EXHIBIT I

DECLARATION OF ERIN MAXWELL, LCSW

I, Erin Maxwell, declare as follows:

1. This declaration is based on my personal knowledge. If called to testify in this case, I would testify competently about the following facts.

2. My name is Erin Maxwell. I am a Licensed Clinical Social Worker (LCSW). This declaration describes the experience of the unaccompanied child, C[redacted] C[redacted] G[redacted], as she has related this experience to me during weekly meetings, as well as information gathered from speaking with her case manager and common law father-in-law.

Experience Serving Youth in ORR Custody

3. I am a Licensed Clinical Social Worker (LCSW) and have worked as a social worker with children, youth and families since 2005. I graduated from the University of California, Berkeley with a BA in 2003 and obtained my Masters of Social Welfare in 2006. I have been at Legal Services for Children since May 2010 except for a brief period from January 2019 to April 2019 during which time I worked at another organization that represents unaccompanied minors. Prior to working at Legal Services for Children, I worked at Luther Immigration and Refugee Services (LIRS) making best interest recommendations about the safe placement of immigrant children in ORR custody and with detained children in ORR custody at the Florence Immigrant and Refugee Rights Project. I have worked internationally with immigrants and refugees at the United Nations High Commissioner for Refugee Office in Panama.

4. At Legal Services for Children I work on an attorney/social worker team providing KYR presentations and legal screenings to unaccompanied immigrant children detained in the custody of the Office of Refugee Resettlement.

Experience of C[redacted] C[redacted] G[redacted]

5. C[redacted] C[redacted] G[redacted] "C[redacted]" is a 17 year old indigenous youth from Mexico. She speaks both Mixteco and Spanish. C[redacted] arrived to the United States with her 18 month old child and common law husband. C[redacted] is almost eight months pregnant. C[redacted]'s husband, just a few years older than her, is over 18 and was subsequently transferred to ICE custody. C[redacted] and her son were transferred to ORR custody and placed at the Bethany Christian Services shelter in Modesto, California. It is my understanding that this is a shelter that is licensed to care for up to 12 pregnant and parenting youth and their children.

6. I was last able to meet with C[redacted] in person on March 10, 2020 prior to the implementation of California's shelter in place order. Starting the week of March 16, 2020, I have had weekly video meetings with C[redacted].

Delays in Reunification Due to COVID-19

7. C[redacted] is almost eight months pregnant. She is due on May 20th, 2020 and has been told by her current physician that due to complications from her first pregnancy she will require a cesarean section with her second child. While she has had regular prenatal visits since her arrival to the detention facility, it was only at her last visit on April 1, 2020 that she was provided with proper face covering. She has reported that staff at the facility have since started wearing face coverings as well.

8. C[redacted] and her son have two potential sponsors: a maternal aunt in California and her partner's father, who she refers to as her father-in-law, in Mississippi. C[redacted] has never met her aunt and would prefer to live with her father-in-law. C[redacted] considers her father-in-law to be like a father to her and she and her son have lived with him in the past. Both C[redacted]'s father-in-law and aunt have submitted the completed ORR family reunification packet. C[redacted] would like to be released prior to the birth of her second child. She has expressed a desire to be with family and receive support from family, rather than with strangers at a detention facility after her child's birth. Were C[redacted] to give birth in detention, her 18 month old son would be left at the detention center without

his mother or his father, who remains in ICE detention. Because C will have a cesarean section, her son might go several days without one of his primary caregivers in the hands of strangers. Were they to be reunified with C 's father-in-law, her son would be with his grandfather while awaiting his mother's return from the hospital.

9. I was informed by C [redacted]'s case manager at Bethany Christian Services that neither C 's father-in-law, nor her aunt have been able to have their fingerprints done as required by ORR because the digital fingerprinting sites closest to their homes are closed and police stations are not providing this service because it is not deemed essential. C 's father-in-law also confirmed to me that he has not been able to have his fingerprints done for these reasons.

10. In the situation described above, ORR has needlessly delayed C and her son's release for reasons that do not meaningfully protect their safety. Moreover, it is best for both C [redacted] and her son's emotional well-being to be reunified with their sponsor in Mississippi as soon as possible. This will allow C to receive the much needed familiar support that she will require post partum and will ensure that her son does not experience another family separation when his mother gives birth.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this 7th day of April, 2020, at Kensington, California

Erin Maxwell

EXHIBIT J

Declaracion de Porfirio Tzoc Paau

1. Mi nombre es Porifrio Tzoc Paau, tengo 31 años de edad y nací en Playa Grande, Quiche, Republica de Guatemala. Actualmente vivo en Apopka, FL con mi hijo de 11 años y comparto el apartamento con otras personas que incluyen una familia con 3 niños. Yo soy el tío de W[redacted] F[redacted] M[redacted] T[redacted] quien nació el [redacted] de [redacted] del 2005. La madre de W[redacted], Vilma Tzoc Paau es mi hermana.

2. W[redacted] entro a los Estados Unidos en Mayo, 2018 y ha estado bajo la custodia de la Oficina de Refugiados desde entonces. Yo llegue a los Estados Unidos en el mes de diciembre del año 2018 con mi hijo de 11 años. Mas o menos en Marzo, 2019 me contactaron desde el Centro de Tratamiento Shiloh donde se encontraba mi sobrino para preguntar si yo quería patrocinarlo. Yo soy el único familiar que W[redacted] tiene en los Estados Unidos.

3. *El albergue me proporciono una aplicación para solicitar que mi sobrino* W[redacted] fuese *dejado en libertad bajo mi custodia.* La trabajadora social me explico que yo tenía que *firmar una autorización para que se investigaran mis antecedentes y tenía que proveer* mis huellas. Además me explicaron que como parte de la aplicación, todos los adultos que vivían en el apartamento también tenían que firmar para autorizar a que se investigaran sus antecedentes y tenían que proporcionar sus huellas.

4. Cuando expliqué que las personas adultas que compartían el apartamento no querían firmar la autorización y proporcionar sus datos, fui descalificado para patrocinar a mi sobrino antes de poder completar la aplicación.

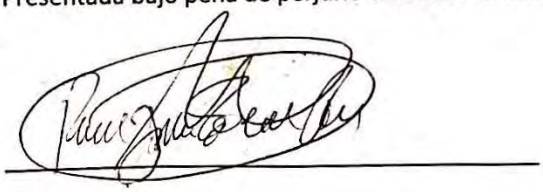
5. A principios del año 2020, fui contactado para preguntarme si todavía estaba interesado en patrocinar a W[redacted] y yo les dije que si estaba interesado en hacerlo. Mi sobrino ya

no se encontraba en Shiloh y había sido trasladado a Children's Village en New York. Me informaron que el caso iba a ser reabierto y me explicaron nuevamente que como parte de la aplicación, todos los adultos que vivan en el apartamento conmigo tenían que firmar una autorización para que les revisaran los antecedentes y debían proporcionar sus huellas. Además, como parte del proceso seria necesario realizar una estudio del hogar.

6. Como las personas con las que comparto el apartamento no están dispuestas a firmar la autorización, empecé a buscar un nuevo apartamento para mudarme solo con mi hijo. Le informe a Estrella Vasquez, la trabajadora social, que estaba buscando apartamento y me dijo que no podía llenar la aplicación de patrocinio hasta que me mudara. Desde principios del mes de marzo he estado buscando apartamento, pero aún no he encontrado algo adecuado.

7. Yo estoy muy preocupado por el bienestar de mi sobrino W[redacted] ya que El se encuentra en Children's Village en el estado de Nueva York donde hay muchos casos de Coronavirus. Además, mi sobrino se encuentra muy triste y deprimido. Esta retraido y desesperado porque ha pasado mucho tiempo y El todavía no ha sido dejado en libertad para vivir con mi hijo y conmigo.

Presentada bajo pena de perjurio este dia 7 de abril del 2020



Porfirio Tzoc Paau

Declaration of Porfirio Tzoc Paau

1. My name is Porfirio Tzoc Paau. I am 31 years old and I was born in Playa Grande, Quiche, Republic of Guatemala. I currently live in Apopka, FL with my 11-year-old son and I share the apartment with other people including a family with 3 children. I am W[redacted] F[redacted] M[redacted] T[redacted]'s uncle. He was born on [redacted], 2005. W[redacted]'s mother is Vilma Tzoc Pau and she is my sister.

2. W[redacted] came to the United States in May, 2018 and he has been under the custody of the Office of Refugees since then. I came to the United States in December, 2018 with my 11-year-old son. Approximately in March 2018, I was contacted by Shiloh Treatment Center where my nephew was detained and I was asked if I wanted to sponsor him. I am W[redacted]'s only family member in the United States.

3. The shelter provided an application to request that W[redacted] would be released under my custody. The social worker explained to me that I had to sign a background check authorization and that I had to provide my fingerprints. In addition, she explained that as part of the application, all the adults living in the apartment with me had to sign the background check authorization and they needed to provide their fingerprints as well.

