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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

ANGEL DE JESUS ZEPEDA RIVAS, BRENDA RUIZ TOVAR, LAWRENCE MWAURA, LUCIANO GONZALO MENDOZA JERONIMO, CORAIMA YARITZA SANCHEZ NUÑEZ, JAVIER ALFARO, DUNG TUAN DANG,

Petitioners-Plaintiffs,

v.

DAVID JENNINGS, Acting Director of the San Francisco Field Office of U.S. Immigration and Customs Enforcement; MATTHEW T. ALBENCE, Deputy Director and Senior Official Performing the Duties of the Director of the U.S. Immigration and Customs Enforcement; U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT; GEO GROUP, INC.; NATHAN ALLEN, Warden of Mesa Verde Detention Facility,

Respondents-Defendants.

CASE NO.

PETITIONERS-PLAINTIFFS' NOTICE OF MOTION AND MOTION FOR TEMPORARY RESTRAINING ORDER

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NOTICE OF MOTION AND MOTION

PLEASE TAKE NOTICE that, as soon as they may be heard, Plaintiffs will and hereby do move, pursuant to Civil L. R. 7-1 and 65-1, for a temporary restraining order directing ICE[1] to release a sufficient number of putative class members in order to allow for social distancing at Mesa Verde ICE Processing Facility (Mesa Verde) and Yuba County Jail (YCJ). This motion is supported by the following Memorandum of Points and Authorities, the Class Petition for Writ of Habeas Corpus and Complaint for Injunctive and Declaratory Relief, the Motion for Provisional Class Certification, and declarations of each of the Class Representative Plaintiffs, or their attorneys on their behalf, and various experts, all of which are filed contemporaneously.

Pursuant to Civil L.R. 65-1(b), on April 20, 2020 at 4 p.m., counsel for Plaintiffs called Assistant U.S. Attorney Sara Winslow at the U.S. Attorney's Office for the Northern District of California and sent an e-mail to Ms. Winslow to advise of the emergency reasons requiring them to seek a temporary restraining order. In addition, Plaintiffs' counsel e-mailed to Ms. Winslow copies of (1) the Class Petition for Writ of Habeas Corpus and Class Complaint for Injunctive and Declaratory Relief, (2) Motion for Temporary Restraining Order, (3) Motion for Provisional Class Certification, and (4) associated proposed orders.

I. INTRODUCTION

As COVID-19 ravages the country and the world, Plaintiffs are trapped in close quarters in two immigration detention centers, Mesa Verde and YCJ. Plaintiffs spend their days within arm's reach of one another, share communal bathrooms and showers, and are forced into tightly spaced single-file lines throughout the day. To prevent contracting and spreading COVID-19, the Centers for Disease Control and Prevention ("CDC") has recommended that individuals avoid contact with others and practice social distancing.[2] Yet, Plaintiffs' continued detention in Mesa Verde and YCJ prevents them from doing exactly what the CDC recommends.

[1] References to "Defendants" in this motion are not intended to suggest that Plaintiffs here seek injunctive relief against any non-governmental entities.

[2] *See* Coronavirus Disease 2019 (COVID-19), Prevent Getting Sick, How to Protect Yourself & Others, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html.

Social distancing is critical with COVID-19 because the disease has no known vaccine or cure and is highly contagious. It can survive on hard surfaces and be transmitted by touch. It can be carried and transmitted by people who exhibit no symptoms. To implement the CDC's guidance, 95% of Americans—about 316 million people—have been ordered to stay at home.[3] Until there is a vaccine or cure for COVID-19, which will likely take over a year,[4] the disease will continue to spread and could threaten the life of any adult who contracts it.

Defendants' response to has been dangerously inadequate. Experts have been warning Defendants that COVID-19 will spread "like wildfire" in congregate settings, like Mesa Verde and YCJ, where people cannot consistently maintain a distance of at least six feet from one another. In other jails and detention center, it has, with deadly results. Defendants have the power to reduce the detained populations at both Mesa Verde and YCJ to sufficiently accommodate consistent, meaningful social distancing. They refuse to do so. Indeed, in recent weeks, Defendants *increased* the detained immigrant population at YCJ.[5]

Recognizing the profound risk that continued detention in Mesa Verde and YCJ poses to those detained there, multiple judges in this District have ordered ICE to release detained immigrants on the grounds that their continued detention would violate the Constitution.[6] Plaintiffs here are currently suffering the *same* constitutional violation that has justified individual release in these cases.

Hundreds of lives are at stake. The systemic crisis at Mesa Verde and YCJ must be resolved at a systemic level. And it must be resolved quickly. As of April 17, there have been

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[3] *See* Sarah Mervosh, et al., N.Y. Times (Apr. 7, 2020), *See Which States and Cities Have Told Residents to Stay at Home*, https://www.nytimes.com/interactive/2020/us/coronavirus-stay-at-home-order.html.

[4] Carolyn Kormann, New Yorker (Mar. 8, 2020), *How Long Will It Take to Develop a Coronavirus Vaccine?*, https://www.newyorker.com/news/news-desk/how-long-will-it-take-to-develop-a-coronavirus-vaccine (quoting Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases).

[5] As of April 18, 2020, there were 157 ICE detainees at YCJ. This marks a net increase of seven ICE detainees at YCJ compared to April 2. During the same period, the net YCJ population of criminal detainees decreased by several dozen. Thus, during the same period that YCJ responded to COVID-19 by decreasing its population of criminal detainees, ICE made the facility more crowded than it otherwise would have been. Riordan ¶ 9.

[6] *See Doe v. Barr*, No. 20-cv-02141-LBR, 2020 WL 1820667, at *9-10 (N.D. Cal. Apr. 12, 2020) (granting TRO and ordering release of ICE detainee in YCJ on grounds that risk of continued confinement was excessive in relation to government interest); *Bent v. Barr*, No. 19-cv-06123-DMR, 2020 WL 1812850 at *4-6 (N.D. Cal. Apr. 9, 2020) (same Mesa Verde); *Bahena Ortuño v. Jennings*, No. 20-cv-02064-MMC, 2020 WL 1701724, at *3-5 (N.D. Cal. Apr. 8, 2020) (same for Mesa Verde and YCJ detainees).

124 confirmed COVID-19 cases among ICE detainees nationwide—a jump of over 50 cases from the previous week.[7] This Court should grant a temporary restraining order to implement a system for class members' expedited release until conditions in Mesa Verde and YCJ can accommodate the required social distancing.

II. FACTS

A. COVID-19 Poses Grave Risk of Harm to Plaintiffs

COVID-19 is a deadly, highly contagious viral disease that has no cure. It has caused a global pandemic, infecting millions of people and killing over a hundred thousand in a matter of months.[8] In the United States, there are at least 720,630 cases and 37,202 confirmed deaths.[9] In California, there are at least 31,530 cases and 1,178 confirmed deaths.[10]

COVID-19 poses a serious health risk to all adults. Although certain characteristics such as advanced age or underlying health conditions exacerbate the risk of death or serious illness from COVID-19, any adult who contracts the disease can experience severe illness, require hospitalization, or die. While people under the age of 20 have largely been protected from severe effects of the coronavirus, 55% of COVID-19 hospitalizations and 20% of deaths were from people between the ages of 20 and 64. Greifinger ¶ 8. Early CDC data shows nearly 40% of COVID-19 patients hospitalized in the U.S. have been between the ages of 18 and 54.[11] In New York, approximately one-third of the patients between the ages of 30 and 39 who died

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[7] U.S. Immigr. & Customs Enforcement, Confirmed Cases, ICE Guidance on COVID-19 (last updated Apr. 17, 2020, 8:00 p.m.), https://www.ice.gov/coronavirus.

[8] *See* World Health Org., Coronavirus Disease 2019 (COVID-19) Situation Report – 89 (Apr. 18, 2020), https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200418-sitrep-89-covid-19.pdf?sfvrsn=3643dd38_2.

[9] *See* Ctrs. for Disease Control & Prevention, Coronavirus Disease 2019 (COVID-19), Cases, Data, & Surveillance, Cases of Coronavirus Disease (COVID-19) in the U.S. (last updated Apr. 19, 2020), https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html. Kern County, where Mesa Verde is located, has seen 574 cases and three deaths. *See* Kern Cty. Pub. Health Servs. Dep't, COVID-19 Dashboard (last updated Apr. 19, 2020), https://kernpublichealth.com/covid-19_dashboard/. Yuba and Sutter Counties have seen 40 cases and three deaths, while neighboring Sacramento and Yolo Counties have seen more than 1,000 cases and 400 deaths. *See* Yuba Cty., Coronavirus Update for Yuba-Sutter (last updated Apr. 19, 2020, 6:18 p.m.), https://www.yuba.org/coronavirus/. Dr. Greifinger has cautioned that according to at least one model, as few as ten confirmed cases in a county indicate a near-certainty of an existing, undetected epidemic. Greifinger ¶ 45.

[10] *See* L.A. Times, *Tracking Coronavirus in California* (last updated Apr. 19, 2020, 11:50 p.m.), https://www.latimes.com/projects/california-coronavirus-cases-tracking-outbreak/.

[11] *See* Dr. Sanjay Gupta, *The Mystery of Why the Coronavirus Kills Some Young People,* CNN (Apr. 6, 2020), http://www.cnn.com/2020/04/05/health/young-people-dying-coronavirus-sanjay-gupta/index.html.

from COVID-19 did not appear to have any risk factors,[12] and physicians treating COVID-19 have noted the "randomness" with regard to which young people are unable to survive contraction of the illness.[13] Short of death, COVID-19 can cause prolonged illness and suffering in people of any age who contract it. In addition to requiring ventilation to stabilize oxygen intake, increasing numbers of patients also risk kidney failure and require dialysis, possibly permanently.[14] People of all ages and medical backgrounds who have contracted COVID-19 describe painful symptoms including vomiting, diarrhea, fever, relentless shivering, and severe difficulty breathing.[15]

In addition, many people have undiagnosed risk factors. For example, hypertension makes someone at higher risk of severe illness from COVID-19,[16] but the CDC has stated that about 11 million adults in the U.S. have high blood pressure but do not know it.[17] Under-diagnosis of risk factors is particularly likely among the proposed class, who are part of a population that often lacks adequate access to healthcare. Among the nonelderly population, 23% of noncitizens with lawful status and more than four in ten (45%) undocumented

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[12] *See* Chris Mooney et al., *Hundreds of Young Americans Have Now Been Killed by the Coronavirus, Data Shows*, Wash. Post (Apr. 8, 2020), https://www.washingtonpost.com/health/2020/04/08/young-people-coronavirus-deaths/.

[13] *Id*.

[14] Reed Abelson et al., *An Overlooked, Possibly Fatal Coronavirus Crisis: A Dire Need for Kidney Dialysis*, N.Y. Times (Apr. 18, 2020), https://www.nytimes.com/2020/04/18/health/kidney-dialysis-coronavirus.html.

