Multiple Documents

Part	Description
1	2 pages
2	1
3	2
4	3
5	4
6	5
7	6
8	7
9	8
10	9
11	10
12	11
13	12
14	13
15	14
16	15
17	16
18	17
19	18
20	19
21	20

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF PENNSYLVANIA

BHARATKUMAR G. THAKKER et al.

Petitioners-Plaintiffs,

vs.

CLAIR DOLL et al.

Respondents-Defendants.

Case No. _____

DECLARATION OF WITOLD J. WALCZAK

Pursuant to 28 U.S.C. §1746, I declare under penalty of perjury that the following is true and correct to the best of my knowledge and belief:

1. My name is Witold J. Walczak. I am the Legal Director for the American Civil Liberties Union of Pennsylvania and am counsel for Petitioners-Plaintiffs. I make this declaration in support of Petitioners'/Plaintiffs' Verified Writ of Habeas Corpus and Complaint for Declaratory and Injunctive Relief.
2. Attached hereto are true and correct copies of the following materials, identified as lettered exhibits in the petition:

Ex. 1 Declaration of Joseph J. Amon, Ph.D. MSPH

Ex. 2 Declaration of Dr. Jonathan Louis Golob

Ex. 3 Declaration of Petitioner Bharatkumar G. Thakker

Ex. 4 Declaration of Petitioner Adebodun Adebomi Idowu

Ex. 5 Declaration of Petitioner Courtney Stubbs

Ex. 6 Declaration of Danielle Arizzi (Petitioner Stubbs' fiancé)

Ex. 7 Declaration of Petitioner Rigoberto Gomez Hernandez

Ex. 8 Declaration of Petitioner Rodolfo Agustín Juarez Juarez

Ex. 9 Declaration of Petitioner Meiling Lin

Ex. 10 Declaration of Petitioner Henry Pratt

Ex. 11 Declaration of Petitioner Jean Herdy Christy Augustin

Ex. 12 Declaration of Petitioner Mayowa Abayomi Oyediran

Ex. 13 Declaration of Petitioner Agus Prajoga

Ex. 14 Declaration of Petitioner Mansyur

Ex. 15 Declaration of Petitioner Catalino Domingo Gomez Lopez

Ex. 16 Declaration of Petitioner Dexter Anthony Hillocks

Ex. 17 Declaration of Andrew Lorenzen-Strait

Ex. 18 Declaration of Andrew Baranoski, Executive Director of PIRC

Ex. 19 Declaration of Monica Ruiz, Executive Director, Casa San Jose

Ex. 20 March 13, 2020 Letter from ACLU-PA to Simona Flores-Lund, Field Office Director, Enforcement and Removal Operations, Philadelphia Office re: ICE Enforcement and COVID-19

Dated: March 24, 2020

/s/ Witold J. Walczak
Witold J. Walczak

Thakker, et al. v. Doll, et al.
Plaintiffs exhibits

Exhibit 1

Declaration of Joseph J. Amon, Ph.D. MSPH

I, Joseph J. Amon, declare as follows:

Background and Expertise

1. I am an infectious disease epidemiologist, Director of Global Health and Clinical Professor in the department of Community Health and Prevention at the Drexel Dornsife School of Public Health. I also hold an appointment as an Associate in the department of epidemiology of the Johns Hopkins University Bloomberg School of Public Health. My Ph.D. is from the Uniformed Services University of the Health Sciences in Bethesda, Maryland and my Master's of Science in Public Health (MSPH) degree in Tropical Medicine is from the Tulane University School of Public Health and Tropical Medicine.

2. Prior to my current position, I have worked for a range of non-governmental organizations and as an epidemiologist in the Epidemic Intelligence Service of the US Centers for Disease Control and Prevention. Between 2010 and 2018, I was a Visiting Lecturer at Princeton University, teaching courses on epidemiology and global health. I currently serve on advisory boards for UNAIDS and the Global Fund against HIV, TB and Malaria and have previously served on advisory committees for the World Health Organization.

3. I have published 60 peer-reviewed journal articles and more than 100 book chapters, letters, commentaries and opinion articles on issues related to public health and health policy.

4. One of my main areas of research focus relates to infectious disease control, clinical care, and obligations of government related to individuals in detention settings, in which I have published a number of reports assessing health issues in prison and detention settings and more than a dozen peer-reviewed articles. In 2015-2016, I was a co-editor of a special issue of the British journal, "The Lancet," on HIV, TB and hepatitis in prisons. I also serve on the editorial boards of two public health journals. My resume is attached as Exhibit A.

Information on COVID-19 and Vulnerable Populations

5. COVID-19 is a coronavirus disease that has reached pandemic status. As of today (3/23), according to the World Health Organization, more than 332,900 people have been diagnosed with COVID-19 in 190 countries or territories around the world and 14,510have died.[1] In the United States, about 41,000 people have been diagnosed with the disease and 479 people have died thus far.[2] In Pennsylvania, there are 644

[1] See https://www.who.int/emergencies/diseases/novel-coronavirus-2019 accessed March 23, 2020.
[2] See https://coronavirus.jhu.edu/map.html Accessed March 23, 2010

confirmed cases and five deaths thus far.[3] These numbers are likely an underestimate, due to the lack of availability of testing. In many settings, the numbers of infected people are growing at an exponential rate.

6. COVID-19 is a serious disease, ranging from no symptoms or mild ones for people at low risk, to respiratory failure and death. There is no vaccine to prevent COVID-19. There is no known cure or anti-viral treatment for COVID-19 at this time. The specific mechanism of mortality of critically ill COVID-19 patients is uncertain but may be related to virus-induced acute lung injury, inflammatory response, multiple organ damage and secondary nosocomial infections.

7. The World Health Organization (WHO) identifies individuals at highest risk to include those over 60 years of age and those with cardiovascular disease, diabetes, chronic respiratory disease, and cancer.[4] The WHO further states that the risk of severe disease increases with age starting from around 40 years.

8. The US CDC identifies "older adults [65 and older] and people of any age who have serious underlying medical conditions" as at higher risk of severe disease and death.[5] The CDC identifies underlying medical conditions to include: blood disorders, chronic kidney or liver disease, compromised immune system, endocrine disorders, including diabetes, metabolic disorders, heart and lung disease, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy.[6]

9. Data from US COVID-19 cases published by the CDC on March 19, 2020, found that hospitalization rates and intensive care unit (ICU) admission rates were nearly identical for individuals aged 45-54 and individuals aged 55-64 (between approximately 20-30% for both groups for hospitalization and between 5-11% for both groups for ICU admission).[7] This suggests that individuals >45 years could be considered high risk for severe disease while those ≥54 years could be considered high risk for severe disease and death.

10. Public Health England, the public health authority of the United Kingdom, identifies a broader list of individuals at increased risk of severe illness and who should be "particularly stringent in following social distancing measures".[8] These include: individuals with: chronic (long-term) respiratory diseases, such as asthma, chronic obstructive pulmonary disease (COPD), emphysema or bronchitis; chronic heart

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[3] See https://www.health.pa.gov/topics/disease/coronavirus/Pages/Coronavirus.aspx accessed March 23, 2020
[4] See https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200311-sitrep-51-covid-19.pdf?sfvrsn=1ba62e57_4 accessed March 21, 2020
[5] See https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html accessed March 21, 2020
[6] See https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf accessed March 21, 2020
[7] See https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm, accessed March 21, 2020
[8] See https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults accessed March 21, 2020

disease, such as heart failure; chronic kidney disease; chronic liver disease, such as hepatitis; chronic neurological conditions, such as Parkinson's disease, motor neurone disease, multiple sclerosis (MS), a learning disability or cerebral palsy; diabetes; spleen-related disorders or having had your spleen removed; having a weakened immune system; having a body mass index (BMI) of 40 or above; and those who are pregnant.

Health profile of plaintiffs

11. I have reviewed the declarations of the following individuals: Bharatkumar G. Thakker; Adebodun Adebomi Idowu; Courtney Stubbs; Meiling Lin; Rodolfo Agustín Juarez Juarez; Dexter Anthony Hillocks; Rigoberto Gomez Hernandez; Henry Pratt; Mayowa Abayomi Oyediran; Mr. Mansyur; and Agus Prajoga.

12. Bharatkumar G. Thakker is a 65-year-old citizen of India. He has been detained by ICE at Pike County Correctional Facility for the last 27 months. Including his age, Mr. Thakker has several health conditions, according to his declaration, that put him at high risk for severe illness and death from COVID-19, including chronic kidney disease and high blood pressure and high cholesterol which are associated with cardiovascular disease. He currently reports that he has chills, myalgia, asthenia and dizziness and has been coughing for a few days, and that his cell mate recently started coughing.

13. Courtney Stubbs is a 52-year-old citizen of Jamaica. He has been detained by ICE at Clinton County Correctional Facility since June 2019. Mr. Stubbs has several health conditions, according to his declaration, that put him at high risk for severe illness and death from COVID-19, including diabetes, cardiovascular disease, chronic kidney disease, and immunosuppression stemming from a kidney transplant.

14. Meiling Lin is a 45-year-old citizen of China. She has been detained by ICE at York County Prison since March 2019. Ms. Lin, according to her declaration, she suffers from chronic hepatitis B and liver disease, that puts her at high risk for severe illness and death from COVID-19.

14.a. Jean Herdy Christy Augustin is a 34-year-old citizen of Haiti. He is detained by ICE at York County Prison. According to his declaration, Mr. Augustin suffers from diabetes which puts him at high risk for severe illness and death from COVID-19. Mr. Augustin also has multiple other health issues, including high blood pressure and anemia that might complicate his treatment if infected with the virus causing COVID-19.

15. Rodolfo Agustín Juarez Juarez is a 21-year-old citizen of El Salvador. He has been detained by ICE at York County Prison since February 26, 2020. Mr. Juarez, according to his declaration, suffers from diabetes which puts him at high risk for severe illness and death from COVID-19. In addition, in his declaration he states that he has had a fever, persistent cough, and trouble breathing for the past week, all of which are common symptoms of COVID-19 and, according to current guidance, require testing and isolation. In his declaration, he states that he has not been tested for COVID-19 and

has been told by correctional officers that COVID-19 tests are not available at York.

16. Adebodun Adebomi Idowu is a 57-year-old from Nigeria. He has been detained by ICE at Clinton County Correctional Facility for the past 17 months. Mr. Idowu has several health conditions, according to his declaration, that put him at high risk for severe illness and death from COVID-19, including diabetes and high blood pressure and high cholesterol which are associated with cardiovascular disease.

16.b. Catalino Domingo Gomez Lopez is a 51-year-old citizen of Guatemala. He is detained by ICE at York County Prison. According to his declaration, since being detained in November 2018, Mr. Gomez Lopez has had the flu four times. He states that the most recent instance he was ill for four weeks, during which time he had a fever and a cough with hemoptysis (coughing blood). Hemoptysis requires medical assessment as it may be related to a range of serious health conditions, including tuberculosis, lung cancer, and pneumonia (among others). Due to his age and his stated history of hemoptysis, Mr Gomez Lopez may be at high risk for severe illness and death from COVID-19.

17. Dexter Anthony Hillocks is a 54-year-old from Trinidad and Tobago. He has been detained at the Pike County Correctional Facility since 2015. Mr. Hillocks, according to his declaration, has several health conditions that put him at high risk for severe illness and death from COVID-19, including diabetes, high blood pressure and high cholesterol which are associate with cardiovascular disease, and leukemia.

18. Rigoberto Gomez Hernandez is a 52-year-old Mexican national. He is detained by ICE at Pike County Prison. Mr. Gomez Hernandez, according to his declaration, has diabetes, which puts him at high risk for severe illness and death from COVID-19. He also reports that his detention has also caused him mental anguish.

19. Henry Pratt is a 50-year-old citizen of Liberia. He is detained by ICE at Clinton County Correctional Facility. According to his declaration, Mr. Pratt suffers from Type II diabetes and high blood pressure, which puts him at high risk for severe illness and death from COVID-19.

20. Mayowa Abayomi Oyediran is a forty-year-old citizen of Nigeria. He has been detained by ICE since November 7, 2019 at York County Prison. Mr. Oyediran, according to his declaration, has severe asthma and an infection in his lungs, which put him at high risk of severe illness and death from COVID-19. His declaration states that he has not been given an inhaler or any other kind of treatment for his asthma or treatment for his lung infection.

21. Mr. Mansyur is a 41-year-old citizen of Indonesian. He is detained by ICE at Pike County Prison since December 19, 2019. Mr. Mansyur, according to his declaration, has diabetes and high blood pressure, which puts him at high risk for severe illness and death from COVID-19.

22. Agus Prajoga is a 48-year-old citizen of Indonesia. He is detained by ICE at Pike County Prison since January 13, 2020. Mr. Parjoga has diabetes and high blood pressure and cholesterol which are associated with cardiovascular disease, which puts him at high risk for severe illness and death from COVID-19.

Understanding of COVID-19 Transmission

23. According to the US CDC, the disease is transmitted mainly between people who are in close contact with one another (within about 6 feet) via respiratory droplets produced when an infected person coughs or sneezes.[9] It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.[10] People are thought to be most contagious when they are most symptomatic (the sickest), however there is increasing evidence of asymptomatic transmission.[11] **This suggests that, while hand washing and disinfecting surfaces is advisable, the main strategy for limiting disease transmission is social distancing and that for such distancing to be effective it must occur before individuals display symptoms.**

24. Recognizing the importance of social distancing, public health officials have recommended extraordinary measures to combat the spread of COVID-19. Schools, courts, collegiate and professional sports, theater and other congregate settings have been closed as part of risk mitigation strategy. 50 states, 7 territories, and the District of Columbia have taken some type of formal executive action in response to the COVID-19 outbreak.[12] Through one form or another, these jurisdictions have declared, proclaimed, or ordered a state of emergency, public health emergency, or other preparedness and response activity for the outbreak. Earlier this month Pennsylvania Governor, Tom Wolf, declared a state of emergency, which he buttressed on March 19 with an order closing non-essential businesses.[13] On Monday, March 23, 2020, Governor Wolf issued a stay at home order for residents of Bucks, Chester, Delaware, Monroe and Montgomery counties. Philadelphia has been under a stay at home order since Saturday, March 21, 2020.[14]

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[9] See https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html accessed March 21, 2020
[10] See https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html accessed March 21, 2020
[11] See https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html accessed March 21, 2020; See also: Bai Y, Yao L, Wei T, et al. Presumed asymptomatic carrier transmission of COVID-19.JAMA. Published online February 21, 2020. doi:10.1001/jama.2020.2565 and Zhang W, Du RH, Li B, et al. Molecular and serological investigation of 2019-nCoV infected patients: implication of multiple shedding routes. Emerg Microbes Infect. 2020;9(1):386-389.
[12] See https://www.astho.org/COVID-19/ accessed March 21, 2020
[13] See https://www.governor.pa.gov/wp-content/uploads/2020/03/20200319-TWW-COVID-19-business-closure-order.pdf
[14] See https://www.wtae.com/article/stay-at-home-order-to-begin-tonight-for-several-pa-counties-including-allegheny/31900786 accessed March 23, 2020

25. As of March 23, in response to the threat of COVID-19 transmission, five states (California; Illinois; New Jersey; New York; and Ohio) prohibit gatherings of any size; nine states prohibit gatherings of >10 individuals (Colorado; Hawaii; Louisiana; Maine; Maryland; Texas; Utah; Vermont and Wisconsin); four states prohibit gatherings of >25 individuals (Alabama; Massachusetts; Oregon and Rhode Island) and eight states prohibit gatherings of >50 individuals. The five states that prohibited gathering have also issued quarantine orders directing residents to stay at home except under certain narrow exceptions.[15] These orders are expanding, increasing for example from at least 158 million people in 16 states, nine counties and three cities are being urged to stay home on March 23 to at least 163 million people in 17 states, 14 counties and eight cities being urged to stay home on March 24, 2020.[16]

26. These public health measures aim to "flatten the curve" of the rates of infection so that those most vulnerable to serious complications from infection will be least likely to be exposed and, if they are the numbers of infected individuals will be low enough that medical facilities will have enough beds, masks, and ventilators for those who need them.

27. In countries where the virus's course of infection began earlier, and where death rates grew steadily governments have imposed national emergency measures to prevent contagion from human contact, In Italy and Spain, for example, the governments have imposed national lockdowns to keep people from coming into contact with each other.[17]

28. In Spain, immigration authorities began gradually releasing people held in closed immigration detention centers (CIEs) on March 18.[18] In Belgium, federal authorities released an estimated 300 migrants from detention on March 19 because detention conditions did not allow for safe social distancing.[19] The UK government released 300 people from detention centers following legal action which argued that the government had failed to protect immigration detainees from the COVID-19 outbreak and failed to identify which detainees were at particular risk of serious harm or death if they do contract the virus due to their age or underlying health conditions. As part of the legal action, Professor Richard Coker of the London School of Hygiene and Tropical Medicine stated that prisons and detention centers provide "ideal incubation conditions for the rapid spread of the coronavirus, and that about 60% of those in detention could be rapidly infected if the virus gets into detention centers."[20]

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[15] See https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address-coronavirus/#socialdistancing accessed March 23, 2020

[16] See https://www.nytimes.com/interactive/2020/us/coronavirus-stay-at-home-order.html accessed March 24, 2020

[17] See https://www.cnbc.com/2020/03/14/spain-declares-state-of-emergency-due-to-coronavirus.html accessed March 23, 2020

[18] See: https://www.lavanguardia.com/politica/20200319/474263064358/interior-abre-puerta-liberar-internos-cie.html accessed March 23, 2020

[19] See: https://www.demorgen.be/nieuws/300-mensen-zonder-papieren-vrijgelaten-coronavirus-zet-dvz-onder-druk~bf3d626d/ accessed March 23, 2020

[20] See: https://www.theguardian.com/uk-news/2020/mar/21/home-office-releases-300-from-detention-centres-amid-covid-19-pandemic accessed March 23, 2020

Risk of COVID-19 in Immigration Detention Facilities

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

30. Immigration detention facilities are enclosed environments, much like the cruise ships that were the site of the largest concentrated outbreaks of COVID-19. Immigration detention facilities have even greater risk of infectious spread because of conditions of crowding, the proportion of vulnerable people detained, and often scant medical care. People live in close quarters and are also subject to security measures which prohibit successful "social distancing" that is needed to effectively prevent the spread of COVID-19. Toilets, sinks, and showers are shared, without disinfection between use. Food preparation and food service is communal, with little opportunity for surface disinfection. Staff arrive and leave on a shift basis; there is little to no ability to adequately screen staff for new, asymptomatic infection.

31. Based upon the declarations of Bharatkumar G. Thakker; Adebodun Adebomi Idowu; Courtney Stubbs; Meiling Lin and Rodolfo Agustín Juarez Juarez, conditions at Pike County Correctional Facility, York County Prison and Clinton County Correctional Facility do not appear to be adopting the procedures necessary to prevent COVID-19 transmission.

32. In the York facility, plaintiff declarations stated a range of concerns that suggest an inability to control transmission of COVID-19, including: crowding and inability to practice social distancing (e.g., 56 people held in one large area; close seating during meals); potential exposure via a large number of people sharing facilities and objects not frequently disinfected (water fountains, phones and tablets); the lack of availability of tests for infection, which would hamper isolation of infected detainees; and lack of screening or use of masks among facility staff (Declaration of Juarez). The Declaration by Lin on conditions in the York facility similarly highlights crowding and inability to practice social distancing (50 people in one large area with beds 3-4 feet apart; close seating during meals); shared objects and facilities (shared bathrooms, three phones and eleven tablets among 50 people).

33. In the Clinton County facility, the plaintiff declaration by Idowu stated similar concerns including crowding and inability to practice social distancing (72 people in one open unit with bunk beds); lack of staff screening and precautions; lack of screening of new detainees; and potential exposure via shared facilities (bathrooms, sinks, showers) (Declaration of Idowu).

34. In the Pike County facility, plaintiff declarations by Thakker and Stubbs stated similar concerns including crowding and inability to practice social distances (including in social areas and during meals); lack of staff precautions (masks) (Thakker); and the transfer of detainees from one block to another, despite symptoms of illness (Stubbs).

35. Many immigration detention facilities also lack adequate medical care infrastructure to

address the spread of infectious disease and treatment of high-risk people in detention. As examples, immigration detention facilities often use practical nurses who practice beyond the scope of their licenses; have part-time physicians who have limited availability to be on-site; and facilities with no formal linkages with local health departments or hospitals. Based on my review of declarations, it appears that, even without a public health crisis, inadequate provision of medical care led to health complications (Declaration of Idowu). A COVID-19 outbreak would put severe strain on this already strained system.

Risks of COVID-19 to and from Police, First Responders, and Corrections Officers

36. Police, first responders and correctional officers all face an increased risk of COVID-19 exposure as they are less able to practice the recommended strategy of social distancing in carrying out their official duties. These officials also potentially present a link from transmission occurring in the community to those who are detained.

37. An increasing number of public safety personnel – police officers, firefighters, EMTs and paramedics have been found to be infected with COVID-19 and a larger number have been ordered into 14-day quarantine at home or in quarters after exposure to an individual with COVID-19. For example, in Kirkland Washington 27 firefighters and two police officers were in quarantine along with four King County (Wash.) EMS paramedics. In San Jose California 77 firefighters were in quarantine.[21] More than 140 firefighters were quarantined in Washington DC.[22] Six New Jersey police officers tested positive for COVID-19 and another 20 officers were under self-quarantine, as of March 19.[23]

38. So far, two state prison employees tested positive for COVID-19 in California,[24] two in Michigan,[25] a county jail officer in Washington state,[26] and one Georgia Department of Corrections employee tested positive.[27] 21 inmates and 17 employees in Rikers Island (NY) have tested positive; an investigator with NYC's department of corrections died

[21] See https://www.policeone.com/coronavirus-covid-19/articles/how-long-to-quarantine-covid-19-exposed-police-officers-firefighters-emts-and-paramedics-XJnE4WGakSF1wtS0/ accessed March 21, 2020
[22] See https://www.firerescue1.com/coronavirus-covid-19/articles/more-than-140-dc-firefighters-quarantined-after-third-positive-covid-19-test-rHWizxNkyiEbtc6C/ accessed March 21, 2020
[23] https://www.nj.com/coronavirus/2020/03/6-officers-test-positive-for-coronavirus-20-others-self-quarantined-nj-police-union-says.html accessed March 21, 2020 See also: "COVID-19 Diagnosed at Essex County Correctional Facility," Tapinto.net (Mar. 23, 2020) https://www.tapinto.net/towns/soma/sections/health-and-wellness/articles/covid-19-diagnosed-at-essex-county-correctional-facility;
[24] See https://www.sacbee.com/news/coronavirus/article241371616.html accessed March 21, 2020
[25] See https://www.correctionsone.com/coronavirus-covid-19/articles/2-mich-doc-employees-test-positive-for-covid-19-Hmbc7yRomp3WbtBb/ accessed March 21, 2020
[26] See https://www.kitsapsun.com/story/news/2020/03/19/kitsap-county-jail-officer-diagnosed-covid-19-second-case-connected-county-campus/2881899001/ accessed March 21, 2020
[27] See https://www.ajc.com/news/crime--law/employee-inside-prison-tests-positive-for-covid/a40bWvX7LFFERMjoeLggyH/ accessed March 21, 2020

of COVID-19.[28] In Wisconsin, a prison doctor tested positive.[29]

39. In New Jersey, a member of the medical staff at Elizabeth Detention Center in New Jersey a private immigration detention center tested positive for coronavirus.[30] A correctional officer at Bergen County Jail (NJ), which contracts with ICE, also tested positive for COVID-19.[31] As a result of these cases, hunger strikes have broken out in three ICE detention centers in New Jersey "as detainees protest what they describe as deteriorating conditions and a failure to adequately address the potential spread of COVID-19".[32]

40. If police, first responders, and corrections officers are significantly affected by COVID-19, whether through being infected, exposed by detainees, their fellow officers or in the community, large numbers will be unavailable to work due to self-quarantine or isolation, at the same time that large numbers of detainees who are potentially exposed will need to be put into individual isolation or transferred to advanced medical care, putting tremendous stress on detention facilities.