4. When I explained that the adults sharing the apartment with me did not want to sign the authorization and provide their information, I was disqualified to sponsor my nephew before I could even complete the application.

5. At the beginning of the year 2020, I was contacted and asked if I was still willing to sponsor W[redacted] and I replied that I was willing to do it. My nephew was not in Shiloh anymore as he had been transferred to Children's Village in New York. I was told that the case was going to be re-opened and I was explained again that as part of the application, all the adults living in the apartment with me had to sign the background

check authorization and they had to provide their fingerprints. In addition, as part of the process, it was necessary to do a home study.

6. Since the people I live with are not willing to sign the authorization, I started looking for an apartment for my son and I. I told Estrella Vasquez, the social worker, that I was looking for an apartment and she told me that I could not complete the sponsorship application until I moved. Since the beginning of March, I have been looking for an apartment but I have not been able to find anything adequate yet.

7. I am very concerned about the well-being of my nephew, W[redacted] because he is in Children's Village in the State of New York where there are a lot of Coronavirus cases. In addition, my nephew is very sad and depressed. He is withdrawn and he is desperate because a lot of time has passed and he has not been released to live with my son and I.

Submitted under penalty of perjury on this 7th day of April, 2020.

Signed by Porfirio Tzoc Paau

CERTIFICATE OF TRANSLATION

I, Sylvia Rodriguez, am competent to translate from Spanish into English and certify that the translation of the declaration of Porfirio Tzoc Paau, provided in his native language of Spanish, is true and accurate to the best of my abilities.

Date: April 7, 2020

Sylvia Rodriguez
Wayne, New Jersey
(973) 769-8346

EXHIBIT K

DECLARATION OF MARIA J. BOCANEGRA

I, Maria J. Bocanegra, declare as follows:

1. This declaration is based on my personal knowledge. If called to testify in this case, I would testify competently about the following facts.

2. My name is Maria J. Bocanegra and I am an attorney licensed to practice in the State of Texas and in the State of Washington. This declaration describes my experiences and observations working with unaccompanied migrant youth detained at BCFS Baytown.

Experience Serving Youth in ORR Custody

3. Since January 30, 2019, I have been an attorney with the Unaccompanied Children Program ("UCP") at YMCA International Services ("YMCA"), a legal service provider that works with immigrants, including immigrant youth.

4. Since January 2019, the YMCA has served unaccompanied children in the legal custody of the Office of Refugee Resettlement ("ORR"). As of the date of this declaration, the UCP at the YMCA provides legal services to minors placed by ORR at: (1) Shiloh Residential Treatment Center ("Shiloh"); (2) BCFS Baytown ("Baytown"); (3) Urban Strategies – Refugio ("Refugio"), care programs within the ORR network of care providers. Over the last year, the YMCA has served over one-thousand (1,000) youth in ORR custody. Although the majority of these youth come from Mexico, Honduras, Guatemala and El Salvador, youth placed at these facilities may come from all over the world.

5. As the legal service provider for Shiloh, Baytown, and Refugio, our attorneys and staff maintain regular contact with the youth at the facilities. We provide ongoing consultations and presentations concerning the legal rights of detained minors, as well as provide direct legal representation to youth.

BCFS Baytown

6. Baytown provides short-term shelter care to male children between the ages 15 and 17. The YMCA began providing services to minors placed at Baytown in November 2019. Although the total facility capacity is 168, the amount of children in their care has been approximately 30 to 40 during this time. Based on the most recent census distributed by Baytown, there are currently 40 youths placed at the shelter.

7. It is my understanding that Baytown consists of a campus that includes approximately four buildings. Youth at this facility are held in a communal setting in close quarters with other children. Based on my observations, each room has at least two sets of bunk beds, which are placed on opposite sides of the room. The minors are assigned to a specific room along with at least one other occupant. Youth at Baytown receive educational programming and all other services within the facility. They are expected to share common equipment such as telephones, televisions, video game consoles, dining tables, chairs, recreational games, and other amenities. Meals and snacks are served throughout the day. Minors eat in close quarters and various staff are present during meals

Delays in Reunification

8. Up until April 7, 2020, ORR had not shared official guidance regarding the release of unaccompanied immigrant children during this pandemic. It has been unclear in what circumstances release would be delayed due to COVID-19 related issues, or in what circumstances we could expect the release process to proceed as per usual.

9. On or around April 1, 2020, we received notice from ORR that a stop placement had gone into effect at Baytown, meaning the facility would not be receiving any new minors. ORR did not provide us a reason for the stop placement.

10. On April 2, 2020, we became aware that more than one staff from Baytown had tested positive for COVID-19, which seemed to explain the stop placement directive. To be clear, we were not contacted by anyone from ORR and/or the facility to inform us

of this development about the staff who tested positive. To the contrary, we only learned of the situation as a result of a report on the nightly news.

11. At least thirteen of the minors from Baytown were scheduled to physically appear in court within a few days of April 2. As such, on April 2, I immediately contacted key personnel at the facility. The individuals I spoke to declined to confirm or deny the news report.

12. One of the Baytown staff informed me that all reunifications had been suspended. The last minors who were reunified from Baytown prior to the reunification suspension were released from the facility on March 21, 2020.

13. This same Baytown staff person further informed me that, as of April 3, 2020, seven cases had received final approval for release by the Federal Field Specialist ("FFS"). However, the releases were on hold indefinitely. Despite several attempts, I was unable to get clarification from Baytown staff as to why these minors whose reunifications had already been approved were not being released.

14. The Baytown staff person also indicated that Baytown would be continuing to submit to ORR cases for release, but that since the rest of the reunification process was in ORR's control and not the facility's, it remained unclear how these cases would be handled. Indeed, based on the available information, it seems that a release decision from ORR is currently pending for at least nine youth at Baytown.

15. Youth who are at risk of aging out are of particular concern because youth who age out are required to be transferred to custody of U.S. Immigration and Customs Enforcement ("ICE"). Per my conversations with Baytown personnel, the facility does not intend to hold youth who are eligible for release until their 18th birthdays. At the same time, Baytown staff have been unable to explain what we can expect to happen with the numerous minors who will be turning 18 years of age in the next few months. Significantly, under the reunification suspension currently in place, two of these minors will age out within less than one week of this declaration. One of these children is a Category 1, meaning Baytown has identified a viable parental or legal guardian sponsor.

The other youth, unfortunately, does not have a potential sponsor. However, a long-term non-congregate placement has been secured for this minor and his Request for Release on Recognizance is pending before ICE.

16. In the situations described above, ORR has needlessly delayed children's release for reasons that do not meaningfully protect children's safety.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this 8th day of April, 2020, at Houston, Texas.

Maria J. Bocanegra

EXHIBIT L

Through evidence, change is possible.

Physicians for Human Rights

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phr.org

Declaration of Dr. Katherine Peeler (MD, FAAP)

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

I. Background

1. I am Dr. Katherine Peeler. I am a medical expert for Physicians for Human Rights (PHR), and instructor of pediatrics at Harvard Medical School. I am a pediatric critical care physician at Boston Children's Hospital where I am a staff physician in the Division of Medical Critical Care. A Fellow of the American Academy of Pediatrics, I completed my residency training at the University of Michigan Pediatrics Residency program. I completed my fellowship training in pediatric critical care medicine at Boston Children's Hospital, where I also served as chief fellow. I received my medical degree from The Geisel School of Medicine at Dartmouth.

2. I am the faculty leader for Harvard Student Human Rights Collaborative, a role in which I supervise and advise medical students in activities related to promoting health as a human right. In addition, I am the medical director of the Harvard Medical School Asylum Clinic, which focuses on medical-legal issues of asylum seekers, including immigration detention. I have written extensively and given talks and lectures about such issues nationally and internationally. In my role as medical expert at PHR, I have performed dozens of forensic evaluations of pediatric and adult asylum-seeker cases, testifying to the consistency between their physical and psychological scars and their histories of trauma for which they seek asylum, including for asylum seekers in detention. In this same role, I have also researched, written about, and been interviewed the health of immigrants in federal custody.[1] I am regularly quoted in the media as an expert on child and family detention.[2]

3. As an attending physician at Boston Children's Hospital, I work with a diverse population, routinely taking care of patients aged newborn through their 40s, some previously healthy, many with a background of medical complexity, and with myriad socioeconomic backgrounds, hailing from all 50 states and many countries around the world. I routinely come into contact with victims of abuse, trauma, and poverty, where I regularly assess their medical as well as psychosocial needs in the context of their and their family's social determinants of health (such as

[1] *See*, *e.g.* Katherine Peeler, "Thousands Of Immigrant Kids Are Detained, Far From Their Parents. They Need Protection From COVID-19, Too," *Cognoscenti* (Mar 20, 2020), https://www.wbur.org/cognoscenti/2020/03/20/migrant-kids-coronavirus-covid-19-katherine-peeler; Katherine Peeler, "Forced Family Separation Isn't Just Traumatic. It's Torture," *Cognoscenti* (Feb 28, 2020), https://www.wbur.org/cognoscenti/2020/02/28/p-h-r-family-separation-katie-peeler; Katherine Peeler, et al. "Sleep Deprivation of Detained Children: Another Reason to End Child Detention," *Health and Human Rights Journal* (Jan 20, 2020).