[15] *See* Marissa J. Lang, *Nightmares, Flashbacks, Uncertainty: A 29-year-old Recovers After Coronavirus Brought Him Near Death*, Wash. Post (Apr. 17, 2020), https://www.washingtonpost.com/local/coronavirus-covid-19-recovery-francis-wilson-virginia-dc/2020/04/16/0bb55974-7858-11ea-a130-df573469f094_story.html (describing experience of otherwise healthy 29-year-old who survived COVID-19 after requiring an 11-day medically induced coma); Lizzie Presser, *A Medical Worker Describes Terrifying Lung Failure from COVID-19—Even in His Young Patients*, ProPublica (Mar. 21, 2020), https://www.propublica.org/article/a-medical-worker-describes--terrifying-lung-failure-from-covid19-even-in-his-young-patients (respiratory therapist describing COVID-19 as "knocking out what should be perfectly fit, healthy people. Patients will be on minimal support, on a little bit of oxygen, and then all of a sudden, they go into complete respiratory arrest, shut down and can't breathe at all."); Fiona Lowenstein, *I'm 26. Coronavirus Sent Me to the Hospital.*, N.Y. Times (Mar. 23, 2020), https://www.nytimes.com/2020/03/23/opinion/coronavirus-young-people.html (describing feeling "desperate for oxygen" before being hospitalized); Sui Lee Wee & Vivian Wang, *Two Women Fell Sick from Coronavirus. One survived.*, N.Y. Times (Mar. 13, 2020), https://www.nytimes.com/interactive/2020/03/13/world/asia/coronavirus-death-life.html (describing experiences of two otherwise healthy nurses in China who contracted COVID-19 and were hospitalized, one of whom died).

[16] Ctrs. for Disease Control & Prevention, Coronavirus Disease 2019 (COVID-19), People Who Need Extra Precautions, People Who are at Higher Risk for Severe Illness, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html.

[17] Ctrs. for Disease Control & Prevention, CDC Features, Diseases & Conditions, 5 Surprising Facts About High Blood Pressure, https://www.cdc.gov/features/highbloodpressure/index.html.

immigrants were uninsured as of March 2020, compared to less than one in ten (9%) citizens.[18] Lack of health insurance often results in a failure to identify chronic diseases or other health conditions.[19]

There is no vaccine, antiviral treatment, or cure for COVID-19. Greifinger ¶ 6. The disease is believed to spread through "respiratory droplets" through "close exposure" of up to six feet. Mishori ¶ 6; Greifinger ¶ 11. "Transmission also is possible through contact with contaminated surfaces." Greifinger ¶ 10. Individuals infected with COVID-19 can transmit it to others even if they have no symptoms. Mishori ¶ 6.

Because of its highly contagious nature, the only available strategy to reduce the risk of injury or death from COVID-19 is to prevent people from being infected in the first place. Greifinger ¶ 6; Mishori ¶ 22. "Social distancing," or maintaining a minimum of six feet of separation at all times from other people, paired with "hand hygiene," is the only effective means of stopping the spread of the disease. Greifinger ¶ 11; Hernandez ¶ 12 ("The most effective mitigation measures are community-wide social distancing."). Social distancing is the "cornerstone" of the CDC's prevention plan.[20] In the last month, state governments and the federal government have fundamentally restructured American life to limit all interaction except within one's own household, and, when such interaction is unavoidable, to require social distancing.[21]

B. Adequate Social Distancing is Impossible at Current Population Levels at Mesa Verde and YCJ

In early April, Mesa Verde had detainee population of 286 people. *See Bahena Ortuño v. Jennings*, No. 20-cv-02064-MMC (N.D. Cal.), Supp. Dec. of Erik Bonnar ¶ 2 (ECF No. 29-2).

[18] Health Coverage of Immigrants, Kaiser Family Foundation (Mar. 18, 2020), https://www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants/.
[19] Jennifer Tolbert et al., Key Facts about the Uninsured Population, Kaiser Family Foundation (Dec. 13, 2019), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.
[20] Ctrs. for Disease Control & Prevention, Coronavirus Disease 2019 (COVID-19), Prevent Getting Sick, Cloth Face Covers, Recommendation Regarding the Use of Cloth Face Coverings, Especially in Areas of Significant Community-Based Transmission, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover.html.
[21] Mervosh et al., *supra* note 2 (listing orders by state).

YCJ has a current detainee population of approximately 286 people—approximately 157 of those are ICE detainees, while the remainder are detained pursuant to the Yuba County criminal justice system. Riordan ¶ 9. Social distancing is incompatible with every aspect of life in detention at Mesa Verde and YCJ.

First, Plaintiffs and the proposed class cannot maintain physical distance from other detainees in the units where they sleep. YCJ contains several different types of housing units, each with its own alphabetical designation. There are four dorms (B, C, P, R) in which detainees sleep in bunk beds in close proximity to one another. Riordan Exh. A (Berg Report at p. 9); *id*. Exh. C (photograph marked as DSC "198" is unit C); *id*. Exh. D (photographs marked as DSC 112 and DSC 114 are of housing unit R); Kavanagh ¶¶ 5-6, 10-11. The C and D dorms have 50 beds. Kavanagh ¶ 6. Six other housing units (G, H, I, J, K, L) have bunk beds bolted to the wall and are separated from corridors by a set of bars with open space between the bars, so air flows freely between the cells and the corridors. Riordan Exh. A at 9; *id*. Exh. D (photograph marked as DSC 105 is of housing unit I); Kavanagh ¶ 9. The distance from top to bottom bunk throughout the facility is less than six feet. Mwaura ¶ 10; Zepeda ¶ 15. Several other housing units (D, E, F) involve two-person cells surrounding a common area where half of each unit's detainees are released at a time during the day. Riordan Exh. A at 9.

Throughout the sleeping quarters in YCJ, social distancing is impossible. Mwaura ¶¶ 9-10; Tovar ¶ 14; Zepeda ¶¶ 14-15. From their own beds, Plaintiffs can reach out and touch the beds beside them. Tovar ¶ 14; Mwaura ¶ 10 (describing two bunks within two feet of him and four more within four feet). The dorms in which plaintiffs live are crowded. Tovar ¶ 14 (dorm is "completely full"); *see also* Mwaura ¶ 10 (only 8 detainees out of 36 do not have a bunk mate); Zepeda ¶ 15 (describing that all bottom bunks are less than a meter apart and occupied).

In Mesa Verde, all detainees sleep in bunk beds only a few feet apart in 100-bed dormitory spaces. Knox Dec. ¶ 9; Riordan Exh. E (2018 PREA Audit) at 2. Mesa Verde has three isolation cells in a restricted housing unit that hold one person each. Riordan Exh. E at 2. Plaintiffs also describe being arm's width from others while in their beds. Dang ¶ 13; Nuñez ¶

14; Alfaro ¶ 18 ("[The bunk beds] are so close to one another I can reach out my arms and touch another bunk bed."). Social distancing is impossible at current levels. *See* Dang ¶ 11 (surrounded by full bunks in at-capacity dorm); Nuñez ¶¶ 12, 14 (sleeping in half-capacity dorm less than six feet from two other women); Alfaro ¶ 16 (describing one or two beds free out of 100).

"[B]y definition [the sleeping arrangements in both facilities] prohibit[] social distancing, as the distance between the upper and lower bunks is less than six feet." Greifinger ¶ 34. Further, "[b]ecause detainees get in and out of bed, bunk beds that are closer than ten feet from one another will not allow adequate social distancing." *Id*. ¶ 35. At Mesa Verde specifically, Dr. Greifinger has concluded that it "is fundamentally a congregate living space where there is a high risk of infectious spread." Greifinger Dec. ¶ 34(a). Similarly, at YCJ, although there are number of different unit layouts, "none of the sleeping arrangements appear safe in the context of the coronavirus." Greifinger ¶ 34(b).

Second, Plaintiffs and the proposed class cannot maintain safe physical distance from one another when sharing common areas in their housing units, including when eating and using the bathroom and shower. In the dining areas in both facilities, most tables and chairs in common spaces are bolted to the ground and cannot be moved. Kavanagh ¶ 3 (YCJ); Riordan Exhs. C & D (Takei ECF No. 197-17 & 197-15) (YCJ); Riordan Exh. F (Takei at 5, 24, 25) (Mesa Verde); Tovar ¶ 14 (YCJ); Alfaro ¶ 22 (Mesa Verde). At the tables, class members sit "right next to each other," Zepeda ¶ 16 (YCJ), "elbow to elbow," Mwaura ¶ 13 (YCJ); Alfaro ¶ 22 ("When we watch television, we sit right next to one another") (Mesa Verde). There is not enough space between chairs to maintain social distances at the tables and not enough tables for detainees to space themselves among them. Kavanagh ¶ 9 (YCJ); Dang ¶¶ 17-18 (Mesa Verde); Nuñez ¶ 14 (Mesa Verde). At Mesa Verde, "[t]he people serving food are an arm's length distance or less" from Plaintiffs when they serve them. Dang ¶ 17.

Plaintiffs regularly have to line up without sufficient space to maintain social distancing in the line. At Mesa Verde, guards force Plaintiffs to line up and take them to the dining area;

they are "inches apart in line." Dang ¶ 17; *see also* Nuñez ¶ 14. At YCJ, Plaintiffs must also regularly line up in close quarters. *See* Zepeda ¶ 21 (to use the bathroom), ¶ 23 (to see medical staff); ¶ 24 (to receive afternoon medication); Mwaura ¶ 12 (to go to dining hall).

It is likewise impossible to maintain social distance when using the bathrooms and showers at both facilities. At Mesa Verde, there are five toilets, five showers, and seven sinks per 100-person dormitory. Riordan Exh. E at 2. Plaintiffs are "shoulder to shoulder" when washing their hands. Nuñez ¶ 12. At YJC, toilets and showers are shared and are separated by curtains or thin dividers that generally rise to shoulder height. Tovar ¶ 15 ("you do not have any privacy or space"); Kavanagh ¶ 6; *see also* Mwaura ¶ 16. Plaintiffs' experiences illustrate that "the structure and facilities of the Mesa Verde Detention Center and the Yuba County Jail [make] social distancing [] impossible . . . and there is a serious risk of infection for all of those who are detained." Greifinger ¶ 43.

C. Plaintiffs Face an Imminent and Substantial Risk of Exposure to COVID-19 in Mesa Verde and YCJ

Jail and detention settings like Mesa Verde and YCJ "pose a heightened public health risk to the spread of COVID-19, even greater than other non-carceral institutions." Greifinger ¶ 16. According to Dr. Mishori, "The risk posed by infectious diseases in immigration detention facilities is significantly higher than in the community, both in terms of risk of exposure and transmission and harm to individuals who become infected." ¶ 7. In addition, at Mesa Verde and YCJ, the risks inherent in detainees' inability to maintain six feet of physical distance from others are compounded by other conditions of confinement, including poor sanitation, inadequate access to personal hygiene, substandard medical care, and the entry of newly-detained people into the population without proper screening or quarantine. Greifinger ¶¶ 39, 41, 42, 49-56 (identifying factors within Mesa Verde and YCJ that compound the risk inherent in Plaintiffs' inability to maintain social distancing).