41. Large numbers of ill detainees and corrections staff will also strain the limited medical infrastructure in the rural counties in which these detention facilities are located. If infection spreads throughout the detention center, overwhelming the center's own limited resources, the burden of caring for these individuals will shift to local medical facilities. The few facilities will likely not be able to provide care to all infected individuals with serious cases, increasing the likelihood that these individuals will die.[33]

Conclusions

42. Current conditions and procedures in place at the three ICE facilities, as described by plaintiff declarations, cannot be seen as sufficient to prevent the introduction of COVID-19 or prevent its rapid transmission among both detainees and staff. The lack

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[28] See https://www.nbcnewyork.com/news/coronavirus/21-inmates-17-employees-test-positive-for-covid-19-on-rikers-island-officials/2338242/ accessed March 23, 2020; See also: Monsy Alvarado, "Coronavirus outbreak locks down Hudson county jail after two inmates test positive," NorthJersey.com March 22, 2020 https://www.northjersey.com/story/news/coronavirus/2020/03/22/coronavirus-outbreak-locks-down-hudson-county-jail/2895687001/. Accessed March 23, 2020

[29] See https://fox6now.com/2020/03/19/employee-or-client-at-waupun-prison-tested-positive-for-covid-19/ March 21, 2020

[30] See https://www.themarshallproject.org/2020/03/19/first-ice-employee-tests-positive-for-coronavirus accessed March 21, 2020

[31] See https://www.insidernj.com/bergen-county-jail-corrections-officer-tests-positive-covid-19/ accessed March 21, 2020

[32] See https://www.vice.com/en_us/article/pkew79/immigrants-are-now-on-hunger-strike-in-3-ice-detention-centers-over-coronavirus-fears accessed March 21, 2020

[33] See https://www.post-gazette.com/news/health/2020/03/20/Rural-counties-in-Pennsylvania-struggle-on-their-own-as-COVID-19-spreads/stories/202003180034 accessed March 23, 2002. Even in regions with highly developed health systems, COVID-19 is straining ability to care, creating cause for alarm for less-equipped health care systems in regions that do not act to mitigate risk of infection. See https://www.nytimes.com/2020/03/12/world/europe/12italy-coronavirus-health-care.html accessed March 23, 2020

of daily tests of staff who have ongoing community contacts presents a risk of introduction of the virus into the detention facility. The possibility of asymptomatic transmission means that monitoring fever of staff or detainees is also inadequate for identifying all who may be infected and preventing transmission. This is also true because not all individuals infected with COVID-19 report fever in early stages of infection. The lack of widespread testing in communities and the current presence of COVID-19 in all 50 states means that it is impractical to ask detainees about their travel history– all communities should be assumed to have community transmission which is why statewide and national restrictions on movement and gatherings have been put in place. The crowded conditions, in both sleeping areas and social areas, and the shared objects (bathrooms, sinks, etc.) will facilitate transmission.

43. I have also reviewed the guidance ICE first issued on March 15, and most recently updated March 21.[34] Most notably, the guidance mentions "social distancing" only once, in the first section entitled "What is ICE doing to safeguard its employees/personnel during this crisis?" The strategies that the guidance outline for the protection of individuals in their custody include: 1) temporarily suspending social visitation in all detention facilities; 2) regularly updating infection prevention and control protocols, and issuing guidance to ICE Health Service Corps (IHSC) staff for the screening and management of potential exposure among detainees; 3) working with state and local health partners to determine if any detainee requires additional testing or monitoring to combat the spread of the virus. These are insufficient to prevent introduction or transmission of COVID-19 in facilities.

44. The guidance further states that "In detention settings, cohorting serves as an alternative to self-monitoring at home." "Cohorting" is not defined in the guidance, but can be understood in combination with the guidance under the section entitled "How does ICE mitigate the spread of COVID-19 within its detention facilities?" which states that "ICE places detainees with fever and/or respiratory symptoms in a single medical housing room, or in a medical airborne infection isolation room specifically designed to contain biological agents, such as COVID-19. Detainees who do not have fever or symptoms, but meet CDC criteria for epidemiologic risk, are housed separately in a single cell, or as a group, depending on available space."

45. Even if ICE is to implement this guidance at the facilities, it will not prevent the spread of COVID-19 because of the potential for asymptomatic transmission from other detainees or ICE facility staff of COVID-19, as referred to in paragraph 17. Although the ICE guidance states that individuals at epidemiologic risk will be housed separately, based upon the plaintiffs' declaration, this practice is not being implemented. This puts plaintiffs' at increased risk for exposure to COVID-19 as discussed above. The close quarters, the lack of testing and the inability to enforce appropriate social distancing are an urgent problem. Procedures that may have worked for other outbreaks, like flu, will not be sufficient to control COVID-19 and physical

[34] See: https://www.ice.gov/covid19 accessed March 23, 2020

distancing is essential.

46. The ICE guidance repeatedly refers to CDC guidance, for example stating that "ICE reviews CDC guidance daily and continues to update protocols to remain consistent with CDC guidance." CDC guidance on correctional and detention facilities,[35] posted March 23, 2020 reiterates many of the points previously made in this declaration, including: 1) Incarcerated/detained persons are at "heightened" risk for COVID-19 infection once the virus is introduced; 2) There are many opportunities for COVID-19 to be introduced into a correctional or detention facility, including from staff and transfer of incarcerated/detained persons; 3) Options for medical isolation of COVID-19 cases are limited; 4) Incarcerated/detained persons and staff may have medical conditions that increase their risk of severe disease from COVID-19; 5) The ability of incarcerated/detained persons to exercise disease prevention measures (e.g., frequent handwashing) may be limited and many facilities restrict access to soap and paper towels and prohibit alcohol-based hand sanitizer and many disinfectants; and 6) Incarcerated persons may hesitate to report symptoms of COVID-19 or seek medical care due to co-pay requirements and fear of isolation.

47. CDC guidance specifically recommends implementing social distancing strategies to increase the physical space between incarcerated/detained persons "ideally 6 feet between all individuals, regardless of the presence of symptoms" including: 1) increased space between individuals in holding cells, as well as in lines and waiting areas such as intake; stagger time in recreation spaces; restrict recreation space usage to a single housing unit per space; stagger meals; rearrange seating in the dining hall so that there is more space between individuals (e.g., remove every other chair and use only one side of the table); provide meals inside housing units or cells; limit the size of group activities; reassign bunks to provide more space between individuals, ideally 6 feet or more in all directions.

48. Based upon the plaintiffs' declarations, none of the ICE facilities are following CDC guidance in relation to social distancing putting all detainees, and especially those at high risk of severe disease and death, in jeopardy. The only viable public health strategy available is risk mitigation. Even with the best-laid plans to address the spread of COVID-19 in detention facilities, the release of individuals who can be considered at high-risk of severe disease if infected with COVID-19 is a key part of a risk mitigation strategy. In my opinion, the public health recommendation is to release high-risk people from detention, given the heightened risks to their health and safety, especially given the lack of a viable vaccine for prevention or effective treatment at this stage.

49. Other individuals who may not be identified as high risk should also be considered for release. Reducing the overall number of individuals in detention facilities will facilitate social distancing for remaining detainees and lessen the burden of ensuring the safety

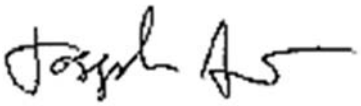
[35] See: https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html accessed March 23, 2020

of detainees and corrections officers.

50. To the extent that vulnerable detainees have had exposure to known cases with laboratory-confirmed infection with the virus that causes COVID-19, they should be tested immediately in concert with the local health department. Those who test negative should be released to home quarantine for 14 days. Where there is not a suitable location for home quarantine available, these individuals could be released to housing identified by the county or state Department of Health.

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

Executed this 24th day in March 2020 in Princeton, New Jersey.



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EDUCATION

08/1998-10/2002	Dept. of Preventive Medicine/Biometrics, Uniformed Services University of the Health Sciences, F. Edward Hebert School of Medicine *PhD, Dissertation: Molecular Epidemiology of Malaria in Kenya*	Bethesda, MD
08/1991-12/1994	Dept. of Parasitology and Tropical Medicine, Tulane University School of Public Health & Tropical Medicine *MSPH, Tropical Medicine*	New Orleans, LA
08/1987-05/1991	Hampshire College *BA, Interdisciplinary Studies*	Amherst, MA

ACADEMIC APPOINTMENTS

9/2018 – Present	Dornsife School of Public Health, Drexel University *Director, Global Health* *Clinical Professor, Dept of Community Health and Prevention*	Philadelphia, PA
01/2010 – Present	Dept. of Epidemiology and Center for Public Health and Human Rights, Bloomberg School of Public Health, Johns Hopkins *Associate*	Baltimore, MD
09/2010 – 06/2018	Woodrow Wilson School of Public and International Affairs, Princeton University *Visiting Lecturer*	Princeton, NJ
01/2015 – 05/2018	Dept. of Epidemiology, Mailman School of Public Health, Columbia University *Adjunct Associate Professor*	New York, NY
06/2014 – 07/2014	School of Social Science, Institute for Advanced Study *Short-term Visitor*	Princeton, NJ
09/2012 – 12/2012	Institut d'Études Politiques de Paris (SciencesPo) *Distinguished Visiting Lecturer*	Paris, France
01/2003–06/2007	Dept. of Preventive Medicine, Hebert School of Medicine, Uniformed Services University of the Health Sciences *Adjunct Assistant Professor*	Bethesda, MD

TEACHING EXPERIENCE

Professor		
2019 - Present	Drexel University	Theory and Practice of Community Health (graduate) Health and Human Rights (undergrad/graduate) Community Health: Cuba (graduate)
2011 – 2018	Princeton University	Health and Human Rights (undergraduate) Epidemiology (undergraduate)
09-12/2012	SciencesPo	Health and Human Rights (graduate)
Co-Instructor		
2012-2013	Global School of Socioeconomic Rights, Harvard University	Health Rights Litigation (graduate)

COMMITTEES AND ADVISORY BOARD MEMBERSHIP

Editorial

09/2019 – Present	Senior Editor, Health and Human Rights Journal
01/2010 – Present	Journal of the International AIDS Society, Editorial Board
07/2012 – Present	Journal of the International AIDS Society, Ethics Committee
01/2015 – 07/2016	Co-Editor, The Lancet HIV Special Issue on HIV and Prisoners
09/2017 – 06/2018	Co-Editor, Health and Human Rights Journal Special Issue on NTDs and Human Rights

Advisory

09/2016 – Present	The Global Fund, Working Group on Monitoring and Evaluating Programmes to Remove Human Rights Barriers to HIV, TB and Malaria Services
12/2014 – Present	UNAIDS, Strategic and Technical Advisory Group
07/2008 – Present	UNAIDS, HIV and Human Rights Reference Group (co-chair Aug 2014 – present)
06/2012 – 6/2018	Global Institute for Health and Human Rights, University at Albany, International Advisory Board
02/2012 – 01/2016	Founding member, Coalition for the Protection of Health Workers in Armed Conflict
01/2014 – 01/2016	Founding member: Robert Carr Award for Research on HIV and Human Rights
07/2011 – 07/2012	XIX International AIDS Conference, Scientific Programme Committee
11/2009 – 09/2012	WHO/STOP TB Partnership, TB and Human Rights Task Force

FULL-TIME WORK EXPERIENCE

09/2018-Present **Drexel University, Dornsife School of Public Health,** *Philadelphia, PA.*
- Director, Global Health
- Clinical Professor, Dept of Community Health and Prevention

02/2016–08/2018 **Helen Keller International,** *New York, NY.*
- Vice President, Neglected Tropical Diseases

Provided strategic, technical and overall management for >$125m portfolio of work on NTDs. Led development of proposals resulting in >$80m in new projects.

08/2005–01/2016 **Human Rights Watch,** *New York, NY.*
- Director, Health Division (Sept 2008 – Jan 2016)
- Founded Disability Rights Division (2013); Environment Division (2015)
- Director, HIV/AIDS Program (August 2005 – August 2008)

Led research and advocacy division focused on human rights and health. Founded programs on disability rights and environment. Responsible for financial and personnel management, fundraising and communications.

07/2003–06/2005 **Centers for Disease Control and Prevention,** *Atlanta, GA.*
- Epidemiologist, EIS Officer

Led hepatitis outbreak investigations in US and overseas. Collaborated with U.S. and international academic and government researchers. Analyzed trends in hepatitis prevalence and vaccination rates in diverse populations.

07/2000–09/2002 **Walter Reed Army Institute of Research,** *Silver Spring, MD.*
- Research Fellow

Conducted molecular epidemiologic and immunologic research on malaria, examining host-parasite interaction, vaccine efficacy, and correlates of disease severity.

07/1995–06/1998 **Family Health International,** *Arlington, VA.*
- Technical Officer (Jan – June 1998)
- Evaluation Officer (Aug 1996 – Dec 1997)
- Associate Evaluation Officer (July 1995 – July 1996)

Designed and analyzed HIV behavioral research and program evaluation studies. Supervised field-based research and evaluation staff in U.S., Brazil, Jamaica, Dominican Republic, Kenya, Ghana, and Haiti.

09/1992–11/1994 **U.S. Peace Corps,** *Lomé, Togo.*
- Volunteer

Designed and implemented process monitoring system for national Guinea Worm eradication program. Conducted health education training. Supervised village health workers.

SHORT-TERM AND CONSULTING EXPERIENCE

Human Rights Watch, *New York, NY.*	Provide technical review for research design, analysis and documents related to health and environment and human rights.	Sept 2018 – Present
The Futures Group International, *REACH Project, Washington DC.*	Co-investigator for HIV/AIDS operations research related to orphans and vulnerable children and adolescent-oriented HIV volunteer counseling and testing.	Mar 2002 – June 2003
Walter Reed Army Institute of Research, *Silver Spring, MD.*	Developed database and provided statistical support to malaria vaccine clinical trial project.	Apr 2002 – June 2003
John Snow, Inc., *Arlington, VA.*	Developed curriculum and provided training on HIV/AIDS monitoring and evaluation to Ministry of Health staff from 8 countries.	Dec. 2002 – June 2003
TvT Associates, *SYNERGY Project, Washington, DC.*	Designed $20+ million comprehensive HIV/AIDS strategy for USAID Ukraine and USAID Russia.	Dec. 2001 – April 2003
PACT, *Washington, DC.*	Designed outcome and impact evaluation of HIV behavioral intervention project.	June 2002
Encompass LLC, *Bethesda, MD.*	Designed evaluation of World Bank health sector reform training.	January – May 2002
U of Washington, *Center for Health Education and Research.*	Developed guidelines and training materials for monitoring and evaluating HIV/AIDS programs.	April – May 2002
Family Health International, *Arlington, VA.*	Analyzed HIV-related behavioral surveillance results from studies in Honduras, Nigeria, Ghana, and Senegal.	Sept 1998 – Mar 2002
Datex Inc., *Falls Church, VA.*	Provided expert review for USAID-funded HIV/AIDS behavioral intervention grants competition.	May– Jun 2001 Jan – Feb 2000
PLAN International *Bamako, Mali and Arlington, VA.*	Designed and implemented quantitative and qualitative evaluation of HIV/AIDS program and developed $6 million follow-on program.	May – Dec 2000
Ministry of Health, *Kingston, Jamaica.*	Analyzed behavioral surveillance results and facilitated workshop examining HIV trends.	Oct 1998
Eli Lilly Foundation, *Diabetes Control Program, Accra, Ghana.*	Designed and implemented outcome and impact evaluation of diabetes prevention and care program.	Sept 1996
Carter Center, *Niger Guinea Worm Eradication Program, Zinder, Niger.*	Designed and implemented outcome and impact evaluation of guinea worm eradication program.	Mar – May 1995

PEER REVIEW JOURNAL PUBLICATIONS

1 Kotellos KA, **Amon JJ**, Githens Benazerga W. *Field Experiences: measuring capacity building efforts in HIV/AIDS prevention programmes.* AIDS 1998; 12 (supl 2):109-17.

2 Figueroa JP, Brathwaite AR, Wedderburn M, Ward E, Lewis-Bell K, **Amon JJ**, Williams Y, Williams E. *Is HIV/STD control in Jamaica making a difference?* AIDS 1998; 12 (supl 2):S89-S98.

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4 **Amon JJ**. *Preventing HIV Infections in Children and Adolescents in Sub-Saharan Africa through Integrated Care and Support Activities.* African Journal on AIDS Research. 2002; 1(2):143-9.

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33 Dekker AM, **Amon JJ**, le Roux KW, Gaunt CB. *What is Killing Me Most: Chronic Pain and the Need for Palliative Care in Eastern Cape, South Africa*. Journal of Pain and Palliative Care Pharmacotherapy. 2012;26:1–7.

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52 Biehl J, Socal MP, Gauri V, Diniz D, Medeiros M, Rondon G, **Amon JJ**. *Judicialization 2.0: Understanding right-to-health litigation in real time.* Global Public Health. May 2018 22:1-0.

53 Sun N and **Amon JJ**. *Addressing Inequity: Neglected Tropical Diseases and Human Rights.* Health and Human Rights Journal. June 2018.

54 **Amon JJ**, Addiss D. *"Equipping Practitioners": Linking Neglected Tropical Diseases and Human Rights.* Health and Human Rights Journal. June 2018.

55 Géopogui A, Badila CF, Baldé MS, Nieba C, Lamah L, Reid SD, Yattara ML, Tougoue JJ, Ngondi J, Bamba IF, **Amon JJ**. Baseline trachoma prevalence in Guinea: Results of national trachoma mapping in 31 health districts. PLoS neglected tropical diseases. June 2018; 12(6):e0006585.

56 Coltart CE, Hoppe A, Parker M, Dawson L, **Amon JJ**, Simwinga M, Geller G, Henderson G, Laeyendecker O, Tucker JD, Eba P. Ethical considerations in global HIV phylogenetic research. The Lancet HIV. Aug 2018

57 **Amon JJ**, Eba P, Sprague L, Edwards O, Beyrer C. Defining rights-based indicators for HIV epidemic transition. PLoS medicine. Dec 2018; 15(12):e1002720.

58 Bah YM, Bah MS, Paye J, Conteh A, Saffa S, Tia A, Sonnie M, Veinoglou A, **Amon JJ**, Hodges MH, Zhang Y. *Soil-transmitted helminth infection in school age children in Sierra Leone after a decade of preventive chemotherapy interventions.* Infectious diseases of poverty. 2019 Dec;8(1):41.

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60 Socal MP, **Amon JJ**, Biehl J. *Institutional Determinants of Right-to-Health Litigation: The Role of Public Legal Services on Access to Medicines in Brazil.* Global Public Health. (in press)

61 Ward E, Hannass-Hancock J, **Amon JJ**. *Invisible: The Exclusion of Persons with Disabilities from HIV Research and National Strategic Plans in East and Southern Africa.* (Article: submitted)

BOOK CHAPTERS

1 **Amon J**. *Africa, Southern* in: Encyclopedia of AIDS, Ray Smith, ed. Chicago: Fitzroy Dearborn Publishers, 1998.

2 **Amon JJ**, Kotellos KA, Githens Benazerga W. *Evaluating Capacity Building*. HIV/AIDS Prevention and Control Synopsis Series. Family Health International, Arlington, VA: 1997.

3 **Amon JJ,** Saidel TJ, Mills S. *Behavioral Surveillance Survey Methodology: Experiences from Senegal and India.* WHO/UNAIDS Best Practices Series. WHO/UNAIDS. Geneva, June 2000.

4 **Amon J**, Brown T, Hogle J, MacNeil J, et al. *Behavioral Surveillance Surveys: Guidelines for repeated behavioral surveys in populations at risk of HIV*. FHI/IMPACT, USAID, DFID Publication. August 2000.

5 Kolars-Sow C, Saidel T, Hogle J, **Amon J**, Mills S. Indicators and questionnaires for behavioral surveys. In: Rehle T, Saidel T, Mills S, and Magnani R., (eds.) Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries: A Handbook for Program Managers and Decision Makers. Family Health International, Arlington, VA. August 2001.

6 **Amon JJ**, Bond KC, Brahmbhatt MN, *et al*. *Bellagio Principles on Social Justice and Influenza.* Johns Hopkins. Berman Institute of Bioethics. July 2006.

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8 **Amon J**. *High Hurdles for Health.* In: M. Worden (ed.) China's Great Leap: The Beijing Games and Olympian Human Rights Challenges. Seven Stories Press. May 2008.

9 **Amon J.** *Preventing the Further Spread of HIV/AIDS: The Essential Role of Human Rights.* In: N. Sudarshan (ed.) HIV/AIDS, Health Care and Human Rights Approaches. Amicus Books. Jan 2009.

10 **Amon J.** *Abusing Patients.* In: Human Rights Watch, 2010 World Report. New York: Seven Stories Press. Jan 2010.

11 **Amon JJ** and Kasambala T. Structural barriers and human rights related to HIV prevention and treatment in Zimbabwe. In: M. Seglid and T. Pogge (eds) Health Rights. London: Ashgate. Oct 2010.

12 **Amon JJ.** *HIV and the Right to Know: Whose right to know what? The discourse of human rights in the global HIV response*. In: J. Biehl and A. Petryna (eds.) "When people come first: Anthropology and social innovation in global health". Princeton: Princeton University Press. July 2013.

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EDITORIAL/COMMENT

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12 **Amon JJ.** *Political Epidemiology of HIV.* Journal of the International AIDS Society. 2014, 17:19327

13 **Amon JJ.** *Law, Human Rights and Health Databases: A roundtable discussion.* Health and Human Rights Journal. September 2014.

14 Otremba M, Berland G, **Amon JJ.** *Hospitals as Debtor Prisons.* The Lancet Global Health. 3, 5: e253–e254, May 2015.

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17 **Amon JJ.** *WHO Focus on Human Rights: Will it Extend to Neglected Tropical Diseases?* Health and Human Rights Journal. Nov 2017.

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19 **Amon JJ**, Sun N. *Subverting Rights: Addressing the Increasing Barriers to Reproductive Rights.* Health and Human Rights Journal. May 2018.

20 Biehl J, **Amon JJ**. *The Right to Remedies: On Human Rights Critiques and Peoples' Recourses.* Humanity Journal. Oct 2019

21 Williams C, **Amon JJ**, Bassett MT, Roux AV, Farmer PE. *25 Years: Exploring the Health and Human Rights Journey*. Health and Human Rights. 2019 Dec;21(2):279.

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23 **Amon JJ**. *Ending discrimination in healthcare.* Journal of the International AIDS Society. 2020 Feb;23(2).

LETTERS

1 **Amon JJ.** *The HIV/AIDS Epidemic in Ukraine: stable or still exploding?* Sexually Transmitted Infections. 2003 79(3):263-4.

2 Lohman D, **Amon JJ**. *HIV Testing*. Lancet. 2008 Feb 16;371(9612):557-8.

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5 Hsieh A, **Amon JJ**. *Ratification of human rights treaties: the beginning not the end.* Lancet. 2009 Aug 8;374(9688):447

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7 **Amon J**. *Harm reduction and the Catholic Church.* Conscience. Winter 2010.

8 **Amon J.** *Human Rights Abuses, Ethics, and the Protection of Subjects When Conducting Research on Intravenous Drug Users in China.* JAIDS: Journal of Acquired Immune Deficiency Syndromes. June 2011.

9 Cohen EJ, **Amon JJ**. *Lead Poisoning in China.* Lancet, 2011, 378(9803):e3.

10 **Amon JJ.** *Chinese Addiction Study and Human Rights.* Science, 2012, 337:522-523.

11 Pearshouse R and **Amon JJ.** *Human Rights and HIV Interventions in Chinese Labour Camps.* Sex Transm Infect. doi:10.1136/sextrans-2015-052193

12 Biehl J, **Amon JJ**, Socal M, Petryna A. *The Challenging Nature of Gathering Evidence and Analyzing the Judicialization of Health in Brazil.* Cadernos de Saúde Pública. July 2016.

13 Biehl J, Socal M, **Amon JJ**. *On the Heterogeneity and Politics of the Judicialization of Health in Brazil.* Health and Human Rights Journal. Dec 2016.

14 **Amon J**. *Re: Attacks on Ebola Health Workers in the Democratic Republic of Congo.* New York Times. May 23, 2019.