[2] 12 detained babies have been released from ICE custody in Dilley, Texas, CBS News, https://www.cbsnews.com/news/immigrant-children-detained-12-babies-released-from-ice-custody-detention-center-dilley-texas-2019-03-04/; 'It's Horrifying to Think About': Migrants and Their Young Children Are Held in Isolation at Family Detention Centers, Rewire News, https://rewire.news/article/2019/03/05/its-horrifying-to-think-about-migrants-and-their-young-children-are-held-in-isolation-at-family-detention-centers/; A fifth migrant child died in US custody. Why does this keep happening?, Pacific Standard, https://psmag.com/news/a-fifth-migrant-child-died-in-u-s-custody-why-does-this-keep-happening.

housing and food insecurity).

4. My CV is attached as Exhibit A.

5. I have read the April 6, 2020 Declarations of Mr. Michael Sheridan, Mr. Christopher George, and Ms. Mellissa Harper, and my declaration herein takes into account the information they have declared.

II. COVID-19

6. The novel coronavirus, officially known as SARS-CoV-2, causes a disease known as COVID-19. COVID-19 has now reached pandemic status. As of April 7, 2020, according to the World Health Organization (WHO), 1,279,722 people have been diagnosed with COVID-19 around the world (including 68,766 is just the prior 24 hours) and 72,614 have died.[3] In the United States, about 397,754 people have been diagnosed and at least 12,956 people have died as of the same date.[4] The numbers of infection and death in the United States are likely underestimated due to the continued lack of test kits available.

7. The transmission of SARS-CoV-2 is growing exponentially. Nationally, projections by the Centers for Disease Control and Prevention (CDC) indicate that more than 200 million people in the United States could be infected with SARS-CoV- 2 over the course of the pandemic without effective public health intervention, with as many as 1.5 million deaths in certain projections.

8. The novel coronavirus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but also survives on surfaces for some period of time and can sometimes be spread as an airborne pathogen during certain aerosol-generating procedures like suctioning a patient. It is possible that people can transmit the virus before they start to show symptoms or for weeks after their symptoms resolve. In China, where SARS- CoV-2 originated, the average infected person passed the virus on to two the three other people; transmission occurred at a distance of three to six feet. The "contagiousness" of this novel coronavirus – its Ro (the number of people who can get infected from a single infected person) – is twice that of the flu. Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of infection because our immune systems have never been exposed to or developed protective responses against this virus.

9. COVID-19 is a serious disease, which can lead to respiratory failure, kidney failure, and death. Older patients and patients with chronic underlying conditions are at a particularly high risk for severe cases and complications.[5] While children seem to be less susceptible to COVID-19 compared with adults, there have still been a significant number of pediatric cases reported, including those becoming critically ill.[6] In my work as a pediatric intensivist, I have seen this firsthand. Often, the children most susceptible are those with baseline immunodeficiencies or other complex medical disorders. The need for care, including intensive care, and the likelihood

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[3] *See* Coronavirus disease 2019 (COVID-19) Situation Report - 78, World Health Organization, https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200407-sitrep-78-covid-19.pdf?sfvrsn=bc43e1b_2, accessed April 8, 2020 (at 10:30 AM EST).

[4] *See* Mitch Smith, et al., Coronavirus in the U.S.: Latest Map and Case Count, *The New York Times*, https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html?action=click&module=Spotlight&pgtype=Homepage, access April 8, 2020 (at 10:30 AM EST).

[5] Fei Zhou, et al., "Clinical Course and Risk Factors for Mortality of Adult Inpatients with COVID-19 in Wuhan, China," *The Lancet* (published online Mar. 11, 2020), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext.

[6] Yuanyuan Dong, et al., "Epidemiological Characteristics of 2143 Pediatric Patients With 2019 Coronavirus Disease in China," *Pediatrics* (pre-publication release online Mar. 16, 2020), https://pediatrics.aappublications.org/content/pediatrics/early/2020/03/16/peds.2020-0702.full.pdf

of death, is much higher from COVID-19 than from influenza. According to recent estimates, the fatality rate of people infected with COVID-19 is about 10 times higher than a severe seasonal influenza, even in advanced countries with highly effective health care systems. According to preliminary data from China, serious illness, sometimes resulting in death, occurs in up to 16 percent of cases.[7]

10. The CDC previously identified underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age, including: blood disorders, chronic kidney or liver disease, immunosuppression, endocrine disorders (including diabetes), metabolic disorders, heart and lung disease, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy.

11. Those in high-risk categories who do not die may have prolonged serious illness, for the most part requiring expensive hospital care, including ventilators that are likely to soon be in very short supply, and an entire team of care providers, including 1:1 or 1:2 nurse-to-patient ratios, respiratory therapists, and intensive care physicians. Public health officials anticipate that hospital settings will likely be overwhelmed and beyond capacity to provide this type of intensive care as COVID-19 becomes more widespread in communities. Patients who do not die from serious cases of COVID-19 may also face prolonged recovery periods, including extensive rehabilitation from neurological damage and loss of respiratory capacity.

12. Complications from COVID-19, including severe damage to lung, heart, liver, or other organs, can manifest at an alarming pace. Patients can show the first symptoms of infection in as little as two days after exposure, and their condition can seriously deteriorate in as little as five days or sooner.

13. There is no vaccine to prevent COVID-19. There is no known cure or specific antiviral treatment for COVID-19 at this time.

14. COVID-19 prevention strategies include containment and mitigation. Containment requires identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment. Unfortunately, due to the lack of testing availability, most public health experts agree that it is too late to effectively implement a containment strategy in the United States at large.

15. As the infectious disease spreads in a community, public health demands mitigation strategies, which include scrupulous hand hygiene and social distancing. For that reason, public health officials have recommended extraordinary measures to combat the rapid spread of COVID-19. Schools, courts, collegiate and professional sports, theater, and other congregate settings have been closed as part of this risk mitigation strategy. Additionally, many cities have requested that all non-essential businesses close, and that all citizens stay at-home until instructed otherwise unless they work for an essential operation.

III. Detention Centers, Shelters, and other Group Facilities

16. The risk posed by infectious diseases in immigration detention facilities holding children, including temporary influx facilities and shelters, is significantly higher than in the community, both in terms of risk of exposure and transmission and harm to individuals who become infected. There are several reasons this is the case, as delineated further below.

17. Globally, outbreaks of contagious diseases are all too common in confined detention settings and are more common than in the community at large. Though they contain a captive population, these settings are not isolated from exposure. ICE has temporarily suspended social visitation in

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

all detention facilities.[8] However, staff arrive and leave on a shift basis; there is no ability to adequately screen staff for new, asymptomatic infection. Contractors and vendors also pass between communities and facilities and can bring infectious diseases into facilities. People are often transported to, from, and between facilities.

18. Unaccompanied alien children (UAC) are in the custody of the U.S. government and housed in a variety of location types ranging from large temporary influx facilities, to group homes, to shelters, all managed by the Office of Refugee Resettlement (ORR). As of April 8, 2020, there was still no information on ORR's website as to how it was responding to the COVID outbreak either in terms of protecting the children in its care or its staff. All it lists are links to the CDC.[9]

19. Influx facilities are shelters used by ORR when its other facilities are at full or near full capacity. These facilities are exempt from many of the guidelines other permanent facilities must follow as they are supposed to be used in emergencies and for temporary periods only. As they are built on federal sites, this further exempts them from state child welfare licensing requirements, enabling poor health and safety standards and making children more vulnerable to physical and mental health risks. Such lack of regulatory oversight and poor infrastructure have enabled the sexual assault, medical neglect, and physical abuse of children in ORR custody.[10] It is not clear what regulations they are required to follow when it comes to public health and pandemics.

20. Detention centers and ORR facilities housing children often do not have access to vital community health resources that can be crucial in identifying infectious diseases, including sufficient testing equipment and laboratories. This is especially true when, as now, there is a shortage in available test kits, and the state and commercial laboratories are overwhelmed with high numbers of test requests.

21. During an infectious disease outbreak, a containment strategy requires people who are ill to be isolated and that caregivers have adequate personal protective equipment (PPE). Detention centers and shelters are often under-resourced and ill-equipped to provide sufficient PPE for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak. This is especially true when, as now, facemasks are already in short supply. Per Mr. George's declaration, in paragraph 17a, residents are informed about the availability of PPE, but this is only provided upon request. Per the recent CDC guidance, everyone should be wearing masks when in public settings, which would certainly include congregate settings such as ORR shelters or FRCs.[11]

22. When detained, people have much less opportunity to protect themselves by social distancing than they would in the community. Congregate settings such as detention centers and shelters allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When children live in close, crowded quarters and must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater.

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[8] *ICE Guidance on Covid-19*, U.S. Immigration and Customs Enforcement, accessed Mar. 24, 2020 (at 10pm EST), https://www.ice.gov/covid19.