Plaintiffs describe sanitary and hygienic conditions that are wanting. At Mesa Verde, detainees must wash their hands, shower, and clean their personal items using hotel-size

shampoo and soap. Nuñez ¶ 11. On April 17, 2020, they received a liquid soap dispenser and napkin dispenser, ostensibly in response to COVID-19. Nuñez ¶¶ 11, 16. There is no access to hand sanitizer. Dang ¶ 20. Plaintiffs are paid $1 per day to clean their dorms and the bathrooms they share with up to 99 other detainees for themselves, using only a mop, gloves, and cleaning solution. Dang ¶ 16. One individual describes that everyone in his dorm must "use and re-use the same little towel over and over again to dry [their] hands or wipe surfaces, and it smells and is unsanitary." Alfaro ¶ 23. At YCJ, the solitary bathroom in the yard is "disgusting," (Tovar ¶ 17) and clothes often come back from laundry with a foul smell (Zepeda ¶ 26). Detainees without protective gear were forced to clean up after a visibly ill woman was removed from a dorm in which she languished for days. Tovar ¶ 21.[22] Moreover, Defendants' responses to people with symptoms have been delayed and inconsistent with CDC recommendations and their own internal policies. *See* Tovar ¶¶ 7-9, 21 (describing delayed, inadequate response to sick woman in dorm); Mwaura ¶ 30 (sick detainees in dorm room not receiving attention); Alfaro ¶ 39 ("I have also never heard of anyone here who has been isolated or quarantined.").

Perhaps even more shockingly, Defendants have continued to introduce *new* detainees into the ghastly existing conditions at Mesa Verde and YCJ, including people transferred from facilities with known COVID-19 cases and who entered without a two-week quarantine. Alfaro ¶ 17 ("within hours of someone leaving, a new person comes in to take their place"); Dang ¶ 12 (describing newly-detained people who are coughing and sick); Nuñez ¶ 16 (detailing transfer from YCJ to MV who was not quarantined before joining dorm); Zepeda ¶¶ 29-30 (noting two transfers from Santa Rita Jail, one of whom entered YCJ dorm after five days in cell alone and another who was isolated for only six hours) [23]; Mwaura ¶ 31 (describing new detainee who entered Apr. 17, 2020).

[22] Even outside the context of the pandemic, Plaintiffs have experienced substandard medical care in both YCJ and Mesa Verde. *See* Tovar ¶ 18 (YCJ); Mwaura ¶ 6 (not receiving care for Valley Fever at YCJ); Zepeda ¶ 9 (10 outstanding requests to see medical staff at YCJ); Dang ¶ 24 (MV failed to respond to request for medical records).

[23] Santa Rita Jail has 27 confirmed cases of COVID-19. *See* Rick Hurd, *Coronavirus: Alameda County Now Has Second-Most Cases in Bay Area*, East Bay Times (Apr. 17, 2020), https://www.eastbaytimes.com/2020/04/17/coronavirus-alameda-county-now-has-second-most-cases-in-bay-area/.

Defendants' own medical subject matter experts have recognized that conditions like those present currently at Mesa Verde and YCJ amount to a "tinderbox scenario" for the rapid spread of COVID-19. *See* Letter from Drs. Scott A. Allen & Josiah Rich to Rep. Bennie Thompson, *et al*. (Mar. 19, 2020), https://www.documentcloud.org/documents/6816336-032020-Letter-From-Drs-Allen-Rich-to-Congress-Re.html#document/p4/a557238 (hereafter "Drs. Allen & Rich Letter"). So, too, have Plaintiffs' experts. As Dr. Mishori described, "A coronavirus brought into a detention facility can quickly spread among the dense detainee cohort. Soon many are sick—including high-risk groups such as those with chronic conditions—quickly overwhelming the already strained health infrastructure within the facility." ¶ 16. Dr. Greifinger has specifically reviewed ICE's response to the threat of COVID-19 and concludes that it "is deficient, putting detainees . . . in imminent danger of serious illness and death." ¶ 43.

In addition, it is clear that the only way to mitigate against this doomsday scenario is to significantly reduce the population of both Mesa Verde and YCJ. As Dr. Greifinger explains, ICE has failed "to appreciate the importance of releasing detainees to limit the risk for the individuals released, for those who remain detained, and for the general public." Greifinger ¶ 47.[24] All experts agree that social distancing, paired with vigilant hygiene, is the most effective measure to prevent transmission of COVID-19, *see* Hernandez Dec. ¶¶ 11-12; Mishori Dec. ¶¶ 10-11; Greifinger Dec. ¶ 11, 30, 31, and it is clear that both Mesa Verde and YCJ have "fail[ed] to meet minimally acceptable standards of social distancing, putting the residents at grave and unacceptable risk of pervasive infections, [which will] lead[] to serious illness and death." Greifinger ¶ 59. In turn, release is "the most important means of mitigating the spread of COVID-19 in ICE detention centers … even if the conditions inside the facility were impeccable." Greifinger ¶ 48.

At this point, ICE does not need to hypothesize as to what might happen in Mesa Verde or YJC once COVID-19 takes hold as, sadly, in other congregate facilities where conditions are

[24] Greifinger identifies numerous other deficiencies in ICE's national response. *See* Greifinger ¶¶ 39, 41, 42, 48-55.

similar to those in Mesa Verde and YCJ, tragedy has struck. In three weeks across March and April, the jail at Rikers Island in New York jumped from no cases among inmates to 273 cases, a higher rate of infection than in the most infected places in the world; four corrections staff members and one inmate have died. Greifinger ¶¶ 21-22. The Cook County Jail has likewise seen an alarming rise in cases: the Jail went from two confirmed inmate cases on March 23, 2020, to 342 confirmed inmate cases on April 17, 2020.[25] Three inmates have died.[26] As of April 17, 2020, there were at least 124 confirmed cases among detainees in ICE custody, including at least eighteen at the Otay Mesa Detention Center in San Diego.[27] These tragedies are foreseeable and preventable.

The catastrophe of a concentrated outbreak, which endangers the lives of not only those trapped in custody, but also those on the outside because it can overwhelm an already-stressed public health infrastructure, are precisely why multiple jurisdictions, including Los Angeles, Detroit, Travis County, New York City, and more than half of states have released thousands of people from criminal custody.[28]

III. LEGAL STANDARD

Plaintiffs are entitled to a temporary restraining order if they establish that they are "likely to succeed on the merits, . . . likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in [their] favor, and that an injunction is in the public interest." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008); *Stuhlbarg Int'l Sales Co. v. John D. Brush & Co.*, 240 F.3d 832, 839 n.7 (9th Cir. 2001) (noting that preliminary injunction and temporary restraining order standards are "substantially identical").

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[25] Andy Grimm, *'I feel like I lost the battle for my husband,' widow of dead Cook County Jail detainee says*, Chicago Sun Times, https://chicago.suntimes.com/2020/4/16/21224183/lost-battle-husband-widow-dead-cook-county-jail-detainee-coronavirus (Apr. 16, 2020).

[26] *Id.*

[27] U.S. Immigration and Customs Enforcement, Confirmed Cases, ICE Guidance on COVID-19 (last updated Apr. 13, 2020, 11:43 a.m.), https://www.ice.gov/coronavirus (click on "Confirmed Cases"); *see also* Max Rivlin Nadler, KPBS, *Otay Mesa COVID-19 Outbreak Now The Largest At A US Immigration Detention Center*, https://www.kpbs.org/news/2020/apr/14/otay-mesa-detention-center-now-largest-immigration/ (Apr. 14, 2020).

[28] *See* Responses to COVID-19 pandemic, Prison Policy Initiative (Apr. 10, 2020) (collecting instances where jails and prisons have released detainees due to COVID-19), https://www.prisonpolicy.org/virus/virusresponse.html#releases.

A temporary restraining order may likewise issue where "serious questions going to the merits [are] raised and the balance of hardships tips sharply in [plaintiff's] favor." *All. for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1131 (9th Cir. 2011) (citation omitted). To succeed under the "serious question" test, Plaintiffs must show that they are likely to suffer irreparable injury and that an injunction is in the public's interest. *Id*. at 1132.

IV. ARGUMENT

As the institutions of American life, including jails and prisons across the country, fundamentally transform to accommodate social distancing, ICE stands virtually alone in defying the medical and societal consensus. Despite overwhelming expert evidence to the contrary, ICE asserts that immigrants detained in facilities where no one has tested positive for COVID-19 are not at risk of infection at all, even as the disease ravages the communities outside and regardless of whether ICE has administered any tests. ICE maintains that it can keep immigrants in custody safe by ordering increased access to soap and sanitizer, conducting screenings that fail to account for asymptomatic transmission, and issuing bare recommendations that encourage social distancing while simultaneously admitting that "strict social distancing may not be possible in congregate settings such as detention facilities."[29]

ICE has made clear that it will not act of its own volition to make social distancing possible. Although on April 10, ICE issued a non-binding recommendation that detention centers consider reducing their populations to 75% of capacity (regardless of whether such a reduction was actually sufficient to accommodate social distancing in any particular facility), a week later, ICE's Acting Director Matthew T. Albence told a Congressional oversight committee that the agency contemplated no further releases.[30] Before Congress, Acting Director Albence went further, testifying that ICE cannot release any more detainees because it would suggest that the Administration is "not enforcing our immigration laws," which would be a

[29] ICE ERO, *COVID-19 Pandemic Response Requirements*, https://www.ice.gov/doclib/coronavirus/eroCOVID19responseReqsCleanFacilities.pdf (Apr. 10, 2020).

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

"huge pull factor" and create a "rush at the borders."[31] ICE's actions in California bear out this strategy of relative inaction. Just in the past few weeks, the population of ICE detainees at YCJ has *increased*. Riordan ¶ 9. In court, ICE has taken the position that the threat of COVID-19 is speculative because there are no confirmed cases at Mesa Verde or YJC.[32]

Courts in this circuit have seen ICE's responses to the COVID-19 crisis for what they are: half-measures that do not effectively protect the civil detainees in ICE's custody from a serious risk of infection. *See e.g.*, *Castillo v. Barr*, No. cv-20-00605, 2020 WL 1502864, at *5 (C.D. Cal. Mar. 27, 2020) ("Civil detainees must be protected by the Government. Petitioners have not been protected. They are not kept at least 6 feet apart from others at all times.") As a result, judges have required ICE to release individual detainees from Mesa Verde and YCJ on the grounds that their continued detention would violate due process. *See Bahena Ortuño v. Jennings*, No. 20-cv-02064-MMC, 2020 WL 1701724 at *4 (N.D. Cal. Apr. 8, 2020); *Bent v. Barr*, No. 19-cv-06123-DMR, 2020 WL 1812850 at *6 (N.D. Cal. Apr. 9, 2020); *See Castillo v. Barr*, No. cv-20-00605 TJH (AFMX), 2020 WL 1502864, at *5 (C.D. Cal. Mar. 27, 2020).

The population levels in Mesa Verde and YCJ are a structural barrier that prohibit necessary social distancing and, as a result, the risk of contracting COVID-19 looms over every single Plaintiff every single day. This Court's intervention is urgently needed to prevent the catastrophic harm to Plaintiffs that will result if ICE is permitted to proceed in its intransigent refusal to reduce the population of its facilities.

