to asylum seekers detained while in the expedited removal process.

7. Las Americas also represents detained asylum seekers in other procedural settings, such as in connection with bond and parole requests, and on the merits of their asylum applications in regular removal proceedings in immigration court.

8. Our goal in all of our work with asylum seekers is to ensure that detained low-income individuals have a fair opportunity to establish their eligibility for protection and are not wrongfully removed to persecution or torture. Reaching and effectively representing asylum seekers during the expedited removal process is absolutely essential to our mission of ensuring that they have a chance to fully develop and present their claims.

9. Although our work generally does not include providing representation to the following areas, given the severity of COVID-19, and ICE's continued transfer of individuals from facility to facility, we have begun to take on cases of individuals detained at the El Paso Service Processing Center ("ESPC"), Joe Corley Detention Facility ("Conroe"), and South Louisiana Ice Processing Center ("South Louisiana"). Since the outbreak of COVID-19, Las Americas has not been able to visit individuals inside of ICE detention facilities and has instead spoken by phone to individuals inside of the facilities. The information we have obtained from our clients demonstrates ICE's failure to protect individuals in its custody during this pandemic. Below are but a few of the horrific conditions that clients have expressed in the past two weeks.

South Louisiana Ice Processing Center

10. Another client detained in South Louisiana told me they have no access to soap, hand sanitizer, that the guards had run out of gloves and toilet paper is extremely limited and that multiple people in her barrack were coughing.

11. One HIV positive woman was still working in the kitchen up until March 20, 2020.

12. HIV positive, and otherwise immunocompromised, clients are being transferred through various detention centers (that means getting on and off multiple buses and flights). For example, 4 clients (2 HIV positive) are scheduled to be transferred into a detention facility where an HIV positive woman has already been exposed to COVID19 in court.

13. We have multiple cases of individuals who are parole-eligible and have family in the U.S. and ICE is refusing to even adjudicate paroles (several have been pending for 3 weeks.)

El Paso Service Processing Center

14. ICE has made very little effort to accommodate access to counsel amid COVID-19. Legal calls at ESPC have been coordinated from the barracks where we can clearly hear other detained individuals and guards in the background. Other legal calls are held from "processing" where guards are supposedly "out of earshot" but can be heard in the background – we had one client tell us she didn't feel comfortable talking on the phone at all during the legal call.

15. These legal calls are not fully confidential, which makes it extremely difficult for Las Americas to advocate for our clients and to protect them from COVID-19 – especially medically vulnerable clients who, for instance, cannot comfortably share the details of their conditions in detention.

16. A member of my team asked a guard at EPPC on 3/17/2020 about COVID protocols and he told them that they had not received any special training on how to keep themselves or detained individuals safe during the pandemic, and then said "if it happens, it happens."

Joe Corley Detention Facility

Instructive Client Concerns

17. We have received a number of disturbing complaints coming from clients in the Joe Corley Detention Facility in Conroe, Texas, which seems to be stemming from concerns (or lack thereof) regarding coronavirus. In addition to ICE's failure to provide medical treatment for each of these medically vulnerable clients generally, to my knowledge, they also have not conducted any evaluation of their underlying health conditions to determine whether any additional precautionary measures should be taken to protect them from COVID-19.

18. Client 1: There was a three-day long strike among cafeteria workers regarding lack of precautions taken for COVID-19. During those three days, access to food was disrupted. His third night at the facility, he suffered an epileptic seizure. The facility is only giving him epilepsy medication every other day.

19. Client 2 reports that there are three people in his barracks that are sick with what seems like the flu but might be COVID-19. All three have requested to be sent into medical, and all three have been denied.

20. Client 3 has asthma and has not received an inhaler. He had an asthma attack 5 days go, which he credits to the crowded confinement, musty air, and poor conditions.

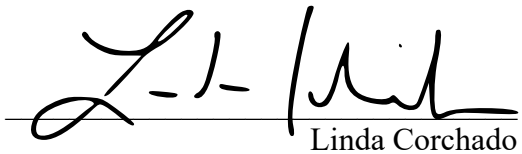
21. Client 4 also has asthma and has not received an inhaler. Respiratory problems put people at higher risk of contracting respiratory illnesses. Additionally, Client 4 has two bullets in his legs, and is not receiving pain medication.

General Concerns

22. All clients inform us that Conroe places 36 people in each barrack. At such close proximity, they are at extreme risk of contracting COVID-19. As previously stated, people displaying symptoms of coronavirus, and people who have conditions that put them at higher risk for contracting and suffering deadly consequences from COVID-19, are not being taken to medical. This seems like an intentional abandonment of responsibility and is impermissibly reckless.

23. Deportation Officers have explicitly told all but one of our clients in Conroe that they will not consider their paroles because they were formerly in MPP and not parole eligible. In El Paso, persons formerly placed in Migrant Protection Protocols ("MPP") but then removed from MPP after passing a non-refoulement interview, are eligible for parole. Humanitarian parole is

generally available to individuals in ICE custody – including for medical vulnerability – and ICE has granted our clients such parole in the past. ICE is now taking an excessively hard line on humanitarian parole, which appears to not encompass concerns over a global pandemic.



Linda Corchado

Executed this 23rd day of March 2020

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
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FAOUR ABDALLAH FRAIHAT, *et al.*,

Plaintiffs,

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Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

Declaration of Laura G. Rivera in Support of Motion for Preliminary Injunction and Class Certification

Date: March 24, 2020

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**Pro Hac Vice Application Forthcoming

DECLARATION OF LAURA G. RIVERA, ESQ.

I, Laura G. Rivera, Esq., make this declaration on my personal knowledge and if called to testify, I could and would do so competently as follows:

1. I serve as the Director of the Southeast Immigrant Freedom Initiative of the Southern Poverty Law Center ("SIFI"). SIFI provides *pro bono* representation to detained immigrants in proceedings before the Executive Office for Immigration Review and U.S. Immigration and Customs and Enforcement ("ICE"). SIFI prioritizes representing detained individuals in seeking their release from ICE custody.

2. SIFI represents individuals confined inside the following detention centers in Louisiana and Georgia: the LaSalle Detention Center ("LaSalle") in Jena, Louisiana; the Pine Prairie ICE Processing Center ("Pine Prairie") in Pine Prairie, Louisiana; the Irwin County Detention Center ("Irwin") in Ocilla, Georgia; the Folkston ICE Processing Center ("Folkston") in Folkston, Georgia; and the Stewart Detention Center ("Stewart") in Lumpkin, Georgia.

3. Since SIFI's founding in 2017, SIFI has represented hundreds of individuals confined inside these five detention centers, primarily on custody matters. SIFI currently has clients inside all five of these detention centers. To date, our primary mode of contact with confined individuals is through a free and confidential hotline through which confined individuals may reach us. The hotline has typically been staffed by two full-time SIFI staff who operate the hotline Monday through Thursday of each week during business hours. Since March 16, 2020, in light of the COVID-19 pandemic, SPLC has closed its offices, and three SPLC employees have rotated staffing the hotline on Mondays and Thursdays only.

4. Since the outbreak of the novel coronavirus, several SIFI staff have visited individuals inside four of the detention centers and spoken by phone to individuals at all five detention centers. What SIFI staff have personally witnessed and learned in conversation with detained individuals reveals a grossly deficient response by government officials and private contractors to stem the spread of the virus inside these detention centers.

5. Since the COVID-19 outbreak was declared a pandemic, SIFI and partner orgs have submitted two letters to ICE and facility administrators requesting information about their response plans for this pandemic; yet to date, SIFI has received no response.

Pine Prairie Detention Center, Pine Prairie, LA

6. Perhaps the most alarming information SIFI has documented relates to Pine Prairie, a detention center operated by private prison contractor GEO Group. On March 16, 2020—well after public health authorities had declared the novel coronavirus a global pandemic—a SIFI staff

member conducted in-person visitation with five individuals inside Pine Prairie. As a condition to visitation, she was required to submit to a temperature check and to sign paperwork stating that she had not traveled out of the country and that she did not have physical symptoms. She was permitted to wear her own mask and gloves into the visitation area. None of the GEO Group staff or detained people wore masks or gloves.

7. Visitation at Pine Prairie is contact visitation only. The SIFI staff member was seated at a table about six feet from those she visited. The five individuals she visited independently gave her a consistent message: none had received any information about the coronavirus. They also mentioned lacking access to hand soap. When she asked them whether the GEO Group staff had changed any protocols in response to the pandemic, they said their conditions have not changed in any noticeable way. The five individuals had engaged in a hunger strike and had been subjected to solitary confinement. Three of them independently told her that while segregated inside one- or two-person cells, they were not given water to drink for almost a week, and they were forced to drink water from the toilet.

8. On March 18, 2020, the same staff member conducted legal visitation by video teleconference with a man inside Pine Prairie. The man was wearing a mask and gloves. He told her that he and roughly sixty others inside his housing unit, Charlie Alpha, were under quarantine. Guards had told those in Charlie Alpha that someone inside that unit was suspected of having COVID-19. The suspected COVID-19 carrier had been removed from the Charlie Alpha unit. Everyone else remained inside Charlie Alpha. He told her that detained people inside Charlie Alpha were responsible for cleaning their own unit. They had access to some chemicals to clean with. However, they had no access to hand soap or hand sanitizer, only the soap given to them for showers. The GEO Group guards had not taken any measures to space people out inside the unit.

9. The next day, on March 19, 2020, a different person inside Pine Prairie contacted SIFI to seek legal assistance. The caller said he had received some information about the coronavirus through the use of a tablet device. He said those in his unit were receiving hygiene supplies every two days. He reported that two people with symptoms of coughing, fever, or shortness of breath had been removed from his unit.

10. The following day, March 20, 2020, a SIFI staff member conducted in-person visitation at Pine Prairie with five individuals from the quarantined Charlie Alpha unit. Upon entering the detention center, she signed a form stating that she was not symptomatic and had not been exposed to COVID-19 or traveled to high risk areas. Her temperature was not checked. Some staff wore masks; others did not. As before, she sat at a six-foot table in the visitation area. Because the table is located in a common area, the visits were not private or confidential. The five men from the quarantine unit wore masks but no gloves. As they waited in the common area, they sat alongside other detained people awaiting visitation who did not have masks or gloves. They told her that they were only given masks when they left the dorm, not while they were inside of it. They also told her that detained individuals are still cleaning the dorms, and they are given neither masks nor gloves. Guards and ICE agents sometimes wear masks and gloves when they enter Charlie

Alpha and sometimes do not. Several of them also reported to her that ICE continues to bring new people into confinement at Pine Prairie. It is putting those new people into the Charlie Alpha unit, a known high-risk unit.