[9] *ORR COVID-19 Resources*, Office of Refugee Resettlement, accessed April 8, 2020 (at 10:30 AM EST), https://www.acf.hhs.gov/orr/orr-covid-19-resources.

[10] Jennie Rose Nelson, "The Fight for Unaccompanied Immigrant Children's Rights", *North American Congress on Latin America,* January 14, 2020, https://nacla.org/news/2020/01/03/unaccompanied-immigration-children

[11] *Recommendation Regarding the Use of Cloth Face Coverings, Especially in Areas of Significant Community-Based Transmission*, Centers for Disease Control and Prevention, accessed April 8, 2020 (at 10:40 AM EST) https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover.html

23. Toilets, sinks, and showers are shared, without disinfection between use. Children are congregated for group legal visits in small rooms without evidence of cleaning the rooms before or after. Placing a child in such a setting therefore dramatically reduces her ability to protect herself from being exposed to and acquiring infectious diseases.

24. Additionally, ORR facilities are often unable to adequately provide the mitigation recommendations described above. During an infectious disease outbreak, people can protect themselves by washing hands. During a recent visit to an ORR shelter, attorneys from Kids in Need of Defense (KIND) noted that the soap in the bathroom was watered down.[12] High-touch surfaces (doorknobs, light switches, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but this not done frequently enough in these settings given the high frequency of touch that occurs.

25. Detention centers and shelters are often poorly equipped to manage infectious disease outbreaks. Most lack onsite medical facilities or 24-hour medical care. The medical facilities at such centers are not sufficiently equipped to handle large outbreaks of infectious diseases. To prevent transmission of droplet-borne infectious diseases, children who are infected and ill need to be isolated in specialized negative pressure rooms. It is not clear how many, if any, negative pressure rooms exist at the various ORR facilities.

26. Even assuming adequate space, solitary confinement is not an effective disease containment strategy. Isolation of people who are ill using solitary confinement is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms, air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other people in prison and staff. This makes both containing the illness and caring for those who have become infected much more difficult.

27. Mr. George's declaration, paragraph 12, discussing cohorting residents who have been exposed to an individual who tests positive for COVID-19 but is asymptomatic. Cohorting is not the same as quarantine. Cohorting is a practice of grouping together patients who are known to have the same infectious disease in order to treat them while keeping other sick patients without the disease separate. Cohorting asymptomatic but potentially exposed people is much more likely to lead to an outbreak within that cohorted cluster because some of those people have not been infected, and likely some have. This is a dangerous practice.

28. By definition, UAC in ORR facilities are already far away from their families. Many of these children suffer from mental health disorders related to the trauma they suffered in their home countries, their journeys to the United States, and exacerbated by their separation from their families. Solitary isolation of children is never appropriate developmentally, and this specifically vulnerable group of children would be at high risk of mental health emergencies if placed in solitary isolation.

29. Infectious disease outbreaks, such as COVID-19, may exacerbate existing mental health conditions and contribute to the development of new mental health conditions.[13] Mental health conditions may be exacerbated by the stress of detention during the COVID-19 pandemic, including isolation and lack of visitation and lack of information leading to increased worry and uncertainty. Moreover, failure to provide adequate mental health care to UAC, as is already firmly

[12] Katherine Peeler, "Thousands Of Immigrant Kids Are Detained, Far From Their Parents. They Need Protection From COVID-19, Too," *Cognoscenti* (Mar 20, 2020), https://www.wbur.org/cognoscenti/2020/03/20/migrant-kids-coronavirus-covid-19-katherine-peeler.

[13] Brian Honermann, *An "Epidemic Within an Outbreak:" The Mental Health Consequences of Infectious Disease Epidemics*, O'Neill Institute for National and Global Health Law (Feb. 26, 2015), accessed Mar. 24, 2020 (10:30pm EST), https://oneill.law.georgetown.edu/epidemic-within-outbreak-mental-health-consequences-infectious-disease-epidemics/.

documented in ORR facilities, is likely to worsen during an outbreak such as COVID-19, given the already stretch healthcare force responding to this pandemic.[14] The scientific evidence points to a bi-directional relationship between mental health conditions and infectious diseases. Not only are individuals with mental health conditions more at risk for communicable diseases, they are also harder to treat, once infected, due to the nature of their underlying mental health disorder. For individuals in these facilities, especially those with chronic mental health conditions, the experience of an epidemic and the lack of care while confined to small, crowded quarters can itself be traumatizing, compounding the trauma of incarceration.

30. A coronavirus brought into a detention facility can quickly spread among the dense detainee cohort. Soon enough many are sick – including high-risk groups such as those with chronic conditions – quickly overwhelming the already strained health infrastructure within the facility. This can also lead to a strain on the surrounding hospitals to which these individuals may be transferred.

31. As has been documented, there is already evidence of SARS-CoV-2 at ORR facilities, with 3 staff members and one foster parent confirmed positive in New York as of March 23, 2020,[15] and 7 staff members confirmed positive at a Houston-area shelter as of April 7, 2020.[16] This demonstrates that despite the measures taken as described in the declarations of Ms. Harper, Mr. George, and Mr. Sheridan, the virus continues to spread.

32. The risk of a rapid spread of infectious disease has been borne out during past epidemics of influenza in confined settings, namely jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in two facilities in Maine, resulting in two inmate deaths.[17] Subsequent CDC investigations of 995 inmates and 235 staff members across the two facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the H1N1-strain flu outbreak in 2009 (known as the "swine flu"), jails and prisons experienced a disproportionately high number of cases.[18] H1N1 is far less contagious than COVID- 19. These scenarios occurred in the "best case" of influenza, a viral infection for which there was an effective and available vaccine and antiviral medications – unlike COVID-19, for which there is currently neither.

33. In recent years in immigration detention facilities, overcrowding, poor hygiene measures, medical negligence, and poor access to resources and medical care have led to outbreaks of other infectious diseases as well, including mumps and chickenpox.

34. Additionally, as health systems inside facilities are taxed, children with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the

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[14] *Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody* (Sep. 3, 2019), U.S. Department of Health and Human Services Office of Inspector General, accessed Mar. 24, 2020 (10:30pm EST). https://oig.hhs.gov/oei/reports/oei-09-18-00431.asp?utm_source=website&utm_medium=asp&utm_campaign=uac-mental-health-report.

[15] Camilo Montoya-Galvez, "3 workers at facilities housing migrant kids in U.S. custody test positive for coronavirus," *CBS News* (Mar. 23, 2020), https://www.cbsnews.com/news/coronavirus-migrant-children-workers-test-positive/.

[16] Elizabeth Trovall, "7 Staff Members Test Positive At Houston-Area Shelter For Migrant Children," *Houston Public Media* (April 7, 2020), https://www.houstonpublicmedia.org/articles/news/health-science/coronavirus/2020/04/07/366215/7-staff-members-test-positive-at-houston-area-shelter-for-migrant-children/.

[17] *Influenza Outbreaks at Two Correctional Facilities — Maine, March 2011*, Centers for Disease Control and Prevention, Apr. 6, 2020, https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm.

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

care they need for these conditions. There has been a history of delayed recognition both of chronic disorders and serious medical needs in ORR facilities.[19]

35. We have ample basis to conclude that detention settings are equally unprepared for the rapid spread of SARS-CoV-2. Not surprisingly, Chinese prison officials report that more than 500 COVID-19 cases in the current outbreak stemmed from the Hubei province prisons. In Israel, an entire prison was quarantined.

36. In my professional opinion, it is inevitable that SARS-CoV-2, the virus that causes COVID-19, will continue to infect federal immigration detention centers and ORR facilities in the United States. This is consistent with the prediction of other experts that all prisons and jails and other facilities where people are detained involuntarily should anticipate that the coronavirus will enter their facility.

IV. Conclusion and Recommendations

37. For the reasons above, it is my professional judgment that children placed in ORR's facilities are at a significantly higher risk of infection with SARS-CoV-2 as compared to the population in the community and that they are at a significantly higher risk of complications and poor outcomes if they do become infected. These outcomes include severe illness (including respiratory, cardiac, and kidney failure) and even death.

38. Given that the only viable public health strategy available in the United States currently is risk mitigation, reducing the size of the population in detention facilities is crucially important to reducing the level of risk both for those within those facilities and for the community at large. Not doing so is not only inadvisable but also reckless, given the public health realities we now face in the United States.

39. Even with the best-laid plans to address the spread of SARS-CoV-2 in detention facilities, the release of children at a high risk of infection, complications, and poor outcomes is a key part of a risk mitigation strategy. Despite efforts taken by ICE and ORR, I continue to that the only viable 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 an effective vaccine for prevention or effective treatment for the disease at this stage. My professional opinion is consistent with the view of the medical profession as a whole that there are no conditions of confinement in detention settings that can adequately manage the serious risk of harm for high-risk individuals during the COVID-19 pandemic.

40. Immediate and safe release is crucial for individuals with chronic illnesses or other preexisting conditions (e.g., blood disorders, chronic kidney or liver disease, immunosuppression, endocrine disorders, metabolic disorders, heart and lung disease, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy).