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OPINION

1 Empowering Women and Realizing Rights. *Toronto Star.* August 11, 2006

2 Why We Need an International AIDS Conference. *Toronto Globe and Mail.* August 15, 2006

3 Curb HIV infection rates in Texas prisons. *Austin American Statesman.* May 10, 2007

4 Diagnosis and Prescriptions. *Foreign Affairs.* May/June 2007

5 The Bush Policy On AIDS. *Huffington Post.* July 26, 2007

6 Saudi Move on HIV/AIDS will make the epidemic worse. *Saudi Debate.* Oct 24, 2007

7 How not to fight HIV/Aids. *The Guardian.* Jan 28, 2008

8 Blaming Foreigners. *The Korea Times.* March 12, 2009

9 Progress against HIV at risk. *Phnom Penh Post.* November 16, 2009

10 HIV Travel Bans: Small Steps, Big Gaps. *Huffington Post.* January 11, 2010

11 Don't Improve Drug Detention: End It. *Huffington Post.* January 15, 2010

12 Torture in health care. *Huffington Post.* January 22, 2010

13 Treatment or punishment? *Bangkok Post.* January 24, 2010

14 Rights abuses threaten HIV risk. *Phnom Penh Post.* January 27, 2010

15 Cambodian drug rehab centers: Abusive, illegal, ineffective. *The Nation (Bangkok).* Jan 27 2010

16 Drug dependence is not a moral issue. *Phnom Penh Post.* January 29, 2010

17 Condoms and Bibles. *The National (PNG)*. February 8, 2010

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19 Invisible Women. *Huffington Post.* March 8, 2010

20 How Not to Protect Children. *Phnom Penh Post.* March 8, 2010

21 Choam Chao needs independent investigation. *Phnom Penh Post.* March 24, 2010

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23 Who Will Defend Children in Cambodian Drug Rehab Centres? *The Nation.* March 31, 2010
24 Holiday in Cambodia? *Huffington Post.* April 6, 2010
25 When the Government Sponsors Stigma. *Huffington Post.* April 27, 2010 (with M. McLemore)
26 Zambia's TB-ridden prisons. *The Guardian*. April 27, 2010
27 Chinese Corruption Is Hazardous to Your Health. *Asia Wall Street Journal*. May 13, 2010
28 Why the Vietnamese Don't Want to Go to Rehab. *Foreign Policy.* May 28, 2010
29 Aids and TB are breaking out of prisons. *East African*. June 7, 2010
30 Uganda AIDS Policy: from Exemplary to Ineffective. *The Observer* (Kampala) June 24, 2010
31 When a Problem Comes Along, You Must Whip It. *Huffington Post*. June 26, 2010
32 Action not Rhetoric on HIV and Human Rights. *Huffington Post.* July 2, 2010
33 The Truth About China's Response to HIV/AIDS. *Los Angeles Times*. July 11, 2010
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35 HIV and Human Rights: Here and Now? *Huffington Post*. July 19, 2010
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38 Rights and Health, Right Now, for Migrants. *Africa Now (Tokyo).* October 2010 (with Kanae Doi)
39 Why Democracies Don't Get Cholera. *Foreign Policy.* October 25, 2010.
40 The Beginning of the End for the War on Drugs? *San Francisco Chronicle.* November 21, 2010
41 Rights Abuses Belie Success in AIDS Fight. *South China Morning Post.* December 1, 2010
42 World AIDS Day: Prevention, Treatment for Prisoners. *Zambia Post.* December 1, 2010
43 Lead poisoning in Nigeria: unprecedented. *Global Post.* December 2, 2010
44 China is hurting its future by not acting on lead. *South China Morning Post.* June 20, 2011
45 Hard life in Ugandan prisons. *The Independent (Uganda).* July 8. 2011
46 'Utterly Irresponsible': Donor Funding in Drug 'Treatment' Centers. *Huff. Post.* Sept 14, 2011
47 National Cashew Day: More Than Nuts. *Global Post.* October 3, 2011
48 A centre for abuse and beating. *The Nation* (Bangkok). October 11, 2011
49 Laos' Murky War on Drugs. *The Diplomat.* October 12, 2011
50 One AIDS march that should end. *Washington Blade.* October 28, 2011
51 Seoul's Broken Promises on HIV Testing. *The Diplomat.* June 29, 2013
52 Drug treatment centres give more abuse than therapy. *Bangkok Post*. December 18, 2013
53 Enlightened drug policies emerge globally, Cambodia remains rigid**.** *Global Post.* Jan 9, 2014
54 Health Under Attack. HRW Dispatch. May 19, 2014 (with Jennifer Pierre)
55 Canada's prostitution bill a step in the wrong direction. *Ottawa Citizen.* June 18, 2014
55 In The HIV Response, Who is 'Hard to Reach'? HRW Dispatch. July 23, 2014
56 Defeating AIDS. HRW Dispatch. June 30, 2015
57 How not to handle Ebola. CNN. September 12, 2014

58 Taking Care of the Caregivers. HRW Dispatch. December 17, 2014

59 Alert in a Time of Cholera. HRW Dispatch. March 26, 2015

60 Stop Using Hospitals as Debtor Prisons. HRW Dispatch. April 14, 2015

61 COP21: The Impact of Climate Change on the World's Marginalized Populations: Turkana County, Kenya. Health and Human Rights Journal Blog. October 27, 2015. (with Katharina Rall)

62 An Important, but Imperfect, Agreement by an Unprecedented Coalition. *US News and World Report.* December 18, 2015

63 Health workers are under attack around the world. Here's how bad it's getting. *Philadelphia Inquirer.* May 28, 2019. (with Jennifer Taylor)

INVITED PRESENTATIONS (SELECT)

1 *Surveillance design and evaluation approach of the Togo Guinea Worm Eradication Program.* III West African Guinea Worm Eradication Conference, Abidjan, Cote d'Ivoire, November 1993.

2 *Knowledge, attitudes and behaviors related to Guinea Worm Eradication, Togo.* IV West African Guinea Worm Eradication Conference, Ouagadougou, Burkina Faso, October 1994.

3 *Synthesis of evaluation results from the AIDSCAP project: 1992-1996.* HIV/STD/AIDS National Forum, Port-au-Prince, Haiti, June 3-5, 1996. Research and Evaluation Panel Chair.

4 *International Trends in HIV-Risk Related Behavior Change.* National Conference on HIV/AIDS, Kingston, Jamaica, November 25-26, 1996.

5 *HIV/AIDS and Adolescents in Ukraine.* Ukrainian-American Medical Society Annual Meeting. Philadelphia, PA, May 2003.

6 *Expanding HIV testing and respecting rights.* International conference on HIV/AIDS and Human Rights. Smolny College. St Petersburg, Russia. October 2005.

7 *HIV in Conflict Settings*. Joint Congressional Human Rights Caucus meeting. Washington DC. March 2006.

8 *Reflections and recollections.* Masters Internationalist - US Peace Corps Symposium. Washington DC. April 2006. (Keynote)

9 *Civil Society Participation in the Response to HIV/AIDS and Accountability.* Presented in panel 1: Breaking the cycle of infection for sustainable AIDS responses. United Nations General Assembly Special Session on HIV/AIDS. New York. June 2006.

10 *HIV testing and human rights.* Public Health Agency of Canada Meeting on HIV Testing. Toronto. August 2006.

11 *Hot Topics in Human Rights*. XVI International AIDS Conference. Toronto. August 2006.

12 *Burma, HIV and Human Rights.* Asia Society. New York. September 2007.

13 *HIV and Youth*. 12th Annual Herbert Rubin and Justice Rose Luttan Rubin International Law Symposium. New York University. New York. October 2007.

14 *HIV testing: human rights considerations*. Funders Network on Population, Reproductive Health and Rights. Annual Meeting, San Antonio, TX. October 2007.

15 *Human Rights and Epidemic Disease: TB control and constraints on rights.* Human Rights Funders Group. Annual Meeting. New York, NY. July 2008.

16 *Promoting Public Health and Human Rights in MDR-TB Care.* International Union against Lung and Tuberculosis Disease. Paris, France. October 2008.

17 *Public Health and Human Rights: Challenges around the World.* New York Academy of Sciences and Johns Hopkins School of Public Health Conference on Public Health and Human Rights. New York, NY. Dec 2008.

18 *Human Rights and Anti-Narcotics Policy.* UN General Assembly, Special Session on Drugs. Vienna, Austria. March 2009.

19 *Rights-based approaches to health.* Interaction Annual Meeting. Arlington, VA. July 2009. (panel moderator)

20 *Health and Human Rights: New orthodoxies and on-going conflicts in repressive states.* Stanford University, Palo Alto, CA. October 2010.

21 *HIV in Asia.* Asia Society. December 1, 2010.

22 *HIV Rights and Wrongs.* GlobeMed National Conference. Northwestern University, Chicago, IL. April 2011. (Keynote)

23 *Human Rights Perspective.* International Workshop on Treatment as Prevention. Vancouver, Canada. May 2011.

24 *Sustaining Environmental, Occupational and Public Health and Community Security: Lead Poisoning in China and Nigeria.* 12th National Conference on Science, Policy and the Environment. Washington, DC. January 2012.

25 *Health and Human Rights in Prisons.* European Infectious Disease meeting. Italy. September 2012. (Keynote)

26 *Measuring Violence against Children and the Effectiveness of Violence Prevention and Reduction Initiatives.* Columbia University. October 2013. (Panel Discussion Moderator)

27 *Political Epidemiology of HIV.* HIV 2014: Science, Community and Policy for Key Vulnerable Populations. New York Academy of Sciences. May 2014.

28 *On the Radar: Police Brutality, Politics & Public Health.* Princeton University. March 2015.

29 *Global Inequalities of Wealth and Health.* Bernstein Institute for Human Rights Annual Conference. New York University School of Law. April 2015.

30 *Environmental and occupational health and human rights.* Health and Human Rights Principles and Pedagogy. Florence, Italy. June 2015.

31 *Interviewing Victims of Human Rights Abuses.* Buzzfeed. New York. June 2015.

32 *Global Health and Governance.* Brookings Institution. May 2016.

33 *Access to pain medicine and human rights.* O'Neill Institute Health Rights Litigation. June 2016

33 *The Morbidity Management and Disability Prevention Project.* Global Alliance for Elimination of Trachoma 2020. Geneva, Switzerland. April 2017.

34 *Human Rights and Phylogenetic Analysis.* Ethics of Phylogenetics. Gates Foundation, UNAIDS, National Institutes for Health. London, UK. May 2017.

35 *Judicialization and access to medicines in Brazil.* O'Neill Institute Health Rights Litigation. Washington DC. June 2016.

36 *Implementing health related SDGs through a human rights perspective.* United Nations Social Forum. Geneva. October 2017.

37 *Indicators, Equity, Rights*. Making the end of AIDS real: Consensus building around what we mean by “epidemic control”. Glion, Switzerland. October 2017.

CONFERENCE PRESENTATIONS

1 Wedderburn M, **Amon J**, Samiel S, Brathwaite A, Figueroa P. *Knowledge, attitudes, beliefs and practices (KABP) about HIV/AIDS among male STD clinic attendees in Jamaica.* XI Latin American Congress on STIs/V Panamerican Conference on AIDS**,** Lima, Peru, December 3-7, 1997.

2 **Amon J**, Bolanos L, Gonzales MT, Zelaya A, Lopez C, Rodriguez J. *Knowledge of, availability, and use of condoms among commercial sex workers in four cities in Honduras.* XI Latin American Congress on STIs/V Panamerican Conference on AIDS**,** Lima, Peru, December 3-7, 1997.

3 Wedderburn M, **Amon J**, Samiel S, Brathwaite A, Figueroa P. *Knowledge, attitudes, beliefs and practices (KABP) about HIV/AIDS among youth aged 12-14 in Jamaica.* XII Int Conf AIDS. 1998; 12:191 (abstract no. 13527).

4 Wedderburn M, **Amon J,** Samiel S, Brathwaite A, Figueroa P. *Behavioral explanations for elevated prevalence of HIV in St. James Parish, Jamaica.* XII Int Conf AIDS. 1998; 12:216-7 (abstract no. 14171).

5 D'Angelo LA, **Amon J,** Lemos ME, Rebeiro MA, Gitchens W, Kotellos K. *Evaluating capacity building of implementing agencies in the AIDSCAP Brazil project*. XII Int Conf AIDS. 1998;12:945 (abstract no. 43503).

6 Saidel T, Mills S, **Amon J,** Rehle T. *Behavioral Surveillance Surveys (BSS) on specific target groups: a valuable complement to standardized general population surveys*. XII Int Conf AIDS. 1998;12:233 (abstract no.14256).

7 Essah KAS, Jackson D, Attafuah JD, **Amon J**, Yeboah KG. *Findings from the 2000 behavioral surveillance survey in Ghana*. XIV International AIDS Conference: Abstract no. C11062

8 Chatterji M, Murray N, Dougherty L, Alkenbrack S, Winfrey B, **Amon J**, Ventimiglia T, Mukaneza A. *Examining the impact of orphanhood on schoolleaving among children aged 6-19 in Rwanda, Zambia, and Cambodia.* XV Int Conf on AIDS, 2004 (Abstract WePeD6602).

9 Murray NJ, Chatterji M, Dougherty L, Winfrey B, Buek K, **Amon J**, Mulenga Y, Jones A. *Examining the impact of orphanhood and duration of orphanhood on sexual initiation among adolescents ages 10-19 in Rwanda and Zambia.* XV Int Conf on AIDS, 2004 (Abstract TuOrD1218).

10 **Amon J**, Devasia R, Xia G, *et al. Molecular Epidemiologic Investigation of Hepatitis A Outbreaks, 2003*. 4th International Conference on Emerging Infectious Disease, Atlanta, GA, March 2004.

11 **Amon J**, Devasia R, Xia G, *et al. Multiple Hepatitis A Outbreaks Associated with Green Onions among Restaurant Patrons – Tennessee, Georgia, and North Carolina, 2003.* 53rd EIS Conference, Atlanta, GA, April 2004. (Winner, Mackel Award)

12 Chatterji M, Murray N, Dougherty L, Ventimiglia T, Mukaneza A, Buek K, Winfrey B, **Amon J**. *Examining the impact of orphanhood on schoolleaving among children aged 6-19 in Rwanda, Zambia, and Cambodia.* International Union for the Scientific Study of Population XXV International Population Conference Tours, France, July, 2005.

13 Murray NJ, Chatterji M, Dougherty L, Mulenga Y, Jones A, Buek K, Winfrey B, **Amon J**.. *Examining the impact of orphanhood and duration of orphanhood on sexual initiation among adolescents ages 10-19 in Rwanda and Zambia.* International Union for the Scientific Study of Population. International Population Conference France, July, 2005.

14 Cohen J, Schleifer R, Richardson J, Kaplan K, Suwannawong P, Nagle J, **Amon J.** *Documenting Human Rights Violations Against Injection Drug Users: Advocacy for Health*. 17th International Conference on the Reduction of Drug Related Harm. May 2006. Vancouver.

15 Schleifer R, Cohen J, Nagle J, **Amon J.** *Injection Drug Users, Harm Reduction, and Human Rights in Ukraine.* 17th International Conference on the Reduction of Drug Related Harm. May 2006. Vancouver, Canada.

16 Bencomo C, **Amon J,** Iordache R, Schleifer R, Asandi S, Bohiltea A, Bucata C, Terragni C, Velica L. *How gaps in Romania's social support undermine HIV/AIDS prevention and treatment for children and youth.* XVI International AIDS Conference: Abstract no. MOPE0922. August 2006.

17 Tate T, Bencomo C, Lisumbu J, Mafu Sasa R, Schleifer R, **Amon J**. *Local and cultural beliefs about HIV transmission fuel childrenīs rights abuses in the Democratic Republic of Congo (DRC).* XVI International AIDS Conference: Abstract no. CDE0086. August 2006.

18 Cohen J, Epstein H, **Amon J**. *Human rights implications of AIDS-affected children's unequal access to education.* XVI International AIDS Conference: Abstract no. TUAE0202. August 2006.

19 Schleifer R, Skala P, Lezhentsev K, **Amon J**. *Rhetoric and risk: human rights abuses impeding Ukraine's fight against HIV/AIDS.* XVI International AIDS Conference: Abstract no. THAE0302. August 2006.

20 **Amon, J**. *Using a Human Rights Framework to Examine HIV/AIDS Programs and Policies.* Abstract #139834. American Public Health Association Annual Meeting. November 2006. Boston, MA.

21 Ngonyama L, Lohman D, Clayton M, **Amon J**. *The Role of Lay Counselors in Expanding HIV Testing: Lesotho's Know Your Status Campaign.* Abstract 1631. 2008 HIV/AIDS Implementers Meeting. Kampala, Uganda. June 2008.

22 Lohman D, Ovchinnikova M, **Amon J**. *The role of Russia's drug dependence treatment system in fighting HIV.* XVII International AIDS Conference: Abstract no. TUAX0102. August 2008.

23 **Amon J**. *HIV-specific travel restrictions: human rights, legal and ethical considerations.* XVII International AIDS Conference: Abstract no. TUSS0406. August 2008.

24 Lohman D, Ngonyama L, Clayton M, **Amon J**. *Expanding HIV testing and human rights: Lesotho's Know Your Status Campaign.* XVII International AIDS Conference: Abstract no. TUPE0469. August 2008.

25 Cohen JE, **Amon J.** *Human Rights abuses and threats to health: recent experiences of Chinese drug users in detoxification and re-education through labor centers in Guangxi Province*. XVII International AIDS Conference: Abstract no. THPE1085. August 2008.

26 **Amon J**. Protecting the human rights of people at risk of and affected by TB. 3rd Stop TB Partners Forum, Rio March 2009

27 **Amon J.** *Undocumented Migrants and Drug Users in Asia: Tuberculosis Care and Human Rights.* 3rd Stop TB Partners Forum, Rio March 2009

28 **Amon J.** *Protecting the rights of drug users in China.* 20th International Conference of the International Harm Reduction Association meeting. April, 2009.

29 Lohman D, **Amon J.** *Pain and Policy: The Battle with Needless Suffering.* Unite for Sight, Yale University. April, 2009.

30 **Amon J.** *HIV testing for hard-to-reach populations.* In: New Strategies and Controversies in HIV Testing and Surveillance, International AIDS Society Conference. Cape Town, South Africa. July 2009.

31 **Amon J**. *Human Rights context of routine testing.* In: Maximizing the benefits of treatment for individuals and communities. International AIDS Society Conference. Cape Town, South Africa. July 2009.

32 **Amon J.** *Scaling up HIV testing through scaling up human rights protections.* In: Scaling up

Biomedical Prevention and Treatment Interventions - The Critical Role of Social Science, Law and Human Rights. International AIDS Society Conference. Cape Town, South Africa. July 2009.

33 **Amon J.** *HIV testing and human rights: competing claims and conflicting views.* American Anthropological Association. Philadelphia, PA. December 2009.

34 Pearshouse R, **Amon JJ**. *Engagement with compulsory drug detention centers: a legal and ethical framework.* 21st International Conference of the International Harm Reduction Association meeting. April, 2010.

35 Lohman D, Tymoshevska V, Rokhanski A, Kotenko G, Druzhinina A, Schleifer R, **Amon J**. *Availability and accessibility of opioid medications in Ukraine.* XVIII International AIDS Conference. July 2010. Abstract no. MOAF0202

36 Jones L, Akugizibwe P, **Amon J**, et al. *Human rights costing of ART for prevention.* XVIII International AIDS Conference. July 2010. Abstract no. TUPE1033

37 Lemmen K, Wiessner P, Haerry DHU, Todrys K, **Amon J**. *Deportation of HIV-positive migrants in 29 countries: impact on health and human rights.* XVIII International AIDS Conference. July 2010. Abstract no. TUAF0101

38 McLemore M, Winter M, **Amon J**. *Sentenced to stigma: segregation of HIV-positive prisoners.* XVIII International AIDS Conference. July 2010. Abstract no. THPE0942

39 Todrys K, Malembeka G, Clayton M, McLemore M, Shaeffer R, **Amon J**. *HIV and TB management in 6 Zambian prisons demonstrate improved but ongoing prevention, testing and treatment gaps.* XVIII International AIDS Conference. July 2010. Abstract no. THPDX105 (Awarded prize for best abstract on HIV/TB integration)

40 Pearshouse R, Cohen JE, **Amon J**. *Drug detention centers and HIV in China and Cambodia.* XVIII International AIDS Conference. July 2010. Abstract no. MOAF0203

41 Lohman D, Palat G, Nair S, **Amon J**, Schleifer R. *Palliative care: needs of and availability for people living with HIV in India.* XVIII International AIDS Conference. July 2010.

42 Kippenberg J, Thomas L, Lohman D, **Amon J**. *Children's access to HIV testing, treatment and palliative care in Kenya.* XVIII International AIDS Conference. July 2010.

43 Lohman D, Thomas L, **Amon J.** *Access to pain treatment and palliative care as a human right.* XVIII International AIDS Conference. July 2010. Abstract no. WEPE0982.

44 **Amon J.** *HIV and human rights.* XVIII International AIDS Conference. July 2010.

45 **Amon J.** *HIV treatment as prevention: human rights issues.* HIV10 Conference. Glasgow, Scotland. November 2010.

46 **Amon J.** *TB and human rights in Zambian prisons.* IULTB. Berlin, Germany. Nov 2010.

47 **Amon J.** *TB and Human Rights.* IULTB. Berlin, Germany. November 2010. (panel chair)

48 Todrys K, Kwon S-R, Burnett M, Lamia M, **Amon J.** *HIV and TB Prevention, Testing, and Treatment in 16 Ugandan Prisons.* 6th IAS Conference on HIV Pathogenesis, Treatment and Prevention. Rome, July, 2011.

49 Pearshouse R, **Amon J.** *Drug Detention Centers and HIV In Vietnam.* 10th International Congress on AIDS in Asia. August, 2011.

50 **Amon J.** *Reforms to protect health and rights in East African prisons.* IULTB. Lille, France. Oct. 2011.

51 **Amon J.** *Ethics and Human Rights in Publishing.* (Meet the Editors session). XIX International AIDS Conference. July 2012.

52 **Amon J.** *Balance Between Justice System and Provision of Services.* XIX International AIDS Conference. Washington, DC. July 2012. (co-moderator)

53 **Amon J.** *Advancing global health through human rights accountability.* IV Consortium of

Universities for Global Health. Washington, DC. March 2013.

54 **Amon J.** *Enhanced HIV testing in the context of human rights*. 8th IAS Conference on HIV Pathogenesis, Treatment and Prevention. Vancouver, July 2015.

55 Beletsky L, Vera A, Gaines T, Arredondo J, Werb D, Bañuelos A, Rocha T, Rolon ML, Abramovitz D, **Amon J**, Brower K, Strathdee SA. *Utilization of Google Earth to Georeference Survey Data among People who Inject Drugs: Strategic Application for HIV Research.* 8th IAS Conference on HIV Pathogenesis, Treatment and Prevention. Vancouver, July 2015.

56 **Amon J.** *The impact of climate change and population mobility on neglected tropical disease elimination*. International Meeting on Emerging Diseases and Surveillance (IMED). Vienna, Nov 2016.

57 **Amon J.** *Getting to Zero: Lessons for NTD Elimination from Successful STH Control Programs.* Neglected Tropical Disease NGO Network Annual Meeting. Dakar, Senegal, Sept 2017. (moderator)

58 Hoppe A, Coltart C, Parker M, Dawson L, **Amon JJ,** et al. *Ethical Considerations in HIV Phylogenetic Research.* 2018 International AIDS Conference. Amsterdam, Netherlands.

59 **Amon J.** Epidemic transition: How will we achieve it while ensuring equity and quality? 2018 International AIDS Conference. Amsterdam, Netherlands.

INVITED LECTURES

1 University of North Carolina School of Public Health (March 2006)

2 Duke University School of Public Policy (October 2006)

3 University of Chicago (October 2006)

4 University of Toronto Law School (November 2006)

5 Columbia University Law School (Dec 2006, 2007, 2009)

6 University of Denver School of International Affairs (March 2007)

7 Georgetown University Law School (April 2007)

8 Columbia University School of International and Public Affairs (Feb and Oct 2007)

9 University of Connecticut School of Law (April 2009)

10 New York University (January 2011, November 2014)

11 University of Zurich (September 2011)

12 Columbia University Mailman School of Public Health (Feb, Nov 2009; Dec 2013; Nov 2014,-15)

13 Yale University Law School (March 2013)

14 Johns Hopkins University Bloomberg School of Public Health (annually: May 2008-2019)

15 UCLA Law School (January 2014)

16 Stanford University Law & Medical Schools (January 2014)

17 University of Melbourne, Nossal Institute for Global Health (July 2014)

18 Fordham Law School (October 2014)

19 Northwestern University (November 2014; Nov 2015)

20 Dornsife School of Public Health, Drexel University (February 2018)

21 University of California San Diego (March 2018)

AWARDS

Centers for Disease Control and Prevention, Epidemic Intelligence Service, Mackel Award (Apr 2004)
Department of Health and Human Services, Public Health Service, Unit Commendation (Oct 2004)
Department of Health and Human Services, Secretary's Award for Distinguished Service (Aug 2005)

AD HOC REVIEWER

Journals:

New England Journal of Medicine, Lancet, International Journal of Epidemiology, STI, Global Public Health, Addiction, Hepatology, Health and Human Rights, Bulletin of the World Health Organization, Journal of the International AIDS Society, PLoS One, PLoS Medicine, Journal of the American Public Health Association, Anthropological Quarterly, Drug and Alcohol Dependence, Conflict and Health, BMC Public Health, Harm Reduction Journal, Law & Social Inquiry, Social Science and Medicine, Health and Human Rights Journal, International Journal of Drug Policy.

Grants:

Open Society Foundations, Public Health Program

Exhibit 2

DECLARATION OF DR. JONATHAN LOUIS GOLOB

I, Jonathan Louis Golob, declare as follows:

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

2. COVID-19 is an infection caused by a novel zoonotic coronavirus SARS-COV-2 that has been identified as the cause of a viral outbreak that originated in Wuhan, China in December 2019. The World Health Organization has declared that COVID-19 is causing a pandemic. As of March 21, 2020, there are over 260,000 confirmed cases of COVID-19 worldwide. COVID-19 has caused over 11,000 deaths, with exponentially growing outbreaks occurring at multiple sites worldwide, including within the United States.

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

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

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

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

7. A lack of proven cases of COVID-19 in the context of a lack of testing is functionally meaningless for determining if there is a risk for COVID-19 transmission in a community or institution.

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

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

10. There is no vaccine for this infection. Unlike influenza, there is no known effective antiviral medication to prevent or treat infection from COVID-19. Experimental therapies are being attempted. The only known effective measures to reduce the risk for a

vulnerable person from injury or death from COVID-19 are to prevent individuals from being infected with the COVID-19 virus. Social distancing, or remaining physically separated from known or potentially infected individuals, and hygiene, including washing with soap and water, are the only known effective measures for protecting vulnerable communities from COVID-19.

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

12. COVID-19 strains have specifically traced infection between residents and staff members of a skilled nursing facility in the Seattle area. This evidence suggests that COVID-19 is capable of spreading rapidly in institutionalized settings. The highest known person-to-person transmission rates for COVID-19 are in a skilled nursing facility in Kirkland, Washington and on afflicted cruise ships in Japan and off the coast of California.

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

14. This information provides many reasons to conclude that vulnerable people, people over the age of 50 and people of any age with lung disease, heart disease, diabetes, or immunocompromised (such as from cancer, HIV, autoimmune diseases), blood disorders (including sickle cell disease), chronic liver or kidney disease, inherited metabolic disorders, stroke, developmental delay, or pregnancy living in an institutional setting, such as an immigration detention center, prison, or jail, with limited access to adequate hygiene facilities, limited ability to physically distance themselves from others, and exposure to potentially infected individuals from the community are at grave risk of severe illness and death from COVID-19.