LaSalle Detention Center, Jena, LA

11. On March 19, 2020, SIFI staff also received a call from a person confined inside LaSalle, another detention center operated by private prison contractor GEO Group. The caller complained of having a fever, chest pain, difficulty breathing while trying to sleep, and of coughing blood. He reported having been tested for the flu and having returned a negative result; however, to his knowledge, he had not been tested for coronavirus. The only treatment he reported receiving inside LaSalle was ibuprofen, syrup, and salt, which had not helped. He reported sharing a unit, HD, with others who had symptoms of coughing, fever, or shortness of breath. None had been removed from the unit. New people were being brought into the unit. GEO Group staff were not routinely using gloves. He reported that a different housing unit, OD, had been quarantined earlier for two to three weeks. His understanding was that some individuals inside that unit had been infected with the common flu.

12. Two other callers confined inside LaSalle, both women, reported suffering from health problems. Both said that neither ICE nor GEO Group guards had told them anything about the coronavirus. One caller reported having asthma, thyroid problems, and liver problems; the other reported having high blood pressure.

13. On March 20, 2020, the New Orleans ICE Field Office denied release on parole to two SIFI clients with medical complications who are confined inside LaSalle. The clients, asylum seekers, have both engaged in a hunger strike for more than 120 days. Their frustration with the delay and process of their asylum cases led them to engage in a hunger strike. Despite evidence from a leading medical expert in detainee health, Dr. Allen Keller, that they are medically vulnerable, and strong evidence that the individuals pose no risk to public safety and no flight risk, ICE denied their parole requests a second time. The clients told a SIFI attorney that they would likely be force fed with nasogastric tubes yesterday or today. Given the available data on the high rates of transmission of the novel coronavirus and the most likely method of transmission through the mucosa, force feeding medically fragile individuals inside likely contaminated detention center medical wings may compound their risk of infection.

14. ICE enjoys broad discretion to release people in its custody at various stages of their removal proceedings through mechanisms that include humanitarian parole, release on recognizance, conditional release on bond, and release on an order of supervision. Federal law provides for release on humanitarian parole for people in ICE custody who have serious medical conditions for whom continued detention would not be appropriate. 8 U.S.C. § 1182(d)(5)(A); 8 C.F.R. § 212.5. Yet the New Orleans ICE Field Office rarely grants release to individuals in its custody; and the responses from the Atlanta ICE Field Office to recent requests for release remains

spotty for SIFI clients, as many applications are denied or languish without agency action for months on end.

15. For example, a SIFI client with serious medical conditions has been awaiting a decision on his humanitarian parole request for about seven months, all the while suffering from inadequate medical treatment. The parole request, submitted in August 2019 (while the man was confined inside Folkston), included medical evidence of diabetes or pre-diabetes, hypertension, high cholesterol, a possible bone infection, and weight gain of some 40 pounds in detention. That month, an ICE official told his SIFI attorney that the parole request remained under review, reassuring her that the facility had appropriate medical resources to manage his medical condition. In early 2020, he was transferred to Stewart and placed in solitary confinement in the medical unit, where he spent ten days with the lights on 24 hours a day and with air-conditioning on full blast. In February 2020, SIFI staff contacted ICE about his case, and was told the August 2019 parole request was still pending; ICE agents then resubmitted the parole request to the region's ICE field office headquarters in Atlanta. Concerned about the potential impact that contracting COVID-19 could have on this client, the SIFI attorney pressed ICE on this man's case on March 17 and 18, 2020, only to be told that the parole request was still pending.

16. Another disturbing trend in ICE parole adjudication relates to a rash of denials of parole to asylum seekers who have passed their initial fear interview, based on differing interpretations of current law among individual ICE adjudicators. The denials have concerned individuals who—due to the third-country transit ban—have received positive *reasonable fear* but not *credible fear* findings. Despite no binding law articulating such restrictions, some ICE adjudicators have interpreted the law to forbid grants of parole to such individuals. With thousands of asylum seekers subject to the third-country transit ban, such an arbitrary restriction could foreclose parole to untold people in ICE custody with special medical vulnerabilities.

Irwin Detention Center, Ocilla, GA

17. In Georgia, reports from people confined inside Irwin reveal a lack of access to information about the coronavirus and a growing threat of contagion. A kitchen worker who contacted SIFI staff yesterday reported that there were confirmed cases of COVID-19 inside the facility and that it was under quarantine. In terms of precautions, the only one he reported was that he and other kitchen workers have been instructed to replace plastic ware with paper plates. The man, who suffers from diabetes and high blood pressure, expressed concern that he would be at higher risk of contracting the virus and experiencing respiratory complications. He requested SIFI's assistance in obtaining release from custody to avert becoming infected.

18. A caller from Irwin on March 19, 2020 reported that he suffered from high blood pressure and that he had stopped receiving medication for it. Neither ICE nor guards had given him any information about coronavirus. At least one person inside his housing unit was coughing, and the cough was worsening, but that person had not as yet been removed from his housing unit.

Folkston ICE Processing Center, Folkston, GA

19. Requirements for in-person legal visitation inside Folkston, another detention center operated by GEO Group, seem to mirror those at Pine Prairie. A SIFI attorney who visited individuals inside both wings of the detention center on March 16, 2020 was required to undergo a temperature check and to sign a form affirming several things: that she had not been experiencing symptoms, traveled outside the United States, traveled to China or any other affected area, or had contact with anyone who has traveled outside of the United States within fourteen days. She was told that persons who answered yes to any of these questions, or had a fever greater than 100.4 degrees Fahrenheit, would not be allowed to conduct legal visitation unless the warden approved it. She was permitted to bring her own gloves and disinfectant wipes into the visitation area.

20. That day, the SIFI attorney observed an ICE officer walk into the facility from the parking lot and deliver a box with a thermometer to the front entry staff. The ICE officer said he had driven to different drugstores to find thermometers because they were sold out. The SIFI attorney took this to mean that ICE headquarters had not supplied the facility with sufficient thermometers to meet the facility's needs.

21. Two individuals confined inside Folkston contacted SIFI to seek legal services on March 19, 2020. One of the callers reported that neither ICE nor guards had given him any information about the coronavirus, and that he lacked access to soap and hand sanitizer. He reported that there was at least one person inside of his housing unit who had symptoms like coughing, fever, or shortness of breath; this person had not been removed from the caller's housing unit as of the time of his call. He reported delays in receiving medical attention, including waits of five to six days to see medical staff after initiating a request. The other caller reported feeling sick due to the lack of ventilation inside the detention center. He reported being aware of the coronavirus outbreak, and expressed fear of contracting the virus because he thought the detention center most likely would not provide proper medical treatment.

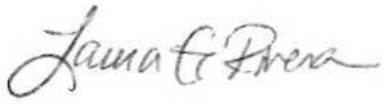
Stewart Detention Center, Lumpkin, GA

22. At Stewart, a detention center operated by private prison company CoreCivic, no reports of suspected COVID-19 infections have directly reached SIFI staff. A SIFI attorney who has visited the facility in the past week reported that people entering Stewart were not required to submit to temperature checks or pass any screening. Some but not all CoreCivic staff wore gloves; no staff wore masks. The SIFI attorney saw no change in the volume of staff traffic in and out of the facility. When she asked a CoreCivic staff member whether staff considered vulnerable could stay home, the CoreCivic staff member responded that she knew nothing about that. For legal visitation, which is non-contact, CoreCivic staff wiped down both sides of the visitation room before the visits began, but not between visits; the SIFI attorney once saw CoreCivic staff give wipes to a client to take into his side of the visitation room. The SIFI attorney was allowed to bring her own gloves, disinfectant wipes, and hand sanitizer.

23. Seven people confined inside Stewart called SIFI to seek services on March 19, 2020. Only one reported feeling ill. That caller reported feeling numbness in his left arm and pressure on his chest. None reported instances of cellmates exhibiting symptoms like coughing, fever, or shortness of breath. Most reported having received at least some information about the coronavirus from ICE or guards. A couple reported seeking signs about coronavirus posted inside the facility; two also reported having been told to wash their hands often. All reported having access to soap.

24. Just under two years ago, in February 2008, I conducted a stakeholder tour of Stewart, and observed concerning practices in their intake unit. Thinking these practices were relevant to Stewart's ability to minimize transmissions during this outbreak, I returned to my notes, which state: "One holding cell in use near entrance to intake; cell was overcrowded. Seems like bad protocol to handle potential infectious disease by crowding sick people into one small cell."

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on March 22, 2020 in Decatur, Georgia.



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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE

FAOUR ABDALLAH FRAIHAT, *et al.*,

Plaintiffs,

v.

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, *et al.*,

Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

Declaration of Keren Zwick in Support of Motion for Preliminary Injunction and Class Certification

Date: March 24, 2020

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**Pro Hac Vice Application Forthcoming

DECLARATION OF KEREN ZWICK

I, Keren Zwick, make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct.

1. My name is Keren Zwick and I serve as the Director of Litigation at the National Immigrant Justice Center (NIJC). I have been an attorney at NIJC for nearly nine years, working as a litigator and direct service provider, focusing largely on asylum and protection-based claims for individuals in immigration detention.

2. I have knowledge of the following information relating to the conditions facing migrants in immigration detention centers, and I can testify to it if needed.

3. NIJC operates numerous programs providing legal services to individuals in Immigration and Customs Enforcement (ICE) custody. Our Adult Detention Project provides direct legal representation and know-your-rights programming to immigrants in detention at the following facilities: the McHenry County Jail in Woodstock, Illinois; the Jerome Combs Detention Center in Kankakee, Illinois; the Boone County Jail in Burlington, Kentucky; the Clay County Detention Center in Brazil, Indiana; the Kenosha County Detention Center in Kenosha, Wisconsin; the Pulaski County Detention Center in Ullin, Illinois; and the Dodge County Detention Center in Juneau, Wisconsin.