41. Releasing children into the custody of properly screened family sponsors is the best and safest way to prevent the spread of disease and reduce the threat to this vulnerable detained people. This includes allowing families detained at family detention centers to be released together. It is my professional opinion that this step is both necessary and urgent. The window of opportunity is rapidly narrowing for mitigation of COVID-19 in these facilities. It is a matter of days, not weeks.

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[19] Rosa Flores, et al. "Nearly a year after a 10-year-old died in US custody, her father remembers the last time he saw her alive," *CNN* (May 27, 2019), https://www.cnn.com/2019/05/27/us/darlyn-cristabel-cordova-valle-funeral-father-aunt/index.html.

42. Release of the most vulnerable people also reduces the burden on these facilities' limited health care infrastructure, as it lessens the likelihood that an overwhelming number of children or staff will become seriously ill from COVID-19 at the same time. It also allows for decreased staffing if the census is decreased, mitigating the likelihood of further spread.

43. Release of the most vulnerable people also reduces the burden on regional hospitals and health centers, which will otherwise bear the brunt of having to treat these individuals when infected, thus reducing the number of hospital beds and equipment available for the general population.

V. Expert Disclosures

44. I have not testified as an expert at trial or by deposition in the past twelve months. I declare under penalty of perjury that the foregoing is true and correct, executed this 8 day of April, 2020 in Boston, MA.

Katherine Peeler, M.D, FAAP

EXHIBIT M

DECLARATION OF DR. CRAIG W. HANEY, PHD

I, Craig W. Haney, declare as follows:

1. I am a Distinguished Professor of Psychology and UC Presidential Chair at the University of California Santa Cruz in Santa Cruz, California, where I engage in research applying social psychological principles to legal settings, including the assessment of the psychological effects of living and working in institutional environments, especially the psychological effects of incarceration. I was a co-founder and co-director of the UC Criminal Justice & Health Consortium – a collaborative effort of researchers, experts and advocates from across the University of California system working to bring evidence-based health and healthcare solutions to criminal justice reform in California and nationwide.

2. I also have served as a consultant to numerous governmental, law enforcement, and legal agencies and organizations on jail- and prison-related issues. Those agencies and organizations include the Palo Alto Police Department, various California Legislative Select Committees, the National Science Foundation, the American Association for the Advancement of Science, the United States Department of Justice, the Department of Health and Human Services (HHS), the Department of Homeland Security, and the White House (under both the Clinton and Obama Administrations).

3. I was the detention expert for the U.S. Commission on International Religious Freedom's study group on the treatment of asylum seekers in expedited removal, and testified to Congress in 2005 about the conditions of confinement to which they were exposed nationwide. In 2012, I testified as an expert witness before the Judiciary Committee of the United States Senate in a hearing that focused on the use and effects of solitary confinement and was appointed as a member of a National Academy of Sciences committee analyzing the causes and consequences of high rates of incarceration in the United States. My research, writing, and testimony have been cited by state courts, including the California

Supreme Court, and by Federal District Courts, Circuit Courts of Appeal, and the United States Supreme Court.[1]

4. COVID-19 is a serious, highly contagious disease and has reached pandemic status. At least 234,073 people around the world have received confirmed diagnoses of COVID-19 as of March 20, 2020,[2] including 15,219 people in the United States.[3] At least 9,840 people have died globally as a result of COVID-19 as of March 20, 2020,[4] including 201 in the United States.[5] These numbers are predicted by health officials to increase, perhaps exponentially. For example, the CDC has estimated that as many as 214 million people may eventually be infected in the United States, and that as many as 21 million could require hospitalization.[6]

5. The COVID-19 Pandemic poses such a threat to the public health and safety in the State of California that, on March 4, 2020, Governor Gavin Newsom declared a statewide State of Emergency/ On March 19, 2020, he ordered all California residents to stay home or at their place of residence except to facilitate certain authorized necessary activities.[7] His office has estimated that, in the absence

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[1] For example, see *Brown v. Plata*, 563 U.S. 493 (2011).

[2] World Health Organization, *Coronavirus disease (COVID-19) Outbreak*, https://www.who.int/emergencies/diseases/novel-coronavirus-2019

[3] Center for Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19): Cases in U.S.*, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html.

[4] *Supra,* fn. 2.

[5] *Supra,* fn. 3.

[6] Sheri Fink, *Worst-Case Estimates for U.S. Coronavirus Deaths,* N.Y. TIMES (Mar. 18, 2020), https://www.nytimes.com/2020/03/13/us/coronavirus-deaths-estimate.html.

[7] Executive Department, State of California, Executive Order N-33-20, https://covid19.ca.gov/img/Executive-Order-N-33-20.pdf

of taking appropriate steps to mitigate the spread of the virus, as many as 56% of all Californians will contract it.[8]

6. COVID-19 is a novel virus. At present there is no vaccine and no cure for COVID-19. No one has immunity. Currently, the most effective way to control the virus is to use preventive strategies, including social distancing, in order to maximize our healthcare capacity to treat a manageable number of patients. Otherwise, healthcare resources will be overwhelmed and the Pandemic will certainly be exacerbated.

7. Social distancing presents serious challenges for everyone in every part of our society, but nowhere more than in penal institutions and detention facilities, where living conditions are unusually sparse, prisoners necessarily live in unescapably close quarters, and have unavoidable contact with one another. Juvenile institutions and detention facilities (including those for accompanied and unaccompanied minors in various forms of immigration detention) are no exception to this general institutional rule.

8. Moreover, jails, prisons, and immigration facilities are already extremely stressful environments for adult prisoners and for children who are confined in secure facilities.[9] Research has shown that these environments are psychologically and medically harmful

[8] Office of the Governor, "Letter to President Donald Trump" (March 18, 2020), https://www.gov.ca.gov/wp-content/uploads/2020/03/3.18.20-Letter-USNS-Mercy-Hospital-Ship.pdf.

[9] Much of this evidence is summarized in several book-length treatments of the topic. For example, see: Haney, C., *Reforming Punishment: Psychological Limits to the Pains of Imprisonment*. Washington, DC: American Psychological Association (2006); Liebling, A., & Maruna, S. (Eds.), *The Effects of Imprisonment*. Cullompton, UK: Willan (2005); and National Research Council (2014). *The Growth of Incarceration in the United States: Exploring the Causes and Consequences*. Washington, DC: The National Academies Press. In addition, there are numerous empirical studies and published reviews of the available literature. For example, see: Haney, C., Prison effects in the age of mass incarceration. *Prison Journal, 92,* 1-24 (2012); Johns, D., Confronting the disabling effects of imprisonment: Toward prehabilitation. *Social Justice, 45(1),* 27-55.

in their own right, leaving formerly incarcerated persons with higher rates of certain kinds of psychiatric and medical problems.[10] In fact, incarceration leads to higher rates of morbidity (illness rates) and mortality (i.e., it lowers the age at which people die).[11]

9. The COVID-19 Pandemic presents penal institutions and detention facilities with an enormous challenge that they are ill-equipped to handle. Secure juvenile facilities in particular lack the operational capacity to address the needs of youth in custody in a crisis of this magnitude. They do not have the resources needed to provide youth with ready access to cleaning and sanitation supplies, or to ensure that staff sanitize all potentially contaminated surfaces during the day. Most lack the capacity to provide more than minimal emergency mental health or medical care. Yet the demand for such services in this crisis will grow, stretching already scarce treatment resources even further. In addition, secure juvenile facilities typically provide children in custody with very limited access to telephonic or other forms of remote visiting. However, these ways of connecting to others will become critically important if contact visiting is limited or eliminated. Furthermore, secure juvenile facilities cannot readily protect youth from contact with staff who regularly enter facilities after having been in the outside world.

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[10] E.g., see: Schnittaker, J. (2014). The psychological dimensions and the social consequences of incarceration. *Annals of the American Association of Political and Social Science, 651,* 122-138; Turney, K., Wildeman, C., & Schnittker, J., As fathers and felons: Explaining the effects of current and recent incarceration on major depression. *Journal of Health and Social Behaviour, 53(4),* 465-481 (2012). See, also: Listwan, S., Colvin, M., Hanley, D., & Flannery, D., Victimization, social support, and psychological well-being: A study of recently released prisoners. *Criminal Justice and Behavior, 37(10),* 1140-1159 (2010).

[11] E.g., see: Binswanger, I., Stern, M., Deyo, R., et al., Release from prison: A high risk of death for former inmates. *New England Journal of Medicine, 356,* 157-165; Massoglia, M. Incarceration as Exposure: The Prison, Infectious Disease, and Other Stress-Related Illnesses. *Journal of Health and Social Behavior, 49(1),* 56-71; and Massolglia, M., & Remster, B., Linkages Between Incarceration and Health. *Public Health Reports, 134*(Supplement 1), 85-145 (2019); and Patterson, E. (2013). The dose-response of time served in prison on mortality: New York state, 1989-2003. *American Journal of Public Health, 103(3),* 523-528.