A. Plaintiffs are Likely to Succeed on the Merits

1. Plaintiffs' Detention in an Environment Where Social Distancing is Impossible is Unreasonably Dangerous in Violation of Substantive Due Process

The Constitution prohibits the government from exposing people in its custody to unjustifiable or unreasonable risks of harm. These constitutional protections are strongest for

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

[32] Opp. Brief at 16, *Bahena Ortuño v. Jennings*, No. 3:20-cv-02064 (N.D. Cal. Mar. 30, 2020) ("In any event, Petitioners' assertion that detention per se poses an increased risk of health complications or death from COVID-19 is purely speculative. COVID-19 has not spread to the facilities where Petitioners are being detained.")

civil detainees like Plaintiffs, who are in detention pursuant to civil immigration laws. *See Zadvydas v. Davis*, 533 U.S. 678, 690 (2001). Their constitutional rights while in custody are derived from the Due Process Clause of the Fifth Amendment, which provides significantly greater protection than the Eighth Amendment's ban on cruel and unusual punishment. *Youngberg v. Romeo,* 457 U.S. 307, 321-22 (1982). Plaintiffs are likely to prevail on either of two due process theories. First, the risks presented by COVID-19 in the congregate detention environments of Mesa Verde and YCJ are excessive in relation to the government's interests and could be achieved by alternative and less harsh methods. Second, the government's decision to maintain robust population levels at Mesa Verde and YCJ constitutes deliberate indifference.

a. The Impossibility of Social Distancing Exposes Plaintiffs to an Unjustifiable Risk of Contracting A Deadly Virus in Light of Alternatives to Detention that Would Equally Serve the Government's Interests in Appearance for Removal Proceedings and Community Safety

Conditions of confinement violate due process when they expose civil detainees to a risk of harm that is either excessive in relation to a legitimate government objective, or is imposed to achieve an objective that could be accomplished using "alternative and less harsh methods." *Jones v. Blanas*, 393 F.3d 918, 932 (9th Cir. 2004); *see also Jackson v. Indiana*, 406 U.S. 715, 738 (1972) ("[D]ue process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.").

Conditions of confinement for civil detainees are presumptively unconstitutional when they are "identical to, similar to, or more restrictive than" those afforded their criminal counterparts. *Unknown Parties v. Nielsen*, No. CV-15-00250-TUC-DCB, 2020 WL 813774, at *4 (D. Ariz. Feb. 19, 2020) (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321-22 (1982)). There is currently a nationwide trend of mass releases of people serving sentences for criminal convictions to protect their health and facilitate social distancing within jails and prisons.[33] Los Angeles County alone has released at least 1,700 people from county jails, Washington State

[33] *See supra* n. 27.

has released at over 1,100 people serving sentences for convictions, and Michigan is releasing at least 1,000 people per month.[34] Plaintiffs, as civil detainees, are entitled to "more considerate treatment" than their criminal counterparts, *Jones*, 393 F.3d at 931-32, but Defendants have notably not extended them similar treatment. Out of well over 30,000 civil ICE detainees nationwide, the agency has released 693,[35] and does not intend to release more.[36] In YCJ, also home to individuals incarcerated for criminal offenses, the county has released some prisoners in response to COVID-19, but ICE has *increased* its population of civil detainees.[37] Instead of depopulating detention centers in line with criminal justice authorities nationwide, Defendants have sought to make changes at the margins that do not effectively address the risk that their current custody imposes on Plaintiffs. *See* Greifinger ¶ 47. Because Plaintiffs have been afforded considerably inferior treatment than their criminal counterparts, their continued detention is presumptively unconstitutional.

It is well-settled that a detained individual's constitutional protections extend to "future harm," including a "condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or years." *Helling v. McKinney*, 509 U.S. 25, 33 (1993); *see also id.* at 34 ("It would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening condition in their prison on the ground that nothing yet had happened to them"); *Parsons v. Ryan*, 754 F.3d 657, 679 (9th Cir. 2014) (affirming the certification of a class of prison inmates and explaining that "every single [] inmate faces a substantial risk of serious harm if [the prison's] policies and practices provide constitutionally deficient care for treatment of medical, dental, and mental health needs").

As detailed *supra*, under the current conditions in Mesa Verde and YCJ, Plaintiffs are exposed to a risk of infection with a deadly, incurable virus because consistent social distancing

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[34] *Id*.
[35] Hott Decl. ¶¶ 10, 13, ECF No. 125-1, *Fraihat v. ICE*, No. 5:19-cv-01456 (C.D. Cal. Apr. 15, 2020).
[36] Press Release, House Comm. on Oversight and Reform, *DHS Officials Refuse to Release Asylum Seekers and Other Non-Violent Detainees Despite Spread of Coronavirus* (Apr. 17, 2020), https://oversight.house.gov/news/press-releases/dhs-officials-refuse-to-release-asylum-seekers-and-other-non-violent-detainees.
[37] Riordan ⁋ 9 (noting increase in ICE population at YCJ); *id*. Exh. G, David Wilson, *Yuba County Jail Population Reduced*, Appeal Democrat (Apr. 15, 2020).

is impossible. *Supra* § II.B. Defendants cannot seriously dispute this. Three judges in this district have ordered detainees released from Mesa Verde and YCJ, pointing to their risk of infection without the ability to maintain social distance. *Bahena Ortuño*, 2020 WL 1701724 at *4 (finding that four "petitioners cannot practice meaningful social distancing in [Mesa Verde and YCJ]"); *Bent*, 2020 WL 1812850 at *6 ("[E]ven assuming that Respondents accurately describe [Mesa Verde]'s current practices, these practices are inadequate to ensure the 'safety and general wellbeing' of [Mesa Verde] detainees during the COVID-19 pandemic."); *Doe v. Barr*, No. 3:20-cv-02141 LB, 2020 WL 1920667 at *10-11 (citing *Bahena Ortuño* and *Bent* in holding same for YCJ detainee).

Because *all* adults risk serious harm if they contract COVID-19, *see* Greifinger ¶ 8, and all individuals are at the same risk of contracting COVID-19, all putative class members are at serious risk of harm from COVID-19. *Cf. Savino v. Souza*, No. 1:20-cv-10617-WGY, 2020 WL 1703844 at *7 (D. Mass. Apr. 8, 2020) (certifying class of all ICE detainees in Bristol County House of Corrections and recognizing that "[c]rucial to the Court's determination is the troubling fact that even perfectly healthy detainees are seriously threatened by COVID-19. . . . it cannot be denied that the virus is gravely dangerous to all of us"); *Malam v. Adducci*, No. 2:20-cv-10829, 2020 WL 1809675 at *3) (E.D. Mich. Apr. 9, 2020) ("declin[ing] to set a floor for the level of risk a party must show to warrant immediate release from immigration detention due to the COVID-19 pandemic" and ordering release of ICE detainee who did not fall into CDC risk category.)

The Government's judicially-recognized interest in the continued detention of Plaintiffs—ensuring public safety and that Plaintiffs appear at their removal proceedings—cannot justify exposing them to a substantial risk of contracting a deadly, incurable virus and suffering severe bodily harm or death as a result. Judges in this District have already ordered individual detainees released, finding that the government's interests can be accomplished through "alternative, less harsh methods," like release on supervision and conditions. *Bahena Ortuño* 2020 WL 1701724 at *4 (finding that despite the government's "non-punitive purpose"

in detaining petitioners their current detention is "excessive in relation to that purpose"); *Doe*, 2020 WL 1820667 at *10 (same for YCJ detainee); *Bent*, 2020 WL 1812850 at *7-8 (same for Mesa Verde detainee). Courts throughout the country have reached similar conclusions. *See, e.g.*, *Rafael L.O. v. Tsoukaris*, No. 20-3481, 2020 WL 1808843 at *7 (D.N.J. Apr. 9, 2020) (recognizing that "COVID-19, and its associated risks, is the difference maker—it changes the equation in evaluating the government's legitimate objectives"); *Thakker v. Doll*, No. 1:20-cv-480, 2020 WL 1671563 at *8 (M.D. Pa. Mar. 31, 2020) (same for ICE detainees in York County Jail in Pennsylvania). ICE itself has recognized as much when it issued a statement recognizing the need for alternatives to detention for *new arrestees* to protect public health.[38] Inexplicably, however, ICE has refused to apply that same logic to its current detainees.

This is particularly troubling because it is well established that 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. *See Thakker*, 2020 WL 1671563 at *8 (noting "that ICE has a plethora of means *other than* physical detention at their disposal by which they may monitor civil detainees and ensure that they are present at removal proceedings, including remote monitoring and remote check-ins") (emphasis in original). These alternatives to detention are highly effective: for example, a federally contracted evaluation of a program that featured monitoring instead of immigration detention reported a 99% attendance rate at all immigration court hearings and a 95% attendance rate at final hearings. *See* 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. 2014), https://www.gao.gov/assets/670/666911.pdf; *see also Brief of 43 Social Science Researchers and Professors as Amici Curiae in Support of Respondents*, at 36-37, *Jennings v. Rodriguez*, 2016 WL 6276890, (No. 15-1204) (discussing an alternatives to detention program studied in

[38] *See* ICE Guidance on COVID-19, https://www.ice.gov/covid19 (Apr. 17, 2020) (during pandemic, in many circumstances ICE "will exercise discretion to delay enforcement actions until after the crisis or use alternatives to detention, as appropriate."), available at https://www.ice.gov/covid19.

2011 that saw fewer than 1% of participants removed from the program due to arrest by another law enforcement agency).

Plaintiffs and the proposed class are therefore likely to demonstrate that the government's interests could be satisfied by alternatives to detention and that their current detention in dangerous conditions is unconstitutionally excessive.

b. Plaintiffs are also Likely to Prevail by Showing Defendants' Refusal to Ensure Adequate Social Distancing Constitutes Deliberate Indifference

People in government custody have a right to reasonable health and safety. *See Youngberg v. Romeo*, 457 U.S. 307, 315–16 (1982). "The rationale for this principle is simple enough: when the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs—e.g., food, clothing, shelter, medical care, and reasonable safety—it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause." *DeShaney v. Winnebago Cty. Dep't of Soc. Servs*., 489 U.S. 189, 200 (1989).

As individuals who are detained for civil offenses, Plaintiffs need not prove "deliberate indifference" to prevail on a substantive due process claim. *Jones*, 393 F.3d at 933. Nonetheless, here, Defendants clearly are being deliberately indifferent to the substantial risks posed by COVID-19 within the congregate detention environments of Mesa Verde and YCJ. In contrast to the subjective Eighth Amendment standard, the Fifth Amendment deliberate indifference standard is purely objective. The government violates due process when "there is a substantial risk of serious harm" to Plaintiffs and the proposed class "that could [be] eliminated through reasonable and available measures that [Defendants] did not take" and that are likely to "caus[e] the injury the plaintiff [will] suffer[]." *Castro v. Cnty. of Los Angeles*, 833 F.3d 1060, 1070 (9th Cir. 2016). Where Defendants are fully aware of the serious risks facing Plaintiffs and fail to take the only measures known to effectively mitigate those risks, they are deliberatively indifferent under the Fifth Amendment. *See, e.,g.*, *J.P. v. Sessions*, 2019 WL 6723686 at *36 (C.D. Cal. Nov. 5, 2019) (finding the plaintiffs likely to succeed in proving the government was

deliberately indifferent where they presented evidence that immigration enforcement agencies were aware of risks associated with a policy and implemented it anyways).