4. In addition to the work of NIJC's Adult Detention Program other programs within NIJC serve detained individuals in other regions. For example, our LGBT Immigrant Rights Initiative provides direct representation services to immigrants who identify as LGBTQI throughout the country. Through this work, NIJC has routinely represented individuals in the Otay Mesa Detention Center in San Diego California, in the Cibola County Correctional Center in Milan, New Mexico, and in the South Texas Detention Complex in Pearsall, Texas. Several of NIJC's clients were transferred from Cibola to the Aurora Contract Detention Facility in Aurora, Colorado, when ICE unilaterally transferred the transgender detained population from Cibola.

5. Through a cooperative initiative with the San Diego Federal Defenders, NIJC staff routinely serve individuals in criminal custody and in their transition to immigration custody following a criminal prosecution. Those individuals are generally housed in the Otay Mesa Detention Center in San Diego, California, and in the Imperial Regional Detention Facility in Calexico, California.

6. Finally, NIJC's Federal Litigation Project represents a significant number of detained individuals both in petitions for review before the federal courts and in habeas litigation to challenge their prolonged detention.

7. As the COVID-19 pandemic progresses, NIJC attorneys continue to work zealously to represent our clients who remain in ICE custody. Our attorneys and legal assistants are in regular touch with clients, generally via phone. In light of the pandemic, I and my colleagues directing NIJC's Detention Project and LGBT Immigrant Rights Initiative have instructed NIJC staff that works with individuals in detention to speak to their clients about their current detention conditions and the possible vulnerabilities they face

in detention. Numerous members of NIJC's staff have been involved in these interviews, and they have reported their findings to me.

8. Across the board, NIJC clients express a palpable fear at the vulnerability they face while remaining in detention during the COVID-19 pandemic. They are worried not only for themselves but for their families with whom they have difficulty communicating outside the detention centers. This fear is exacerbated by a universal perception that little to nothing has changed in the operation of the detention centers where they are housed since the onset of the pandemic. Our clients also universally report that neither ICE nor facility staff have provided them with meaningful information or education about the pandemic, leaving them to manage their anxieties—and medical issues—with little or no reliable information about what precautionary measures they could be taking.

Failure To Provide Information About COVID-19

9. Not one NIJC client in detention reports receiving reliable information or training about what COVID-19 is and precautionary measures that might be taken to halt its spread. Most clients reported that they received no information whatsoever from ICE or facility staff, much less medical staff, about the virus, and were learning what they knew almost exclusively from watching television.

10. Two clients detained at the Jerome Combs and another client detained at the Aurora Contract Facility reported that no one at the facility had communicated directly with them about the virus, but that they learned about the virus from the news.

11. Another client detained at McHenry reported that he knew about the virus because visitation was cancelled, and an official told him that if one person in detention got in contact with coronavirus, then everyone might be "down for a minute," but if the detainees got sick, they wouldn't let them go to the doctor. Other clients at McHenry confirmed that they learned of the virus only through the television, one noting he was concerned by news reports that people who are incarcerated are at greater risk.

12. One NIJC client at Pulaski did report that an ICE officer told them about the virus, but this notification appeared to go no further than explaining that detainees are at risk of getting the virus, and that there was a risk that they had already gotten it. The officer, our client reported, told them not to panic.

13. Two clients in Dodge similarly reported receiving no information about the virus other than through posted signs or what they see on the news.

14. Learning of the pandemic through the television and correspondence with family and friends on the outside, but without reliable information or training on precautionary measures from staff, leaves our clients in detention with more questions than answers as to how to protect themselves and others. One of the men detained at the Jerome Combs who learned of the virus through the news explained that "everyone is anxious" because they have been watching the news and seeing recommendations that people not cluster in groups of 10 or more people, which is impossible at that facility because it houses 48 people per block.

Failure To Provide Necessary Supplies

15. NIJC clients all report that little to nothing has changed since the onset of the COVID-19 pandemic with regard to their access to supplies that would allow them to take precautionary measures to protect their health and the health of others detained with them, such as soap, hand sanitizer, or other cleaning supplies.

16. One NIJC client at Jerome Combs meets the CDC definition of a person of higher risk for COVID-19 because he suffers from diabetes and high blood pressure. Yet he reports that the facility has not "done much of anything" in response to COVID-19. As far as he has observed, there is no additional presence of medical personnel at the facility, and the staff has not asked him about symptoms at all. He additionally noted that he and other immigrants in detention do not have access to any extra cleaning supplies to keep their living areas sanitized.

17. Across all facilities where NIJC clients are detained, our clients report that they lack ready access to soap and hand sanitizer. Two NIJC clients at McHenry report that they and others in detention do not have access to hand sanitizer or cleaning supplies and can only access soap through the commissary, which is unavailable for those lacking funds.

18. Another NIJC client at Otay Mesa, noted that while he and other immigrants in detention have access to soap they do not always have access to clean water, and have no access to disinfectant or other cleaning supplies, even though their living spaces are very dirty.

19. An NIJC client at Dodge echoed similar concerns, noting that she and others have no access to hand sanitizer (even though it is provided for jail officials) or cleaning supplies.

20. In Aurora, an NIJC client reported that the immigrants in detention must ask officers for soap and it is only sometimes provided; the only guaranteed way to get bar soap is to buy it for approximately $3 at the commissary.

21. A person detained at the Winn Correctional Center in Louisiana noted similarly that neither soap nor hand sanitizer is available.

22. And an NIJC client recently transferred to the Eden Detention Center in Texas explained that he had been given shampoo, a toothbrush and toothpaste, but no hand soap, despite having asked multiple times.

23. Others noted particular concern with the lack of precautions taken by ICE and facility staff in the kitchen, where many immigrants provide labor. Two NIJC clients detained at the McHenry expressed concern that although they continue working in the kitchen through the pandemic, they have not been given any new safety supplies.

24. In Aurora, an NIJC client reports that immigrants in detention also continue to bear responsibility for daily cleaning the bathrooms and floors. They are not provided with masks or other safety supplies, and only sometimes get gloves.

25. A person detained in Otay Mesa reported to us that some officials appear to be coming to work at the detention center with the flu or another illness, and that there are rumors that

some people may be infected or will be transferred. This conduct continues with no announcements from ICE or the facility officials about how to prepare for the virus.

Uncertainty Regarding Quarantine or Isolation Practices

26. NIJC clients and the immigrants detained with them observe what appears to be random practices with regard to the use of quarantine. In Aurora one individual reported that there are approximately ten people in quarantine, but no officials have explained why. This person is afraid that the others might be quarantined because of exposure to the COVID-19 virus, and is therefore afraid for everyone's health.

27. At the Winn Correctional Center, an individual has observed that more than 35 new individuals arrived at the facility last week, and are being kept separate from the rest of the population. This person sees that the jail officials are not using gloves or masks and is concerned that people coming into the facility could be bringing the virus in.

Dangerous Transfer Practices

28. Over the past week, one NIJC client was transferred out of the Otay Mesa and then back again, and reports that he is gravely concerned that during his transfer he may have been exposed to COVID-19. Our client was called out of his room and told he was being transferred last Friday; at Otay, he was taken from booking and then put into a room with eight other people. He describes the room where they were held as small, hot and stuffy, with two people in the room coughing and visibly ill. Our client and the other seven people were left in the room all night, sleeping next to each other for lack of space, with no access to soap.

29. The next morning, our client was transported on a bus with about thirty people, including the two people who were visibly ill, to the Adelanto ICE Processing Center in Adelanto, California. At Adelanto, our client was held in a large room, now separated from the two people who had appeared ill. Our client is now back at the Otay Mesa Detention Center, but being held in quarantine with others. He is very scared regarding his own exposure and vulnerabilities, and those around him. The client reported no temperature checks or other screening during these transfers.

30. Similarly, all individuals at the facility that NIJC serves in Kenosha, Wisconsin, were abruptly transferred out of the facility. Those individuals, were transported to other facilities, some in Illinois but others as far off as Eden, Texas. Individuals who were transferred in this process received no testing or separation on either end of their journeys. Of the people we have spoken to as part of this transfer, we are aware of no temperature checks or other screening.

31. NIJC has tried to raise these issues in a variety of manners. With the jails that detain individuals in the Chicago Area of Responsibility—NIJC's primary service area—we have contacted the jails directly by mail and in some cases email or phone. We have not received responses to our queries about what they intend to do to safeguard our clients.

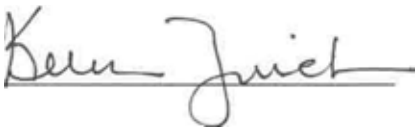
32. We also sent a letter to the ICE Field Office Director for the Chicago Area of Responsibility inquiring about ICE's protocols and raising concern about the health and safety of our clients, but we have not received a response.

33. In the case of one of our clients facing prolonged detention in Aurora we amended a pending request for release to ask that COVID-19 be taken into consideration in the request for release for our client. We pointed out that ICE has the authority to release such individuals and cited notice from ICE stating that it would adjust detention practices as to new enforcement efforts. We got an immediate rejection notice to this request.

34. Additionally concerning, the ICE Field Office in Chicago indicated that it was closed, leaving us with little hope that requests pertaining to individual clients in our area will receive a response.

I declare under penalty of perjury and under the laws of the United States, pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my knowledge, memory, and belief.

Executed on the 21st day of March, in the year 2020, in the city of Chicago, Illinois.



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UNITED STATES DISTRICT COURT
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FAOUR ABDALLAH FRAIHAT, *et al.*,

Plaintiffs,

v.

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, *et al.*,

Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

Declaration of Jaimie Meyer in Support of Motion for Preliminary Injunction and Class Certification

Date: March 24, 2020

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**Pro Hac Vice Application Forthcoming

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

I. BACKGROUND AND QUALIFICATIONS

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

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

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

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

5. To date, I am not being paid for my work in this case, although I am being paid $1,000 for my time spent on a case filed in federal court in New York involving similar issues. In making the following statements, I am not commenting on the particular issues posed by this case. Rather, I am making general statements about the realities of persons in jails and prisons.