Staff members are at risk of contracting COVID-19 and then transmitting it to both youth and other staff inside.

10. Penal and detention settings have extremely limited options to implement the social distancing that is now required in response the COVID-19 Pandemic. It is very likely that many of them will resort to the use of solitary confinement. Indeed, I have seen precisely this form of social distancing utilized as a matter of course in numerous correctional institutions throughout the country, where medical quarantines are conducted in prison infirmaries or other housing units by effectively placing prisoners in solitary confinement.

11. Yet the experience of solitary confinement inflicts an additional set of very serious harmful effects that significantly undermine mental and physical health. The scientific literature on the harmfulness of solitary confinement in jails and prisons is now widely accepted and the research findings are consistent and alarming.[12] This research has led a number of professional mental and physical health-related, legal, human rights, and even correctional organizations to call for severe limitations on the degree to which solitary confinement is employed—specifically by significantly limiting when, for how long, and on whom it can be imposed.[13]

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[12] These many studies have been carefully reviewed in a number of publications. For example, see: K. Cloyes, D. Lovell, D. Allen & L. Rhodes, Assessment of psychosocial impairment in a supermaximum security unit sample. *Criminal Justice and Behavior, 33*, 760-781 (2006); S. Grassian, Psychiatric effects of solitary confinement. *Washington University Journal of Law & Policy, 22*, 325-383 (2006); C. Haney, Restricting the use of solitary confinement. *Annual Review of Criminology, 1*, 285-310 (2018); C. Haney & M. Lynch, Regulating prisons of the future: The psychological consequences of solitary and supermax confinement. *New York Review of Law & Social Change, 23*, 477-570 (1997); and P. Smith, The effects of solitary confinement on prison inmates: A brief history and review of the literature, in Michael Tonry (Ed.), *Crime and Justice* (pp. 441-528). *Volume 34.* Chicago: University of Chicago Press (2006).

[13] For a list of these organizations and their specific recommendations, see: Haney, C. (2018) Restricting the use of solitary confinement. *Annual Review of Criminology, 1*, 285-310; Haney, C., Ahalt, C., & Williams, B., et al. (2020).

12. Although there is some variation in the specific recommendations, virtually all of them call for the drastic reduction or outright elimination of the use of solitary confinement with juveniles.[14] That is, because of the categorically greater vulnerability of children to harsh conditions of confinement and the potentially irreversible mental and physical harm that they are more likely to experience, solitary confinement should rarely if ever be imposed on them. In fact, current California law significantly limits the use of solitary or solitary-like confinement[15] for juveniles to durations of no longer than four hours. In rare instances when longer times are absolutely necessary, in response to emergency or exigent circumstances, they must be limited to the shortest amount of additional time possible and, even then, always under the care of a licensed physician.[16] These severe limitations on the use of solitary confinement with children are critically important to acknowledge and adhere to in the face of the COVID-19 Pandemic and in the context of the social distancing steps that juvenile institutions are likely to engage in.

13. The COVID-19 Pandemic will be a traumatic experience for many, especially for children. In the case of children housed in juvenile institutions, this trauma will affect an already highly traumatized population. In addition to the traumatic effects of incarceration

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Consensus statement of the Santa Cruz summit on solitary confinement. *Northwestern Law Review*, in press.

[14] For example, in December 2015, the U.N. General Assembly adopted the United Nations Standard Minimum Rules for the Treatment of Prisoners ("The Nelson Mandela Rules") that, among other things, prohibited the use of solitary confinement for juveniles. See: Commission on Crime Prevention and Criminal Justice. 2015. *United Nations standard minimum rules for the treatment of prisoners.* New York: UN Economic and Social Council.

[15] Juvenile facilities often use different terms for solitary confinement, such as "segregation," "isolation," "seclusion," and "room confinement." My statements about solitary confinement apply to these terms as well. (E.g. see, Sue Burrell and Ji Seon Song, Ending "Solitary Confinement" of Youth in California. *Children's Legal Rights Journal, 39*, 42, 45 (2019).)

[16] Calif. Welf. & Inst. Code § 208.3.

itself for children,[17] and the added trauma produced by harsh conditions of juvenile confinement (such as solitary confinement), it is important to recognize that most incarcerated children have already experienced numerous childhood "risk factors" or "adverse childhood experiences."[18] Thus, juvenile incarceration represents a form of "retraumatization" for many of them. And even this retraumatization can be made worse, for example by placement in solitary confinement. It is thus hard to imagine a more vulnerable population whose very significant needs should be treated with the utmost sensitivity in the face of this Pandemic.

14. Indeed, the United States Center for Disease Control and Prevention (CDC) has acknowledged that the COVID-19 Pandemic poses a threat the mental as well as physical health of the nation, especially to its children and teens.[19] In order to mitigate the stressors created by the COVID-19 Pandemic, the CDC has recommended that parents and other caregivers undertake the following practices to support their children:[20]

- Take time to talk with your child or teen about the COVID-19 outbreak. Answer questions and share facts about COVID-19 in a way that your child or teen can understand.
- Reassure your child or teen that they are safe. Let them know it is ok if they feel upset. Share with them how you deal with your own stress so that they can learn how to cope from you.

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[17] For example, see: Sue Burrell, Trauma and the Environment of Care in Juvenile Institutions, *National Child Traumatic Stress Network* (2013).

[18] For example, see: Carly Dierkhising, Susan Ko, Briana Woods-Jaeger, et al., Trauma Histories among Justice-Involved Youth: Findings from the National Child Traumatic Stress Network, *European Journal of Psychotraumatology*, *4*, (2013)

[19] Center for Disease Control and Prevention, *Manage Anxiety & Stress*, https://www.cdc.gov/coronavirus/2019-ncov/prepare/managing-stress-anxiety.html

[20] *Ibid.*

- Limit your family's exposure to news coverage of the event, including social media. Children may misinterpret what they hear and can be frightened about something they do not understand.
- Try to keep up with regular routines. If schools are closed, create a schedule for learning activities and relaxing or fun activities.
- Be a role model. Take breaks, get plenty of sleep, exercise, and eat well. Connect with your friends and family members.

15. Similarly, the World Health Organization (WHO) also has recognized that the COVID-19 poses an existential threat to the mental health of children.[21] The WHO recommended that care providers undertake the following practices to support the mental health of children in their care:[22]

- Help children find positive ways to express feelings such as fear and sadness. Every child has their own way to express emotions. Sometimes engaging in a creative activity, such as playing, and drawing can facilitate this process. Children feel relieved if they can express and communicate their feelings in a safe and supportive environment
- Keep children close to their parents and family, if considered safe for the child, and avoid separating children and their caregivers as much as possible. If a child needs to be separated from their primary caregiver,

[21] World Health Organization, *Helping children cope with stress during the 2019-nCoV outbreak,* https://www.who.int/docs/default-source/coronaviruse/helping-children-cope-with-stress-print.pdf?sfvrsn=f3a063ff_2

[22] World Health Organization, *Mental Health and Psychosocial Considerations During COVID-19 Outbreak,* https://www.who.int/docs/default-source/coronaviruse/mental-health-considerations.pdf

ensure that appropriate alternative care is provided and that a social worker, or equivalent, will regularly follow up on the child. Further, ensure that during periods of separation, regular contact with parents and caregivers is maintained, such as twice-daily scheduled phone or video calls or other age-appropriate communication (e.g., social media depending on the age of the child).

- Maintain familiar routines in daily life as much as possible, or create new routines, especially if children must stay at home. Provide engaging age appropriate activities for children, including activities for their learning. As much as possible, encourage children to continue to play and socialize with others, even if only within the family when advised to restrict social contract.
- During times of stress and crisis, it is common for children to seek more attachment and be more demanding on parents. Discuss COVID-19 with your children using honest and age appropriate way. If your children have concerns, addressing those together may ease their anxiety. Children will observe adults' behaviors and emotions for cues on how to manage their own emotions during difficult times.

16. The COVID-19 Pandemic is a natural disaster that has already had a significant worldwide impact whose catastrophic effects are beginning to mount in the United States. The Pandemic has traumatic psychological as well as physical consequences. The consequences are especially severe for children who are not only experiencing the Pandemic but also trying to comprehend its magnitude and implications. They are seeking safety in an otherwise suddenly unsafe-feeling world. Not surprisingly, the CDC and WHO both recommend intense and expansive forms of family support, caring, and coping to ameliorate these traumatic effects. Yet this kind of familial support, caring, and coping is simply unavailable in (and in essence precluded by) secure juvenile institutions.

17. Thus, it should be obvious that few if any of the CDC or WHO recommendations for the appropriate way to address the needs of children in light of the present Pandemic can be effectively

implemented in a secure juvenile facility. Of course, their recommendations for optimizing children's meaningful family contacts and ensuring that children are able to follow as normal a routine as possible should apply no less forcefully to children who have been placed in secure juvenile institutions. In fact, for the aforementioned reasons, in light of the likely past trauma they have suffered and the traumatic nature of their present circumstances, the recommendations apply with even more logic and force.