Here, Defendants have acted, and continue to act, with deliberate indifference to known and obvious risks of COVID-19 transmission. On February 25, 2020, March 13, 2020, and March 19, 2020, Defendants' own medical experts warned them that COVID-19 endangered everyone in their custody and that "social distancing is essential to slow the spread of the coronavirus to minimize the risk of infection." *See supra* Drs. Allen & Rich Letter (Mar. 19, 2020). On March 17, 2020, these same medical experts published an opinion piece in the *Washington Post* explaining the need to act immediately to stem the spread of COVID-19 in jails and prisons.[39] They warned Defendants that only release from custody on a large scale could prevent calamity. Scores of medical experts, including the expert testimony in this case, have subsequently agreed. Greifinger ¶¶ 47, 58; Hernandez ¶ 30; Mishori ¶¶ 22-23. Respondents have disregarded their advice and instead adopted a series of half-measures that are "patently insufficient to protect Petitioners." *Basank v. Decker*, No. 20 Civ. 2518, 2020 WL 1481503, at *6-7 (S.D.N.Y. Mar. 26, 2020) (ordering release from immigration detention because Defendants were deliberately indifferent to risk of COVID-19 infection); *see also Castillo*, 2020 WL 1502864, at *5 (ordering release from Adelanto ICE Processing Center because "Petitioners have not been protected. They are not kept at least 6 feet apart from others at all times. They have been put into a situation where they are forced to touch surfaces touched by other detainees, such as with common sinks, toilets, and showers.").

It is not possible to mitigate the risk of contracting COVID-19 in Mesa Verde and YCJ without consistent social distancing. Greifinger ¶ 31 ("If there is inadequate social distancing, hygiene and sanitation, there will almost certainly be infection and an outbreak."), ¶ 59 ("The only way to avoid these unacceptable risk is to materially reduce the population, implement social distancing as described herein, and ensure appropriate hygiene."). According to the CDC

[39] Josiah Rich *et. al*, *We must release prisoners to lessen the spread of coronavirus*, Washington Post (Mar. 17, 2020), https://www.washingtonpost.com/opinions/2020/03/17/we-must-release-prisoners-lessen-spread-coronavirus/.

a "cloth face cover is not a substitute for social distancing."[40] The uniform medical consensus, embraced by the CDC, maintains that even when vigilant hygiene and sanitation are maintained,[41] it simply is not possible to prevent contagion unless people can maintain a physical distance of at least six feet from one another at all times. Greifinger ¶47.

While Defendants have issued guidance to "promote" social distancing,[42] it is patently insufficient at Mesa Verde and YCJ, where social distancing is currently impossible. Greifinger Dec. ¶ 47 ("The measures outlined in ICE's April 10 Guidance are impossible to carry out given the limits of the infrastructure" at Mesa Verde and YCJ). Even if, as the guidance suggests, detention centers actually reduce their populations to 75% of capacity, Dr. Greifinger points out that "ICE provides no evidence that 70% of 75% capacity would facilitate effective social distancing within dormitories or cells, which requires that individuals maintain six feet of separation." Greifinger Dec. ¶ 48(a). As Judge Phillips just found in a case involving prisoners, "The County's assurances that it has provided unlimited free soap to prisoners and advised prisoners to remain physically distant—without establishing that it is physically possible to do so—is unlikely to be sufficient to defeat a claim of deliberate indifference . . . In sum, Defendant has failed to demonstrate that it is currently taking adequate precautions to protect the health of the prisoners in the country jails." *Gray v. Cty. of Riverside*, 5:13-cv-0444-VAP-OPx (C.D. Cal. Apr. 14, 2020), Order at *5 (ECF 191).

Similarly, courts have already found that ICE's current actions to date—which include providing free soap, increasing sanitation supplies, screening staff for body temperature, and encouraging good hygiene—do not satisfy Defendants' constitutional duty to mitigate the risk of harm to detainees in Mesa Verde and YCJ because they do not accommodate social distancing. *Doe*, 2020 WL 1820667 at *11 ("The petitioner cannot meaningfully protect himself at the Yuba County jail from the risks of his custody"); *Bahena Ortuño*, 2020 WL 1701724 at

[40] CDC, Coronavirus Disease 2019 (COVID-19) Protect Yourself: Know How It Spreads, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html.
[41] Vigilant hygiene and sanitation are not possible at Mesa Verde and YCJ. *Supra* § II.C.
[42] ICE ERO COVID-19 Pandemic Response Requirements at 4, 13 (Apr. 10, 2020), available at https://www.ice.gov/covid1.

*4 (ordering release of petitioners with medical vulnerabilities because they "cannot practice meaningful social distancing in [Mesa Verde and YCJ]").

The facts are clear: social distancing is the only meaningful measure to prevent the spread of COVID-19 among the Plaintiff class. Social distancing is currently impossible in Mesa Verde and YCJ. It will continue to be impossible in Mesa Verde and YCJ unless Defendants significantly reduce the detained populations in each detention center. Mishori ⁋⁋ 22-23. The law is also clear: because Defendants have failed to take known, available measures to mitigate an obvious, substantial risk to Plaintiffs, the law is also clear: the conditions of Plaintiffs' confinement violate due process. *See Castro*, 833 F.3d at 1071.

B. Plaintiffs Satisfy the Remaining Factors for Preliminary Relief

1. Exposure to a Lethal Virus Which Lacks Any Vaccine, Treatment, or Cure Constitutes Irreparable Harm

"[T]he deprivation of constitutional rights 'unquestionably constitutes irreparable injury.'" *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012) (quoting *Elrod v. Burns*, 427 U.S. 347, 373 (1976)). Irreparable harm exists where government actions threaten an individual's health. *See M.R. v. Dreyfus*, 663 F.3d 1100, 1111 (9th Cir. 2011), *as amended by* 697 F.3d 706 (9th Cir. 2012); *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1047, 1050 (9th Cir. 2008). Likewise, continued immigration detention under "substandard physical conditions, [and] low standards of medical care" is a form of irreparable harm supporting injunctive relief. *See Padilla v. ICE*, 953 F.3d 1134, 1148 (9th Cir. 2020). Defendants cannot dispute that all adults face a risk of serious illness upon contracting COVID-19. Greifinger Dec. ¶ 8, that social distancing is the only effective measure to prevent the spread of COVID-19, Hernandez Dec. ¶ 12, and that social distancing will not be possible inside Mesa Verde and YCJ without reducing the detained population. Greifinger Dec. ¶¶ 33-35. "Inadequate health and safety measures at a detention center cause cognizable harm to every detainee at that center." *Hernandez v. Wolf*, No. 20-cv-00617, slip op. at 8-9 (C.D. Cal. Apr. 1, 2020), *citing Parsons*,

754 F.3d at 679. The entire Plaintiff class is at risk or irreparable harm that can be remedied only be depopulating Mesa Verde and YCJ.

2. Public Interest and Balance of Equities Weigh Heavily in Plaintiffs' Favor

Plaintiffs' continued detention at current population levels "threatens the health of detainees, staff and the broader population." Greifinger Dec. ¶ 24. For these reasons, as in the cases where this Court has already granted relief, the balance of equities falls squarely in the Plaintiffs' favor. *See Doe*, 2020 WL 1920667 at *11; *Bent*, 2020 WL 1812850 at *7; *Bahena Ortuño*, 2020 WL 1701724 at *4.

As an initial matter, "[f]aced with . . . preventable human suffering, [the Ninth Circuit] ha[s] little difficulty concluding that the balance of hardships tips decidedly in plaintiffs' favor." *Hernandez v. Sessions*, 872 F.3d 976, 996 (9th Cir. 2017) (quotation omitted). Moreover, it is in both ICE's and the broader public interest to reduce the threat of an imminent COVID-19 outbreak at Mesa Verde and YCJ. ICE has an interest in preventing any potential spread of COVID-19 in its detention facility, which may then affect guards, visitors, attorneys, and others who may potentially interact with detainees. An outbreak of COVID-19 at Mesa Verde and YCJ would doubtless put significant pressure on or exceed the capacity of local health infrastructure. Hernandez Dec. ¶¶ 23 (stating that an outbreak at Mesa Verde or YCJ would likely "strain[] and overload[]" nearby emergency medical facilities) As a judge of this Court explained:

> [U]nder the highly unusual circumstances presented, i.e., a global pandemic of a type not seen within recent memory, the public interest is served by the requested injunction. Specifically, the public interest in promoting public health is served by efforts to contain the further spread of COVID-19, particularly in detention centers, which typically are staffed by numerous individuals who reside in nearby communities.

Bahena Ortuño, 2020 WL 1701724 at *4. Accordingly, the balance of equities favors Plaintiffs. To the extent ICE has public safety or flight concerns about any particular detainee, those can be accounted for through the alternatives to detention discusses above. *See supra* at 17-18.

C. Justice Requires Comprehensive Relief for the Class

"[T]he appropriate capacity of a jail during a pandemic obviously differs enormously from its appropriate capacity under ordinary circumstances." *Bent*, 2020 WL 1812850 at *4, *quoting Basank*, 2020 WL 1481503 at *6. There are hundreds of ICE detainees at Mesa Verde and YCJ. Should the Court deny Plaintiffs' motion for provisional class certification and a temporary restraining order, dozens of individual Mesa Verde and YCJ detainees will likely file claims for relief depending on their access to lawyers. Those individual petitions would vindicate individual Petitioners through release, but, given the time-consuming nature of individual habeas litigation, would leave hundreds of identically situated people detained under conditions that violate their due process rights. They also would constitute an enormous tax on this Court's resources, will likely take too long and would, at best, result in constitutional rights turning on the happenstance of whether a detainee has access to a lawyer, or on their language skills and education level. That is fundamentally unfair. *All* of the Proposed Class Members are at grave risk of COVID-19 infection under their current conditions of confinement, regardless of whether their circumstances permit them to file individual claims. The appropriate remedy for the system-wide crisis at Mesa Verde and YCJ is system-wide relief for all those whose rights are being violated.

Litigation on behalf of the detainees in both facilities, which share in the jurisdiction of the San Francisco ICE Field Office, also prevents absurd efforts that depopulate one facility but result in increased populations in the other, like transfers *between* the facilities. During the course of the COVID-19 pandemic, ICE has transferred detainees from YCJ to Mesa Verde, thus reducing the population in one while increasing the other, and unjustifiably placing the transferred detainee and detainees in the new facility at risk. Sanchez-Nunez ¶ 16 (detainee transferred from YCJ to Mesa Verde immediately introduced into general population).

Another district court recently certified a class of ICE detainees held at two detention centers in Bristol County, Massachusetts, recognizing that a systemic remedy was necessary "*in order to protect everyone* [in the facility] from the impending threat of mass contagion." *See Savino*, 2020 WL 1703844 at *7 (emphasis added). That court issued an order requiring a

reduction of the population of those detention centers on an expedited, individualized basis. *Id*. at 28.

Plaintiffs propose that this Court adopt a similar procedure, as set forth in the Proposed Order, by which claims for relief are processed fast enough that there is a chance social distancing could be established at Mesa Verde and YCJ before a serious outbreak occurs, but also allows this Court to assess the individual circumstances of detainees at Mesa Verde and YCJ and craft appropriate conditions of release. Of course, nothing in Plaintiffs' Proposed Order bars Defendants from implementing an alternative plan to rapidly reduce the populations to a level where they could implement social distancing at both facilities.

ICE, however, has steadfastly refused to implement such a system to date— leaving no doubt that this Court's intervention is desperately needed. This Court should grant the temporary restraining order, adopt Plaintiffs' proposal for considering release requests on an expedited basis, and keep that system in place until the Government takes the necessary steps to cease the ongoing system wide Fifth Amendment violation at Mesa Verde and YCJ.