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

II. HEIGHTENED RISK OF EPIDEMICS IN JAILS AND PRISONS

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

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

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

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

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

12. Reduced prevention opportunities: During an infectious disease outbreak, a containment strategy requires people who are ill with symptoms to be isolated and that caregivers have access to personal protective equipment, including gloves, masks, gowns, and eye shields. Jails and prisons are often under-resourced and ill-equipped to provide sufficient personal protective equipment for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak.

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

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

chronic lung disease, chronic liver disease, and lower immune systems from HIV.

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

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

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

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

18. Safety and security: As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick

and do not show up to work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public.

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

III. PROFILE OF COVID-19 AS AN INFECTIOUS DISEASE[4]

20. The novel coronavirus, officially known as SARS-CoV-2, causes a disease known as COVID-19. The virus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but may also survive on inanimate surfaces. People seem to be most able to transmit the virus to others when they are sickest but it is possible that people can transmit the virus before they start to show symptoms or for weeks after their symptoms resolve. In China, where COVID-19 originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of infection because

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

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

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

our immune systems have never been exposed to or developed protective responses against this virus. A vaccine is currently in development but will likely not be able for another year to the general public. Antiviral medications are currently in testing but not yet FDA-approved, so only available for compassionate use from the manufacturer. People in prison and jail will likely have even less access to these novel health strategies as they become available.

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

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

23. COVID-19 prevention strategies include containment and mitigation. Containment requires intensive hand washing practices, decontamination and aggressive cleaning of surfaces, and identifying and isolating people

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[5] *Coronavirus Disease 2019 (COVID-19): Situation Summary*, Centers for Disease Control and Prevention (March 14, 2020), https://www.cdc.gov/coronavirus/2019-ncov/summary.html.

[6] *Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study.* The Lancet (published online March 11, 2020), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext

[7] *Coronavirus Disease 2019 (COVID-19): Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease*, Centers for Disease Control and Prevention (March 7, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

who are ill or who have had contact with people who are ill, including the use of personal protective equipment. Jails and prisons are totally under-resourced to meet the demand for any of these strategies. As infectious diseases spread in the community, public health demands mitigation strategies, which involves social distancing and closing other communal spaces (schools, workplaces, etc.) to protect those most vulnerable to disease. Jails and prisons are unable to adequately provide social distancing or meet mitigation recommendations as described above.

24. The time to act is now. Data from other settings demonstrate what happens when jails and prisons are unprepared for COVID-19. News outlets reported that Iran temporarily released 70,000 prisoners when COVID-19 started to sweep its facilities.[8] To date, few state or federal prison systems have adequate (or any) pandemic preparedness plans in place.[9] Systems are just beginning to screen and isolate people on entry and perhaps place visitor restrictions, but this is wholly inadequate when staff and vendors can still come to work sick and potentially transmit the virus to others.

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

March 22, 2020
New Haven, Connecticut

Dr. Jaimie Meyer

[8] *Iran temporarily releases 70,000 prisoners as coronavirus cases surge*, Reuters (March 9, 2020), https://www.reuters.com/article/us-health-coronavirus-iran/iran-temporarily-releases-70000-prisoners-as-coronavirus-cases-surge-idUSKBN20W1E5.

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

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE

FAOUR ABDALLAH FRAIHAT, *et al.*,

Plaintiffs,

v.

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, *et al.*,

Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

Declaration of Francis L. Conlin in Support of Motion for Preliminary Injunction and Class Certification

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**Pro Hac Vice Application Forthcoming

DECLARATION OF FRANCIS L. CONLIN

I, Francis L. Conlin, make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct.

1. My name is Francis L. Conlin. I am the Chairperson for Friends of Miami-Dade Detainees (FOMDD). FOMDD is a 501(c)(3) non-profit organization that advocates for immigrants. Our mission is to end isolation, curb abuse, spread awareness, and end immigrant detention. We accomplish our mission by operating visitation programs that offer friendship, a link to legal representation, phone time, books, and other support to immigrants in detention.

2. FOMDD operates visitation programs at Krome Service Processing Center (Krome) in Miami, Florida, Broward Transitional Center (BTC) in Pompano Beach, Florida, and Glades County Jail (Glades) in Moore Haven, Florida. FOMDD has operated visitation programs for over six years and has conducted over 3,000 visits to people in detention.

3. Since the outbreak of the COVID-19 pandemic, FOMDD volunteers have been in continuous contact with detained individuals at the three facilities we serve and have reported their findings to me.

4. All community visitation has been suspended at the three facilities since March 13, 2020. Only legal visits are allowed until further notice. We are not permitted to bring in cleaning supplies, masks, gloves, or hand sanitizer.

5. Based on FOMDD's knowledge and understanding, ICE and its contractors have not effectively disseminated vital information about COVID-19 to individuals in the following detention centers: Krome, BTC, and Glades. The lack of information has heightened fear and anxiety amongst the detained populations and led to a rampant spread of unverified information throughout all three facilities. FOMDD has heard from several detained individuals about their increased anxiety and fear that COVID-19 will spread throughout the facilities. The only education that detained individuals have received on COVID-19 has been informative flyers posted at Krome.

6. Based on FOMDD's knowledge and understanding, there has been no material change in protocols or procedures in place in light of COVID-19 at Krome, BTC, or Glades

7. At all three facilities, we have heard that staff are wearing surgical masks, but surgical masks have not been provided to the detained population. Detained individuals at all three facilities report not being provided extra soap, extra cleaning supplies, or hand sanitizer.

8. FOMDD has heard reports from people detained at Krome that guards are reluctant to report to work for fear they will not be allowed to leave, and for their own well-being and safety. We heard there had been a decrease in contracted staff to a "skeleton crew" that would potentially stay on-site 24/7.

9. FOMDD has not heard of a change in the number of staff at either BTC or Glades.

10. Detained individuals from all three detention centers report being sick or witnessing other people with coughs, chills, fevers, and other symptoms and report that they were receiving minimal to no medical treatment.

11. One individual with a work assignment that requires being in contact with the food trays reported feeling ill. He went to the medical unit to report his illness and was not provided with adequate medical care. He ultimately decided not to continue his work assignment because he was afraid to expose other detained individuals to his illness, and he was not being provided with extra sanitizing materials.

12. The quarantines in place result in a large number of individuals being placed together in a crowded and cramped area without space necessary for social distancing. The quarantines combined with the lack of information that ICE and its contractors at both Glades and Krome have failed to provide resulted in detained individuals contacting FOMDD to tell us that there are several cases of COVID-19 at the two facilities.

13. FOMDD has documented ICE indiscriminately transferring people from Krome Service to other detention centers during this pandemic. Individuals are not being screened or getting their temperature checked before being transferred.

14. FOMDD has heard from detained individuals that Krome, BTC, and Glades continue to accept dozens of new transfers into the facilities' custody with only cursory screening.

15. FOMDD is aware of dozens of people detained at Krome, Glades, and BTC who are elderly or immunocompromised due to diabetes, high blood pressure, and other underlying medical conditions that put them at high risk of contracting and suffering deadly consequences from COVID-19.

16. I, along with the other members at FOMDD, are terrified for the safety and well-being of the detained individuals at the three facilities. We are deeply frustrated and horrified by the lack of efforts ICE and its contractors have made to prevent COVID-19 from spreading throughout these three detention centers. We fear that its actions are putting hundreds of individuals at serious risk of harm or death.

I declare under penalty of perjury and under the laws of the United States, pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my knowledge, memory, and belief.

Executed on the 23st day of March, in the year 2020, in the city of Key Largo, Florida.

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE

FAOUR ABDALLAH FRAIHAT, *et al.*,

Plaintiffs,

v.

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Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

Declaration of Elissa Steglich in Support of Motion for Preliminary Injunction and Class Certification

Date: March 24, 2020

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**Pro Hac Vice Application Forthcoming

DECLARATION OF ELISSA STEGLICH

I, Elissa Steglich, hereby declare the following:

1. My name is Elissa Steglich. I am a licensed attorney in good standing. I have been practicing immigration law since 2001, and I have represented immigrants in detention in Illinois, New York, New Jersey and Texas. I have visited and/or toured over a dozen immigration detention centers in those areas.
2. I currently serve as Clinical Professor and Co-Director of the Immigration Clinic at the University of Texas School of Law. The Clinic represents low-income individuals and families before the immigration courts, Board of Immigration Appeals, federal courts and US Citizenship and Immigration Services.
3. I am writing this declaration to provide information regarding the response of Immigration and Customs Enforcement ("ICE") and its contractors to the COVID-19 pandemic at the South Texas Detention Center (STDC) located in Pearsall, Texas.
4. On Tuesday, March 17, 2020, I was present at STDC, an ICE detention center managed by Geo Group. In addition to holding both male and female detainees, the facility houses the Pearsall Immigration Court consisting of an administrative area with filing window and four courtrooms with staff and judges of the Department of Justice's Executive Office for Immigration Review located at the facility. ICE Office of Chief Counsel (OCC) staff and attorneys also have an office inside STDC. OCC attorneys appear before the Pearsall Immigration Court. Finally, officers with ICE Enforcement and Removal Operations (ERO) have offices at STDC.
5. On March 17, 2020, we met with at least six individuals detained at STDC. We spoke with both men and women about information and education they had been provided about COVID-19 at STDC and any changes in policy or practice at the facility they had witnessed or were made aware of. They were scared and concerned, recognizing that their health was in the hands of their jailers. The lack of information increased their anxiety.
6. No one reported having received any information in writing or otherwise about COVID-19 from the facility. Two individuals reported that the news programs being shown inside the dorms were the only source of information on the novel coronavirus. One individual reported learning from a contracted guard that family visitation was being stopped due to the COVID-19 crisis. No one reported medical staff providing education or materials about symptoms or precautionary measures that detainees should be taking. One person was very concerned that no medical professional had come to talk to the dorm.
7. Based on our conversations, no gloves or masks or other protective gear was made available. No known testing for COVID-19 was being performed. One individual was extremely worried by the continuing steam of new arrivals at the facility and to the dorm, without information as to whether the new arrivals had been screened or tested for COVID-19. No one reported screening for high-risk or medically vulnerable people. No one reported temperature checks.