18. As I have noted, the continued detention/confinement of children during the COVID-19 Pandemic constitutes a grave threat to their physical and mental health. Young people confined to secure juvenile facilities are vulnerable emotionally; they are separated from their families; they likely face unhealthy and unsanitary physical conditions in such institutions, which will exacerbate any existing medical conditions and heighten the risk of their contracting and transmitting coronavirus; and their incarceration in the midst of this crisis will likely result in their placement in settings that are the equivalent of solitary confinement, placing them at even greater risk. The combination of these factors argues in favor of removing them from secure institutions and returning them to their families for proper protection and care. Of course, the release of children from secure institutions can and should be done with adequate measures to protect them, their families and the broader community.[23]

19. With these things in mind, it is my professional opinion that returning incarcerated children to their families, where they can receive the kind of familial support that the CDC and WHO recommend, is the best possible course of action to take in response to the COVID-19 Pandemic.

20. I have recently reviewed declarations filed by Melissa B. Harper, Christopher George, and Michael Sheridan. Despite the steps that these declarations indicate ICE facilities have been directed to take (without independent, outside verification of whether and to what extent they have actually been taken), it is still my opinion that

[23] *See* Council for State Governments, Justice Center, "Seven Questions About Reentry Amid COVID Confusion."

children in custody in secure facilities face an unnecessary risk of infection (compounded by the psychological vulnerabilities that secure detention intensifies) and would be far safer if released to the custody of relatives in free society, with adequate measures being taken to protect them, their families, and the broader community.

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

Executed on April 8, 2020 at Santa Cruz, California.

Craig W. Haney Ph.D., J.D

DR. CRAIG W. HANEY, PH.D., J.D.

EXHIBIT N

DECLARATION OF BRIDGET CAMBRIA, ESQ.

I, Bridget Cambria, declare and say as follows:

1. My name is Bridget Cambria, and I am providing this supplemental declaration to depict the situation of detained families in immigration detention in Pennsylvania during the COVID-19 pandemic, and the incorporation of protective measures. This is also a declaration in response to the statements provided by the government in the *O.M.G. v. Wolf* litigation as well as the ongoing litigation concerning the *Flores Settlement*.

2. My statements are based on my review of the evidence provided by the government and my organization's continued representation of detained families in Pennsylvania during the COVID-19 pandemic.

3. As of this writing, persons detained in Immigration and Customs Enforcement ("ICE") x detention centers in Pennsylvania are suffering the devastating impact of the COVID-19 pandemic. Pennsylvania detention centers have the most positive cases of the novel coronavirus among ICE detainees than any other area in the country. The same Enforcement and Removal branch of the Department of Homeland Security ("DHS") that controls ICE detention centers in Pennsylvania, also oversees the family detention center in PA. The outbreak ensuing at Pennsylvania detention centers is occurring despite DHS assurances of precautions.

4. The Berks County Residential Center ("BCRC") is a family detention facility in Leesport, Pennsylvania housing immigrant families. Primarily, the families who are brought to the detention center are seeking asylum in the United States. Each family currently detained has a close family member living in the United States who is willing to receive each family member, today.

5. Additionally, ICE contracts with the County of Berks, PA to provide housing, care and guard services pursuant to an Intergovernmental Service Agreement. The ICE contract requires that no family brought to the BCRC have an adverse or criminal history. In turn, no family currently detained at the BCRC has a criminal history.

6. In return for the services performed by the County, ICE provides compensation to the County of Berks for every person that is detained, as well as supplemental compensation for the costs and additional services rendered. Medical services, however, are not provided by the County of Berks, but rather all medical care and decisions are made by an ICE contracted medial service provider called "ICE Health Service Corps."

7. Our organization, Aldea – the People's Justice Center ("Aldea"), continues to provide universal *pro bono* representation to families at the BCRC. As of this writing, Aldea represents every family who remains in the BCRC, consisting of six asylum seeking immigrant families.

8. Currently in the BCRC are a family from Ecuador with a five-year-old daughter, a Mexican family with a one-year-old daughter, a Haitian family with a one-year-old

daughter, a Haitian family with an 11-year-old daughter and a three-year-old daughter, a Haitian family with a two-year-old daughter, and a Haitian family with a seven-year-old son.

9. Each family is in the process of seeking asylum in the United States.

10. Legal visitation has ceased in the BCRC since March 20, 2020. Since then, Aldea staff has only been permitted phone visitation. The phone visitation provided is not offered at the historically normal legal visitation times, from 8AM to 8PM. Rather, we are only permitted phone visitation when it can be scheduled by a caseworker, if and when the caseworker is present for a shift. When a caseworker is on shift, with the exception of one occasion, they have facilitated phone visitation. From experience, my staff and I can report that the phones in the Berks facility have a very low-quality connection and often drop calls. Calls from the facility are very difficult to hear. Unlike the other family detention facilities, ICE has not arranged for video visitation in the Berks facility, despite our request.

11. Even though legal visitation has ended, efforts to deport families who are participating in a legal process to seek asylum have not. Court hearings and asylum interviews continue with minimized legal access. The lack of proper legal access is detrimental to not only their case, but the lives of each and every parent and child. The outcome of a family's case at the BCRC is a life and death determination.

12. Importantly, every part of the legal asylum process can, and is, conducted both inside and outside detention. Continued detention is not necessary to facilitate the asylum process. By and large families seeking asylum are not detained, but rather are placed in a removal proceeding outside of detention to pursue protection.

13. As of this writing, every family at the BCRC has expressed a fear of contracting COVID-19 and dying.

14. As mentioned in Assistant Field Office Director Christopher George ("AFOD George)'s declaration, one child currently in the BCRC was tested for COVID-19. Her parents were not tested, despite displaying cold symptoms themselves and the fact that even asymptomatic people can carry the novel coronavirus. AFOD George offers that child's symptoms of "coughing and wheezing" were considered cold symptoms and not COVID-19 symptoms, despite coughing and difficulty breathing being primary conditions of COVID-19. He testifies that the child was tested "in an abundance of caution," however, it was determined by a hospital provider that she be tested for COVID-19 and that she be quarantined to await the test results. She and her mother were quarantined, but her father – with whom she had traveled to the United States with and was detained with – was not. If, in fact the results were different, and she had been positive, their negligent handling of this child's medical condition would have resulted in every person in the facility being exposed to COVID-19.

15. During the incident with this child, Aldea requested medical confirmation of the child's test result and corresponding records on behalf of our client, the child's father. We requested such records and/or confirmation of the negative results of the COVID-19 test

on March 25, 2020. We provided a notice of representation, a HIPPA authorization, along with the request. Thereafter, and at the AFOD's request, we provided a Berks medical authorization, and a duly executed DHS privacy waiver form. DHS refused to release any results or records to us. However, DHS did release the results of the test to a reporter from Mother Jones and to this court.

16. AFOD George only provided a response to the child's counsel today, April 7, 2020, confirming that the child's test was negative.

17. Following the orders of Judge Gee and Judge Boasberg, ICE has attempted to engage in precautionary measures to prevent the spread of COVID-19 in the BCRC, a congregate care facility. I have observed the video and declaration provided by AFOD Christopher George. Attempts to create social distancing in the BCRC, a single building and congregate care facility for children, with no ability to leave the facility, is not sufficient to ensure that no family contracts COVID-19.

18. Since the filing of the lawsuit, ICE has reduced the number of family's currently detained at the BCRC.

19. However, the families who remain detained are still at risk of contracting COVID-19 given not only there being six whole families, but also the fact that the facility continues to house staff from the County of Berks, Immigration and Customs Enforcement and medical staff. It is unknown the total number of employees who come and go from the Berks facility, however the families, themselves, constitute more than 10 individuals, unrelated who are present within this facility.

20. The last family to arrive at the BCRC arrived on March 18, 2020. Fifteen families have been brought to the BCRC since March 1, 2020. Notably the first confirmed test in the United States was on January 21, 2020. From March 8, 2020 through April 7, 2020 the number of confirmed cases has reached at or about 400,000 cases.

21. Families reported that the only time their temperature was affirmatively taken was at intake, and that at intake no family was questioned regarding the coronavirus. In fact, the word coronavirus was not mentioned to the detained families until the week of March 23, 2020. In fact, many of the last detained families to enter the facility, came to the facility sick and each family had entered the BCRC after placement in a hielera ("icebox") which is a notoriously unsanitary environment. Despite this, they were not tested for COVID-19 or per AFOD George screened for COVID-19. In fact, the precaution listed is that a detainee will be "screened for the symptoms with 24 hours of known exposure." At this point, it's too late.

22. Prior to legal visitation being suspended, a sign posted on the outside of the visitation door described the pandemic as a "flu outbreak."

23. Detained families were not spoken to about COVID-19 until the week of March 23, 2020. They reported a meeting where they were advised to wash their hands. Other questions like how the facility can help them prevent an outbreak or what would happen if they became sick, went unanswered. Besides this one meeting during the week of March 23,

2020, no continued education about COVID-19 has taken place.