V. SECURITY

"Rule 65(c) invests the district court with discretion as to the amount of security required, if any." *Jorgensen v. Cassiday*, 320 F.3d 906, 919 (9th Cir. 2003) (internal quotation marks and citation omitted). District courts routinely exercise this discretion to require no security in cases brought by indigent and/or incarcerated people. *See, e.g.*, *Toussaint v. Rushen*, 553 F. Supp. 1365, 1383 (N.D. Cal. 1983) (state prisoners); *Orantes–Hernandez v. Smith*, 541 F. Supp. 351, 385 n. 42 (C.D. Cal. 1982) (detained immigrants). This Court should do the same.

VI. CONCLUSION

This Court should grant Plaintiffs' motion and order ICE to release people from Mesa Verde and YCJ in order to facilitate social distancing.

Dated: April 20, 2020

Respectfully submitted,

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

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Petitioners-Plaintiffs,

v.

DAVID JENNINGS, Acting Director of the San Francisco Field Office of U.S. Immigration and Customs Enforcement; MATTHEW T. ALBENCE, Deputy Director and Senior Official Performing the Duties of the Director of the U.S. Immigration and Customs Enforcement; U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT; GEO GROUP, INC.; NATHAN ALLEN, Warden of Mesa Verde Detention Facility,

Respondents-Defendants.

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Declaration of Sandra Hernandez

1. I am the president and CEO of the California Health Care Foundation, which works to improve health care systems in California. Prior to joining CHCF, I was CEO of The San Francisco Foundation, which I led for 16 years. From 1994 to 1997, I served as Director of Health for the City and County of San Francisco. I also co-chaired San Francisco's Universal Healthcare Council which designed Healthy San Francisco, an innovative health access program for the uninsured.

2. In February 2018, I was appointed by Governor Jerry Brown to the Covered California Board of Directors. In December 2019, I was appointed by Governor Gavin Newsom to the Healthy California for All Commission. I served on President Bill Clinton's Commission on Consumer Protection and Quality in the Healthcare Industry, and on two Institute of Medicine committees, including one on the Implementation of Antiviral Medication Strategies for an Influenza Pandemic. Since 2017, I have been on the Planning Committee for the Future of Health Services Research at the National Academy of Medicine. I also serve on the University of California Regents Health Services Committee and the University of California-Davis Gordon & Betty Moore School of Nursing National Advisory Committee.

3. I practiced at San Francisco General Hospital in the HIV/AIDS Clinic from 1984 to 2016 and was an assistant clinical professor at the UCSF School of Medicine. I am a graduate of Yale University, the Tufts School of Medicine, and the certificate program for senior executives in state and local government at Harvard University's John F. Kennedy School of Government.

4. Attached as Exhibit A is my curriculum vitae.

A. Respiratory Spread of COVID-19

5. The COVID-19 strain was isolated on January 7, 2020 after the first cases of the 2019 novel coronavirus (SAS-CoV-2) were identified in December 2019. The public health

response in Wuhan, China, where the strain first appeared, was a mass quarantine of 59 million people in Wuhan and surrounding cities in mid-January. By the end of January, the World Health Organization declared the spread of COVID-19 an international public health emergency.

6. Transmission of COVID-19 is largely through community contact via respiratory spread. Droplets carrying the virus are transmitted primarily through hands and surfaces. As a result, infection control must focus on reducing droplet spread. Studies have shown viral shedding before symptom onset and in asymptomatic patients, suggesting that these individuals are important in disease transmission.

7. Any publicly reported tally of reported cases and deaths from COVID-19 almost certainly represents an undercount of infections given the constrained availability and accessibility of COVID-19 testing. The overwhelming majority of cases, in the United States and around the world, have resulted from community transmission.

8. About 5% of patients with COVID-19 will develop acute respiratory distress syndrome (ARDS) and require intensive care. Approximately 20% of infected individuals may need hospitalization for clinical reasons.

B. U.S. and California Public Health Response to COVID-19

9. Testing capacity for COVID-19 was slow to become available in the United States. It is now increasing in California and across the country but remains insufficient to respond to the need. As testing increases, it is expected that the number of confirmed cases will increase markedly.

10. There is currently no treatment or vaccine for COVID-19. The clinical response for most individuals with COVID-19 is limited to infection control. Patients with COVID-19 will require isolation and, depending on the severity of symptoms, hospitalization.

11. Limiting the growth of new cases can be achieved by (1) limiting social contact through social distancing and self-quarantine; (2) limiting the probability of infection during social contacts through, i.e., ensuring personal hygiene and hand-washing, disinfecting frequently touched surfaces and, where appropriate, wearing personal protective equipment; (3) decreasing the infectious period through contact tracing, case isolation, and timely treatment if medication is available; and ultimately (4) reducing population susceptibility to the virus through vaccination.

12. At this point, given the lack of more widespread community testing, and the lack of available treatments, the only option is mitigation. The most effective mitigation measures are community-wide social distancing.

13. The public health response to COVID-19 in California has been extensive. The primary goal of the response has been to limit the growth of new cases in order to flatten the outbreak. If effective, this serves to protect limited health care resources and allow time for the development of effective medication and vaccines. Without an intervention, the pandemic will quickly overwhelm the capacity of the health systems to respond to both COVID-19 and other medical needs.

14. To that end, on March 4, Governor Gavin Newsom declared a state of emergency to make resources available, formalize emergency actions, and assist in state preparations for an anticipated spread of COVID-19.[1] He also used the state's authority to make all medically necessary screening and testing for COVID-19 free for 24 million more California residents.[2] This includes waiving all fees for emergency room, urgent care or provider office visits related to the screening and testing of COVID-19. The state also encouraged health plans to expand telehealth services in order to increase screening and testing capacity.

[1] See https://www.gov.ca.gov/wp-content/uploads/2020/03/3.4.20-Coronavirus-SOE-Proclamation.pdf (accessed Mar. 21, 2020).
[2] See https://www.cdph.ca.gov/Programs/OPA/Pages/NR20-012.aspx (accessed Mar. 21, 2020).

15. In a March 15 proclamation, Governor Newsom advised all people over the age of 65 to shelter in place; ordered the closure of bars, nightclubs, wineries and brewpubs; decreased restaurant capacity by half to permit social distancing; and severely restricted visitors to long-term care facilities and hospitals. He also announced that 51% of school districts, which represent 80-85% of all students in California, had closed for an extended period. He further expressed the intent of public authorities to procure hotels and motels for homeless people in order to decrease the risk of transmission for the unhoused.

16. On March 16, seven Bay Area counties issued the first "shelter in place" policies in the country. Three other counties followed. Pursuant to these policies, individuals were directed to severely limit activity, travel and business outside the home. Only essential services, such as health care, police, grocery stores, and gas stations, were exempted. On March 19, Governor Newsom expanded the "shelter in place" policy to the entire state.[3] There are a growing number of shelter in place policies across the country.

17. COVID-19 remains a serious public health threat in California and nationwide. However, as of today, these public health measures adopted in California appear to have been effective in "flattening the curve," or reducing the rate of increase of infections and deaths, in the state. Although California was one of the earliest states to experience a significant number of cases and deaths, it now ranks relatively low among the states in terms of infections and deaths as a percentage of the population.

18. There have been COVID-19 cases reported in Kern and Yuba Counties, the sites of the Mesa Verde and Yuba immigration detention centers, respectively. As of April 18, 2020, there are 610 confirmed cases in Kern County[4] and 41 confirmed cases in Yuba and Sutter Counties.[5]

[3] See https://www.gov.ca.gov/wp-content/uploads/2020/03/3.19.20-attested-EO-N-33-20-COVID-19-HEALTH-ORDER.pdf (accessed Mar. 22, 2020).
[4] See https://www.bakersfield.com (accessed Apr. 18, 2020).
[5] See https://www.yuba.org/coronavirus/ (accessed Apr. 18, 2020).

C. Effects on Public Health of a COVID-19 Outbreak in Prisons, Jails or Detention Facilities

19. Jails, prisons and detention facilities are places where individuals eat, sleep and live in close quarters. These are the type of environments where infectious diseases can most quickly spread. This is particularly true as respiratory hygiene within these facilities are limited.

20. Detention facilities have limited ability to allow for social distancing, and therefore are unable to effect the kinds of public health response measures that appear to have been effective to date in slowing the transmission of COVID-19.

21. In addition, detention facilities do not generally have the ability to isolate people who are infected with COVID-19; to test all detainees in order to identify those with COVID-19 infection (whether they are symptomatic or asymptomatic); to provide the acute respiratory support for individuals who manifest severe respiratory distress due to the infection.

22. Prisons, jails and detention facilities are not isolated from the community. They are part of and rely on the broader community. People from the community—including staff, contractors and vendors—come and go for various reasons. Detainees also need to be transported to and from facilities to attend court hearings, for specialized medical care, or for other reasons. There can also be rapid turnover of individuals in the facilities. With each entry and exit, individuals can bring infectious disease into or out of the facilities.

23. Typically, immigration detention facilities are also in medically under-resourced areas. This is true for Mesa Verde, in Bakersfield, California; and Yuba County Jail, in Marysville, California. Marysville and Bakersfield are medically underserved. The immigration detention facilities are not designed to handle specialized or intensive care. Thus, if an individual detainee—or many detainees—need specialized care, they must rely on the medical resources that are available in the community. In rural parts of California, these resources quickly become strained and overloaded.

24. Compelling evidence and current public health mitigation efforts would suggest that all efforts to avoid a COVID-19 infection outbreak in detention centers would significantly reduce the burden both on employees in those centers as well as the larger community in which those centers reside such that the health care delivery system can cope with existing infections better.

25. All counties are already burdened or expecting to be burdened by COVID-19, hence the extraordinary public health interventions. But there would be more capacity to respond if detained individuals are released to their homes—where there is less likelihood of infection because there is greater possibility of social distancing.

26. Access to emergency medical services can be constrained because of the COVID-19 related health burdens increasingly imposed on emergency health services. All individuals in California have access to emergency medical care, regardless of their immigration status. The barrier to emergency COVID-19 care for someone without lawful immigration status in California would be more the capacity of the health system, and not their immigration status.

27. California's rural hospitals would likely be unable to cope with an outbreak of COVID-19 at a local immigration detention facility. This would limit the effectiveness of the response for the individual infected and needing emergency care. But it would also affect others in the community who might have unmet medical needs.

28. For these reasons, an outbreak of COVID-19 at immigration detention facilities would have ripple effects for the community at large. Prison health is public health.

D. Benefits to Public Health from Release of Immigration Detainees

29. In my opinion, there is an opportunity to promote the public health in the communities where the detention centers exist. It would be in the community's best interests to rapidly depopulate these congregate facilities in California.

30. For the reasons elaborated above, and the reasons which are motivating unprecedented public health directives at the local and state levels, it is my expert opinion that it is in the interest of the public health of the State of California for immigration detention facilities to release detainees into the community. This is true so long as the individuals have a home to go to and they are willing and able to abide by local guidelines and directives.

31. It is consistent with the public health guidance and priorities of the State to encourage the release of detainees. The unnecessary detention of individuals in congregate facilities in the midst of a pandemic has risks to the individual and to the broader public.