8. Based on our conversations, no additional supplies of soap have been made available. Two individuals reported soap being in short supply and having to use shampoo. Another questioned the quality of the soap, sharing that it was the cheapest and lowest quality available. No hand sanitizer or disinfectant wipes were available in the dorms.
9. No one reported any significant changes in cleaning the dorms and other areas of the facility.
10. I also observed three of the court rooms functioning as normal. Social distancing practices were not in place. Judges, attorneys, court staff and respondents were all in close proximity to each other. Respondents were sitting within three feet, if not much closer, to each other on benches in the court rooms.
11. Respondents are held in a closed holding cell before and after their hearing in the court rooms. On that day, the holding cell was overly crowded with people standing and sitting shoulder-to-shoulder.

I, Elissa Steglich, declare under pains and penalty of perjury that the foregoing statement is true and correct.

Signed this 21st day of March, 2020

Elissa Steglich

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE

FAOUR ABDALLAH FRAIHAT, *et al.*,

Plaintiffs,

v.

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, *et al.*,

Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

DECLARATION OF HOMER VENTERS IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION AND CLASS CERTIFICATION

Date: March 24, 2020

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**Pro Hac Vice Application Forthcoming

I, Homer Venters, declare the following under penalty of perjury pursuant to 28 U.S.C. § 1746 as follows:

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 a third 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*) which was

published in early 2019 by Johns Hopkins University Press. 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.

COVID-19 in ICE Detention

5. 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.

6. COVID-19 infection rates are growing exponentially in the U.S. 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 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 (CDC) now reports COVID-19 cases in all 50 states.

7. ICE will not be able to stop the entry of COVID-19 into ICE facilities, and the reality is that the infection is likely inside multiple facilities already. When COVID-19 impacts a community, it will also impact the detention facilities. In

[1] https://www.10news.com/news/coronavirus/newsom-56-percent-of-california-expect-to-get-coronavirus

New Jersey, one employee at an ICE detention facility has already tested positive,[2] and this is likely just the tip of the iceberg in terms of the number of ICE staff that 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 of early spread in the U.S., multiple correctional officers and jail and prison inmates have become infected with COVID-19. 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. Staff are more likely to bring COVID-19 into a facility, based solely on their movement in and out every day.

8. 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.[3] 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.

[2] https://www.buzzfeednews.com/article/hamedaleaziz/ice-medical-worker-coronavirus

[3] https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#social_distancing

9. 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, and control rooms for staff, all contribute to many people being in small spaces. 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 created 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, and medical, just to name a few. This movement is required of detained people as well as staff. 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. For officers working in or around patients at risk or with symptoms, there may be an effort to have them wear protective gowns, as one would in any other setting with similar clinical risks. These gowns cover their radios, cut down tools and other equipment located on their belts and in my experience working with correctional staff, are basically impossible to use as a correctional officer.

10. Efforts to lock detained people into cells will worsen, not improve this facility-level contribution to infection control. When people are locked into cells alone, for most of the day, they quickly experience psychological distress that manifests in self-harm and suicidality, which requires rapid response and intensive care outside the facility for mental and physical health emergencies. In addition, units that are comprised of locked cells require additional staff to escort people to and from their cells for showers and other encounters, and medical, pharmacy and nursing staff move on and off these units daily to assess the

welfare and health needs of these people, creating the same movement of virus form the community into the facilities as if people were housed in normal units.

11. Another critical way in which detention settings promote transmission of communicable disease involve lack of access to hand washing. Many common areas lack operable sinks with access to soap and paper hand towels. In addition, many of the sinks utilized in correctional settings do not operate with a faucet that can be turned and left on, but instead rely on pushing a button which provides a limited amount of water over a limited amount of time. These metered faucets are designed to save water by limiting the amount of time water flows. This approach makes adequate hand washing with soap for at least 20 seconds very difficult, if not impossible.

12. As these examples illustrate, my experience is that the design and operation of detention settings promotes the spread of communicable diseases such as COVID-19.

13. 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 included by the CDC include people with heart disease, lung disease, immune compromising conditions and patients who are older. Additional risk factors may also include diabetes, hypertension, asthma and chronic obstructive

pulmonary disease.[4] In correctional settings, the age of 55 is used to identify older patients, because of the extremely high level of physical and behavioral health problems among this cohort of people.[5] I believe the age of 55 should be applied to ICE detainees for the same reason.

14. On the whole, ICE's response to the COVID-19 pandemic is lacking. I've reviewed available documents with their planning. The interim guidance sheet provided by ICE Health Services Corps, which oversees medical care in ICE detention facilities, on March 6, 2020[6] as a protocol for their clinical COVID-19 response, as well as ICE's guidance on its website,[7] is grossly deficient in multiple areas, including;

    a. The protocol focuses on asking questions about travel contacts and other potential ways in which a person may have come into contact with someone who has COVID-19. It is likely that almost everyone in the general public who is not practicing social distancing is in contact with the COVID-19 virus, and these questions give a false impression that they will somehow help identify those most likely to have this type of contact. The appropriate focus should be on checking for active symptoms

[4] https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3464842/
[6] https://www.aila.org/infonet/ice-interim-reference-sheet-coronavirus
[7] https://www.ice.gov/covid19

including fever, and known sick contacts of any type every time a person enters an ICE facility, whether a staff member or detained person. Even this approach is likely to miss staff as they bring in and transmit the virus while asymptomatic, a critical observation mentioned in the newly released CDC guidelines for correctional settings. COVID-19 is a pandemic and the exponential rates of growth in the U.S. mean that once the virus arrives in a community, it will enter the detention facilities, often via staff. These screening questions may be appropriate as a subset of questions in retrospective contact tracing, a process utilized to reveal how an infection has spread, and which is conducted by trained public health professionals, but they are no longer core to establishing the presence of COVID-19 since it has arrived in full force in every state of the U.S.

b. The ICE protocol fails to include basic infection control measures that are present in CDC guidelines for long term care facilities, and other congregate settings, including access to hand sanitizer and use of masks for anyone with a cough.

c. The protocol fails to include guidance for health staff or administrators regarding how to plan their surge capacity needs as the level of medical encounters increases, and the number of available staff decreases, due to illness. This is a critical component of the CDC guidance on long term care response and is a critical omission in this protocol.

d. There is no guidance for clinical staff on when to test patients for COVID-19, which leaves detained patients at a significant disadvantage. 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 COVID-19 response who are also coordinating with local and federal COVID-19 activities.

e. The protocol states that people with suspected COVID-19 contact will be monitored for 14 days with symptom checks. The protocol is written as if this is a rare occurrence, reflecting smaller outbreak management, but the prevalence of COVID-19 is now growing to such an extent that a large share of newly arrived people will have recent contact with someone who is infected. ICE would need to use this level of monitoring for every person arriving in detention. Accordingly, ICE would need to dramatically expand its medical facilities and staffing to conduct this daily monitoring of every newly arrived person for 14 days. The protocol fails to contemplate these necessary changes.

f. The ICE protocol provides no guidance about identification of high-risk patients at the time of entry or any special precautions that will be enacted

to protect them. The protocol also fails to address the identification of high-risk patients who have already been admitted. This is a dangerous omission, because many of the ICE facilities employ paper medical records, and identification of the people who meet criteria for being high risk of serious illness and death from COVID-19 will require significant time and staffing. I have led these types of risk reviews in outbreaks using both electronic and paper based medical records in multiple correctional settings, and there must be a clear direction and protocol for how this process will occur and how often it is repeated, and how critical information will flow from health to security staff. The protocol focuses on whether patients have contact with known COVID-19 patients and whether they are symptomatic. It is true that symptomatic patients require higher levels of assessment and care, but a basic element of outbreak management is protection of patients who, if they become infected, are at high risk of serious illness or death. The ICE protocol fails to address this. Such a management plan would not only include the questions asked during the intake process, but would also include cohorted housing areas, increased infection control measures by staff who come onto the housing areas and increased medical surveillance, likely daily checks of signs and symptoms. I have established this type of surveillance for high risk patients during several outbreak responses, and the two elements that will

pose a significant challenge to ICE are the lack of appropriate housing areas, and the need for significantly more security and health staff. The protocol is crafted to address a relatively small and time-limited outbreak and lacks anticipation of what has already started elsewhere and will soon impact these facilities, widespread infection with a massive impact on the level of staffing, The newly released CDC guidelines for detention settings recommends social distancing in these facilities, maintaining 6 feet separation between people, "Implement social distancing strategies to increase the physical space between incarcerated/detained persons (ideally 6 feet between all individuals, regardless of the presence of symptoms)." ICE will be unable to adhere to this recommendation in virtually every facility it operates, and the practice of facility "lockdowns" stands in direct contradiction to this recommendation by the CDC.

15. Because the ICE response fails to create increased protections for people with risk factors for serious illness and death from COVID-19, they are unlikely to detect illness in these patients until many of them are critically ill. As with the lack of guidance on testing, this lack of clear guidance on how to determine who meets criteria for hospital transfer may prove deadly for detained people, and clinical staff encounter patients seriously ill with COVID-19 for the first time in their careers. While COVID-19 shares some similarities with influenza, there are critical aspects of this pandemic that pose greater risk to both patients and

staff, and asking staff to rely on their historical knowledge of influenza treatment without precise guidance on the critical decisions regarding COVID-19 testing, treatment and hospital transfer will leave them and their patients without clear guidelines. These deficiencies, compounded by the time it will take to evaluate and transport them to a local hospital (especially given the remoteness of many facilities), will likely result in numerous deaths, many of which could have been avoided with earlier care.

16. The ICE response, including the protocol, envisions that "isolation rooms" will be used to monitor people who are symptomatic with COVID-19. My experience in visiting and working in detention facilities across the nation is that each facility has 1-4 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 percent capacity will find this basic approach impossible once they start to see multiple symptomatic patients. Based on my experience visiting detention facilities, this process will be essentially impossible.

17. 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 places 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. In sum, it is my expert opinion that the use of isolation and/or lockdown is not a medically appropriate method for abating the substantial risk of harm from COVID-19.