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

Executed this 23 day in March, 2020 in Ann Arbor, Michigan.

Dr. Jonathan Louis Golob

Jonathan Louis Golob, M.D. Ph.D.
Assistant Professor
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golobj@med.umich.edu jonathan@golob.org

Education and Training

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

Certifications and Licensure

Board Certifications

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

Current Medical Licenses to Practice

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

Academic, Administrative, and Clinical Appointments

Academic

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

Clinical

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

Research Interests

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

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

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

Grants

Present and Active

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

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

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

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

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

Completed

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

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

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

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

Honors and Awards

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

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

Membership in Professional Societies

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

Bibliography

Peer-Reviewed Journals and Publications

1. Gao Z, **Golob J,** Tanavde VM, Civin CI, Hawley RG, Cheng L. High levels of transgene expression following transduction of long-term NOD/SCID-repopulating human cells with a modified lentiviral vector. *Stem Cells* 19(3): 247-59, 2001.
2. Cui Y, **Golob J**, Kelleher E, Ye Z, Pardoll D, Cheng L. Targeting transgene expression to antigen-presenting cells derived from lentivirus-transduced engrafting human hematopoietic stem/progenitor cells. *Blood* 99(2): 399-408, 2002.
3. Boursalian TE, **Golob J**, Soper DM, Cooper CJ, Fink PJ. Continued maturation of thymic emigrants in the periphery. *Nature Immunology* 5(4): 418-25, 2004.
4. Osugi T, Kohn AD, **Golob JL**, Pabon L, Reinecke H, Moon RT, Murry CE. Biphasic role for Wnt/beta-catenin signaling in cardiac specification in zebrafish and embryonic stem cells. *PNAS* 104(23): 9685-9690, 2007.
5. **Golob JL**, Paige SL, Muskheli V, Pabon L, Murry CE: Chromatin Remodeling During Mouse and Human Embryonic Stem Cell Differentiation. *Developmental Dynamics* 237(5): 1389-1398, 2008.
6. **Golob JL**, Kumar RM, Guenther MG, Laurent LC, Pabon LM, Loring JF, Young RA, Murry CE: Evidence That Gene Activation and Silencing during Stem Cell Differentiation Requires a Transcriptionally Paused Intermediate State. *PLoS ONE* 6(8): e22416, 2011.
7. **Golob JL**, Margolis E, Hoffman NG, Fredricks DN. Evaluating the accuracy of amplicon-based microbiome computational pipelines on simulated human gut microbial communities. *BMC Bioinformatics* 18(1):283, 2017.
8. MacAllister TJ, Stednick Z, **Golob JL**, Huang, ML, Pergam SA. Under-utilization of norovirus testing in hematopoietic cell transplant recipients at a large cancer center. *Am J Infect Control* pii: S0196-6553(17)30783-6. doi: 10.1016/j.ajic.2017.06.010. [Epub ahead of print], 2017.
9. **Golob JL**, Pergam SA, Srinivasan S, Fiedler TL, Liu C, Garcia K, Mielcarek M, Ko D, Aker S, Marquis S, Loeffelholz T, Plantinga A, Wu MC, Celustka K, Morrison A, Woodfield M, Fredricks DN. The Stool Microbiota at Neutrophil Recovery is Predictive for Severe Acute Graft versus Host Disease after Hematopoietic Cell Transplantation. *Clin Infect Dis* doi: 10.1093/cid/cix699. [Epub ahead of print], 2017.
10. Bhattacharyya A, Hanafi LA, Sheih A, **Golob JL**, Srinivasan S, Boeckh MJ, Pergam SA, Mahmood S, Baker KK, Gooley TA, Milano F, Fredricks DN, Riddell SR, Turtle CJ. Graft-Derived Reconstitution of Mucosal-Associated Invariant T Cells after Allogeneic Hematopoietic Cell Transplantation. *Biol Blood Marrow Transplant* pii: S1083-8791(17)30758-9. doi: 10.1016/j.bbmt.2017.10.003. Epub 2017 Oct 9.
11. Ogimi C, Krantz EM, **Golob JL**, Waghmare A, Liu C, Leisenring WM, Woodard CR, Marquis S, Kuypers JM, Jerome KR, Pergam SA, Fredricks DN, Sorror ML, Englund JA, Boeckh M. Antibiotic Exposure Prior to Respiratory Viral Infection Is Associated with Progression to Lower Respiratory Tract Disease in Allogeneic Hematopoietic Cell

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

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

Preprint publications

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

Other Publications

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

Abstracts (presenter underlined)

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

Invited Lectures

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

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

Exhibit 3

Declaration of Bharatkumar G. Thakker

1. My name is Bharatkumar G. Thakker. I'm 65 years old and originally from India.

2. I submit this declaration in support of a of a multi-plaintiff petition for a writ of habeas corpus in federal court based on the risks that I and others face because of COVID-19.

3. I came to the United States in 1973 and have lived here ever since with my family. All my family is in the United States – my wife, our three sons, and my elderly mother. They are all United States citizens.

4. I have been detained for 27 months at Pike County Correctional Facility. ICE detained me after I was arrested in 2017 for trying to steal a battery from a store. I know I should not steal and I feel remorse about it. I tried to get help because I am a kleptomaniac. I went to a psychiatrist. I have some other convictions too for petty thefts like this, like in 2014, when I stole three DVDs from a store.

5. I am afraid for my health because of COVID-19. I understand because of my age and health problems I am at high risk if I get infected.

6. I had a heart stent put in in 2006. Right now, I take 11 pills a day. I have high blood pressure (a recent reading was 195 over 100) and my kidneys are not fully functioning. My most recent reading was at 30% to 35%. They told me when my kidneys are at 20% I will have to go on dialysis. I also have high cholesterol.

7. Since September 2019, I have lost 15 pounds. I do not have much of appetite. Right now I weigh 125 pounds. They give me a supplemental shake at night if I want it and a peanut butter sandwich because I do not eat all my meals.

8. Before I was detained, I would catch a cold every two or three years. Now I get a cold every winter. This last winter I also had flu like symptoms twice already—fever, headache, and a runny nose.

9. I have also been hospitalized twice during my time at Pike. The first time was in March or April 2018. I was in my in cell, and I felt dizziness and short of breath. I called the CO and he called medical department. They decided to send me to the hospital where I was evaluated and then sent back to Pike.

10. The second time I was hospitalized was in July 2019. I had come out of the shower and was short of breath. A correctional officer saw and called down to medical, and they checked me. They called the doctor, and sent me to the hospital. At the hospital they did an examine. They told me I might have had a minor heart attack. They sent me back after two days.

11. In my housing block H there are 48 men. I share a cell with 2 other people. It is probably about 8 by 10 or 8 12. There is one bunk bed and a single bed.

12. It is impossible for me to practice social distancing where I am. At any given time during the day, I am usually within 2 feet of someone else. Even our common area – the day room, we cannot be spaced out. The benches seat about 6 men each, it is not bigger to fit more than us. It is the same where we eat – there is not enough space to distance ourselves.

13. Several men in my block are older like me and I worry about them. There are three or four men right now that are coughing. I went to the nurse last week and asked her if I should be worried about the corona virus. She told me no I shouldn't be and that I should take care of myself. But I am worried. I am watching the news and talking with my family.

14. There is a unit worker who does the cleaning in the common areas like the bathroom, but they get paid $1 a day, so I don't know how thorough they really are. We clean our own almost every day and do the best we can, but we share a mop bucket with the entire block, so I don't know how clean we can make it.

15. There is a block called C on quarantine. It has been like this for about two weeks. No inmates are brought out and new ones are not sent in there. It has 48 men. We have not been officially told why they are on quarantine, but I heard they have symptoms similar to the corona virus.

16. There is also a special medical unit (SMU) with six men right now. I do not know why they are there.

17. I have not seen the correctional officers wearing any protective gear.

18. My cellmate started coughing yesterday. He went to medical today. He has the chills and has been achy all day. I have been coughing for a few days. Today, I started to feel weak and dizzy. I told the CO and asked for medical to me. I hope they bring down soon to medical. My bed is about three feet away from my cellmate.

19. We are all so close together here, if anyone is infected, it will spread really quick. I am afraid.

I, Vanessa L. Stine, certify that I have read the foregoing to Mr. Thakker and that he affirmed that the foregoing is true and correct on March 22, 2020 and that new information was provided on March 23, 2020, which was added to paragraph 18. At the time I reviewed the foregoing declaration with Mr. Thakker he certified that everything was true and correct.

/s/ Vanessa L. Stine

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Exhibit 4

Declaration of Adebodun Adebomi Idowu

1. My name is Adebodun Adebomi Idowu. I am from Nigeria and am 57 years old. I have a U.S. citizen wife and U.S. citizen brother.

2. I have lived in the United States since 2012. I entered as a lawful permanent resident. I am seeking immigration relief under the Convention against Torture (CAT). I have a criminal history—I was convicted of money laundering. I feel remorse for what I did and served my time.

3. I have been detained by ICE for 17 months. Because of my health issues, I understand I am at a high risk should I contact COVID-19. I am worried for myself and for other detainees I know.

4. I have lived with type II diabetes since 2000. I take medication for my diabetes – 2 pills in the morning and 2 pills at night. The medications are insulin, Janumet, and Metformin twice a day to treat my condition. I also take medication twice a day for my high blood pressure (even with medication a recent read was 154/94). I also take medication once a day for my high cholesterol.

5. I receive medication from the health center at Clinton County Correctional Facility, but sometimes they run out of my medication. This has led to me being hospitalized three times.

6. The first time I was hospitalized was in 2018. I was at the hospital in Williamsport for about 24 hours and they brought me back.

7. The second time was in July or August 2019. I was at the hospital for two nights. This was also at Williamsport.

8. The third time was in December 2019. It was bad. They ran out of my insulin and I did not have it two days. My sugar was at 600 mg/dL. I passed out. They had to use an oxygen mask for me. They rushed me the hospital in Lock Haven, where I spent two nights.

9. The jail talked to ICE after this because all my medical needs are expensive to see if they would release me. Recently I talked to someone in medical and they told me they did not know why me and the other guys who are vulnerable are not just released. That scared me.

10. It is impossible for me to maintain a safe distance of six feet with the guys I am housed with. I would say I am normally two to three feet from at least one other guy at any time, and usually it is several guys.

11. There are 72 of us in one unit. It is a dormitory style so it all open with bunk beds. But the beds are close together—like the length of your arm. It is close. The beds are in six rows and then there is a small knee height barrier and then another seven rows of beds.

12. Same goes for where we spend time during the day and where we eat. This is in the day room, which is really in the same space as where we sleep. The only divider is a knee height divider between our beds and the day space. In the day space, there are six round tables that seat eight to nine guys close to one another, like shoulder to shoulder, touching.

13. It is hard to maintain good hygiene here. We all try but the bathrooms are small. There are two bathrooms with two sinks each. There are two shower rooms with two shower each. But four showers for 72 men is not a lot and they get dirty. We clean them once a day but it is hard to keep clean. Whether we get gloves depends on the CO, some give us gloves some do not.

14. I have not seen staff taking any precautions. In fact, last week a CO was sick and he was coughing. He said he was sick but has not been back for a few days. None of the COs are wearing masks or gloves.

15. Also last week, I think on Thursday, they brought in four new guys into our unit. They said they were not asked about contact with anyone with COVID-19. They were not tested.

16. I am really worried about my health here at Clinton County Correctional Facility. I know I am at high risk because of all my health problems and I don't know what will happen. They have not even been able to keep my sugar levels steady, so I don't know what kind of treatment they would give to me. Even right now I am sneezing and coughing. I worry about what will happen to me if I get the virus. I am scared. We all are.

I, Vanessa L. Stine, certify that I reviewed this declaration with Mr. Idowu by telephone on March 23, 2020 and that he certified that the declaration was true and correct to the best of his knowledge.

/s/ Vanessa L. Stine

Vanessa L. Stine (PA 319569)
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Exhibit 5

Declaration of Courtney Stubbs

1. My name is Courtney Stubbs. I am 52 years old. I came to the United States from Jamaica in 1991. I have lived here ever since.

2. I met my fiancé 12 years ago. We have a beautiful 9-year-old son together.

3. I have a lot of health issues and am autoimmune compromised. Right now I take about 12 pills a day. I also used to take three vitamins but I cannot get those since being detained.

4. In October 2014, I received a kidney transplant. I have to take medication every day to make sure my body does not reject it. I'm also diabetic – I have Type II diabetes. I had blood clots and had a heart stent put in in 2018.

5. In 2001, I was convicted of conspiracy to distribute marijuana. It was while I was serving my sentence that I went into kidney failure and began dialysis. After I was released, I ended up getting put into removal proceedings and then because of my health issues, I was placed on Order of Supervision (OSUP) with ICE. For 14 years, I complied with the OSUP. I used to have check-ins with ICE every week. Then they moved to it once a month, then once a year. I always complied and communicated with ICE officer on my case.

6. In February 2019, they starting doing home visits again. I don't know why. They put an ankle bracelet on me too. Then told me I had to get a ticket and leave – I could not believe it. In June 2019, they said I should come back in one week and bring my medication and verify I was taking all my medications and they would put me on a new program. When I got there, they detained me. Had I known they were going to do this, I would not have driven (my fiancé had to pay a bunch of money to get my car weeks later). I would have given my son an extra hug.

7. I have been detained at Pike since June 2019. ICE has sent my medical records to Jamaica three times. Each time Jamaica has told them no because my health issues and my medications cost a lot. I know ICE is trying to get them to do this but with the corona virus who knows.

8. I understand that my health conditions make be highly vulnerable to the corona virus. I am worried. I have asked staff about the corona virus. I have no information about what they are doing. I know C block is quarantined, but no one will say why.

9. I have a lot of medical needs. While Pike has been providing me medical care I do not feel like it has been enough. For example, it is very important that my creatinine levels are checked to make sure I am not rejecting my kidneys or going into kidney failure. My doctor who was treating me before I was detained for my kidneys has called Pike to tell them this, and so have I and my fiancé. They said they checked my levels but the test is inconclusive. I do not understand why since they drew my blood.

10. My health has worsened since I have been detained. For one thing, I can't really sleep at night. I talked to medical about something to help with that. They gave me an anti-depressant, but it does not really help me sleep.

11. My fiancé told me about everything going on with the virus and how they are telling people to do social distancing. But I can't do that – I am always within a few feet of people. Even if I stay in my cell, I am still within a five feet of my cellmates. When I go to eat, same thing. When I go to medical, same thing.

12. Every morning around 5:30am I have to get my blood sugar tested. On the weekdays, they come to us but on the weekend I have go down to medical. Everyone from the different units are brought down together. About two or three weeks ago, I saw that the COs from intake started to wear masks.

13. My housing unit is H. There are 47 or 48 men. We sleep three to a cell. There is a bunk bed on one side and a single bed on the other. There is also a toilet and sink. I am no more than 5 feet away from my cellmates in our cell.

14. Outside my cell is the day room. The day room is where we hang out between meals. It is also where we eat. There are four long tables that seat about six men each. There are also two game tables and two folding tables. When we are seated we are within inches of each other.

15. There is a TV in the dayroom. We used to watch CNN sometimes but beginning last week, I think Monday, March 16, they stopped showing the news. Now it is Netflix all the time. We used to ask the COs to put on Netflix to watch movies and they wouldn't. Now it is the only thing they put on. I feel like they did this so we do not get information about the corona virus.

16. We get three pieces of soap each night before we go to bed. It is for all three of us in our cell. They are about the size of four quarters. We have to use the soap to wash our hands in the cell, and to shower with. We don't get more soap until the next night. Sometimes when people leave we try to get their extra soap, but we are not allowed to have it—it is treated like contraband. They take it from us. There is no common area to wash our hands, so every time we need to wash our hands we have to go to our cells.

17. We get two hours of recreation time a day. I do not really use it but others from my block do. They go to the rec yard. It used to let out just one block at a time, but now it is two blocks together, and it varies. Sometimes it is G and H blocks sometimes it is G and K blocks, or H and K blocks.

18. My new cellmate has been coughing. He came over about two weeks ago from another block.

19. I am really concerned about my health with the corona virus. I feel like they do not care about us – they try to cut off our information, they tell us nothing, and we just stay in close quarters. I am high risk. I have a lot health issues and am very fearful.

I, Vanessa L. Stine, certify that I reviewed this declaration with Mr. Stubbs by telephone on March 23, 2020 and that he certified that the declaration was true and correct to the best of his knowledge.

Dated: March 23, 2020

/s/ Vanessa L. Stine

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Exhibit 6

Declaration of Danielle Arizzi

1. My name is Danielle Arizzi. My fiancé Courtney Stubbs has been detained at Pike since June 25, 2019—which is about 9 months. Courtney had been on an order of supervision with ICE for 14 years. He always complied. In June, ICE told him to come to the office, and to bring his medication. He was told it was for a new program. Instead, they detained him. ICE misplaced his wallet and keys and it took me weeks to get it. All that time his car was sitting in a lot. I had to get a new key cut and pay the parking cost. It cost me $750.

2. His detention has been really hard on our family. Courtney and I have a 9-year-old son together. Our son is having a hard time dealing with this. He has fallen behind in school. He went from one of the happiest kids in school to a totally different kid who is acting out and struggling. It has also been really hard on me emotionally.

3. With the corona virus I am really worried about by fiancé. I work as a dialysis technician so I understand the need to take precautions right now to lessen the spread. But that is impossible at Pike. And my fiancé has serious health issues that made him very vulnerable. He received a kidney transplant from a family of a young man. They gave it to save a life. I do not want their donation to be for nothing. But I fear for my fiancé's life.

4. He takes something like a dozen pills a day. Because of his kidney transplant he takes medication every day for that. Missing a day or two could be really serious and make him go back into kidney failure. He also has other medical issues, including diabetes and is autoimmune compromised. He also has heart disease.

5. Jamaica will not accept him right now. ICE already tried three times and Jamaica said no after looking at Courtney's medical records. They said they did not have the means to care for him. ICE told me they would try again next month. But with the coronavirus I don't think Jamaica will be accepting deportees.

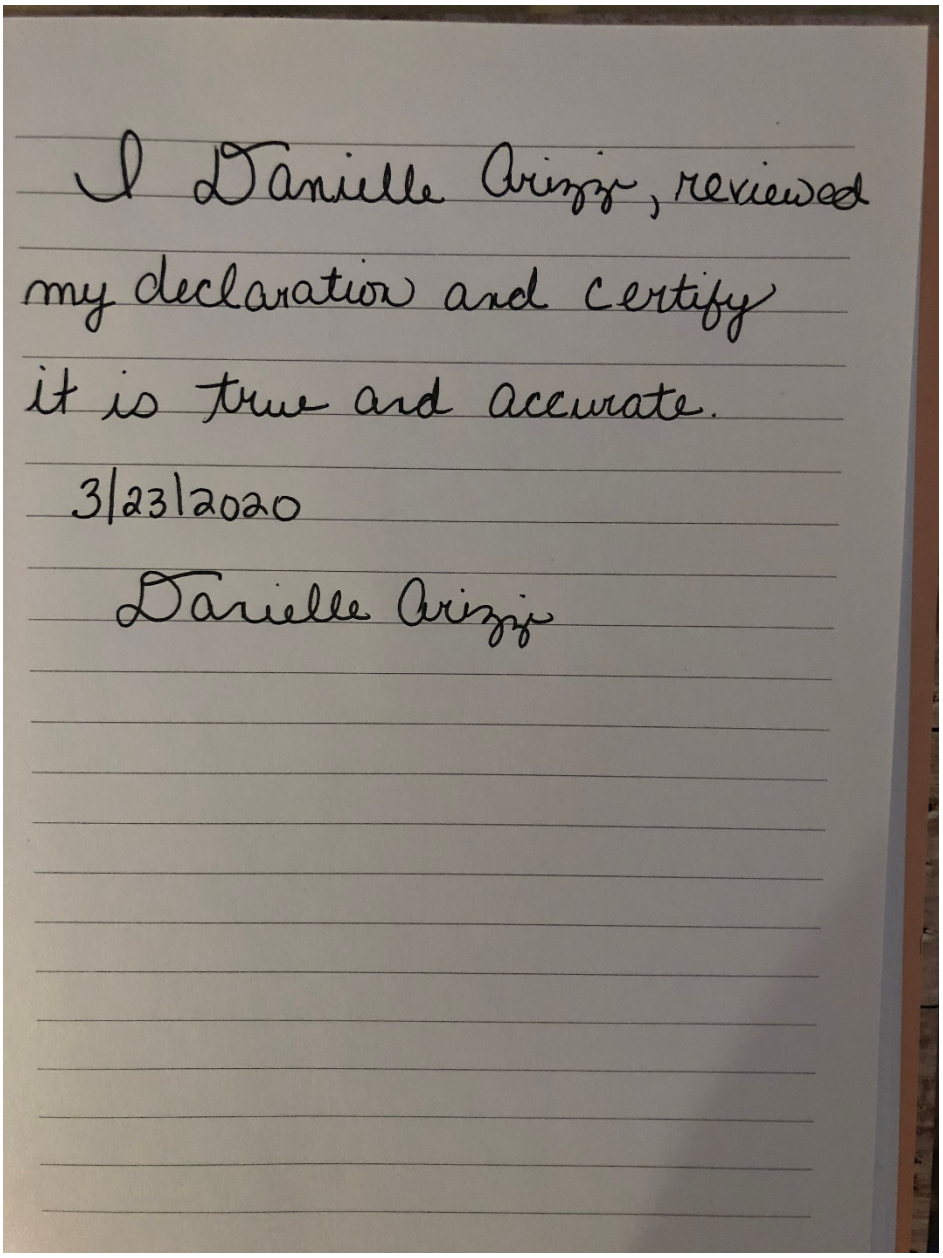
6. I keep calling the ICE officer assigned to Courtney's case but he just tells me I have to wait. When I asked him about the coronavirus and said Courtney is very vulnerable he said they have his medical records so they know. I asked him what they were doing about it, like what precautions they were taking and he told me he did not know he was not a doctor. He told me to call the jail. So I did. But no one has answered me.

7. On March 16, 2020, I emailed Governor Wolf and asked him to please help my fiancé. I did not hear back so I emailed him again on March 19. Someone from his office emailed me back that the issue is managed by the federal government.

They told me to contact my Senators – Pat Toomey and Bob Casey. I sent them emails through their webpages on March 19. I have not heard back.

8. On March 18, called prison – and wanted to know and what was going on given the corona virus. They did not give me any specifics or answer my questions. So I wrote to the Assistant Warden, Jonathan J. Romance, the next day (March 19). I asked him whether they had plans to release any of the elderly detainees or those with health issues. He has not responded to me.

9. I am afraid my son will grow up without his father because he will die if he continues to be detained. Courtney is very vulnerable to the corona virus and I am very worried I can barely sleep.



I Danielle Arizzi, reviewed my declaration and certify it is true and accurate.

3/23/2020

Danielle Arizzi

Exhibit 7

Declaration of Rigoberto Gomez Hernandez

1. My name is Rigoberto Gomez Hernandez. I am 52-years-old and from Mexico. I have two U.S. citizen children (daughter, age 6, son age 11). I am also married. My older brother is a lawful permanent resident. I have lived in the United States continuously since 2005.

2. I have been detained by ICE since September 2019. ICE detained me after a criminal contact.

3. I understand that I am at high risk if I am exposed to COVID-19 because of my health issues.

4. I have diabetes and take medication for an ulcer, which has been operated on twice (before I was detained). I also have some dental problems—two of my crowns need to be fixed. But it is expensive so they said they cannot do it. They give me Tylenol for the pain.

5. For my diabetes I am not quite sure what is going on. I know I was told I had diabetes before I was detained at a community health center. Since I've been detained I have had two blood draws for some tests, but I do not know the results. The last test was a month ago. They do not talk to me about the results, I am not sure why. The doctor does not speak Spanish so communication can be little hard.

6. I hear you are supposed to maintain space between people, like six feet. It is impossible for me to do that. There are 48 of us in the block and not a lot of space.

7. I am worried about the coronavirus and what could happen to me.

I, Vanessa L. Stine, certify that I reviewed this declaration with Rigoberto Gomez Hernandez by reading it to him in Spanish by telephone on March 23, 2020 and that he certified that the declaration was true and correct to the best of knowledge.

/s/ Vanessa L. Stine

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Exhibit 8

Declaration of Rodolfo Agustín Juarez Juarez

1. My name is Rodolfo Agustín Juarez Juarez. I am from El Salvador and I am 21 years old.

2. I submit this declaration in support of a multi-plaintiff petition for a writ of habeas corpus in federal court based on risks that I and others face because of COVID-19.

3. I arrived in the United States four years ago from El Salvador. I have been detained in York County Prison since February 26, 2020.

4. I fled El Salvador with my mother when I was 16-years-old. I have filed an asylum application, which remains pending before the immigration court.

5. I was diagnosed with diabetes seven years ago and was taking medication for it prior to my detention.

6. For the past few weeks I have been suffering with a fever, throat pain, a persistent cough and have trouble breathing. I have also had nose bleeds.

7. I have been taking prescribed medicine for my fever but the medication has not helped with my symptoms and my troubled breathing bothers me a lot.