24. The BCRC is a detention center that consists of a single building. The video provided by government counsel demonstrates that every area, including the rooms where families sleep, do not permit isolated environments. Every common area is a commingling area, every bathroom is a commingling area, the cafeteria is a commingling area, and in fact every area depicted in the video is a commingling area – with the exception of the medical isolation room.

25. The detained families reported that prior to the video being taken, the facility staff cleaned and organized the facility in anticipation of the video. After all the last minute cleaning and organizing, the conditions captured in the video were not representative of how the facility was operating prior to April 2, 2020.

26. It is not true that families since March 12, 2020 have been provided PPE upon request. In fact, no family was advised otherwise, or that they could request PPE. AFOD George also fails to state what PPE was available to detainees and when.

27. Detained families routinely reported being denied their own sanitizer and were not provided masks or gloves, except when cleaning the facility. Only today, April 7, 2020, in conjunction with an order issued by the County of Berks, were masks provided to detained families. The masks that were provided are adult size masks, and were provided to everyone, even the children as young as one year old. Families reported that the masks were so big as to cover the entire face of a child, making it difficult for the children to breathe. Many of the children have already broken the masks. Detained families were provided one mask only and have not been provided replacements.

28. Residents still report that they are required to not only clean their rooms, but also the communal bathrooms and child's playroom. AFOD George represents that additional cleaning measures have been implemented, and the residents did notice the staff clean prior to the filming of the facility, however, he does not provide a schedule of cleaning, who conducts the cleaning, or describe what is cleaned. In any event, rooms are not cleaned after every use by a child, bathrooms are not cleaned after every use, and neither are showers.

29. Since my last declaration, and during the week of March 23, 2020, the detained families report that two sanitizer stations were placed inside the facility.

30. Since the order of this Court, additional posters have been placed within the facility to describe what COVID-19 is. However, families still report that they have not been instructed, in a language they understand, what policies are being implemented to protect them and what the nature of the COVID-19 situation is in the United States. Importantly, the main language currently spoken in the BCRC is Creole. There are no news services available in Creole and no on-site interpreters in Creole. Additionally, few Berks staff members are even bilingual in Spanish. As a result, families are completely isolated and trapped in an institutional setting during a pandemic, and are helpless.

31. The families were present when AFOD George filmed the video of the BCRC. The families

called Aldea to report that they were afraid of someone videoing them. They expressed that, as asylum seekers, they did not want their face on a video, and generally, that it was unnecessary to demonstrate the conditions of the facility. The detained families inherently mistrust authorities given they are fleeing governmental persecution and are in a detention setting. We sent an email to AFOD George and requested that he not film the detainees given their privacy concerns. Despite this request, and his acknowledgement, the detained families appeared on the footage. However, their fears are apparent on camera, as they clearly pull hoods over their faces and flee the areas as AFOD George films.

32. Meals are still provided at one time in the cafeteria. Although the families are to sit one at each table, they still eat together. They are served food one at a time from the buffet by BCRC staff.

33. Finally, since my last declaration ICE has made no efforts to provide suitable medical care to the detained families, has failed to provide a safe facility for the remaining families, and most notably have failed to comply with the Flores orders which require continuous efforts at the release of detained families in accordance with the Settlement.

34. Judge Gee specifically ordered compliance with the conditions of the settlement without regard to the parents' immigration status. She required children to be processed and released within 20 days. She also specifically ordered that ICE provide specific, tangible, and individual reasons to continue the detention of a child beyond that point.

35. AFOD George fails to demonstrate "*continuous efforts at release*" of the children in his care. He states that the parole factors are gathered "shortly after intake" and not that they have worked continuously at securing release of the children in the BCRC. In fact, if at all, it appears only one determination has ever been made, and that is the one made upon arrival at the BCRC. He has not provided the parole worksheets that he alleges have been maintained and has not provided evidence that said parole determinations are continuously maintained.

36. He states that "most families are released within 20 days." This is not true. A family being released from the BCRC within 20 days is the exception and not the rule. Additionally, when a family enters the BCRC most of the time they arrive from a CBP holding facility called a *hielera* ("icebox") where they have been held from anywhere from 1-14 days or more, which factor into the calculation. Even calculating the 20-day number for the time spent at the BCRC, by and large most families remain detained vastly longer. For example, the last two families to be released subsequent to this Courts' order had been detained for 277 days and 39 days, not counting their time in the *hieleras*.

37. As of this date, every family in the BCRC has been detained in excess of 20 days.

38. AFOD George also considers all of the remaining families to be flight risks but offers no indication why they are flight risks. Each family has a suitable sponsor and fixed home to which they could be released and monitored electronically given the pandemic. Each day matters. We will offer information concerning each family in the following paragraphs:

a. M.E.-L., E.O.-E. and five-year-old daughter J. O.-E., are currently the beneficiaries of a stay of removal from the San Antonio Immigration Court and a pending motion to reopen a removal order issued in their case. Importantly, they are victims of human trafficking who have, and will, cooperate with law enforcement. They also have asylum applications pending with the San Antonio Immigration Court. The family's sponsor to receive them is M.E.-L.'s sister and her uncle who reside in Chicago, IL, who have a fixed address and phone which can easily be provided to the government.

   This family was hospitalized in Texas prior to coming to the BCRC on March 14, 2020. They were not immediately isolated in the BCRC or provided PPE or precautions upon entering the BCRC despite hospitalization before entering the BCRC. Rather their child, and each parent, had extreme symptoms of illness including coughing, throat soreness and trouble breathing and were in the general population. Their child was taken to the hospital two times while at the BCRC since March 14, 2020. Following a hospital visit, the child and mother were isolated for three days. The father was not isolated. The five-year-old was tested for COVID-19 and was determined negative, neither parent was tested for COVID-19.

b. J. A.-R., E. G.-M., and one-year-old J.G.-G. are seeking asylum and are in the credible fear process. Should they receive a positive determination, they will be released, should they receive a negative decision, they will seek a reconsideration and/or evaluation concerning the procedural sufficiency of their fear screening for review. The family's sponsor is E.G.-M.'s sister-in-law who resides in North Carolina and has a fixed address and phone which can easily be provided the government.

   As of March 23, 2020 each parent has cold symptoms and expressed that they could barely speak due to sore throats. Their one year old has had an ear infection for many days. Daughter was provided medicine however the parents were advised to drink a lot of water. The one-year-old's formula was confiscated by the BCRC and is now required to drink regular milk.

c. C. N., L. B., and 19-month-old B.K. L.-N. are seeking asylum and are in the credible fear process. Should they receive a positive determination, they will be released, should they receive a negative decision, they will seek a reconsideration and/or evaluation concerning the procedural sufficiency of their fear screening for review. The family's sponsor is L.B.'s cousin who resides in Florida and has a fixed address and phone which can easily be provided the government.

d. G. SC., M.C., 11-year-old N.B.T, and three-year-old G.R. S.-C. are seeking asylum and are in the credible fear process. Should they receive a positive determination, they will be released, should they receive a negative decision, they will seek a reconsideration and/or evaluation concerning the procedural sufficiency of their fear screening for review. The family's sponsor is M.C.'s cousin who resides in Connecticut and has a fixed address and phone which can easily be provided the

government.

e. P.M., M.N. and two-year-old H. M.-N. are seeking asylum and are in the credible fear process. Should they receive a positive determination, they will be released, should they receive a negative decision, they will seek a reconsideration and/or evaluation concerning the procedural sufficiency of their fear screening for review. The family's sponsors are P.M.'s aunts in Brooklyn and have a fixed address and phone which can easily be provided the government.

   H.M.-N. suffered for a fever for four days since their arrival in the BCRC on March 18, 2020. She also developed sores inside and outside of her mouth that resulted in bleeding from her throat and mouth.

f. J.J. S.-J., G.C., and seven-year-old M.S.-J. are seeking asylum and are in the credible fear process. Should they receive a positive determination, they will be released, should they receive a negative decision, they will seek a reconsideration and/or evaluation concerning the procedural sufficiency of their fear screening for review. The family's sponsor is G.C.'s brother who resides in Florida and has a fixed address and phone which can easily be provided the government.

   G.C. has an allergy or infection in her mouth, migraines and has been hospitalized since entering the BCRC mid-March.

39. Insomuch as removal has not occurred, their continued detention becomes more dangerous every single day. COVID-19 cases nationwide have approached 400,000, and in the state of Pennsylvania alone there are 14,956 cases as of the writing of this statement. Deaths are skyrocketing in Pennsylvania and COVID-19 is prevalent in ICE detention centers in Pennsylvania. Two incarcerated persons in the Pike County Correctional facility in Pennsylvania have died. Failure to adhere to very clear and simple obligations under the Flores Settlement and pursuant to the Judge's order places each of the families described in this declaration at risk. ICE can easily place each family outside detention, today, and have available sponsors to provide care and quarantine, and addition may comport with the requirement imposed by ICE to secure their appearance at court or subsequent supervision appointments.

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

Executed this 7th of April, 2020 in Reading, Pennsylvania.

Bridget Cambria, Esq.