18. In addition, transferring large numbers of detained people between facilities to cohort symptomatic and asymptomatic people will increase the spread of COVID-19 infection throughout geographic areas. The newly released CDC guidelines for detention settings recommend a level of infection control measures in transportation of symptomatic patients that would require far more staffing and training ICE has the capacity to provide for large scale transfers: "If a transfer is absolutely necessary, perform verbal screening and a temperature check as outlined in the Screening section below, before the individual leaves the facility. If an individual does not clear the screening process, delay the transfer and follow the protocol for a suspected COVID-19 case – including putting a face mask on the individual, immediately placing them under medical

isolation, and evaluating them for possible COVID-19 testing. If the transfer must still occur, ensure that the receiving facility has capacity to properly isolate the individual upon arrival. Ensure that staff transporting the individual wear recommended PPE . . . and that the transport vehicle is cleaned thoroughly after transport." In other words, transferring people between facilities, as ICE routinely does and as I understand is still going on, requires far more measures than ICE implements and should be ceased.

19. As the number of infections inside ICE facilities rise, there will be fewer health and security staff coming to work. This has already been observed in other law enforcement settings and will inevitably occur inside detention facilities. The ICE response fails to address this central and inescapable reality. Critically, there will be far more work to be done inside these facilities than before, and the lack of available staffing will impact basic operations, as well as the ability to cohort high risk and symptomatic patients (in different areas) as well as provide care inside the facility and even conduct escort for emergency room evaluation and inpatient hospitalization. The protocol fails to detail how patient education will occur, both for newly arrived people and those already in detention.

20. I have reviewed 15 statements by people currently detained by ICE or who represent detained people in multiple facilities, and their observations indicate that, in detention facilities throughout ICE's system, ICE is not following even

the most basic infection control policies that they report as their standard of care including:

a. Failure to provide hand washing supplies including soap and paper towels and ensure access to handwashing, including operable sinks;

b. Failure to check symptoms among newly arrived detained people;

c. Continued transfer among detention centers of detained people;

d. Lack of symptom screening of staff arriving to work in detention centers;

e. Failure to ask about risk factors of serious illness or death from COVID-19 infection;

f. Failure to provide adequate supplies for cleaning of housing areas;

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

h. Failure to provide patient education about hand washing, infection control or COVID-19 in Spanish;

i. Failure to enact social distancing among staff and detained people; and

j. Lack of communication regarding COVID-19 status inside quarantined housing areas.

21. I have also reviewed the declarations of all the named subclass members and agree their medical conditions place them at high-risk and make them medically vulnerable to COVID-19.

22. ICE's inadequate responses to COVID-19—coupled with its pre-existing inadequate healthcare—places people with risk factors at a high risk of contracting COVID-19 and suffering serious complications—including death.

23. ICE must release all people with risk factors to prevent their serious illness and/or death. The ICE response makes clear that they do not plan to establish special protections of 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 have called for high risk patients to be immediately transferred out of detention.[8] ICE faces a completely preventable disaster by keeping high risk patients in detention as COVID-19 arrived in facilities where the virus will quickly spread. The basic limitation 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.

I declare under penalty of perjury that the statements above are true and correct to the best of my knowledge.

[8] https://www.newyorker.com/news/news-desk/a-rikers-island-doctor-speaks-out-to-save-her-elderly-patients-from-the-coronavirus
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/

Signature:

Homer Venters

Date: 3/24/2020

Location: Port Washington, NY

EXHIBIT A

Dr. Homer D. Venters

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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.

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

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

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.

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

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

Honors and Presentations (past 10 years)

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).

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE

FAOUR ABDALLAH FRAIHAT, *et al.*,

Plaintiffs,

v.

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, *et al.*,

Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

DECLARATION OF DR. CARLOS FRANCO-PAREDES

Date: March 24, 2020

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*Admitted Pro Hac Vice
**Pro Hac Vice Application Forthcoming

Declaration of Dr. Carlos Franco-Paredes

The Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2), is a newly emerging zoonotic agent initially identified in December 2019 that, as of today, has spread to more than 150 countries causing 297,000 confirmed cases and 12,755 deaths[a]. This viral pathogen causes the Coronavirus Disease 2019 (COVID-19). Infection with COVID-19 is associated with significant morbidity and mortality especially in patients above 55 years of age and those with chronic medical conditions[b,c,d].

Immigration detention centers in the U.S. are tinderboxes for the transmission of highly transmissible infectious pathogens including the SARS-CoV-2, which causes COVID-19. Given the large population density of immigration detention centers and the ease of transmission of this viral pathogen, the attack rate inside these centers will take exponential proportions, consuming significant medical and financial resources.

As an infectious disease clinician with a public health degree in the dynamics of infectious disease epidemics and pandemics and twenty years of clinical experience, I am concerned about the treatment of immigrants inside detention centers which could make the current COVID-19 epidemic worse in the U.S. by having a high case fatality rate among detainees and potentially spreading the outbreak into the larger community. A copy of my CV is presented in Exhibit A.

I have experience providing care to individuals in a civil detention center and have performed approximately two medical forensic examinations and fifteen medical second opinion evaluations for patients in the custody of the Department of Homeland Security (DHS). Based on my conversations with patients, my own observations, and information that exists regarding the resources available within immigration detention facilities as detailed by the ICE Health Services Corps, it is my professional opinion that the medical care available in DHS custody cannot

properly accommodate the needs of patients should there be an outbreak of COVID-19 in an immigration detention facility. The physical and emotional trauma that detainees and asylum seekers experience can weaken their immune systems, resulting in increased risk of severe manifestations of infections. For example cases of influenza virus infections causing pneumonia and respiratory failure, - albeit influenza infection is not as communicable and not transmitted during asymptomatic infection as it is the case with SARS-CoV-2 -, has caused human deaths inside immigration detention centers [e].

- **For people in the highest risk populations, the fatality rate of COVID-19 infection is about 15 percent.**

According to the CDC, groups deemed to be at high risk of developing severe disease and dying from COVID-19 include those above 55 years of age and those with underlying medical conditions (regardless of their age) (See Table 1). These cases are also amplifiers or hyper-spreaders of the infection since they tend to have high viral concentrations in their respiratory secretions.

The clinical experience in China, South Korea, Italy and Spain has shown that 80% of confirmed cases tend to occur in persons 30-69 years of age regardless of whether they had underlying medical conditions. Of these, 20% develop severe clinical manifestations or become critically ill. Among those with severe clinical manifestations, regardless of their age or underlying medical conditions, the virus progresses into respiratory failure, septic shock, and multiorgan dysfunction requiring intensive care support including the use of mechanical ventilator support. The overall case fatality rate is 10-14% of those who develop severe disease. In China, 80% of deaths occurred among adults $\geq$ 60 years[c].

Table 1. Risk factors for developing severe disease and death outside the U.S.

Age groups at high risk of developing severe disease and dying without underlying medical	50-59 years (1% CFR)* 60-69 years (3.6% CFR) 70-79 years (8% CFR)

conditions	
Groups with underlying medical conditions at high risk of dying regardless of their age	-Cardiovascular Disease (congestive heart failure, history of myocardial infarction, history of cardiac surgery) -Systemic Arterial Hypertension (high blood pressure) -Chronic Respiratory Disease (asthma, chronic obstructive pulmonary disease including chronic bronchitis or emphysema, or other pulmonary diseases) -Diabetes Mellitus -Cancer -Chronic Liver Disease -Chronic Kidney Disease -Autoimmune Diseases (psoriasis, rheumatoid arthritis, systemic lupus erythematosus) -Severe Psychiatric Illness ** -History of Transplantation -HIV/AIDS -Pregnancy***

*CFR= Case Fatality Rate. This is an indicator of lethality used during outbreaks to identify the number of individuals who succumb out of those infected.

** In South Korea, 20% of deaths occurred in what they defined as Psychiatric Illness (J Korean Med Sci 2020; 35(10): e112).

*** Extrapolation from previous influenza pandemics including the 2009 pandemic that increased pregnancy-related mortality 4-fold particularly during second and third trimesters. The reason is due to immune mediated changes during pregnancy and lung function compromise due to gravid uterus (Omer S. N Engl J Med 2017;376(13): 1256-1267.

There is a growing number of confirmed cases in the U.S., increasing number of hospitalizations and admissions to intensive care units, and many deaths. In this wave of the pandemic or in subsequent ones, it is likely the number of infected individuals will continue to augment. In the closed settings of immigration detention centers, where there is overcrowding and confinement of a large number of persons, networks of transmission become highly conducive to spread rapidly.

As of March 16, 2020[c], cases of COVID-19 in the U.S. reported by the CDC shows that 31% of COVID-19 cases, 45% of hospitalizations, and 80% of deaths occurred among adults > 65 years of age. Case-fatality in persons aged > 85 ranged from 10-27%, followed by 3-11% among persons aged 65-84 years, 1% among persons aged 55-64 and <1% among persons 20-54 years of age.

Reports by the Chinese CDC demonstrate that the case fatality rate is highest among critical cases in the high-risk categories with COVID at 49%[f]. Case fatality was higher for patients with comorbidities: 10.5% for those with cardiovascular disease, 7% for diabetes, and 6% each for chronic respiratory disease, hypertension, and cancer. Case fatality for patients who developed respiratory failure, septic shock, or multiple organ dysfunction was 49%[b].

- **For people with these risk factors, COVID-19 can severely damage lung tissue, which requires an extensive period of rehabilitation, and in some cases, can cause permanent loss of respiratory capacity.**

There is preliminary evidence that persons with COVID-19 who are recovering from severe disease and who have developed extensive pulmonary disease including Acute Respiratory Distress Syndrome (ARDS)[g] may have long-term sequelae similar to other infectious pathogens evolving in a similar pattern. Long term sequelae of those with sepsis, ARDS and respiratory failure identified in the literature include long-term cognitive impairment, psychological morbidities, neuromuscular weakness, pulmonary dysfunction, and ongoing healthcare

utilization with reduced quality of life[h] and need for rehabilitation services[i].

- **COVID-19 may also target the heart muscle, causing a medical condition called myocarditis, or inflammation of the heart muscle. Myocarditis can affect the heart muscle and electrical system, reducing the heart's ability to pump. This reduction can lead to rapid or abnormal heart rhythms in the short term, and long-term heart failure that limits exercise tolerance and the ability to work.**

The full description of the pathogenesis of COVID-19 requires to be completely elucidated. However, there is clinical evidence that in addition to the severe lung injury associated to this viral infection, some persons may also develop myocardial involvement that appears to be the result of either direct viral infection or caused by the immune response to SARS-CoV-2. From the published case reports, myocarditis caused by this viral pathogen is associated with congestive heart failure, cardiac arrhythmias and death[j]. Similar to other viral myocarditis, most patients may develop long-term myocardial damage[k].