8. When I request medical attention I have to submit a ticket and usually am not seen until a day or two later. Sometimes longer.

9. I have observed other detainees not receive medical attention right away. One time there was another inmate who was vomiting and he was still required to submit a medical request. He was seen by medical staff the next day but he spent all night vomiting.

10. Because of my diabetes, I understand that I am at a high risk should I contract COVID-19.

11. I am very concerned about my health but I don't think that the staff here are able to respond properly. Even though I have trouble breathing, I cannot be tested for COVID-19 because they do not have tests available at York County Prison.

12. I sleep on the top bunk with an air vent directly above me. The cold air from the vent worsens my condition. I have requested a bottom bunk but was told that only people who have had back surgery can get a bottom bunk.

13. I am in a block with 56 people and we are all held in one large area. Our beds are not far apart and if someone sneezes or coughs, the whole block can hear it.

14. It is physically impossible for us to stay six feet apart from other people at the facility. There are too many of us in one space, even if I tried to keep my distance, it is just not possible. For instance, while eating, we all sit on small tables, with four people on each table. We are probably only one or two feet apart from each other.

15. Any efforts to make the facility more sanitary are made by us detainees. We all drink from two water fountains that are not cleaned often. If they are ever cleaned, it is done by us. We also share phones and tablets, which we try our best to clean since we know a lot of people are using them. But there is only so much we can do on our own.

16. The only thing we've been told to do to protect ourselves from the virus is wash our hands but they do not provide soap to you unless you ask for it. We are not given hand sanitizer. Washing my hands is not enough to ensure my personal safety in detention when I am so close to so many other people all the time.

17. The people that work here do not have their temperature checked when they come in. They do not wear any gloves or masks. Even the medical staff do not always wear gloves or masks when they see us.

18. I am in the cleaning unit and clean the area once or twice a day but cleaning and sanitizing the area is not effective when so many people come in and out of our unit every day.

I, Muneeba S. Talukder, certify that I reviewed this declaration with Rodolfo Agustín Juarez Juarez over video on March 22, 2020 and that he certified that the declaration was true and correct to the best of his knowledge.

Dated: March 22, 2020

/s/ Muneeba S. Talukder

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Exhibit 9

Declaration of Meiling Lin

I, Meiling Lin, hereby declare

My name is Meiling Lin, I am from China. I am 45 years old. I submit this declaration in support of a multi-plaintiff petition for a writ of habeas corpus in federal court based on risks that I and others face because of COVID-19

1. I arrived in the United States March 29, 2019 from China. I was detained on arrival and have been detained in York Detention Center for a year now.

2. I fled China last year and filed for asylum and my case is under appeal at the Board of Immigration Appeals

3. My immigration attorney filed a request for my parole in January 2020.

4. I was diagnosed with chronic hepatitis B virus in 2006. My doctor in China told me my condition was serious and advised me to take medication for it. I also have liver disease.

5. I was forcibly sterilized in China and suffer from severe chronic pain as well as other medical complications as a result of that surgery. I often wake up at night from the severe cramping and pain in my stomach and uterus. It feels like pins and needles. I also experience irregular menstruation because of that surgery.

6. My left leg has a lot of pain and it is hard for me to sit down and get up.

7. Recently I started experiencing a lot of chest pain as well but the doctor at York County Prison could not tell me why I was having that pain.

8. At my last doctor's visit, I was told that I need a colonoscopy and that I likely have liver damage but there has been no follow up and I do not know when I will be having the colonoscopy procedure done.

9. I have so many medical issues but I do not like going to the doctor. They put me in handcuffs and shackle my feet which leaves bruises on my legs and harms. It is very humiliating. I have done nothing wrong and I just wanted to leave from a country that did not give me freedom and forced me to have a surgery that has resulted in so many health problems for me.

10. I receive medication from the clinic at York County Prison for the severe pain I experience but the medication does not help me.

11. Because of my chronic hepatitis B, liver disease, and my chronic pain, I understand that I am at a high risk should I contract COVID-19.

12. I am worried about my health and York County Prison has not done anything differently to address the threat of COVID-19 spread.

13. I am in a block with around 50 people and. Our beds are about 3-4 feet apart. I cannot stay 6 feet away from my fellow block mates because there is simply not enough space for us to do this.

14. We all sit together when we eat and are given food in trays that are open and exposed to the air that we are all sharing.

15. We all share three phones and eleven tablets among 50 people. This is not sanitary. I try to clean the phones and tablets before I use them but they are not being cleaned otherwise.

16. We also share a total of six toilets and six showers. I know that the bathrooms and showers are cleaned but since 50 people are using them, they get dirty quickly. I feel afraid to use the bathrooms but I have no other choice.

17. The staff at York County Prison sometimes give announcements but there is no interpretation of these announcements and I can only speak and understand Mandarin so I don't know what they are saying. If they are giving advice on how to prevent the spread of COVID-19 I do not know what it is. There isn't even anyone here who can translate for me.

18. The staff are leaving and coming into the facility every day and I am afraid that they could be bringing in COVID-19.

19. If released, I would live with my daughter who has lawful permanent status and is in California.

I, Muneeba S. Talukder, certify that I reviewed this declaration with Meiling Lin over video on March 22, 2020. I also certify that I used professional interpretation service

for Mandarin in order to read the declaration to Meiling Lin in English and that she certified that the declaration was true and correct to the best of her knowledge.

Dated: March 22, 2020

/s/ Muneeba S. Talukder

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Exhibit 10

DECLARATION OF HENRY PRATT

1. My name is Henry Pratt. I am 50-years-old and from Liberia. I have been in ICE detention for three years. I am a lawful permanent resident. I fled in 1990 during the Liberian civil war and ended up in the United States, where I won asylum.

2. I ended up in immigration proceedings after I was convicted of fraud, forgery, and theft. I am still fighting my removal case. I initially sought cancellation of removal along with asylum and withholding of removal. I continue to fight my case. I represent myself.

3. I have diabetes and high blood pressure. I am worried because I am high risk if I get COVID-19.

4. I take medication for diabetes and high blood pressure. Right now, I take Metformin in the AM and PM, 1000 mg each time. But I have had issues with getting my medication. My stomach would get upset in the morning if I took my medication and sometimes I would vomit. So my sister talked to the medical department for me and helped explain this. But then the medical department staff changed. And the nurse who took over my medication starting giving it to me in the morning. I told her I could not take it in morning because I would vomit and needed it around 11 or 12. She just stopped giving me my medication, which is not what I was asking for.

5. Without my medication, my sugar got really low and I fell down. A CO saw and he called for help. I had blood in my urine. That is when the Warden, Associate Warden and Captain stepped in. I told them what was going on with my medication and they looked at my records and I guess saw I had not taken my medication for over a month, so they worked out a plan to get me my medication at 11 or 12 so it would be effective and not upset my stomach.

6. We heard all about the need to be doing social isolation but that is impossible in here with 72 guys in my dorm. We are usually not even two feet apart. I mean, I can reach out and touch the guy next to me in the next bunk. One time a guy asked me if I was trying to get something from his bunk because he felt my hand and I just laughed and told him no, I was sleeping. That is how close we are.

7. The dorm layout is as follows. When you walk in it is the day space. Then there is the little divider wall that is knee height. Then it is our beds. There are rows of bunk beds, I think 6 rows, with 5 bunks in each row. Then there is a divider (knee height) and some more rows, 7 rows, with 5 bunks in each row.

8. And the tables where our day space is no better in giving us space. There are not even enough tables and chairs for the guys. So some guys eat in their beds and other guys put food on their lap and sit in some other chairs that are around.

9. It is hard to have good hygiene around here not because we do not try but because of the conditions. The bathrooms are run down. There are four sinks and four showers for 72 guys. There is soap for us, but with so many guys, I do not know how clean they can really keep it. We clean it ourselves but again, not sure we are really keeping it sanitized. We try our best.

10. We also see bugs sometimes in the bathroom, along with mice or rats in the drainage and in between some spaces on the wall where the water pipe is at. I sometimes see rats or mice too in the florescent lighting – it is long, about 10 big lights in a row above the day space. I can see them running sometimes through the lights. I do not think that helps with sanitation.

11. We also have issues with keeping our clothes clean because the washer keeps breaking. This has been going on since October. Sometimes you put your clothes in and there is just a bunch of water that spills out. Then they have to fix it, it takes hours. So the issue is that we only get two sets of clothes—2 jumpsuits, 2 t-shirts, 2 boxers. So if you sweat one day and change clothes to your spare outfit, you have to wash the next day. But sometimes we can't, so we try to wash our clothes in the bathroom which does not work that well.

12. I feel that Clinton County Correctional Facility does not want to address the situation about COVID-19. I asked the COs about it and they told me no one was being tested because they do not have the test at the facility.

13. I was also able to find out from a CO that they are not screening newly arriving detainees for COVID-19. I understand this to mean they are not testing anyone.

14. COs have also come in sick recently. This one CO he was sneezing and joking that he had the virus. I have not seen him for four to six days. There is also a rumor going around that the Deputy Warden has the virus. He has been out for two weeks.

15. Just last week they brought four new guys to our block. I asked them were you asked about the coronavirus, like whether you had contact with anyone. I also asked if they were tested. They said no.

16. I am worried about what will happen to me and others given my health issues if the virus comes to Clinton.

I, Vanessa L. Stine, certify that I reviewed this declaration with Mr. Pratt by telephone on March 23, 2020 and that he certified that the declaration was true and correct to the best of his knowledge.

/s/ Vanessa L. Stine

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Exhibit 11

Declaration of Jean Herdy Christy Augustin

1. My name is Jean Herdy Christy Augustin and I am 34 years old. I submit this declaration in support of a multi-plaintiff petition for a writ of habeas corpus in federal court based on risks that I and others face because of COVID-19

2. I have lived in the United States for 18 years and arrived here from Haiti when I was only 15 years old in the Summer of 2002. I have been detained in York County Prison since June 12, 2018.

3. I am seeking relief under the Convention Against Torture (CAT). My case is currently at the Third Circuit Court of Appeals.

4. I was diagnosed with diabetes within five months of being detained. I was not diabetic before I was detained and I believe my diabetes is directly related to the unhealthy food that we are given here. The food that I am given at York County Prison does not sit well with me and has caused digestive issues and affected my health in a number of ways.

5. I have high blood pressure which has been worsening in the last few days as a result of the stress and fear I have of contracting COVID-19.

6. I also suffer from many medical issues because I was shot five years ago in the groin area. As a result, I had to undergo bladder and intestine reconstruction surgery. The bullet fragments are still lodged in my body close to my spine. Because of this injury, I have limited mobility and also experience severe cramping and pain.

7. I also have nerve pain in my right hand.

8. I have a dangerously low hemoglobin level, it has gone as low as 8.5g/dL, and I am chronically anemic. I take iron pills and there have been times where I am unable to stand because of how lightheaded I feel.

9. In addition to all my physical health issues, I am diagnosed with PTSD, mild psychosis, anxiety, and major depressive order.

10. Since being detained I have experienced multiple medical emergencies and have been hospitalized four to five times. In December 2019 I also had an endoscopy and colonoscopy done to locate the source of internal bleeding that I had but the doctors were unable to figure it out. The doctors told me that the next step was a CAT scan but it has been three months and I have not had the scan done.

11. It was only after I had to be hospitalized a few times that York County Prison realized how serious my medical issues were and allowed me to be taken to doctors outside of the facility.

12. There are medical requests that I made that York County Prison has taken several days to address. I filed grievances complaining about how long it takes for my medical requests to be addressed.

13. I receive medication from the clinic to treat various medical issues. I take medication for diabetes, blood pressure, nerve medication and several other medical issues. I take enough medications that I have lost track what they are for. Because of my several health conditions, I understand that I am at a high risk should I contract COVID-19.

14. I am very fearful that the lack of care at York County Prison will have dire consequences for me. There are no special precautions that are being taken by staff here. No one, not even medical staff wear gloves. One of the medical staff members told me that they do not have access to hand sanitizer. There is an attitude of carelessness amongst staff. I have overheard correctional officers say that they "hope that we get corona, so we can get it over with." They are keeping everyone in the dark and not telling us about any risk of COVID-19 coming into the prison.

15. The prison staff are going home and coming to work every day so there is a great risk even if one of them is carrying COVID-19. I also work in admissions 7 days a week, where we have to process up to 15 people a day. This means that every day I have direct contact with detainees and inmates who have to be processed through admissions. Physical contact with these people is necessary since my job is to hand off clothes, sheets and blankets, as well as other items to new detainees and inmates.

16. In addition to people coming from everywhere, we are housed very close together. I am in block B4 and there are around 54 people in my block in one open area. There is just one wall separating the dining and sleeping areas. We sleep in bunkbeds that are about three feet apart—two people cannot stand in the area between the beds at the same time. Needless to say, I am not able to maintain the recommended six feet distance from the people around me.

17. During the three meal times a day, we are herded in one large group, all 54 of us towards the dining area. There, we sit on small tables of four, with not a lot of space between us. The tables are also close together, maybe three feet apart. It is hard to move around the tables. Our food is given to us on open trays.

18. One of my friends in my block had the job of serving food to and cleaning up after someone who was being quarantined and separated from other inmates. Even though that block was being quarantined and that person was being separated, my friend had to interact with him and then come back to our block. I do not understand the point of quarantining someone and then having people from other blocks have contact with that person. This is not safe.

19. We also share hallways with all the blocks. So if we need to go to a medical office, counselor's office, other social areas, we necessarily interact with people from other blocks as we're passing them. Last week I was walking down the hallway and passed by people from the quarantined blocks who were all wearing masks.

20. We have two bathrooms, with six toilets and six showers in total. 54 people share these bathrooms. They are only cleaned 4 times a day which is just not enough since 54 of us are using these bathrooms. No amount of regular cleaning would prevent the spread of something like COVID-19 here.

21. They told us to wash our hands but there are so many people coming in and out that I know this is not enough. We don't have hand sanitizers or any other kind of alcohol disinfectant.

22. There are so many health issues that I have that put me at a high risk if I am around sick individuals. If I am kept in York County Prison, I know that there is a high chance that I will get COVID-19. And because of my health issues the outcome might not be too good for me.

I, Muneeba S. Talukder, certify that I reviewed this declaration with Jean Herdy Christy Augustin over video on March 23, 2020 and that he certified that the declaration was true and correct to the best of his knowledge.

Dated: March 23, 2020

/s/ Muneeba S. Talukder

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Exhibit 12

Declaration of Mayowa Abayomi Oyediran

1. My name is Mayowa Abayomi Oyediran and I am 40 years old. I submit this declaration in support of a multi-plaintiff petition for a writ of habeas corpus in federal court based on risks that I and others face because of COVID-19.

2. I am originally from Nigeria but was living in France for five years. My wife and our three beautiful children are still in France. I miss them very much.

3. But I had to flee for my life. I was trying to get to Canada to seek asylum. I had a layover in the United States on November 7, 2019 and was detained at the airport. I have been detained since then. I just had my asylum hearing on March 10. I am waiting to hear back from the judge. I pray that I am granted protection.

4. I have had severe asthma since I was born. My asthma condition has been made much worse since being detained. York County Prison is cold, dirty, and crowded. These are all conditions that make asthma worse.

5. I have used an inhaler since as far as I can remember. I requested an inhaler but the prison has not provided me with one yet and it has been weeks. I told the medical unit here that I am having so much trouble breathing that I cannot sleep so instead of giving me an inhaler, they gave me sleeping pills. This is absolutely ridiculous. I often wake up at night wheezing because of my asthma. My wheezing is so loud that it wakes up all those sleeping around me.

6. I have made so many medical requests but they are all ignored. They do not make any effort and do not reply to my requests.

7. Before I left France my doctor there told me that I have a lung infection. I told the medical unit here about the infection and that I have chest pain and they did an x-ray scan on me two weeks ago but I have not heard back about the results. I need to be taking medication for this infection but nothing has been given to me here in the prison.

8. I also have a history of high blood pressure and high cholesterol.

9. I already have a breathing problem and am terrified of the possibility of contracting COVID-19 since I know it impacts your lungs and can make breathing even more difficult. Getting COVID-19 could be deathly for me.

10. I am also afraid because I am surrounded by so many people at York County Prison. There are 60 people in my block with new people coming in every day. We are all packed together in one room, breathing the same air, using the same bathrooms, and eating right next to each other. Even though I try, it is impossible to avoid physical interaction.

11. Beds are crowded right next to each other. There are 60 people in one room, I am number 20 and I am right in the middle. I feel suffocated by the amount of people.

12. A week ago they did a temperature check in my block, MA, and six people had high temperatures. They moved everyone but the sick people out of MA block. Now I am in IC2 block and they have already moved some people out of this block because they were sick. It is so confusing and I am not sure how moving the sick people out will help--there are people who slept close to the sick people and they are still here. There are people getting sick every day.

13. They do not have COVID-19 tests here. Nobody has been tested even though people are sick.

14. I am so worried. I made a long journey to save my life but now I am stuck in a jail. I cannot sleep, I cannot breathe, and I feel like I am going to die. Nobody here can even get me an inhaler, how will they help save us from this virus. They can't and they won't.

I, Muneeba S. Talukder, certify that I reviewed this declaration with Mayowa Abayomi Oyediran over video on March 23, 2020 and that he certified that the declaration was true and correct to the best of his knowledge.

Dated: March 23, 2020

/s/ Muneeba S. Talukder

Muneeba S. Talukder
AMERICAN CIVIL LIBERTIES UNION OF PENNSYLVANIA
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Exhibit 13

DECLARATION OF AGUS PRAJOGA

I, Agus Prajoga, hereby declare:

My name is Agus Prajoga, I am from Indonesia. I am 48 years old. I submit this declaration in support of a multi-plaintiff petition for a writ of habeas corpus in federal court based on risks that I and others face because of COVID-19

Detention in Pike County Correctional Facility

1. I arrived in the United States on January 13, 2001. I have been detained in Pike County Correctional Facility since January 13, 2020.

2. I currently have a Motion to Reopen pending based on changed country conditions regarding the treatment of Christians in Indonesia. I am a Christian and I fear returning to Indonesia.

Medical Issues

3. I was diagnosed with Type 2 diabetes in 2017. I was also diagnosed with high cholesterol/blood pressure and Hepatitis B at the same time.

4. I take medicine every day for these conditions – I currently take 3 pills in the morning, I take 2 pills in the early evening around 4pm, and I take 1 pill in the evening. I took more medications when I was not detained, I don't know why I take less now.

5. Because of my diabetes, high blood pressure, and Hepatitis B, I understand that I am at a high risk should I contract COVID-19.

Detention facility conditions

6. I am very concerned about my healthcare here in Pike County Correctional Facility, because there are not sufficient precautions in place to protect us from sick guards or other sick detainees. There is no consideration of my health issues and the fact that I am at high risk if I am around sick individuals.

7. All they are doing is more cleaning – but that is it.

8. We are housed very close together with people coming from everywhere. We are held in blocks of around 50 – I think right now there are 48 people on my block. Detainees are constantly moving around, and you are exposed to many different people all the time. We are not able to maintain the recommended separation of six feet apart from other people at the facility. At any given time, I am very close to someone, certainly with in 2 feet. Even when I sleep I am 2 or 3 feet from someone.

CC

9. It is very difficult to maintain good hygiene here when we are not provided with adequate instructions around how to prevent spread of the virus. In fact, a few days ago they put up a sign on what we can do to prevent the spread of COVID-19 but they took it down that same day, I don't know why. I have been told that I should wash my hands more, but it is not enough to ensure my personal safety in detention when I am so close to so many other people all the time. We are not given hand sanitizer and have to buy soap – there is no soap dispenser at the sinks, we have to bring our own if we want to wash our hands.

I, Christopher M. Casazza, certify that I have read the foregoing Agus Prajoga and that he affirmed that the foregoing is true and correct. At the time I reviewed the foregoing declaration with Agus Prajoga, the Pike County Correctional Facility by phone.

Date 03/23/2020

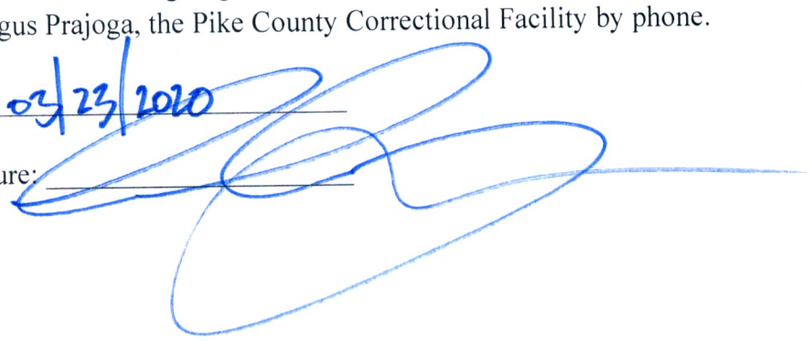
Signature: 

Exhibit 14

DECLARATION OF MANSYUR

I, Mansyur, hereby declare:

My name is Mansyur, I am from Indonesia. I am 41 years old. I submit this declaration in support of a multi-plaintiff petition for a writ of habeas corpus in federal court based on risks that I and others face because of COVID-19

Detention in Pike County Correctional Facility

1. I arrived in the United States on October 17, 1998. I have been detained in Pike County Correctional Facility since December 17, 2019.

2. I currently have a Motion to Reopen pending based on changed country conditions regarding the treatment of religious minorities in Indonesia. The Board of Immigration Appeals has granted my Emergency Stay of Removal.

Medical Issues

3. I was diagnosed with Type 2 diabetes, thyroid issues, and high blood pressure in December 2019. Actually, when I got detained, they did a medical exam and blood test and found that I had diabetes.

4. They were giving me insulin 4 times per day, but it made me feel awful so now they give me a pill in the morning and in the evening.

5. Because of my diabetes and high blood pressure I understand that I am at a high risk should I contract COVID-19.

Detention facility conditions

6. I am very concerned about my healthcare here in Pike County Correctional Facility, because there are not sufficient precautions in place to protect us from sick guards or other sick detainees. There is no consideration of my health issues and the fact that I am at high risk if I am around sick individuals. Nobody is wearing gloves or masks. Sometimes when the nurse here treats me, she doesn't even wear gloves. This has happened about 3 times.

7. All they are doing is more cleaning – but that is it. I heard that two people in C-Block are sick and have high fevers. They wipe the phones when we are done using them, but not much more than that.

8. We used to get information on COVID-19 on the news, but about 10 days ago they stopped putting the news on and we can only watch Netflix now.

CC

9. We are housed very close together with people coming from everywhere. Right now there are 48 people on my block, which is H-Block. Detainees are constantly moving around, and you are exposed to many different people all the time. We are not able to maintain the recommended separation of 6 feet apart from other people at the facility. I am always very close to other inmates, within 2 or 3 feet. A lot of people are coughing.

10. Nobody has told me how to protect myself or others from COVID-19. When we eat, we sit at 1 table with 6 people and we are side- by-side – should-to-shoulder. We are not given hand sanitizer and we have to buy soap – there is no soap dispenser at the sinks, we have to bring our own if we want to wash our hands.

I, Christopher M. Casazza, certify that I have read the foregoing Mansyur and that he affirmed that the foregoing is true and correct. At the time I reviewed the foregoing declaration with Mansyur, the Pike County Correctional Facility by phone.

Date 03/23/2020

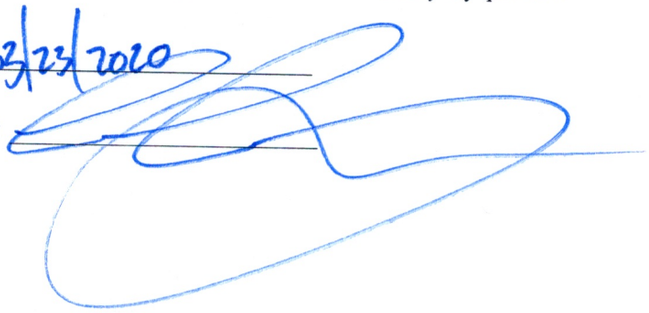
Signature: 

Exhibit 15

Declaration of Catalino Domingo Gomez Lopez

1. My name is Catalino Domingo Gomez Lopez. I am a 51-year-old man from Guatemala. My first language is Mam. My second language is Spanish. I am seeking immigration relief under the Convention against Torture (CAT). I have four children and I am married.

2. I have lived in United States since 2004. In Guatemala, I was a farmworker. In the United States, I have worked in landscaping—helping to plant trees, flowers, mow grass.

3. I have been detained by ICE since November 2018. I am at York County Prison in MD block. There are sixty guys in my dormitory.

4. I understand that I have a higher risk if I am exposed to COVID-19 because I am older.

5. My health has not been good since I've been detained. I have had the flu four times. This most recent time was bad. I was sick for a month. I had a fever and a bad cough. My cough got so bad I coughed some blood. My throat really hurt.

6. I also had an issue where my skin was really dry and my hair was falling out. They gave me a cream. I am not sure what it was but it really bothered me.

7. For medical appointments there is usually a waiting time. For example if I put in a request today, I would be seen in four to five days. It was the same when I had the flu. It was four days until I was called. My throat was so sore it was raw.

8. Our sleeping arrangement is bunk beds. I have the top bunk, which I don't like because it is drafty and I feel like I can't breathe as well. The beds are arranged in two long rows.