32. The current recommendations of health care providers in the state are for individuals to rest and recuperate at home, including if they have been tested and/or exposed to COVID-19, so long as they are not experiencing severe symptoms. Under current guidelines, individuals who are exposed to a COVID-19 patients ought to be tested for COVID-19, quarantined for 14 days, and assessed for COVID-19 infection. Therefore, individuals who have been exposed to COVID-19, including in the detention centers, ought to quarantined where they are not in a congregate living situation and not exposing others to potential infection. This is true for individuals who have exposure to COVID-19 in the detention centers.

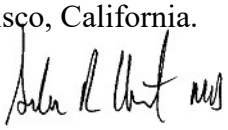
33. Even if the aggressive public health interventions across California ultimately result in a stabilizing or improving infection rate, this would not necessarily eliminate the need to decrease significantly the populations in the detention facilities. This is for several reasons. First, the heightened risk of infectious spread inside the detention facilities would continue because of the unique characteristics of congregate settings, even if things improved somewhat outside the detention facilities. Second, the fact that the detention centers would remain as hotspots, or potential hotspots, would pose a threat both to those detained and also to the health of the public in the facilities and beyond. In some ways, the detention centers pose a unique threat to the public's health after there is stabilization outside of the detention centers in the

community, because an outbreak in the detention centers would threaten to reignite the spread of the pandemic when there has been some containment. Absent widespread testing in the community, which does not currently exist in California, it is also impossible to know current case rates and trends in new case infections. For these reasons, the loosening of social distancing cannot happen overnight; there will not be an on-off switch even for counties and the state. The detention centers will continue to pose a risk for those detained and for the broader public for some time after social distancing is relaxed in the areas around the detention centers.

34. Thus, it is consistent with state and local guidance for the general population to immediately depopulate detention centers as they are extremely high-risk for exacerbating the COVID-19 epidemic.

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

Executed this 20th day in April 2020 in, San Francisco, California.



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Declaration of Robert B. Greifinger, MD

I, Robert B. Greifinger, declare as follows:

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

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

Foundation

3. In connection with my participation as an expert witness in this case, I have reviewed the following documents concerning ICE's policy and practice related to the coronavirus (collectively "ICE COVID protocols"):

   - The March 6, 2020 interim guidance sheet[2] produced by ICE Health Services Corps, the body that oversees ICE detention facilities' medical care,
   - ICE's guidance on its website, last updated April 14, 2020 ("ICE Website Guidance"),[3] and
   - ICE ERO's COVID-19 Pandemic Response Requirements, last updated April 10, 2020 (which I refer to later as the "April 10 Guidance").[4]

4. I have also reviewed the following documents concerning the Mesa Verde and Yuba County Jail immigration detention facilities:

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

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

[3] U.S. Immigration and Customs Enforcement, *ICE Guidance on COVID-19*, ICE.GOV (last updated Apr. 14, 2020), https://www.ice.gov/covid19.

[4] U.S. Immigration and Customs Enforcement, Enforcement and Removal Operations, *COVID-19 Pandemic Response Requirements* (Apr. 10, 2020), https://www.aila.org/infonet/ice-ero-releases-covid-19-pandemic-response.

- The declarations of fact witnesses produced in this case concerning the conditions at Mesa Verde Detention Center and the ICE detention facility at Yuba County Jail (Lisa Knox and Kathleen Kavanaugh, respectively);

- Declarations of Plaintiffs and other declarants in this case describing the conditions at the detention facilities;

- The California Department of Justice Review of Immigration Detention in California (February 2019), including descriptions of the facilities and the capacity of Mesa Verde Detention Center and Yuba County Jail[5] ("CalDOJ Report");

- The 2018 Prison Rape Elimination Act audit for Mesa Verde, describing four dorms, three restricted housing unit cells, and medical isolation rooms (page 2) ("Mesa Verde PREA Audit");

- Declarations of Carl Takei (Dkts. 177-1 & 119-20) from the motion for summary judgment in *Lyon v. ICE*, Case 13-cv-05878 (2016), including exhibits which contain photographs and video stills of Mesa Verde dorms and other facilities circa 2015 (Dkt. 177-1) ("Takei Mesa Verde Declaration"), and providing the foundation for photographs of Yuba County Jail (119-20, including photographs of Unit I (DSC 105 at Dkt. 197-15), Unit R (DSC 112 & 114 at Dkt. 197-15), and Unit C (DSC 198, at Dkt. 197-17);

- Redacted expert report of Michael A. Berg from motion for summary judgment in *Lyon v. ICE*, Case 13-cv-05878 (2016), including a description of the Yuba County Jail housing units ("Berg Report");

- Declaration of Phil Stanley from *Hedrick v. Grant* consent decree proceedings (2016),[6] with a general description of the Yuba County Jail housing units (paragraphs 12-14) ("Stanley Declaration").

COVID-19

5. COVID-19 is a disease caused by a coronavirus that has reached pandemic status. As of April 14, 2020, according to the World Health Organization, nearly two million people have been diagnosed with COVID-19 around the world and 117,000 people have died.[7] In the United States, nearly 700,000 people have been diagnosed and more than 35,000

[5] https://oag.ca.gov/sites/all/files/agweb/pdfs/publications/immigration-detention-2019.pdf.
[6] Declaration of Phil Stanley in Support of Plaintiffs' Motion to Enforce Consent Decree and for Further Remedial Orders, Oct. 20, 2016, Case No. 2:76-cv-00162-GEB, Dkt. 163-4, at https://bloximages.newyork1.vip.townnews.com/appeal-democrat.com/content/tncms/assets/v3/editorial/7/15/71575698-9b0b-11e6-824a-5f3b62160b74/580febccf3c58.pdf.pdf
[7] World Health Organization, Coronavirus Disease 2019 (COVID-19) Situation Report-85, Apr. 14, 2020, https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200414-sitrep-85-covid-19.pdf?sfvrsn=7b8629bb_4 (last accessed Apr. 18, 2020).

people have died thus far.[8] These numbers are likely an underestimate, due to the lack of availability of testing in countries like the United States.

6. There is no vaccine to prevent COVID-19. There is no known cure or anti-viral treatment for COVID-19 at this time. The only way to mitigate COVID-19 is to use scrupulous hand hygiene and social distancing.

7. People in the high-risk category for severe COVID-19, i.e., older adults or those with underlying disease, are likely to suffer serious illness and death. The Centers for Disease Control and Prevention (CDC) has identified underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age including blood disorders, chronic kidney or liver disease, compromised immune system, including from HIV, endocrine disorders, including diabetes, metabolic disorders, heart and lung disease, hypertension, obesity, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy. According to preliminary data from China, 20% of people in high risk categories who contract COVID-19 have died.

8. In the United States, younger adults with COVID-19 have been severely affected by the disease as well. While people under the age of 20 have largely been protected from severe effects of the coronavirus, 55% of COVID-19 hospitalizations and 20% of deaths were from people between the ages of 20 and 64.[9] The World Health Organization has recognized that the risk of severe COVID-19 gradually increases with age, beginning at around 40 years old.[10] Reports from New York City, the area hardest-hit by the virus in the United States, show a surprising number of people severely affected who are younger and without known underlying conditions.[11]

9. A primary concern of medical and public health experts and public officials is the effect that the pandemic is having and will have on health systems. Because severe COVID-19 cases require extended hospitalization and intensive medical care, a significant number of COVID-19 cases can quickly overwhelm a health system. This is true in urban areas, but is particularly true in rural areas where health care facilities have far more limited capacity to respond to an increase in patients who need hospitalization and intensive care.

Mitigation Measures

10. The mode of transmission of COVID-19 is believed to be through close exposure

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[8] Centers for Disease Control and Prevention, Coronavirus Disease 2019: Cases in the US, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html (last accessed Apr. 18, 2020).
[9] Centers for Disease Control and Prevention, "Morbidity and Mortality Weekly Report: Severe Outcomes Among Patients with Coronavirus Disease 2019," Mar. 27, 2020, at https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm (last accessed April 18. 2020).
[10] World Health Organization, "Coronavirus Disease 2019: Situation Report—51," Mar. 11, 2020, at https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200311-sitrep-51-covid-19.pdf?sfvrsn=1ba62e57_10.
[11] *See, e.g.*, Michelle Fay Cortez & Olivia Carville, "Many New York Coronavirus Patients Are Young, Surprising Doctors," Bloomberg, Apr. 1, 2020, at https://www.bloomberg.com/news/articles/2020-04-01/coronavirus-in-young-people-ny-patients-skew-younger-some-die.

of someone to a person who is infected with the virus, most commonly through respiratory droplets released when a person speaks, coughs or sneezes. Transmission is also possible through contact with contaminated surfaces. There is ongoing scientific debate about whether coronavirus is airborne – and transmitted through aerosols, which stay in the air longer than droplets, thus far accepted as the primary means of transmission.[12] The extent and importance of airborne (or aerosol) transmission in the community (non-healthcare setting) is uncertain at this time but a cause for concern and suggests that additional protective measures should be taken.

11. Social distancing and hand hygiene are the only known ways to prevent the rapid spread of COVID-19. The recommended hand hygiene measures are frequent handwashing with soap and water and the use of alcohol-based sanitizers when handwashing is unavailable. Surfaces such as doorknobs and light switches which have a high degree of human contact should be cleaned and disinfected regularly with bleach.

12. In addition, health care providers and individuals who come into contact with those exposed to, or infected with, COVID-19 should have access to personal protective equipment, including gloves, masks, and gowns.

13. In light of the mixed evidence about airborne transmission, public health experts are increasingly recommending additional mitigation measures, such as improved indoor ventilation, a prohibition on indoor gatherings, and a requirement that all individuals wear masks.

14. Recognizing the urgency and severity of the pandemic, 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 a risk mitigation strategy. California Governor Gavin Newsom has directed all California residents to shelter in place in order to limit the spread of the coronavirus.[13]

15. California is one of the states in the United States most severely affected by COVID-19. There are a total of more than 27,500 reported positive cases and nearly 1,000 deaths. The state health authorities have confirmed community transmission since late February.[14]

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[12] *See, e.g.*, World Health Organization, "Modes of transmission of virus causing COVID-19: implications for IPC precaution recommendations," Mar. 29, 2020, https://www.who.int/news-room/commentaries/detail/modes-of-transmission-of-virus-causing-covid-19-implications-for-ipc-precaution-recommendations; Dyani Lewis, "Is the Coronavirus Airborne? Experts Can't Agree," Nature, Apr. 2, 2020, at https://www.nature.com/articles/d41586-020-00974-w.

[13] See https://covid19.ca.gov/img/Executive-Order-N-33-20.pdf , accessed March 20, 2020.

[14] See https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx, accessed March 20, 2020.

Risks in Immigration Detention

16. The conditions of congregate settings, such as jails and immigration detention facilities, pose a heightened public health risk to the spread of COVID-19, even greater than other non-carceral institutions.

17. Immigration detention facilities are enclosed environments, much like the cruise ships and nursing homes that have been and contine to be the sites of some 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, the lack of ventilation, and often scant medical care resources. There have been numerous historic documented influenza outbreaks in detention facilities in the United States and around the world.

18. People live in close quarters and cannot achieve the "social distancing" needed to effectively prevent the spread of COVID-19. Toilets, sinks, and showers are shared, without disinfection between each 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.