- **Emerging evidence also suggests that COVID-19 can trigger an over-response of the immune system, further damaging tissues in a cytokine release syndrome that can result in widespread damage to other organs, including permanent injury to the kidneys and neurologic injury. These complications can manifest at an alarming pace.**

Among persons infected with SARS-CoV-2 and developing COVID-19, severe disease systemic inflammation is associated with adverse outcomes [l]. However, there is evidence that the use of corticosteroids have not shown benefit and they might be more likely to cause harm when administered to persons with ARDS caused by COVID-19[m]. Similar to influenza infection, acute lung injury and

acute respiratory distress syndrome are most likely caused by the respiratory epithelial membrane dysfunction leading to acute respiratory distress syndrome [l,n]. Preliminary evidence from case reports and small cases series from China and South Korea confirm that there is minimal inflammation and evidence of cell necrosis in the form of apoptosis of the respiratory epithelium [o]. The resultant tissue hypoxia is responsible and potential concomitant bacterial sepsis contribute to multiorgan dysfunction and death. If a patient with COVID-19 develops myocarditis, cardiogenic shock caused by fulminant myocarditis may also contribute to the overall occurrence of multiple organ failure [k].

- **Patients can show the first symptoms of infection in as little as two days after exposure, and their condition can seriously deteriorate in five days or sooner.**

There is evidence of substantial undocumented infection facilitating the rapid dissemination of novel coronavirus SARS-CoV-2 which is responsible for 79% of documented cases of COVID-19 in China[o]. Once an individual is exposed to this virus from either a symptomatic individual (21% of cases) or from asymptomatic individuals (79% of cases), the shortest incubation period is 3 days with a median incubation period of 5.1 (95% CI 4.5 to 5.8 days)[p]. Overall, 97.5% of persons who develop symptoms do so within 11.5 days of the initial exposure [p]. Most persons with COVID-19 who develop severe disease do so immediately after admission or within 3-5 days from their initial presentation[c,q] and represent 53% of those requiring intensive care unit admissions and advanced supportive care[c]. At my current institution, the two confirmed deaths occurred within 48 hours of admission to the hospital.

- **Most people in higher risk categories who develop serious disease will need advanced support. This level of supportive care requires highly specialized equipment that is in limited supply, and an entire**

team of care providers, including 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.

There is sufficient evidence that the SARS-CoV-2 pandemic has an overwhelming impact in healthcare utilization in all settings (China, South Korea, Italy, France, Germany, and others). In the U.S.[c], current evidence demonstrates that COVID-19 can result in severe disease, including hospitalization (31%) and admission to an intensive care unit (53% of ICU admissions). To respond to this overwhelming demand in ICU admissions, there is a need for a multidisciplinary approach that is time consuming and requires highly trained personnel including pulmonary and critical care physicians, nurses, respiratory therapists, phlebotomists, social workers, and case managers. The care of this group of patients also requires subspecialists including nephrologists, infectious disease physicians, hematologists, hospitalists, and others. Patients on mechanical ventilation or requiring extracorporeal membrane oxygenation require additional staff including perfusionists and 1:1 dedicated nursing care. Currently, medical centers in many urban and rural settings in the U.S. are functioning at full capacity. Therefore, preventing the occurrence of an outbreak within a detention facility would reduce the risk of overwhelming local healthcare systems. Indeed, a potential outbreak occurring within an immigration detention center, the number of detainees who will require transfer outside the facility for specialized care may exceed the capacity of local hospitals. This is particularly important in rural and semirural settings where many immigration detention centers are located, and where they may have contact with a limited number of surrounding medical centers.

Conclusions:

There is a need to proactively consider alternative strategies to dilute the

potential community-based impact of an outbreak inside immigration detention centers. Therefore, it is my professional view that releasing detainees/asylum seekers on humanitarian parole from these centers constitutes a high-yield public health intervention that may significantly lessen the impact of this outbreak not only within detention centers but among the communities surrounding these centers. In particular, targeting the release of persons in the age groups at risk of severe disease and death; and persons with underlying medical conditions, may lessen the human and financial costs that this outbreak may eventually impose on ICE detention facilities nationwide. Responding to an outbreak requires significant improvements in staffing, upgrading medical equipment, substantial supplies including antibiotics, intravenous infusions, cardiac and respiratory monitors, devices for oxygen supply, and personal protection supplies among persons at high risk of severe COVID-19 disease.

A large outbreak of COVID-19 in an immigration detention facility would put a tremendous strain on the medical system to the detriment of patients in the communities surrounding these centers. It is reasonable to anticipate that there will be the loss of additional lives that could have otherwise been saved.

I declare under penalty of perjury that the statements above are true and correct to the best of my knowledge.

Date: March 21, 2020

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE

FAOUR ABDALLAH FRAIHAT, *et al.*,

Plaintiffs,

v.

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, *et al.*,

Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

Declaration of Anne Rios in Support of Motion for Preliminary Injunction and Class Certification

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DECLARATION OF ANNE RIOS

I, Anne Rios, make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. My name is Anne Rios. I am a licensed attorney in good standing, in the state of California. I have been practicing law since 2009. I am a supervising attorney with the nonprofit organization Al Otro Lado (AOL). I have represented over 75 detainees in release efforts; approximately 35% of those detainees are medically vulnerable.

2. AOL is a legal services organization that serves indigent migrants, refugees, deportees, and their families, and operates primarily in Los Angeles, California; San Diego, California; and Tijuana, Mexico; although it provides referrals and assistance to indigent migrants and refugees across the United States.

3. AOL's mission is to coordinate and provide screening, advocacy, and legal representation for individuals in immigration proceedings; to seek redress for civil rights violations, including disability rights violations; and to provide assistance with other legal and social service needs.

4. Specifically, AOL represents detained migrants in their removal proceedings; this includes representing individuals detained at the Otay Mesa Detention Facility and the Adelanto Detention Facility in Southern California.

OTAY MESA DETENTION CENTER

AOL Staff Unable to Schedule Bond Hearings After COVID 19 Outbreak

5. From March 13, 2020 until March 17, 2020, AOL was unable to schedule bond hearings for our clients detained at Otay Mesa Detention Center ("OMDC") who are eligible for release. Repeatedly, AOL was told that there were no dates available for bond because of the COVID 19 outbreak and that the court staff was determining how to proceed. AOL called the Otay Mesa Immigration Court no less than seven times to try and schedule bond hearings for clients in custody. Each time AOL was told that there were no hearings dates available to be scheduled. Because bond is a function solely under the

jurisdiction of the immigration judge, without a scheduled hearing, there is no way for someone who is medically vulnerable to be released during the COVID 19 epidemic.

6. The delay in scheduling bond hearings caused one of AOL's client to be transferred, without notice, to Houston Detention Facility.

Lack of Preventative Measures at OMDC

7. On March 20, 2020, AOL staff visited OMDC to conduct legal visitations with four AOL clients.

8. AOL staff entered OMDC without undergoing any screening process. AOL staff did not observe any preventive measures taking place to screen anyone entering OMDC. AOL staff did not have their temperature taken nor were they asked if they had any symptoms of COVID 19 such as a cough or shortness of breath.

9. At OMDC, AOL staff observed that OMDC employees were not practicing social distancing. AOL staff observed that OMDC employees were shaking hands, patting each other's shoulders, and working in close proximity to one another.

AOL Staff's Legal Visit Was Via Video Teleconference

10. Starting March 19, 2020, AOL was informed that OMDC had implemented a no contact policy and legal visits were only allowed via video teleconference calls. All video teleconference calls took place in a large room located in the main lobby that has about 15 VTC stations.

11. AOL staff met with four AOL clients via OMDC's video teleconference system and experienced significant difficulty in communicating with clients. During the first call, AOL staff could barely hear the client and had to ask for repetition due to the static nature of the call. During another video call, AOL staff had to request to be moved to a different video station on two different occasions because the client could not hear AOL staff. The telephones were not cleaned prior to beginning the visit.

12. Teleconferencing creates a challenge for AOL to advocate for its clients to protect them against COVID-19, especially medically vulnerable clients. For instance, there are no accommodations made for clients who are hearing impaired, who have mobility issues, or who speak rare languages.

AOL Clients Expressed Increased Anxiety Due to the COVID-19 Pandemic

13. AOL observed that clients have independently expressed increased anxiety and worry due to COVID-19. One client expressed that he was anxious and felt helpless because he felt like the detainees were all "sitting ducks" for an outbreak. Another client expressed that everyone within the detention center seemed tense. Another client who works cleaning pods expressed that he was working almost eight hours doing deep cleanings of the pods because the officers wanted things cleaned well.

14. The lack of information and communication given to detainees seemed to be heightening anxiety levels. None of AOL's clients stated that they were being briefed on how to lower the risk of catching the virus.

AOL Clients Described the Lack of Protective Gear Given While Working Within OMDC

15. AOL's clients told AOL staff they are working within the detention center. One of AOL's clients works by cleaning pods; another client works in the laundry room; and another client works in general cleaning. Two AOL clients told AOL staff that they were now being given gloves to clean, but no other protective gear.

16. When AOL staff was waiting in the lobby, AOL staff observed two detainees cleaning and disinfecting the lobby without any protective gear, except for gloves.

ADELANTO

AOL Clients in Quarantined Dorms

17. Two of the dorms in Adelanto West building are in quarantine as of the night of March 18, 2020. On the morning of March 19, 2020, the East building also

was quarantined. Most of those who are quarantined are "low levels", meaning they are primarily arriving immigrants and other asylum seekers. AOL has yet to receive an update from ICE concerning the reason for the quarantine, however, detained clients have stated that they believe the quarantine is due to detainees who have COVID-19.

Bond Hearings for AOL Clients Have Been Cancelled

18. Due to quarantine, on March 18, 2020, a bond hearing for an AOL client was canceled. AOL was not informed of the cancellation prior to the hearing and the clerks did not have any additional information. The bond hearing was not rescheduled. The cancellation of the hearing leaves the client without a feasible way to be released from detention.