9. There is a divider wall that goes up about 11 or 12 concrete blocks. Behind it is our day room.

10. The showers are three on each side. There are two bathrooms in our block too. There are three sinks per bathroom.

11. Where we sit to eat has tables that seat four, close to one another, like almost touching.

12. I have not seen the staff take precautions like wearing masks or gloves.

13. I am worried about the coronavirus and what could happen to me.

I, Vanessa L. Stine, certify that I reviewed this declaration with Mr. Gomez Lopez by reading it to him in Spanish by video on March 23, 2020 and that he certified that the declaration was true and correct to the best of his knowledge.

/s/ Vanessa L. Stine

Vanessa L. Stine (PA 319569)
American Civil Liberties Union Of Pennsylvania
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vstine@aclupa.org

Exhibit 16

DECLARATION OF DEXTER ANTHONY HILLOCKS

I, Dexter Anthony Hillocks, hereby declare:

1. My name is Dexter Anthony Hillocks, and I am from Trinidad & Tobago. I am 54 years old. I submit this declaration in support of a multi-plaintiff petition for a writ of habeas corpus in federal court based on risks that I and others face because of COVID-19.

Detention at the Pike County Correctional Facility

2. I arrived in the United States in 2000 from Trinidad & Tobago. I am a legal permanent resident. I have been detained at the Pike County Correctional Facility since 2015.

3. On December 12, 2016, the Immigration Court issued an order of removal based on my 2015 Pennsylvania state court conviction for criminal use of a communication facility under 18 Pa.C.S. § 7512. On June 7, 2017, the Board of Immigration Appeals affirmed that order of removal. However, on August 12, 2019, the U.S. Court of Appeals reversed and vacated the order of removal. *See Hillocks v. Attorney Gen. United States*, 934 F.3d 332 (3d Cir. 2019).

4. Despite the Third Circuit's reversal, I have not yet been released from the Pike County Correctional Facility. On September 16, 2019, the Immigration Court ordered that I be released from custody under a bond of $18,000, which I have been unable to pay. A motion to terminate my immigration proceedings and for full release from custody is currently pending in the Board of Immigration Appeals, where my "A number" is 047-365-390.

Medical Issues

5. I have suffered from diabetes since 2004. As a result, staff provide me with insulin four times per day. In addition, for years, I have taken daily medication for high blood pressure and cholesterol.

6. Approximately seven months ago, a nurse at the Pike County Correctional Facility informed me that I have leukemia. However, I have been unable to learn the full extent of this diagnosis.

7. Approximately three months ago, I was diagnosed with anemia.

8. For all of these medical conditions, staff provide me with multiple pills to take on a daily basis.

9. Because of my medical conditions, I understand that I am at a high risk should I contract COVID-19.

Detention Facility Conditions

10. I am very concerned about my healthcare at the Pike County Correctional Facility, because there are not sufficient precautions in place to protect us from sick guards or other sick detainees.

11. At the Pike County Correctional Facility, there are around 50 people in the block in which I am detained. I am exposed to many different people all the time. I am unable to maintain the recommended separation of six feet apart from other people at the facility.

I, M. Patrick Yingling of Reed Smith LLP, attorney for Dexter Anthony Hillocks in his immigration proceedings, certify that I reviewed the foregoing with Mr. Hillocks via phone. Mr. Hillocks affirmed that the foregoing is true and correct.

Dated: March 23, 2020

/s/ *M. Patrick Yingling*

M. Patrick Yingling
REED SMITH LLP
10 S. Wacker Dr., 40th Fl.
Chicago, IL 60606
Tel: (312) 207-2834
mpyingling@reedsmith.com

Exhibit 17

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).

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

[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.

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.

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
EB8EA50B1F4D48A...

Andrew Lorenzen-Strait

EXHIBIT A

ANDREW R. LORENZEN-STRAIT

3491 Constellation Drive • Davidsonville, MD 21035 • (202) 431-4761 • alorenzenstrait@gmail.com

SUMMARY OF SKILLS

A dedicated advocate who is passionate about transforming communities with a mission-driven organization who seeks to better the lives of marginalized populations. An advanced degree holder, Juris Doctorate, specialized in child advocacy. Currently responsible for the strategic management and leadership of the Children and Family Services department within the Lutheran Immigration and Refugee Service. Formerly the Deputy Assistant Director for U.S. Immigration and Customs Enforcement, entrusted to deliver health and welfare programs and services for detained migrants, including families and children, in Federal immigration detention. Dynamic and accomplished individual with over a decade of professional experience in leading teams to create, coordinate, and implement innovative custody policies and programs that promote the safety and welfare of families, and other vulnerable populations. Demonstrated experience leading and managing large and diverse organization focused on high priority initiatives for improving organizational outcomes that have a direct interest in affecting educational programs for those in care and custody of the U.S. government. Principled and effective communicator with the ability to engage, motivate, and build cooperative relationships between government actors and a wide array of stakeholders. A proven and resilient leader with strong analytical to absorb and integrate large amounts of information and quickly identify solutions and remedies to over-come obstacles. A proud volunteer Maryland Court-Appointed Special Advocate for youth in the state's dependency system.

KEY PROFESSIONAL EXPERIENCE

Lutheran Immigration and Refugee Service (LIRS)
Director – Children and Family Services **June 2019 to Present**

- Managed the day-to-day operations and provided strategic leadership to the Children and Family Services LIRS programs department.
- Responsible for the for the implementation and oversight of programs with over 100 partners in 39 states across the country who provide child welfare services to refugee and migrant children who are unaccompanied or separated from family.
- Create and manage a multi-million-dollar budget for the department.
- Responsible for LIRS' for transitional and long-term foster care and family reunification programs and services, inclusive of the Unaccompanied Refugee Minor or URM program.
- Hire, train, and develop staff to fulfill the functions of the department including evaluation, training, technical assistance, program management, and coordination.
- Devise and oversee strategic and performance-based work plans for team members. Mentor and manage performance as necessary.
- Secure and maintain a diverse array of funding for the department by assisting with identification of funding sources, writing grants, and reporting.
- Service as the primary LIRS subject matter expert in Children and Family Services and represent LIRS internally and externally.

U.S. Immigration and Customs Enforcement (ICE), Office of Enforcement and Removal Operations (ERO)
Deputy Assistant Director for Custody Programs (GS-15) **April 2013 to May 2019**

- Direct operational oversight over innovated programs in areas that promote the health, safety, and welfare of vulnerable populations, including youth and families. These operational programs include, but are not limited to; mental health care; parental interests; religious accommodation; sexual assault and abuse prevention and intervention; lesbian, gay, bi-sexual, transgender, and intersex (LGBTI) care; language access; and family case management. Formal coordinator of care between detained parents and children in the care of Health and Human Services.
- Responsible for supporting and strengthening ERO's immigration custody operations by providing objective policy and program development, analysis, and monitoring that seek to improve detention and effectively integrate the agency's detention reform goals.
- Created and managed a new operational division within ICE ERO, the Custody Programs Division. The Custody Programs Division (CPD) creates and coordinates innovative policies and programs that promote the safety and welfare of those encountering the agency's immigration enforcement activities while ensuring effective adherence to the ERO mission. Responsible for the creation and management of CPD's two organizational units, both of which seek to continuously improve detention and effectively integrate ICE's detention reform goals.
- Develop and implement strategic systems and collect, analyze, and evaluate internal and external information to promote and improve compliance with ERO practices, processes, and standards.
- Effective management of over 100 individuals (federal employees, contractors, detailers, and interns). Lead the administrative and human resource management functions, to include budget formulation and execution functions, as well as ensuring staff

compliance with ERO's training requirements. Establish guidelines and performance expectations for employees, which are communicated through the formal employee performance management system, including performance work plans. Meet weekly with senior division leaders to assist them in achieving division goals and promote a workforce that values diversity, respect and professional development.

- Serve as the National ICE Parental Rights Coordinator. Oversee and evaluate implementation of immigration enforcement policies and practices as they apply to parents; particularly parents involved or at risk of becoming involved in the child welfare system. Responsible for the effective oversight of field level enforcement decisions and providing direction to ERO's 24 field offices on cases involving parents and primary caretakers.
- Maintain oversight of the use of segregation in ICE detention facilities (numbering over 250) to ensure compliance with law and policy (immigration detention standards).
- Responsible for the ERO prevention of sexual assault program in all ICE detention facilities. Promote adherence to the U.S. Department of Homeland Security (DHS) regulation titled, "Standards to Prevent, Detect, and Respond to Sexual Abuse and Assault in Confinement Facilities," 79 Fed. Reg. 13100 (Mar. 7, 2014), i.e. DHS Prison Rape Elimination Act (PREA) Standards.
- Manage the agency's Detention Reporting and Information Line (DRIL), a toll-free service that allows agency stakeholders to communicate directly with ERO to answer questions and resolve concerns.
- Serve as the ERO subject matter expert and Operations Coordinator for the care of LGBTI detainees.
- Principal liaison with civil society stakeholders, to include faith-based organizations, non-profit organizations, and quasi-governmental organizations.

Key Achievements

- Initiated and led a multi-year, multi-million-dollar new alternative to detention program for over 800 immigrant families, titled the ICE ERO Family Case Management Program (FCMP), which tests whether providing access to holistic community-based services for eligible families and juveniles released from ICE custody can serve to mitigate flight risk and promote compliance with immigration obligations.
- Pioneered an innovative working group that reviewed existing policies and best practices for the care and treatment of transgender individuals in confinement. Responsible for the drafting and implementation of the June 2015 *ERO Transgender Care Memorandum*. The Transgender Care Memorandum contains guidance in multiple areas of the ICE detention lifecycle to better serve transgender individuals. Serve as ERO's LGBTI Coordinator and lead a team, to include 24 field LGBTI liaisons, which effectively monitors the arrest, processing, and detention of transgender individuals in ICE custody.
- Led the agency in developing and issuing the *Use of Segregation for ICE Detainees* directive. This directive established new policy for field tracking and headquarters review of instances where ERO field office staff assigned an ICE detainee into segregated housing. Responsible for ensuring consistent and appropriate use of segregation, particularly for detainees with special vulnerabilities. In support of this endeavor, led ICE in the creation a SharePoint-based system, the Segregation Review Management System (SRMS), to input, track, review, comment on, and analyze segregation cases. The creation of the system resulted in significant quality improvements in work procedures that improved ERO operations and better ensures the safety, health, and welfare of detainees and ICE personnel.
- Created an ERO dedicated Sexual Abuse and Assault Prevention and Intervention (SAAPI) program from the ground up that demonstrates exceptionally outstanding contributions and dedication to the ICE/ERO mission. Responsible for issuing and providing effective oversight of *Sexual Abuse and Assault Prevention and Intervention*, an ICE directive. Led effective implementation of the directive by ensuring training and technical assistance to ERO officers in all 24 field offices and key facility first responders to better prevent, respond and report sexual abuse and assault. Led a team to create a SAAPI case management system to track the life cycle of all sexual abuse and assault allegations for the agency. Due to the comprehensive systems development and field training, ERO has seen a significant increase in the reporting of sexual abuse and assault allegations.
- Responsible for the expansion of the ERO legal access and educational initiatives. Led an agency-wide effort to facilitate meaningful access to legal and educational resources and representation for individuals for detainees held in ERO custody. This included increasing the availability of, and access to, self-help legal resources, including user-friendly enhancements to an electronic legal research system currently available to individuals detained in ERO custody. Responsible for facilitating expanded availability of, and access to, Know Your Rights presentations and various legal aid programs conducted through the United States Department of Justice, Executive Office for Immigration Review (EOIR), Office of Legal Access Programs (OLAP). Enhanced educational opportunities for adults and juveniles detained in Family Residential Centers.
- Created and manage the ICE national religious access program that ensures religious practice accommodations are provided to all those held in adult immigration facilities. Initiated national tracking of all religious accommodation complaints and inquiries from the Detention Reporting and Information Hotline (DRIL), Joint Intake Center (JIC), Office for Civil Rights and Civil Liberties (CRCL), and various external stakeholders. This tracking and subsequent analysis has allowed ICE to see trends across facilities, identify specific issues, and develop strategic responses. Developed an overview training deck on religious practice accommodation, which combines knowledge from the national survey, national standards, site visit assessments, current law, and trends in complaints. This training, which is continually updated, has been delivered to ICE oversight entities responsible for monitoring facilities. Pro-actively conducted outreach to and established relationships with several faith-based

organizations and subject matter experts in religious accommodation in prisons. Relationships with these key stakeholders enables ERO to quickly request and receive assistance, gather information pertaining specific religious obligations, and locate faith leaders who are able to assist with religious programming.

Public Advocate (GS-15) ~ ERO February 2012 to April 2013

- Served as the agency's first and only Public Advocate.
- Serve as a dedicated ICE point of contact for individuals, including those in immigration proceedings, NGOs, and other community and advocacy groups, who have concerns, questions, recommendations or important issues they would like to raise.
- Managed the Office of the Public Advocate which included Federal employees, contractors, and detailers. Performed the administrative and human resource management functions for the Office of the Public Advocate, to include: budget formulation and execution; establishing and maintaining employee work performance plans; employee time and attendance; and employee training.
- Assisted individuals and community stakeholders in resolving complaints and concerns with agency policies and operations, particularly those related to the use of ICE enforcement involving U.S. citizens.
- Proposed and facilitated changes and recommendations to fix community-identified problems and concerns.
- Alerted agency leadership to community stakeholder concerns with current or proposed agency policies and/or operations.
- Maintained a collaborative and transparent dialogue with community stakeholders on the agency's mission and core values.

Key Achievements

- Conducted a robust outreach campaign to inform stakeholders on ERO's values and mission that included hosting or coordinating over 100 engagement events bringing together agency stakeholders, field leadership and headquarters personnel to address community concerns, including:
  - 14 local stakeholder roundtables in cities throughout the country.
  - 5 White House Hispanic Community Action Summits.
  - 8 national NGO working/advisory group meetings.
  - 70 field outreach events.
- Responsible for the creation of ICE's DRIL telephone line (i.e. helpline). This is a toll-free service that provides a direct channel for agency stakeholders to communicate directly with ERO to answer questions and resolve concerns. Since it launched in September 2012, the DRIL has resolved more than 2,000 case assistance calls monthly on average.
- Established and continue to manage ERO's Custody Assistance and Inquiry Resolution System (ERO-CAIRS). ERO-CAIRS and the file sharing portions of this site are used to track, store, and manage the data and processes associated with over 600 calls received daily by ICE DRIL.
- Developed the first-ever comprehensive *Outreach Guide* for ERO's 24 dedicated outreach liaisons. It assists them in establishing relationships with local stakeholders, gathering information about community concerns and perspectives, and addressing those concerns in a more uniform and efficient manner.
- Developed a centralized database of NGOs, faith-based organizations and advocacy groups organized by issue areas and by area of responsibility. This database assists ICE/ERO in establishing a list of external stakeholders for each field office, and eases the burden of organizing public outreach and engagement events.

Senior Advisor for Custody (GS-15) ~ ERO September 2011 to February 2012

- Advised ICE/ERO senior leaders on detention: standards, compliance/inspections tools, and detainee classification procedures used in ICE detention facilities.
- Developed, coordinated, analyzed, and finalized detention operational policy directives and other policy-related documents in accordance with formal ICE processes and structures.
- Maintained an active and comprehensive understanding of ICE detention policy, procedures, rules and regulations.
- Possessed an advanced knowledge of civil immigration detention standards and compliance measures in order to effectively communicate to both ICE senior leaders and external stakeholders on detention facility operations and management.
- Served as a lead member on ICE's internal civil detention reform working groups.
- Served as a lead technical advisor on policies and procedures meant to improve the agency's detention compliance mechanisms.
- Provided ICE senior leadership with weekly reports and briefings on any tensions, issues, and/or crises involving the implementation of ICE initiatives with NGO and community stakeholders.

Key Achievements

- Partnered with a group of key senior ICE leaders to design a new automated risk-based custody intake process to ensure consistent nationwide decision making about who is detained, released, or granted bond, taking into account public safety and risk of flight factors. Ensured that this intake process took into consideration special vulnerabilities to include: disability,

advanced age, pregnancy, nursing, sole caretaking responsibilities, mental health issues, and whether the individual is a victim of torture, persecution, abuse or trafficking.
- Led the agency in developing a new set of detention standard that substantially improved conditions of confinement and ensured enhanced medical care, religious programming, recreation and visitation for over 400,000 individuals detained annually (i.e., Performance-Based National Standards of 2011).
- Launched an Online Detainee Locator System, translated into nine languages, which allows families, counsel and friends to locate detainees.

Chief Public Engagement Officer (GS-14) ~ Office of State, Local, and Tribal Coordination July 2010 to September 2011
- Managed the pubic engagement portfolio for the agency, as the team lead of 4 staff members.
- Maintained and enhanced senior-level partnerships with the division's stakeholder portfolio, which includes: non-governmental organizations (NGOs); quasi-governmental entities (e.g. United Nations High Commissioner for Refugees (UNHCR) and the Organization of American States (OAS)); faith-based organizations, members of academia, law practitioners and associations; the private sector; and the public.
- Promoted the division's engagement goals internally and externally in order to ensure: (1) greater operational efficiency; (2) improved credibility with the public; (3) early warning of potential issues and community concerns; and (4) better understanding of the community's needs.
- Coordinated the agency's engagement activities on immigration detention policies, procedures, rules and regulations.
- Attended and spoke at internal and external stakeholder trainings, national conferences, and seminars.
- Led special events or roundtable meetings on ICE priority issues.
- Managed the operation of field outreach activities (i.e., 287(g) steering committees, and regional community relations officers).

Awards and Accolades: Director's Meritouris Service Award ~ June 2011 *(Civil Detention Reform)*
Exceptional Performance Award ~ May 2011

Special Assistant (GS-14) ~ Office of Policy May 2009 to July 2010
- Served as the lead Policy Analyst/Advisor on policy issues pertaining to immigration enforcement.
- Maintained an active and comprehensive understanding of ICE policy, procedures, rules and regulations so as to communicate intelligently and informatively about issues of concerns to stakeholders.
- Advised and helped author ICE's Immigration Detention Standards, to include the National Detention Standards (NDS), Performance-Based National Detention Standards of 2008 (PBNDS 2008), and Family Residential Standards.
- Served as a lead member on one of ICE's civil detention reform working group and helped author the PBNDS 2010.
- Advised and assisted the ICE Policy Director on the office's budget development, analysis and execution, to include submitting cost estimates for new positions and authoring budget proposals for future office projects.
- Provided ICE senior leadership with weekly reports and briefings on any tensions, issues, and/or crises involving the implementation of ICE initiatives with NGO and community stakeholders.
- Represented the agency at intra-department and inter-agency community outreach meetings.
- Directed or conducted mediation and conciliation sessions with disputing parties, applying dispute resolution techniques when addressing civic, labor, education, religious, ethnic, racial, and other groups, businesses, or government entities.

Awards and Accolades: Assistant Secretary's International Achievement Award ~ June 2010 *(Authored agency's Revised Parole Policy Directive – issued December 2009)*
Assistant Secretary's ICE Core Value Award (*ICE Policy Manual*) ~ June 2010
Exceptional Performance Award ~ October 2008

Detention and Removal Policy Advisor (GS-14) ~ Office of Policy March 2008 to May 2009
- Served as the team lead Policy Analyst/Advisor on policy issues pertaining to immigration detention and removal laws, policies, programs and procedures.
- Advised the ICE Policy Director on detention standards, detention assessment/inspections tools, and detainee classification procedures in ICE detention facilities.
- Developed, coordinated, analyzed and finalized operational policy directives and other policy-related documents in accordance with formal ICE processes and structures.
- Evaluated ICE programs and procedures to improve enforcement and detention program effectiveness and efficiency.
- Strengthened ICE Office of Policy's Immigration Division by attaining and displaying comprehensive knowledge of: (1) the theories, practices and principles of U.S. Immigration Policy; and (2) the procedures, programs and functions of the agency and other DHS components especially as they impact detention and removal operations.
- Served as the Acting Outreach Coordinator from May 2008 to May 2009.

VOLUNTEER EXPERIENCE

County of Prince George's Maryland
Court-Appointed Special Advocate or CASA (Pro Bono) Oct. 2017 to Present

- Serve as a CASA for complex cases, to include medically fragile children and LGBTQ children.

State of Maryland
Family Law Attorney (Pro Bono) ~ Community Legal Services of Prince George's County Inc. June 2005 to June 2008

- Provided legal guidance and representation to clients in the areas of: adoption, family law, tort defense, and contracts.
- Drafted and negotiated complex settlement agreements for quick and equitable disposition of cases.
- Independently drafted complex legal memoranda, briefs, and court motions.
- Counseled *pro se* litigants on their legal rights and obligations and suggest appropriate course of action.

Awards and Accolades: 2007 Maryland Attorney of the Year for Pro Bono Service ~ June 2007

PREVIOUS PROFESSIONAL EXPERIENCE

United States Secret Service (USSS)

Senior Policy Advisor and Project Leader ~ Management and Organization Division Oct. 2006 to March 2008

- Served as Project Leader on Director's Action Group initiated program evaluations, recent evaluations to include the Secret Service Employment Program and the Office Inspection Program.
- Evaluated the policies, objectives and strategies of existing programs to improve program: 1) effectiveness (to include cost-effectiveness); 2) efficiency; 3) applicability to the policies contained within the agency's strategic plan; and 4) return on agency investment.
- Developed the U.S. Secret Service Strategic Plan (FY 08' – FY 12') and served as technical advisor on the agency's improvement of the office inspection and compliance process.

Awards and Accolades: Exceptional Performance Award ~ October 2007
"On the Spot" Performance Award ~ March 2007

PRESIDENTIAL MANAGEMENT FELLOWSHIP

Drug Enforcement Administration (DEA)

Policy Analyst ~ DEA - Office of the Chief of International Programs Sept. 2005 to Oct. 2006

- Managed and conducted internal evaluations to ensure integrity and effectiveness of agency international narcotics policies.
- Reviewed and reported on pending drug legislation affecting international operations.
- Performed comprehensive legal and policy analysis on counter-narcotics policies and operations worldwide, to include the tracking and review of germane international legal agreements.
- Developed and utilized complex methodologies to measure effectiveness of international enforcement programs.
- Assisted in the planning and development of the agency's foreign operations budget totaling more than $400 million.
- Formulated and revised personnel, infrastructure, and fiscal policy affecting DEA employees in 60 countries.

Presidential Management Fellow (PMF) ~ Office of International Programs Sept. 2004 to Sept. 2005

- Served as policy advisor for DEA's counter-narcotics initiative within Afghanistan.
- Reviewed and reported on foreign program activities in AOR for conformance with federal drug policy.
- Developed and authored regional drug strategy reports to conform to the National Drug Control Strategy.
- Examined Mutual Legal Assistance Treaties, Extradition Treaties, and germane international conventions for AOR.
- Authored briefings and position papers on AOR drug threat situation for incoming U.S. Ambassadors.

Congressional Liaison (PMF) ~ Office of Congressional Affairs Sept. 2003 to Feb. 2004

- Prepared testimony and written documents for Congressional hearing and other legislative matters with potential impact on the strategic priorities of DEA.
- Reviewed Freedom of Information Act requests and authored appropriate agency response.
- Represented agency priorities to members of Congress and staff in furtherance of DEA's objectives and mission.

Awards and Accolades: Exceptional Performance Awards ~ December 2005 and September 2006

United States Senate

Health and Social Policy Legislative Fellow/PMF ~ Senator Debbie Stabenow (D-MI) Feb. 2004 to Aug. 2004

- Drafted and monitored legislation, prepared briefings, and met with constituent/interest group representatives relating to various health & social policy areas, i.e.: education, TANF, Medicare/Medicaid, and prescription drug reform. Advised the Senator on Special Committee on Aging, areas included: Social Security reform, drug discount cards, issues concerning long

term care health insurance, and prescription drug abuse. Coordinated FY 2005 Health, Education and Labor Appropriation requests.

ADDITIONAL EXPERIENCE

Certified Law Clerk ~ United States Attorney's Office — May 2002 to July 2002
Judicial Clerk ~ Hon. Justice Bedsworth, California Court of Appeal — Jan. 2002 to April 2002
Law Clerk ~ Los Angeles District Attorney - Family Violence Division — May 2001 to Aug. 2001

PUBLIC SERVICE

Volunteer Park Ranger ~ National Park Service, Arlington House, Robert E. Lee Memorial — Oct. 2005 to Oct. 2012
Child Mentor ~ Northern Virginia Aids Ministry — Oct. 2003 to Jan. 2005
Volunteer Coordinator ~ National World War II Memorial — Oct. 2003 to May 2004
White House Intern ~ Office of the First Lady and the White House Millennium Council — Aug. 1998 to Jan. 1999

EDUCATION, TRAINING & CERTIFICATIONS

Juris Doctorate with Emphasis in Child Advocacy ~ Whittier Law School, *Top Tier Graduate* — May 2003
- Child Advocacy Fellow ~ Center for Children's Rights and Dean's List recipient 2001-2003

Bachelor of Arts ~ University of California at Irvine, *Cum Laude* — June 2000
Evaluation Training and Cost-Benefit and Cost-Effectiveness Analysis ~ The Evaluator's Institute — July 2007
Certificate, Legislative Studies ~ Georgetown University, Government Affairs Institute — May 2004
Certificate, Juvenile and Family Law ~ Whittier Law School — May 2003
Certificate, National Security Leadership and Decision-Making ~ U.S. National Defense University — September 2008

PROFESSIONAL LICENSES & MEMBERSHIPS

Licensed, Maryland State Bar
Member, Maryland State Bar Association and American Bar Association
Member, United States Supreme Court Bar

EXHIBIT B

Secretary
U.S. Department of Homeland Security
Washington, DC 20528

Homeland Security

November 20, 2014

MEMORANDUM FOR: Thomas S. Winkowski
Acting Director
U.S. Immigration and Customs Enforcement

R. Gil Kerlikowske
Commissioner
U.S. Customs and Border Protection

Leon Rodriguez
Director
U.S. Citizenship and Immigration Services

Alan D. Bersin
Acting Assistant Secretary for Policy

FROM: Jeh Charles Johnson
Secretary

SUBJECT: **Policies for the Apprehension, Detention and Removal of Undocumented Immigrants**

This memorandum reflects new policies for the apprehension, detention, and removal of aliens in this country. This memorandum should be considered Department-wide guidance, applicable to the activities of U.S. Immigration and Customs Enforcement (ICE), U.S. Customs and Border Protection (CBP), and U.S. Citizenship and Immigration Services (USCIS). This memorandum should inform enforcement and removal activity, detention decisions, budget requests and execution, and strategic planning.

In general, our enforcement and removal policies should continue to prioritize threats to national security, public safety, and border security. The intent of this new policy is to provide clearer and more effective guidance in the pursuit of those priorities. To promote public confidence in our enforcement activities, I am also directing herein greater transparency in the annual reporting of our removal statistics, to include data that tracks the priorities outlined below.

The Department of Homeland Security (DHS) and its immigration components-CBP, ICE, and USCIS-are responsible for enforcing the nation's immigration laws. Due to limited resources, DHS and its Components cannot respond to all immigration violations or remove all persons illegally in the United States. As is true of virtually every other law enforcement agency, DHS must exercise prosecutorial discretion in the enforcement of the law. And, in the exercise of that discretion, DHS can and should develop smart enforcement priorities, and ensure that use of its limited resources is devoted to the pursuit of those priorities. DHS's enforcement priorities are, have been, and will continue to be national security, border security, and public safety. DHS personnel are directed to prioritize the use of enforcement personnel, detention space, and removal assets accordingly.

In the immigration context, prosecutorial discretion should apply not only to the decision to issue, serve, file, or cancel a Notice to Appear, but also to a broad range of other discretionary enforcement decisions, including deciding: whom to stop, question, and arrest; whom to detain or release; whether to settle, dismiss, appeal, or join in a motion on a case; and whether to grant deferred action, parole, or a stay of removal instead of pursuing removal in a case. While DHS may exercise prosecutorial discretion at any stage of an enforcement proceeding, it is generally preferable to exercise such discretion as early in the case or proceeding as possible in order to preserve government resources that would otherwise be expended in pursuing enforcement and removal of higher priority cases. Thus, DHS personnel are expected to exercise discretion and pursue these priorities at all stages of the enforcement process-from the earliest investigative stage to enforcing final orders of removal-subject to their chains of command and to the particular responsibilities and authorities applicable to their specific position.

Except as noted below, the following memoranda are hereby rescinded and superseded: John Morton, *Civil Immigration Enforcement: Priorities for the Apprehension, Detention, and Removal of Aliens,* March 2, 2011; John Morton, *Exercising Prosecutorial Discretion Consistent with the Civil Enforcement Priorities of the Agency for the Apprehension, Detention and Removal of Aliens*, June 17, 2011; Peter Vincent, *Case-by-Case Review of Incoming and Certain Pending Cases,* November 17, 2011; *Civil Immigration Enforcement: Guidance on the Use of Detainers in the Federal, State, Local, and Tribal Criminal Justice Systems,* December 21, 2012; *National Fugitive Operations Program: Priorities, Goals, and Expectations*, December 8, 2009.

A. Civil Immigration Enforcement Priorities

The following shall constitute the Department's civil immigration enforcement priorities:

Priority 1 (threats to national security, border security, and public safety)

Aliens described in this priority represent the highest priority to which enforcement resources should be directed:

(a) aliens engaged in or suspected of terrorism or espionage, or who otherwise pose a danger to national security;

(b) aliens apprehended at the border or ports of entry while attempting to unlawfully enter the United States;

(c) aliens convicted of an offense for which an element was active participation in a criminal street gang, as defined in 18 U.S.C. § 521(a), or aliens not younger than 16 years of age who intentionally participated in an organized criminal gang to further the illegal activity of the gang;

(d) aliens convicted of an offense classified as a felony in the convicting jurisdiction, other than a state or local offense for which an essential element was the alien's immigration status; and

(e) aliens convicted of an "aggravated felony," as that term is defined in section 101(a)(43) of the *Immigration and Nationality Act* at the time of the conviction.

The removal of these aliens must be prioritized unless they qualify for asylum or another form of relief under our laws, or unless, in the judgment of an ICE Field Office Director, CBP Sector Chief or CBP Director of Field Operations, there are compelling and exceptional factors that clearly indicate the alien is not a threat to national security, border security, or public safety and should not therefore be an enforcement priority.

Priority 2 (misdemeanants and new immigration violators)

Aliens described in this priority, who are also not described in Priority 1, represent the second-highest priority for apprehension and removal. Resources should be dedicated accordingly to the removal of the following:

(a) aliens convicted of three or more misdemeanor offenses, other than minor traffic offenses or state or local offenses for which an essential element

was the alien's immigration status, provided the offenses arise out of three separate incidents;

(b) aliens convicted of a "significant misdemeanor," which for these purposes is an offense of domestic violence;[1] sexual abuse or exploitation; burglary; unlawful possession or use of a firearm; drug distribution or trafficking; or driving under the influence; or if not an offense listed above, one for which the individual was sentenced to time in custody of 90 days or more (the sentence must involve time to be served in custody, and does not include a suspended sentence);

(c) aliens apprehended anywhere in the United States after unlawfully entering or re-entering the United States and who cannot establish to the satisfaction of an immigration officer that they have been physically present in the United States continuously since January 1, 2014; and

(d) aliens who, in the judgment of an ICE Field Office Director, USCIS District Director, or USCIS Service Center Director, have significantly abused the visa or visa waiver programs.

These aliens should be removed unless they qualify for asylum or another form of relief under our laws or, unless, in the judgment of an ICE Field Office Director, CBP Sector Chief, CBP Director of Field Operations, USCIS District Director, or users Service Center Director, there are factors indicating the alien is not a threat to national security, border security, or public safety, and should not therefore be an enforcement priority.

Priority 3 (other immigration violations)

Priority 3 aliens are those who have been issued a final order of removal[2] on or after January 1, 2014. Aliens described in this priority, who are not also described in Priority 1 or 2, represent the third and lowest priority for apprehension and removal. Resources should be dedicated accordingly to aliens in this priority. Priority 3 aliens should generally be removed unless they qualify for asylum or another form of relief under our laws or, unless, in the judgment of an immigration officer, the alien is not a threat to the integrity of the immigration system or there are factors suggesting the alien should not be an enforcement priority.

[1] In evaluating whether the offense is a significant misdemeanor involving ..domestic violence," careful consideration should be given to whether the convicted alien was also the victim of domestic violence; if so, this should be a mitigating factor. *See generally,* John Morton, *Prosecutorial Discretion: Certain Victims, Witnesses, and Plaintiffs,* June 17, 2011.

[2] For present purposes, "final order" is defined as it is in 8 C.F.R. § 1241.1.

B. Apprehension, Detention, and Removal of Other Aliens Unlawfully in the United States

Nothing in this memorandum should be construed to prohibit or discourage the apprehension, detention, or removal of aliens unlawfully in the United States who are not identified as priorities herein. However, resources should be dedicated, to the greatest degree possible, to the removal of aliens described in the priorities set forth above, commensurate with the level of prioritization identified. Immigration officers and attorneys may pursue removal of an alien not identified as a priority herein, provided, in the judgment of an ICE Field Office Director, removing such an alien would serve an important federal interest.

C. Detention

As a general rule, DHS detention resources should be used to support the enforcement priorities noted above or for aliens subject to mandatory detention by law. Absent extraordinary circumstances or the requirement of mandatory detention, field office directors should not expend detention resources on aliens who are known to be suffering from serious physical or mental illness, who are disabled, elderly, pregnant, or nursing, who demonstrate that they are primary caretakers of children or an infirm person, or whose detention is otherwise not in the public interest. To detain aliens in those categories who are not subject to mandatory detention, DHS officers or special agents must obtain approval from the ICE Field Office Director. If an alien falls within the above categories and is subject to mandatory detention, field office directors are encouraged to contact their local Office of Chief Counsel for guidance.

D. Exercising Prosecutorial Discretion

Section A, above, requires DHS personnel to exercise discretion based on individual circumstances. As noted above, aliens in Priority 1 must be prioritized for removal unless they qualify for asylum or other form of relief under our laws, or unless, in the judgment of an ICE Field Office Director, CBP Sector Chief, or CBP Director of Field Operations, there are compelling and exceptional factors that clearly indicate the alien is not a threat to national security, border security, or public safety and should not therefore be an enforcement priority. Likewise, aliens in Priority 2 should be removed unless they qualify for asylum or other forms of relief under our laws, or unless, in the judgment of an ICE Field Office Director, CBP Sector Chief, CBP Director of Field Operations, USCIS District Director, or USCIS Service Center Director, there are factors indicating the alien is not a threat to national security, border security, or public safety and should not therefore be an enforcement priority. Similarly, aliens in Priority 3 should generally be removed unless they qualify for asylum or another form of relief under our laws or, unless, in the judgment of an immigration officer, the alien is not a threat to the

integrity of the immigration system or there are factors suggesting the alien should not be an enforcement priority.

In making such judgments, DHS personnel should consider factors such as: extenuating circumstances involving the offense of conviction; extended length of time since the offense of conviction; length of time in the United States; military service; family or community ties in the United States; status as a victim, witness or plaintiff in civil or criminal proceedings; or compelling humanitarian factors such as poor health, age, pregnancy, a young child, or a seriously ill relative. These factors are not intended to be dispositive nor is this list intended to be exhaustive. Decisions should be based on the totality of the circumstances.

E. Implementation

The revised guidance shall be effective on January 5, 2015. Implementing training and guidance will be provided to the workforce prior to the effective date. The revised guidance in this memorandum applies only to aliens encountered or apprehended on or after the effective date, and aliens detained, in removal proceedings, or subject to removal orders who have not been removed from the United States as of the effective date. Nothing in this guidance is intended to modify USCIS Notice to Appear policies, which remain in force and effect to the extent they are not inconsistent with this memorandum.

F. Data

By this memorandum I am directing the Office of Immigration Statistics to create the capability to collect, maintain, and report to the Secretary data reflecting the numbers of those apprehended, removed, returned, or otherwise repatriated by any component of DHS and to report that data in accordance with the priorities set forth above. I direct CBP, ICE, and USCIS to cooperate in this effort. I intend for this data to be part of the package of data released by DHS to the public annually.

G. No Private Right Statement

These guidelines and priorities are not intended to, do not, and may not be relied upon to create any right or benefit, substantive or procedural, enforceable at law by any party in any administrative, civil, or criminal matter.

EXHIBIT C

U.S. Department of Homeland Security

U.S. Immigration and Customs Enforcement

DEC 11 2006

MEMORANDUM FOR: Assistant Directors
Deputy Assistant Directors
Field Office Directors

FROM: John P. Torres
Director

SUBJECT: Discretion in Cases of Extreme or Severe Medical Concern

This memorandum serves to review the importance of exercising prosecutorial discretion when making custody determinations for aliens (adults and/or juveniles) transferring from hospitals and social services or law enforcement agencies who have severe medical conditions. The Office of Detention and Removal Operation's (DRO) commitment to maintaining an end to the "catch and release" of illegal aliens does not abrogate the responsibility of DRO staff to use judicious discretion in identifying and responding to meritorious health related cases in which detention may not be in the best interest of U.S. Immigration and Customs Enforcement (ICE).

Aliens Arriving Into DRO Custody

The process for making discretionary decisions is outlined in the attached memorandum of November 7, 2000, entitled "Exercising Prosecutorial Discretion." Field officers are not only authorized by law to exercise discretion within the authority of the agency, but are expected to do so in a judicious manner at all stages of the enforcement process.

In situations where staff must respond to a pickup request or detainer placed against an adult or juvenile alien with a severe medical or psychiatric condition, the Field Office Director (FOD) should weigh the appropriateness of taking that person into federal custody absent a mandatory detention requirement, exceptional concern such as national security, or articulable danger to the community that cannot be addressed by the referring agency. A favorable exercise of discretion should be considered on a case-by-case basis whenever a medical or psychiatric evaluation, diagnosis, treatment plan, or other documentation provided by the referring agency indicates the existence of extreme disease or an impairment that makes detention problematic and/or removal highly unlikely. Exercising prosecutorial discretion when considering whether to accept these types of referrals allows DRO to:

- Show compassion and humanitarian concern, when appropriate.
- Maximize impact on enforcement and removal by not detaining aliens who are unable to complete the removal process because of severe illness.
- Reduce catastrophic health care costs.

The following are some examples of medical conditions that should trigger or flag a need for case review and consideration of prosecutorial discretion:

- Advanced chronic conditions with complications (e.g., dialysis with liver disease).
- Advanced immuno-compromised diseases (e.g., HIV/AIDS, cancer).
- Pending/recent organ transplants.
- End-stage/terminal illnesses (e.g., cancer, renal failure).
- Paraplegics/multi-limb amputees confined to wheelchairs.
- Multi-degenerative diseases in the very elderly.
- Extreme mental retardation/mental illness/mental incompetence.
- Blindness.
- Significant pregnancy complications.

Aliens in DRO Custody

In situations where it is neither practical nor desirable to cancel a detainer or deny the pickup of a seriously ill alien (e.g., high profile case, lack of sufficient documentation), the FOD should take the adult or juvenile into custody and proceed with immigration proceedings and custody determinations as appropriate under the law (e.g., parole or release recognizance). The case of any alien subject to mandatory detention shall be coordinated with local counsel and the Executive Office of Immigration Review (EOIR) to expedite proceedings or arrive at a resolution. The U.S. Public Health Service (PHS) may be consulted when additional information or guidance is needed to clarify the type and severity of a medical condition or to identify the special needs of a detainee. The case of any alien released from custody shall be handled in accordance with policy and procedure for non-detained aliens.

While the ultimate authority to make custody determinations rests with the FOD in most cases, requests for Headquarters assistance to address novel situations or medical conditions as they relate to adult detainees may be addressed to the Detention Management Division or Removal Management Division, as appropriate. For minors detained in the custody of ICE, novel questions should be addressed to the Field Office Juvenile Coordinator (FOJC) or, if unresolved, to the Headquarters National Juvenile Coordination Unit, due to the vulnerabilities and special requirements of this population.

Requests for assistance from the Headquarters' Custody Determination Unit (CDU), Travel Document Unit (TDU), or Air Transportation Unit (ATU) should be accompanied by the necessary medical documentation and immigration case history to enable headquarters staff to arrive at the best determination or arrangement for the alien.

For questions or concerns regarding this memorandum, please contact Jay M. Brooks, Chief, Detention Health Care Unit, at (202) [redacted] b6

EXHIBIT D

Policy Number: 10075.1
FEA Number: 306-112-0026

Office of the Director

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

U.S. Immigration and Customs Enforcement

June 17, 2011

MEMORANDUM FOR: All Field Office Directors
All Special Agents in Charge
All Chief Counsel

FROM: John Morton
Director

SUBJECT: Exercising Prosecutorial Discretion Consistent with the Civil Immigration Enforcement Priorities of the Agency for the Apprehension, Detention, and Removal of Aliens

Purpose

This memorandum provides U.S. Immigration and Customs Enforcement (ICE) personnel guidance on the exercise of prosecutorial discretion to ensure that the agency's immigration enforcement resources are focused on the agency's enforcement priorities. The memorandum also serves to make clear which agency employees may exercise prosecutorial discretion and what factors should be considered.

This memorandum builds on several existing memoranda related to prosecutorial discretion with special emphasis on the following:

- Sam Bernsen, Immigration and Naturalization Service (INS) General Counsel, Legal Opinion Regarding Service Exercise of Prosecutorial Discretion (July 15, 1976);
- Bo Cooper, INS General Counsel, INS Exercise of Prosecutorial Discretion (July 11, 2000);
- Doris Meissner, INS Commissioner, Exercising Prosecutorial Discretion (November 17, 2000);
- Bo Cooper, INS General Counsel, Motions to Reopen for Considerations of Adjustment of Status (May 17, 2001);
- William J. Howard, Principal Legal Advisor, Prosecutorial Discretion (October 24, 2005);
- Julie L. Myers, Assistant Secretary, Prosecutorial and Custody Discretion (November 7, 2007);
- John Morton, Director, Civil Immigration Enforcement Priorities for the Apprehension, Detention, and Removal of Aliens (March 2, 2011); and
- John Morton, Director, Prosecutorial Discretion: Certain Victims, Witnesses, and Plaintiffs (June 17, 2011).

The following memoranda related to prosecutorial discretion are rescinded:

- Johnny N. Williams, Executive Associate Commissioner (EAC) for Field Operations, Supplemental Guidance Regarding Discretionary Referrals for Special Registration (October 31, 2002); and
- Johnny N. Williams, EAC for Field Operations, Supplemental NSEERS Guidance for Call-In Registrants (January 8, 2003).

Background

One of ICE's central responsibilities is to enforce the nation's civil immigration laws in coordination with U.S. Customs and Border Protection (CBP) and U.S. Citizenship and Immigration Services (USCIS). ICE, however, has limited resources to remove those illegally in the United States. ICE must prioritize the use of its enforcement personnel, detention space, and removal assets to ensure that the aliens it removes represent, as much as reasonably possible, the agency's enforcement priorities, namely the promotion of national security, border security, public safety, and the integrity of the immigration system. These priorities are outlined in the ICE Civil Immigration Enforcement Priorities memorandum of March 2, 2011, which this memorandum is intended to support.

Because the agency is confronted with more administrative violations than its resources can address, the agency must regularly exercise "prosecutorial discretion" if it is to prioritize its efforts. In basic terms, prosecutorial discretion is the authority of an agency charged with enforcing a law to decide to what degree to enforce the law against a particular individual. ICE, like any other law enforcement agency, has prosecutorial discretion and may exercise it in the ordinary course of enforcement[1]. When ICE favorably exercises prosecutorial discretion, it essentially decides not to assert the full scope of the enforcement authority available to the agency in a given case.

In the civil immigration enforcement context, the term "prosecutorial discretion" applies to a broad range of discretionary enforcement decisions, including but not limited to the following:

- deciding to issue or cancel a notice of detainer;
- deciding to issue, reissue, serve, file, or cancel a Notice to Appear (NTA);
- focusing enforcement resources on particular administrative violations or conduct;
- deciding whom to stop, question, or arrest for an administrative violation;
- deciding whom to detain or to release on bond, supervision, personal recognizance, or other condition;
- seeking expedited removal or other forms of removal by means other than a formal removal proceeding in immigration court;

[1] The Meissner memorandum's standard for prosecutorial discretion in a given case turned principally on whether a substantial federal interest was present. Under this memorandum, the standard is principally one of pursuing those cases that meet the agency's priorities for federal immigration enforcement generally.

- settling or dismissing a proceeding;
- granting deferred action, granting parole, or staying a final order of removal;
- agreeing to voluntary departure, the withdrawal of an application for admission, or other action in lieu of obtaining a formal order of removal;
- pursuing an appeal;
- executing a removal order; and
- responding to or joining in a motion to reopen removal proceedings and to consider joining in a motion to grant relief or a benefit.

Authorized ICE Personnel

Prosecutorial discretion in civil immigration enforcement matters is held by the Director[2] and may be exercised, with appropriate supervisory oversight, by the following ICE employees according to their specific responsibilities and authorities:

- officers, agents, and their respective supervisors within Enforcement and Removal Operations (ERO) who have authority to institute immigration removal proceedings or to otherwise engage in civil immigration enforcement;

- officers, special agents, and their respective supervisors within Homeland Security Investigations (HSI) who have authority to institute immigration removal proceedings or to otherwise engage in civil immigration enforcement;

- attorneys and their respective supervisors within the Office of the Principal Legal Advisor (OPLA) who have authority to represent ICE in immigration removal proceedings before the Executive Office for Immigration Review (EOIR); and

- the Director, the Deputy Director, and their senior staff.

ICE attorneys may exercise prosecutorial discretion in any immigration removal proceeding before EOIR, on referral of the case from EOIR to the Attorney General, or during the pendency of an appeal to the federal courts, including a proceeding proposed or initiated by CBP or USCIS. If an ICE attorney decides to exercise prosecutorial discretion to dismiss, suspend, or close a particular case or matter, the attorney should notify the relevant ERO, HSI, CBP, or USCIS charging official about the decision. In the event there is a dispute between the charging official and the ICE attorney regarding the attorney's decision to exercise prosecutorial discretion, the ICE Chief Counsel should attempt to resolve the dispute with the local supervisors of the charging official. If local resolution is not possible, the matter should be elevated to the Deputy Director of ICE for resolution.

[2] Delegation of Authority to the Assistant Secretary, Immigration and Customs Enforcement, Delegation No. 7030.2 (November 13, 2004), delegating among other authorities, the authority to exercise prosecutorial discretion in immigration enforcement matters (as defined in 8 U.S.C. § 1101(a)(17)).

Factors to Consider When Exercising Prosecutorial Discretion

When weighing whether an exercise of prosecutorial discretion may be warranted for a given alien, ICE officers, agents, and attorneys should consider all relevant factors, including, but not limited to—

- the agency's civil immigration enforcement priorities;
- the person's length of presence in the United States, with particular consideration given to presence while in lawful status;
- the circumstances of the person's arrival in the United States and the manner of his or her entry, particularly if the alien came to the United States as a young child;
- the person's pursuit of education in the United States, with particular consideration given to those who have graduated from a U.S. high school or have successfully pursued or are pursuing a college or advanced degrees at a legitimate institution of higher education in the United States;
- whether the person, or the person's immediate relative, has served in the U.S. military, reserves, or national guard, with particular consideration given to those who served in combat;
- the person's criminal history, including arrests, prior convictions, or outstanding arrest warrants;
- the person's immigration history, including any prior removal, outstanding order of removal, prior denial of status, or evidence of fraud;
- whether the person poses a national security or public safety concern;
- the person's ties and contributions to the community, including family relationships;
- the person's ties to the home country and conditions in the country;
- the person's age, with particular consideration given to minors and the elderly;
- whether the person has a U.S. citizen or permanent resident spouse, child, or parent;
- whether the person is the primary caretaker of a person with a mental or physical disability, minor, or seriously ill relative;
- whether the person or the person's spouse is pregnant or nursing;
- whether the person or the person's spouse suffers from severe mental or physical illness;
- whether the person's nationality renders removal unlikely;
- whether the person is likely to be granted temporary or permanent status or other relief from removal, including as a relative of a U.S. citizen or permanent resident;
- whether the person is likely to be granted temporary or permanent status or other relief from removal, including as an asylum seeker, or a victim of domestic violence, human trafficking, or other crime; and
- whether the person is currently cooperating or has cooperated with federal, state or local law enforcement authorities, such as ICE, the U.S Attorneys or Department of Justice, the Department of Labor, or National Labor Relations Board, among others.

This list is not exhaustive and no one factor is determinative. ICE officers, agents, and attorneys should always consider prosecutorial discretion on a case-by-case basis. The decisions should be based on the totality of the circumstances, with the goal of conforming to ICE's enforcement priorities.

That said, there are certain classes of individuals that warrant particular care. As was stated in the Meissner memorandum on Exercising Prosecutorial Discretion, there are factors that can help ICE officers, agents, and attorneys identify these cases so that they can be reviewed as early as possible in the process.

The following positive factors should prompt particular care and consideration:

- veterans and members of the U.S. armed forces;
- long-time lawful permanent residents;
- minors and elderly individuals;
- individuals present in the United States since childhood;
- pregnant or nursing women;
- victims of domestic violence, trafficking, or other serious crimes;
- individuals who suffer from a serious mental or physical disability; and
- individuals with serious health conditions.

In exercising prosecutorial discretion in furtherance of ICE's enforcement priorities, the following negative factors should also prompt particular care and consideration by ICE officers, agents, and attorneys:

- individuals who pose a clear risk to national security;
- serious felons, repeat offenders, or individuals with a lengthy criminal record of any kind;
- known gang members or other individuals who pose a clear danger to public safety; and
- individuals with an egregious record of immigration violations, including those with a record of illegal re-entry and those who have engaged in immigration fraud.

Timing

While ICE may exercise prosecutorial discretion at any stage of an enforcement proceeding, it is generally preferable to exercise such discretion as early in the case or proceeding as possible in order to preserve government resources that would otherwise be expended in pursuing the enforcement proceeding. As was more extensively elaborated on in the Howard Memorandum on Prosecutorial Discretion, the universe of opportunities to exercise prosecutorial discretion is large. It may be exercised at any stage of the proceedings. It is also preferable for ICE officers, agents, and attorneys to consider prosecutorial discretion in cases without waiting for an alien or alien's advocate or counsel to request a favorable exercise of discretion. Although affirmative requests from an alien or his or her representative may prompt an evaluation of whether a favorable exercise of discretion is appropriate in a given case, ICE officers, agents, and attorneys should examine each such case independently to determine whether a favorable exercise of discretion may be appropriate.