AOL Legal Visitation

19. All non-legal visitation has been stopped. AOL staff may still meet with non-quarantined clients for a non-contact visit. These visits require AOL staff to use a phone and speak with clients through a glass window. It is not clear how often the phones are cleaned, if at all.

20. AOL is not allowed to bring in cleaning supplies or hand sanitizer.

21. Three of AOL's clients were not available for legal visitation due to the quarantines. When AOL staff asked detention center staff about potential alternatives for legal visitation (e.g. phone or video), the GEO guard on duty explained the only way to communicate with our clients in quarantine is if the clients pay for a recorded call on the phone in their dormitory.

Lack of Preventative Measures at Adelanto

22. Guards appear to enter the facility freely and do not appear to have any kind of temperature or other screening. Guards also do not practice social distancing with one another. Guards were observed standing in groups near the registration desk and engaging in conversation. They did not appear to make any effort to minimalize contact or maintain distance. AOL Clients report that guards don't wear gloves or masks when working with detainees.

23. It appears that the overall cleaning routine remains the same as it was prior to the pandemic. AOL Clients noted that guards sometimes sprayed a solution on door handles but other than that no additional cleaning or safety measures are in place. Detainees continue to be responsible for the majority of the cleaning in the facility and are not being provided with any additional safety equipment such as masks. Clients report that they are not being given extra soap or extra cleaning supplies.

24. AOL clients described the mood in the facility as tense, as detainees are aware of the ongoing situation yet they are not being provided with clear information concerning their personal risk of contracting COVID-19 and they are not being advised as to what they can do to prevent infection.

25. Humanitarian parole is a mechanism available to all individuals in ICE custody. ICE can grant humanitarian parole in its discretion. In fact, AOL has successfully had clients released by ICE, in the past, on their own recognizance under humanitarian parole—especially when they are medically vulnerable. Although this is a viable option for ICE, AOL has not seen an uptick in grants of humanitarian parole in light of COVID; instead, we have at least three parole requests awaiting a decision while our clients remain inside of detention.

I, Anne Rios, declare under penalty of perjury and under the laws of the United States, pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my knowledge, memory, and belief.

Signed: March 22, 2020

Anne Rios

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE

FAOUR ABDALLAH FRAIHAT, *et al.*,

Plaintiffs,

v.

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, *et al.*,

Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

Declaration of Andrew Lorenzen-Strait in Support of Motion for Preliminary Injunction and Class Certification

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**Pro Hac Vice Application Forthcoming

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DECLARATION OF ANDREW LORENZEN-STRAIT

I, Andrew Lorenzen-Strait, hereby declare:

1. I am currently the Executive Director for Health and Wellness at Lutheran Social Services of the National Capital Area where I oversee migrant support services, including programming in behavioral health. Prior to that, from May 2019 to January 2020, I served as the Director of Children and Family Services at Lutheran Immigration and Refugee Services.

2. From 2008 to May 2019, I served in various roles at U.S. Immigration and Customs Enforcement ("ICE"). Most recently, I was the Deputy Assistant Director for Custody Programs in ICE, Office of Enforcement and Removal Operations ("ERO"). I served in this capacity for over six years, from April 2013 to May 2019, under both Democratic and Republican White House administrations. As Deputy Assistant Director, I oversaw health and welfare programs and services in immigration detention, including innovative programs to serve vulnerable populations. Among my relevant responsibilities included overseeing field level enforcement decisions in cases involving parents and primary caretakers, and monitoring compliance with ERO processes and standards. I also served in other capacities within ICE for over five years prior to that leadership position. Attached as Exhibit A is a copy of my curriculum vitae.

3. I submit this declaration to explain how ICE has exercised and still exercises discretion for purposes of releasing both individuals with serious medical conditions and individuals who are vulnerable to medical harm. Exercising prosecutorial discretion over detention was not only common, it was and continues to be an integral aspect of ICE's enforcement practices.

4. During my time at ICE, the agency's policy and practice was to limit the detention of noncitizens with special vulnerabilities.[1] This group includes individuals who are known to be suffering from serious physical or mental illness, who have disabilities, who are

[1] *See, e.g.*, U.S. Immigration and Customs Enforcement, "Detention Reform," (last updated July 24, 2018), https://www.ice.gov/detention-reform#tab1 (referencing use of risk classification assessment tools that "require[] ICE officers to determine whether there is any special vulnerability that may impact custody and classification determinations"); ICE Enforcement and Removal Operations, "Directive 11071.1: Assessment and Accommodations for Detainees with Disabilities" (Dec. 15, 2016), at 9 (providing for release as an option for detainees with disabilities); Doris Meissner, "Exercising Prosecutorial Discretion," Immigration and Naturalization Services (Nov. 17, 2000), at 11 (citing "aliens with a serious health concern" as a trigger for the favorable exercise of discretion); *see also Franco-Gonzalez v. Holder*, 767 F. Supp. 2d 1034, 1061 (C.D. Cal. 2010) (providing for release of individuals with severe mental illnesses unless government could show that ongoing detention is justified).

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elderly, pregnant, or nursing, who demonstrate that they are primary caretakers, who are LGBTI, or whose detention was not in the public interest.[2]

5. ICE exercises its release authority frequently for detainees with serious medical conditions. For instance, pregnant women never give birth in ICE custody because it is common for ICE to release them beforehand.

6. When I was at ICE, some of the medical conditions that constitute serious physical illness included any terminal illness, any condition that required imminent care to prevent deterioration, and any condition that precluded the individual from being housed, such as cancer requiring chemotherapy or leukemia.

7. In addition, under ICE policies, individuals who did not yet have a serious physical illness, but were *vulnerable* to medical harm were considered for release. When deciding whether to release medically-vulnerable detainees from custody, ICE's determinations considered whether they have any physical or mental condition would make them more susceptible to medical harm while in ICE custody. This could include individuals who were very old, toward the end of their life.

8. Under this rubric, ICE would have considered individuals at high risk of suffering complications and/or death if they were to contract a highly infectious and incurable disease such as COVID-19 to be detainees with special vulnerabilities, eligible for release from detention. When confronted with an infection disease, ICE would have consulted guidelines from the Center for Disease Control and other medical experts to identify individuals who are at high risk and should be considered for release.

9. Upon learning that a detainee had a special vulnerability, ICE was required to monitor the detainee's case and consider options as soon as practicable, including transfer to another detention facility with appropriate medical capabilities, or to an off-site treatment facility, or release where appropriate medical care was not available in custody.

10. ICE's policy and practice of releasing individuals with special vulnerabilities from immigration detention was authorized under a range of statutory and regulatory provisions, including INA §§ 212(d)(5), 235(b), 236, 241, and 8 C.F.R. §§ 1.1(q), 212.5, 235.3, 236.2(b).

11. Even individuals held under mandatory detention, pursuant to the Immigration and Nationality Act ("INA") § 236(c), were released pursuant to ICE's guidelines and policies, particularly where the nature of their illness could impose substantial health care

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[2] Jeh Charles Johnson, "Policies for the Apprehension, Detention and Removal of Undocumented Immigrants," U.S. Department of Homeland Security (Nov. 20, 2014), *available at* https://www.dhs.gov/sites/default/files/publications/14_1120_memo_prosecutorial_discretion.pdf, at 5.

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costs or the humanitarian equities mitigating against detention were particularly compelling.

12. ICE's policy and practice regarding individuals with special vulnerabilities was reflected in a memorandum from Jeh C. Johnson, Secretary of the Department of Homeland Security, in 2014 ("Johnson memo").[3] ICE has also issued other guidance for exercising prosecutorial discretion in detention decisions, including a memorandum issued by John P. Torres, Director of ICE, in 2006 regarding ICE's exercise of discretion in cases of extreme or severe medical concern ("Torres memo"),[4] and a memorandum from John Morton, Director of ICE, in 2011 ("Morton memo") regarding the exercise of prosecutorial discretion in ICE's enforcement priorities, including detention.[5] The Johnson memo is attached as Exhibit B, the Torres memo is attached as Exhibit C, and the Morton memo is attached as Exhibit D.

13. Although the Johnson, Torres and Morton memoranda have been rescinded by the current administration, the statutory and regulatory bases for the use of prosecutorial discretion in ICE's custodial determinations remains unchanged.

14. In fact, as stated above, ICE's enforcement priorities have always been shaped by the necessary use of prosecutorial discretion with respect to immigration detention.

15. Moreover, ICE has a range of highly effective tools at its disposal to ensure that individuals report for court hearings and other appointments, including conditions of supervision. For example, ICE's conditional supervision program, called ISAP (Intensive Supervision Appearance Program), relies on the use of electronic ankle monitors, biometric voice recognition software, unannounced home visits, employer verification, and in-person reporting to supervise participants. A government-contracted evaluation of this program reported a 99% attendance rate at all immigration court hearings and a 95% attendance rate at final hearings.[6]

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[3] *See id.*

[4] John P. Torres, "Discretion in Cases of Extreme or Severe Medical Concern," U.S. Immigration & Customs Enforcement (Dec. 11, 2006), *available at* https://www.ice.gov/doclib/foia/dro_policy_memos/discretionincasesofextremeorseveremedicalconcerndec112006.pdf.

[5] John Morton, "Exercising Prosecutorial Discretion Consistent with the Civil Immigration Enforcement Priorities of the Agency for the Apprehension, Detention, and Removal of Aliens," U.S. Immigration and Customs Enforcement (June 17, 2011), *available at* https://www.ice.gov/doclib/secure-communities/pdf/prosecutorial-discretion-memo.pdf.

[6] U.S. Gov't Accountability Office, GAO-15-26, *Alternatives to Detention: Improved Data Collection and Analyses Needed to Better Assess Program Effectiveness* 10-11 (Nov. 201.4), *available at* https://www.gao.gov/assets/670/666911.pdf.

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16. The COVID-19 virus represents an unprecedented risk to detainee health and safety that should prompt officials to examine the custodial status of all those most at risk. Such an examination would result in their immediate release.

I, Andrew Lorenzen-Strait, swear under the penalty of perjury pursuant to 28 U.S.C. § 1746, that the foregoing declaration is true and correct to the best of my knowledge and belief.

Executed on this 23rd day in March, 2020 at Davidsonville, Maryland.

DocuSigned by:
Andrew Lorenzen-Strait
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Andrew Lorenzen-Strait