In cases where, based upon an officer's, agent's, or attorney's initial examination, an exercise of prosecutorial discretion may be warranted but additional information would assist in reaching a final decision, additional information may be requested from the alien or his or her representative. Such requests should be made in conformity with ethics rules governing

communication with represented individuals[3] and should always emphasize that, while ICE may be considering whether to exercise discretion in the case, there is no guarantee that the agency will ultimately exercise discretion favorably. Responsive information from the alien or his or her representative need not take any particular form and can range from a simple letter or e-mail message to a memorandum with supporting attachments.

Disclaimer

As there is no right to the favorable exercise of discretion by the agency, nothing in this memorandum should be construed to prohibit the apprehension, detention, or removal of any alien unlawfully in the United States or to limit the legal authority of ICE or any of its personnel to enforce federal immigration law. Similarly, this memorandum, which may be modified, superseded, or rescinded at any time without notice, is not intended to, does not, and may not be relied upon to create any right or benefit, substantive or procedural, enforceable at law by any party in any administrative, civil, or criminal matter.

[3] For questions concerning such rules, officers or agents should consult their local Office of Chief Counsel.

Exhibit 18

DECLARATION OF PIRC EXECUTIVE DIRECTOR ANDREW BARANOSKI

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

1. I am the Executive Director of PIRC, The Pennsylvania Immigration Resource Center. PIRC's principal place of business is located at 294 Pleasant Acres Road, Suite 202, in York, Pennsylvania.
2. Since its incorporation as a 501(c)(3) non-profit in 1996, PIRC has been the primary provider of legal services to immigrants detained at York Country Prison.
3. Since 2006, PIRC has provided legal information and resources to detained immigrants at York Country Prison through the Legal Orientation Program (LOP). LOP is a national program, funded under the auspices of the Department of Justice, Executive Office of Immigration Review, Office of Legal Access Programs. LOP serves as a critical lifeline to immigrants navigating the deportation court process while in detention. At the center of the program are orientation classes covering rights in removal proceedings, the court process, and defenses. Through LOP, PIRC also performs limited follow-up assistance to self-represented individuals, such as offering individual sessions to answer questions, providing more advanced classes, or help to gather country conditions materials.
4. In addition to the LOP, PIRC provides limited direct representation to detained immigrants in immigration court proceedings. For direct representation, PIRC prioritizes particularly vulnerable individuals, including survivors of domestic violence, sexual assault, and other serious crimes; victims of torture and/or persecution; isolated individuals; people with physical and mental health disabilities; or persons with other deficits limiting their ability to appear in court effectively on their own.
5. PIRC also provides representation to unrepresented persons who cannot represent themselves due to mental incapacity by assignment through the National Qualified Representative Program (NQRP).

6. York County Prison houses both male and female non-citizens held in detention by the United States Department of Homeland Security (DHS) Immigration and Customs Enforcement office of Enforcement and Removal Operations (ICE-ERO). In the past year, at any given time between approximately four-hundred and up to nearly eight-hundred persons have been held in ICE-ERO custody at York County Prison.
7. LOP services from PIRC are facilitated by assistance and cooperation from ICE-ERO and York County Prison officials.
8. Immigrants in detention at York County Prison arrive as transfers from other ICE-ERO facilities, including border facilities operated by Customs and Border Protection, and from ICE-ERO arrests in the U.S. interior, largely within Pennsylvania. Absent unusual circumstances, immigrants detained in York are housed in dormitory style blocks. Often, ICE detainees are assigned to the blocks nearest to the immigration courts. Each of these blocks have a capacity of about 60 detainees. The blocks are divided about evenly, with half of the space consisting of sleeping bunks, and the other half devoted to communal living space, containing tables and open space. Inmates eat meals, congregate, make phone calls and may watch television in the open communal space.
9. Detainees may move beyond the confines of their prison blocks with permission for designated purposes, such as recreation at designated times, for social visits with family and friends or to attend religious services. Detainees may avail themselves of professional and volunteer services provided outside the residential blocks in the prison, such as medical or counseling appointments, or to attend a range of classes, such as parenting classes, or General Equivalency Diploma and English language classes.
10. People with medical conditions screened upon admission can be placed in cells designated for medical segregation. Limited negative air flow cells exist for persons with uncommon serious infectious diseases such as tuberculosis.

11. After admission to York County Prison, it is not uncommon for persons in the communal prison blocks to be diagnosed with infectious diseases, including influenza, measles, or mumps. When this happens, the entire block affected is placed in quarantine (cohorted). When a block is cohorted, movement outside the residential block is restricted. In very limited circumstances, detainees subject to cohorting may leave the block, such as to meet with an attorney. To leave a cohorted block, detainees wear protective barriers, including a face mask and gloves. Detainees subject to cohorting are generally not permitted to attend any volunteer programs, such as PIRC LOP classes.

12. The past week, beginning Monday, March 16, 2020, York County Prison informed PIRC staff that two other prison blocks were cohorted.

13. As noted, York County Prison has facilities to place a limited number of persons in segregated medical isolation. However, the overwhelming majority of persons in immigration detention at York Country Prison reside in communal dormitory style blocks. PIRC is deeply troubled about the risk of COVID-19 contagion to the majority of detained immigrants who reside in communal blocks within York County Prison.

    From our vast experience representing immigrants with mental health disabilities, including through the NQRP program, PIRC is greatly concerned about the mental and emotional states of the most vulnerable persons in immigration detention at York Country Prison. Specifically, interactions with detainees during this past week reveal significant levels of fear by many detainees at York County Prison.

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

Signed at 244 Pleasant Acres Rd York, Pennsylvania on March 24, 2020.

Executive Director

Exhibit 19

DECLARATION OF MONICA RUIZ

1. My name is Mónica Ruiz. I am the Executive Director at Casa San José. Casa San Jose is a community-based organization in Pittsburgh that works with the Latinx community.

2. I hold a master's degree in Social Work and have a bachelor's degree in Social Work from the University of Pittsburgh with a concentration in Psychology.

3. On April 2, 2019, I had the opportunity to tour York County Prison with the Advancement Project, Asian Americans United, Juntos, and Vietlead. We sent a letter to Simona Flores, who is the ICE Field Director for the Philadelphia office (which covers all of Pennsylvania) and to Warden at York. As far as I know they never followed up on our letter which told them about numerous health and hygiene issues. Attached is a copy of the letter.

4. During the tour, I heard about a number of troubling issues. One of the main issues was around hygiene. One gentleman told me how he had to have surgery, I believe for a ruptured appendix. Upon return to the jail he was put in a special housing unit (solitary confinement) after surgery to heal. The mattress that was in his cell was dirty. He described how there was body fluids including blood on the mattress. He was so scared he would get an infection that he did not lay down on the mattress. He asked several people to have it cleaned or replaced and nothing was done. Two days later he saw a nurse he knew walking down the hallway and he started banging on his door to get her attention and when she came to his cell she saw it only then, he was provided with a new one.

5. Another issue is that there is no microwave to heat up ramen noodles, so they have to use the hot water from the bathroom sink. But this is the same sink where people brush their teeth. It is not sanitary. I mean people spit there, and sometimes if people have sensitive gums they bleed. It was really upsetting to hear this.

6. I also heard there is an issue with the hot water running out and that sometimes the water is cold for showers. I wonder about the sinks and whether they are running out of hot water too.

7. York County Prison is large—2400 beds, 800 of which are reserved for ICE detainees. The layout of the prison also makes it impossible for social distancing. They are in pods, with 60 people to a pod. There is limited handwashing options—just 6 sinks for 60 people.

8. They spend 23 of their 24 hours in their pods. They get one hour of recreation, but it is not even outside—it a concrete room. Each pod goes in, so up to 60 people. It is probably half the size of a gym. There is a garage door is open sometimes.

9. Also the prison makes the detainees do the work of cleaning. They do this for free I think, or for something like $1 a day. But the detainees are not given protective gear to clean with (no masks or gloves), and are being exposed to bodily fluids.

10. I also talked with detainees who had issues with getting medical treatment. They told me it would take days to get a medical appointment after putting in the request. They also said that because the request form is only in English and many of them do not speak English, it makes it hard for them to even get a request in.

11. I also heard from detainees about the adequacy of the medical care. Multiple detainees told me that regardless of the ailment they were seeking help with, they were just told to take Tylenol or Motrin.

12. Our letter asked local ICE leadership and the prison to make a number of changes to make it safer and cleaner environment. *See* Letter at 5. And even after ICE and other staff of the jail, including the warden met with us to discuss concerns, no changes have been made. This is very troubling to me, especially now with COVID-19.

Executed on this 23rd day of March 2020, in Pittsburgh, Pennsylvania.

Mónica Ruiz, MSW

Mónica Ruiz, MSW

July 31, 2019

VIA ELECTRONIC MAIL AND U.S. PRIORITY MAIL

Ms. Simona Flores, Philadelphia Field Office Director
Enforcement and Removal Operations
U.S. Immigration Customs and Enforcement
114 North 8th Street
Philadelphia, PA 19107

Mr. Clair Doll, Warden
York County Prison
3400 Concord Road
York, PA 17402

RE: FINDINGS FROM APRIL 2, 2019 STAKEHOLDER VISIT TO YORK COUNTY PRISON

Dear Ms. Flores and Mr. Doll:

On behalf of Advancement Project, National Office, Juntos, and Casa San Jose, together with our partners VietLead and Asian Americans United, this letter addresses our findings from our stakeholder visit and tour of the York County Prison ("York") on April 2, 2019, including a summary of the conversations held that day with people who were detained pursuant to immigration law.[1]

We appreciate that your colleagues from U.S. Immigration and Customs Enforcement ("ICE") took the time to meet with us on April 2nd, including leading us throughout the facility for nearly 2.5 hours and answering the questions that we had along the way. We are also appreciative of having been able to speak to some of the people who were currently detained during the afternoon of the visit. We look forward to continued dialogue with ICE as well as York regarding conditions of confinement in immigration detention facilities in Pennsylvania, including York.

[1] Our organizations obtained written consent from each person we spoke with.

In addition, although VietLead and Asian Americans United were not able to attend the April 2 stakeholder visit to York, both groups wanted to also express some concerns they have repeatedly heard from their community members. VietLead is a community organization that supports the Vietnamese community in Philadelphia and South Jersey. Asian Americans United is a community organization that works primarily in the Chinatown, South and Northeast Philadelphia communities to advocate for the needs of the larger Chinese and other AAPI communities of Philadelphia.

We write to you now to inform you of the findings stemming from our visit. Unfortunately, we witnessed and heard from people a number of issues with which we are deeply concerned. We are worried about the serious problems we witnessed.

As non-profit organizations that believe in and advocate for racial justice for all, including immigrants, we intend to publish a report about our findings in order to provide the public with the same information we witnessed. We therefore invite you to provide any feedback or response to this letter, especially as regards the concerns that we raise. We believe in migration as a human right, and will continue to advocate for the release of all people currently held in immigration detention.

Here are the main issues that we witnessed and heard through interviews:

Hygiene: We witnessed and heard accounts of the awful ways that York denies people in detention basic hygiene and human dignity. This is a direct violation of the PBNDS standards, requiring that facility cleanliness and sanitation be maintained "at the highest level."[2] People we spoke with reported that the only access to water is from a faucet that is used both by the cleaning and the cooking staff, in addition to the sixty people living in each pod. Besides the concerns for cross-contamination between raw, uncooked foods and bodily fluids, there is a baseline concern for the cleanliness and safety of the water itself. We heard complaints of the water smelling like fecal matter and sewage. Individuals also reported that the clothing provided to them was inadequate – the facility is kept so cold that most people we spoke with had to buy additional clothing from the commissary in order to stay warm. We also heard several complaints about the laundry – including reports that clothing sent to be laundered would return more soiled than they were sent.

Access to Medical and Mental Health Care: We observed the medical area of York County Prison during our visit. We were also told by ICE and facility officials that there was a total of eight nurses and four certified nurse aides as well as a dentist on site. According to our guides, individuals are required to have a medical inspection conducted by a registered nurse within 72 hours of their intake at the facility. The existence of these resources, however, does not mean they are used. For example, individuals do not actually receive any dental care unless they have been at the facility for over a year or require an extraction. Similarly with eye care. We also heard

[2] U.S. Immigration & Customs Enforcement, *Performance-Based National Detention Standards, 2011,* Section 1.2.I, Environmental Health and Safety (Revised Dec. 2016). "This detention standard protects detainees, staff, volunteers and contractors from injury and illness by maintaining high facility standards of cleanliness and sanitation, safe work practices and control of hazardous substances and equipment."

several complaints about the severe delays in the provision of medical care – people would sometimes have to wait days or weeks to have their medical needs addressed.

Inhumane Work Conditions: York County Prison first opened in 1979 and has held immigrants through an Intergovernmental Service Agreement (IGSA) contract with ICE since 1992. The facility has a total population of about 1,500, with the capacity to hold up to 800 in ICE custody. At the time of our visit, York was detaining 690 migrating people. Despite these numbers of incarcerated people, York has no outside cleaning service – the upkeep of the facility is mostly left to the people incarcerated. We witnessed this while touring York and spoke with several people with a range of roles. York depends on the labor of those who are currently detained for janitorial services, cleaning, cooking, and several other positions. Although the work program is described as "voluntary" and individuals have to apply to obtain a position, this characterization makes us question how "voluntary" the work is when the facility is so heavily dependent on the people detained as a work force. We also believe that being paid just over $1.40 a day for services like cleaning and cooking is an outrageous abuse of the rights of people being detained at York. Without this source of labor, York would be required to fill these roles by outsiders who would be required to earn at least a minimum hourly wage. [3]

Quality of Life: On our tour of the facility, we saw the "pods" where people are detained. We learned that people are forced to stay in these pods for twenty-three hours a day – including eating all of their meals in the pods. The bathrooms in these pods had no privacy – toilets and showers without any curtains – despite the fact that male and female staff frequently walk into the pods. People who are detained at York also never go outdoors – even the recreation area is a giant, concrete room with garage-door-style "windows" that are opened on occasion. According to the National Institute for Jail Operations, the loss or reduction of recreation-related amenities, such as indoor recreation, and no fresh air or direct sunlight, amounts to a significantly lower quality of life.[4] These are concerns that could very easily be remedied with small changes like curtains for the showers, or some form of outdoor access for recreation.

Food Quality and Quantity: On our tour of the facility, we were told that York does accommodate the meal preferences of the people who are currently detained. However, in reality we found that these accommodations resulted in less than desirable food provided to people. Complaints included half-cooked meat, spoiled juice, and drinking water (from both faucets and water coolers) that smells like sewage. Some described being given a piece of stale bread and a soy patty multiple times a day. Given how lengthy people's incarceration can be, the provision of this nutrient-low meal is especially concerning. We also heard about people relying on commissary to supplement the lackluster meals – despite commissary only having junk food and other nutrition-less snacks like chips and candy. In addition, commissary items are expensive – even compared to other prison

[3] U.S. Immigration & Customs Enforcement, *Performance-Based National Detention Standards 2011*, Section 5.8, 405-509 (2016 ed.), http://www.ice.gov/doclib/detention-standards/2011/pbnds2011r2016.pdf (stating that each work program be in compliance with the PBNDS requiring that "all work, other than personal housekeeping, be voluntary and not required; that compensation be 'at least $1.00 USD per day;' and that work be limited to 8 hours per day, 40 hours per week").

[4] National Institute for Jail Operations, *Prisoner Recreation: Right or Privilege*, 2017, https://jailtraining.org/prisoner-recreation-right-or-privilege/ (last accessed July 28, 2019).

facilities. York also denies access to hot water and microwaves – so even meals available for purchase from the commissary like ramen or macaroni-and-cheese, must be made and eaten with the same cold, smelly bathroom sink water. There is no reason for these practices other than neglect and an unwillingness to provide for the most basic human needs.

Access to Information and to Visitors: As part of the PBNDS guidelines, ICE encourages facilities to provide opportunities for both contact and non-contact visitation with approved visitors. However, the York facility only allows non-contact visits between the people detained and their visitors. Video visitation is available, but costly. Phone calls are also costly – costs which rise depending on the country being called. Despite the availability of tablets in the pods with WiFi, we heard several complaints of the spotty WiFi that rendered the tablets effectively useless. We saw the library at the York facility designed for legal research – it had minimal resources and the legal books had not been updated since 2007. Further, most if not all of the legal resources, including the online databases, are in English, despite the fact that many of the people detained at York do not speak English. We are aware that the Pennsylvania Immigration Resource Center (PIRC) provides "Know-Your-Rights" presentations pro bono and provides pro bono legal services. However, one small pro bono legal services provider cannot meet the legal needs of the over 600 people who are detained at York.

We bring attention to the aforementioned concerns to you in the hopes of remedying these issues. We oppose the criminalization of immigrants, including their detention, for simply existing in the United States. Every person deserves access to basic things like fresh, healthy food, clean, safe drinking water, and responsive healthcare. It is ICE's responsibility to ensure the safety and humane treatment of immigrants detained in its custody – even in those facilities that are run by state entities. It is also York's responsibility to ensure safety and humane treatment as the entity that is housing these migrants. Our visit to York County Prison was eye opening and depressing – witnessing how the current immigration detention system treats, criminalizes, and punishes vulnerable populations – people who should be released to their families and communities whenever possible. The conditions and treatment while they are at York moves us to advocate on their behalf, and to seek remedies for this callous and unnecessary treatment. Moreover, the same can be said about the way the Commonwealth of Pennsylvania treats people who are incarcerated under the criminal legal system. All who are detained at York whether under Federal immigration law or under Pennsylvania law, are subjected to these horrific conditions. We understand that immigration detention is just one piece of the larger mass incarceration machine in the United States.

We cannot sit still while thousands of people are detained at York and other ICE facilities, suffering under what we see as cruel, inhumane, and unnecessary treatment, and in violation of the Universal Declaration of Human Rights and the U.N. Convention Against Torture.[5] Many of the

[5] UN General Assembly, *Universal Declaration of Human Rights*, Article 5 (1948) ("No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."); Article 16, UN General Assembly, *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, Article 16 (1984) ("Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in Article 1, when such acts are committed by or at the acquiescence of a public official or other person acting in an official capacity.")

concerns and issues we have listed here could be easily remedied. We hope that ICE and York will take its responsibility seriously and resolve these concerns. **Please respond** to us about any of the above concerns we have shared **within the next thirty (30) days**, including if you think we have misstated numbers or made any errors in recounting our tour experience. We would also like to request an in-person meeting to discuss our concerns – please also respond within the next thirty (30) days if you would like to schedule that meeting. As mentioned previously, we intend to write up a report with our findings and provide the public with access to this information.

In light of the serious concerns we observed and heard from individuals detained at York, we recommend that ICE take the following steps:

1. End ICE usage of the York facility effective immediately;
2. End the detention of migrating individuals;
3. Release individuals under humanitarian parole who have passed credible fear or individuals who are sole caregivers, are elderly, or have a medical condition.
4. Facilitate access to pro bono legal services for those immigrants who are currently detained;

While we do not believe that any amount of reform at York can justify its continued incarceration of immigrants, we believe that the following implementations would vastly improve the quality of life for people currently detained at the facility. In the short term, we propose the following recommendations that can be implemented immediately to address some of the concerns highlighted in this letter. These include:

1. Require more personnel to staff the facility and stop the dependence on those who are incarcerated, either for immigration or under the criminal legal system, for labor in food service and janitorial duties, or increase the payment to those who are detained to at least the federal minimum wage instead of $1.40/day.
2. Diversify the food items available in the commissary to include healthy items with nutritional value such as fruits, vegetables, yogurt, etc., and ensure that no expired items are sold.
3. Provide people who are detained with access to a separate hot water faucet and microwaves so that they can heat and consume meal items available at the commissary.
4. Create separate sink facilities designated for cleaning the pod, maintaining personal hygiene, food preparation, and drinking, and ensure the quality and safety of the water supply.
5. Utilize bleach and soap in the laundering of all linens and clothes.
6. Require dental screenings after the first month of detention.
7. Allow the implementation of approved contact visits between people who are detained and their families and loved ones.
8. Allow people who are detained to be out of their assigned pods with the exception of counts and meal times.
9. Improve access to legal services, including up-to-date case books and immigration law manuals in multiple languages, not just English.

10. Improve Wi-Fi capability to ensure that people who are detained can benefit from the use of tablets to communicate with friends and family without exorbitant usage rates.

We believe that these are small asks in light of the large amount of money that York County Prison receives from ICE to spend on housing people in immigration detention.

Please do not hesitate to contact us with any questions or concerns. Please direct your questions or concerns to LJimenez@advancementproject.org and JAlcantara@advancementproject.org or (202) 728-9557. Thank you for your time and attention to this matter.

Sincerely,

/s/ Losmin Jimenez
Losmin Jimenez, Project Director,
Immigrant Justice and Senior Staff Attorney*
Advancement Project
*Admitted in Florida, Maryland, and Washington, DC

/s/ Jessica Alcantara
Jessica Alcantara, Staff Attorney*
Advancement Project
*Admitted in New York

/s/ Miguel Andrade
Miguel Andrade
Communications Manager
Juntos

/s/ Nicole Bañales
Nicole Bañales
Case Manager
QVS Fellow
Juntos

/s/ Monica Ruiz
Monica Ruiz, MSW
Executive Director
Casa San Jose

/s/ Alix Webb
Alix Webb
Executive Director
Asian Americans United

/s/ Nancy Dung Nguyen
Nancy Dung Nguyen
Executive Director
VietLead

CC: Joseph D. Dunn, Assistant Field Office Director, ICE (York, PA)
Henry C. Harrison, Supervisory Detention and Deportation Officer, Enforcement and Removal Operations, ICE (York, PA)
Cameron Quinn, Office of Civil Rights and Civil Liberties, DHS
U.S. Representative Elijah E. Cummings, Chairman of the House Committee on Oversight and Reform

Exhibit 20

ACLU
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
Pennsylvania

Eastern Region Office
PO Box 60173
Philadelphia, PA 19102
215-592-1513 T
215-592-1343 F

Central Region Office
PO Box 11761
Harrisburg, PA 17108
717-238-2258 T
717-236-6895 F

Western Region Office
PO Box 23058
Pittsburgh, PA 15222
412-681-7736 T
412-681-8707 F

March 13, 2020

VIA EMAIL TO:
Simona Flores Lund
Field Office Director
Enforcement and Removal Operations, Philadelphia Field Office
U.S. Department of Homeland Security
114 North 8th Street
Philadelphia, PA 19107
Simona.L.Flores@ice.dhs.gov

Re: ICE enforcement and COVID-19

Dear Director Flores-Lund:

We write to ask that you take urgent measures to align the practices of ICE's Philadelphia Enforcement and Removal Operations (ERO) with the public health need to mitigate the coronavirus disease 2019 (COVID-19) pandemic.

Community transmission of COVID-19 is now ongoing in Pennsylvania, and ICE's practices will influence its severity. If residents of immigrant communities decline to seek medical treatment because they fear immigration enforcement, the impact and spread of COVID-19 could worsen. If individuals who have been exposed to COVID-19 are placed in immigration detention, the spread of the virus in detention centers will be swift and unstoppable. And COVID-19's threat to detainees, correctional staff, and the broader community only increases with each additional person detained.

In short, the more people ICE targets and detains during the COVID-19 pandemic, the more deadly the consequences might be for detainees, correctional staff, and others. Accordingly, we urge you to take four immediate actions to protect the health and safety of all Pennsylvania residents:

- Publicly reaffirm the Philadelphia ERO's commitment to treat medical and healthcare facilities, including hospitals and doctors' offices, as "sensitive locations" where ICE enforcement normally will not occur.

- Direct the Philadelphia ERO and its partners to ensure that immigration detainees have adequate and free access to health care, hygiene products, and telephone and other communication services, including confidential calls with attorneys.

- Direct the Philadelphia ERO to increase its use of alternatives to detention, and to cease all new detentions.

- Direct the Philadelphia ERO to undertake a case-by-case review of the individuals currently in its custody and identify those who should be released. This includes individuals who were granted bond but are unable to afford their bond (meaning they remain detained not because they were deemed a danger or flight risk to warrant detention, but simply are unable to afford their bond). It also includes individuals eligible for release through parole redeterminations.

Although ICE may previously have made case-by-case determinations regarding detention, these determinations were presumably not made with a global pandemic in mind. It is now critical to recalibrate each of these decisions in light of the urgent public health risks posed by COVID-19 in a carceral setting.

Although in many respects your office and the ACLU-PA probably have different views about which policies advance public safety, when it comes to COVID-19 perhaps we can find common ground. We hope you will agree that, for the sake of all Pennsylvania residents and communities, customary enforcement practices must be altered to address this pandemic. We would welcome the opportunity to discuss this letter with you. Thank you for your consideration.

Respectfully,

Witold Walczak
Legal Director

Vanessa Stine
Immigrants Rights' Attorney

Muneeba Talukder
Immigrants' Rights Legal Fellow

cc: Gregory Brawley (gregory.s.brawley@ice.dhs.gov)
Joseph Gigliotti (joseph.gigliotti@ice.dhs.gov)
Troy Holl (Troy.Holl@ice.dhs.gov)
Joshua Reid (Joshua.G.Reid@ice.dhs.gov)
Chris VarKonda (Christopher.M.Varkonda@ice.dhs.gov