19. There are often insufficient cleaning supplies, and people to conduct the required intensive cleaning. Detainees are typically not provided hand sanitizer per the rules of the facilities. Personal and shared spaces in immigration detention centers are often poorly ventilated which increases the transmissibility of infectious diseases whether airborne or spread by droplet.

20. Detainees enter the detention centers from outside and new detainees bring with them a new risk of infection transmission. Staff arrive and leave on a shift basis and interact daily with others outside of the detention facility; there is little to no ability to adequately screen staff for new, asymptomatic infection.

21. There are increasingly reports of COVID-19 infections in correctional and detention sites around the country. Once COVID-19 is introduced into these facilities, it spreads like wildfire. In mid-March, the jail at Rikers Island in New York City had not had a single confirmed COVID-19 case. Rikers now has a rate of infection that is far higher than the infection rates of the most infected regions of the world.[15] By March 30, 167 inmates, 114 correction staff and 20 health workers at Rikers tested positive for COVID-19; two correction staff members have died and multiple inmates have been hospitalized.[16] The Chief Medical Officer of Rikers has described a "public health disaster unfolding before

[15] As of March 26, Wuhan, China had an infection rate of 4.59 per 1,000 people, Lombardy, Italy had an infection rate of 3.48 per 1,000 people, and New York City had an infection rate of 2.15 per 1,000 people. Legal Aid

[16] Jan Ransom & Alan Feuer, "'We're Left For Dead': Fears of Virus Catastrophe at Rikers Jail," NY Times, Mar. 30, 2020, at https://www.nytimes.com/2020/03/30/nyregion/coronavirus-rikers-nyc-jail.html.

our eyes." In his view, following CDC guidelines has not been enough to stem the crisis: "infections in our jails are growing quickly despite these efforts."[17]

22. Like the explosive growth at Rikers, the Cook County Jail went from two confirmed COVID-19 cases on March 23 to 134 cases in a matter of one week,[18] and up to 342 confirmed inmate cases on April 16, 2020.[19] Three inmates have died.[20] In one facility for which I work for the federal court as a medical monitor, there have been 47 test-positive custody staff members, and 11 test-positive health care staff, and 24 test-positive inmates, with multiple other tests pending results as of April 17, 2020.

23. For all of these reasons, it is highly likely, and perhaps inevitable, that COVID-19 would reach the immigration detention facilities, including in California, and it has. It has been reported as of April 17, 2020 that ICE has tested only 300 detainees across the country for COVID-19, and that one-third of those tested were confirmed positive.[21] Otay Mesa Detention Center, in San Diego, is reported to have the highest number of confirmed COVID-19 cases.[22] It is notable that there are so many confirmed cases despite evidence of so few tests being conducted at immigration detention facilities.

24. The heightened risk of infectious disease transmission in immigration detention centers threatens the health of detainees, staff and the broader population. An outbreak in the detention facility will likely increase the transmission in the community as detainees will be released, and staff, contractors, and vendors will come and go from the facilities to the communities.

Medical Care in Immigration Detention

25. Many immigration detention facilities lack adequate medical care infrastructure to address the spread of infectious disease and treatment of high-risk people in detention. As examples, immigration detention facilities often use practical nurses who practice beyond

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[17] Ross MacDonald (@RossMacDonaldMD), Twitter (Mar. 30, 2020, 8:03 PM), https://twitter.com/rossmacdonaldmd/status/1244822686280437765?s=12 ("I can assure you we were following the CDC guidelines before they were issued. We could have written them ourselves. . . [I]infections in our jails are growing despite these efforts.").

[18] Sam Kelly, "134 Inmates at Cook County Jail Confirmed Positive for COVID-19," Chicago Sun Times, Mar. 30, 2020, at https://chicago.suntimes.com/coronavirus/2020/3/29/21199171/cook-county-jail-coronavirus-positive-134-cases-covid-19.

[19] Andy Grimm, *'I feel like I lost the battle for my husband,' widow of dead Cook County Jail detainee says*, Chicago Sun Times, https://chicago.suntimes.com/2020/4/16/21224183/lost-battle-husband-widow-dead-cook-county-jail-detainee-coronavirus (Apr. 16, 2020).

[20] *Id.*

[21] Tanvi Misra, "ICE's COVID-19 test figures hint at health crisis in detention," Roll Call, Apr. 17, 2020, at https://www.rollcall.com/2020/04/17/ices-covid-19-test-figures-hint-at-health-crisis-in-detention/.

[22] Kate Morrissey, "Otay Mesa immigration courts closed, hearings postponed as detention facility COVID-19 cases grow," San Diego Union Tribune, Apr. 15, 2020, at https://www.sandiegouniontribune.com/news/immigration/story/2020-04-15/otay-mesa-immigration-courts-closed-hearings-postponed-as-detention-facility-covid-19-cases-grow.

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.

26. Even where they do have formal linkages with local health departments or hospitals, detention facilities are often in under-resourced areas where the local health department or hospital would quickly become overwhelmed in the face of an infectious disease outbreak.

27. Immigration detention facilities and jails are ill-equipped to diagnose and manage the spread of a disease like COVID-19. Health care providers should have access to personal protective equipment, including masks. Access to resources for testing and personal protective equipment are often inadequate in immigration detention facilities.

28. Those infected and symptomatic should be isolated in negative pressure rooms, which rarely exist in jails and detention facilities. Where such negative pressure rooms do exist, there are rarely enough to be available in the event of an outbreak.

Risk Mitigation

29. Risk mitigation is the only viable public health strategy available to limit transmission of infection, morbidity and mortality in immigration detention centers, and to decrease the likely public health impact outside of the detention centers.

30. For a disease that is either spread by droplets or aerosol, the most effective mitigation strategy to limit the spread of the virus is to reduce crowding, as this increases the opportunity for social distancing.

31. The detention center is a microcosm of the broader community. Social distancing and scrupulous hygiene and sanitation are required to avoid infection or an outbreak. If there is inadequate social distancing, hygiene and sanitation, there will almost certainly be infection and an outbreak. In the event of an outbreak, those who are medically vulnerable will be most immediately at risk, but eventually the effect will be felt by all as the health care infrastructure will be inadequate to respond to the needs.

32. In an immigration detention center, even if everyone is isolated in a single cell, there is still an increased risk of transmission among detainees and staff because the institutional setting requires the delivery of food, cleaning supplies, documents, and other items. However, in most immigration detention facilities, individuals are not isolated in a single cell, or housed in an environment where social distancing is an option. This massively increases the risks of transmission and an outbreak in the detention centers.

Mesa Verde Detention Center and ICE Detention at Yuba County Jail

33. From my review of the available evidence, I have grave concerns about the possibility of social distancing, and other risk mitigation measures, at Mesa Verde Detention Center and for ICE detainees at Yuba County Jail.

34. I understand that there is no capacity for social distancing in the sleeping arrangements for detainees at Mesa Verde Detention Center or for the ICE detainees at Yuba County Jail. Detainees are almost all in bunk beds, which by definition prohibits social distancing as the distance between the upper and lower bunks is less than six feet. In almost all cases where there is more than one bunk to a room, detainees who sleep in bunk beds report that they sleep within reaching distance of at least one other bed where someone is sleeping.[23]

    a. At Mesa Verde Detention Center there are four units: A, B, C and D. Unit B is used for women while the remaining units are used for men.[24] Each dormitory room houses 100 detainees in bunk beds only a few feet apart.[25] As one of the declarants described: "[The bunk beds] are so close to one another that I can reach out my arms and touch another bunk bed. I sleep on the bottom bunk and if I sit up, I will bump my head on the upper bunk."[26] This is fundamentally a congregate living space where there is a high risk of infectious spread. From the reports of those currently detained there, some if not all of the units are at or near capacity.

    b. Yuba County Jail has a more diverse set of sleeping arrangements, but none of the sleeping arrangements appear safe in the context of the coronavirus. Detainees sleep in "linear-style open bar front cells," dormitories, or double-celled housing.[27] Regardless of the type of room, most ICE detainees at Yuba sleep in housing units where they are in bunk beds which are fewer than six feet away from the other bed in the same bunk, and fewer than six feet from the next bunk bed.[28] I understand that ICE detainees at Yuba County Jail are typically commingled with County detainees held for criminal offenses or awaiting trial.[29] This means that there are significant numbers of detainees transferred in and out of the units, something reported at both facilities by declarants,[30] which carries inherent risks as described above. While Yuba County Jail has reportedly released some people so the jail is not at capacity, from the current reports of those detained, the units are still sufficiently crowded that social distancing is not possible.

        i. The "tanks" in the "Old Jail" at Yuba—Units G through L—are "not enclosed rooms" but are "separated from the corridors only by a set of bars, with open spaces between the bars, so air flows freely between the tanks and corridors." Each "tank" has space for

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[23] *See, e.g.*, Declaration of Dung Tuan Dang, paras. 11, 13-14; Declaration of Javier Alfaro, para. 18; Declaration of Coraima Yaritza Sanchez Nuñez, para. 14.
[24] Berg Report at 10.
[25] Mesa Verde PREA Audit at 2; Knox Declaration, para. 9; Takai Mesa Verde Declaration at 4, 10-12.
[26] Declaration of Javier Alfaro, para. 16.
[27] Stanley Declaration, para. 12-14.
[28] Kavanagh Declaration, para. 5 (Yuba). *See, e.g.*, Declaration of Brenda Rubi Ruiz Tovar, para. 14; Declaration of Lawrence Kuria Mwaura, para. 10.
[29] Kavanagh Declaration, para. 3 (Yuba).
[30] *See, e.g.*, Declaration of Dung Tuan Dang, para. 12; Declaration of Javier Alfaro, para. 17; Declaration of Coraima Yaritza Sanchez Nuñez, para. 16.

approximately two dozen men who sleep in "sets of bunk beds that are spaced only a few feet apart."[31] In the tanks, according to the Kavanagh fact declaration, it is "impossible for people to be six feet apart from each other."[32]

ii. B and C pods are "large open rooms" with bunk beds holding approximately 50 people each, with each bed only a few feet apart from the next. B pod includes both ICE and County detainees; C pod is exclusively ICE detainees.[33] T is compromised of "two interconnected small rooms with multiple bunks lining the walls."[34]

iii. P and R Pods are female housing units of congregate living space. R Pod includes "approximately two dozen bunk beds spaced a few feet apart lining one wall, a half wall dividing the room lengthwise, and a row of tightly spaced tables," as well as "approximately three showers with plastic dividers between them." According to the Kavanagh fact declaration, "the size and layout . . . make[s] it hard to navigate without coming very close to or into direct physical contact with others."[35] P Pod, another female housing unit, includes space for a dozen women in a very compact space.[36]

iv. D, E and F pods are "approximately twenty two-person cells" where individuals sleep in bunk beds. Each cell has a bunk bed, sink and toilet. According to the Kavanagh fact declaration, "When two detainees are anywhere in their small cells, it would be impossible for them to be six feet apart."[37] Q1 and Q2 are two-person cells.[38]

v. There are two "administrative segregation units—the 'A-pod' for men and the 'S-Tank' for women." These are "one- and two-person celled housing," which together have the capacity for 46 individuals.[39] Even if these units created the possibility of achieving greater social distancing for a small number of persons at Yuba, they would be nowhere near sufficient to solve the social distancing problems confronted by the vast majority of the detainee population.

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[31] Kavanagh Declaration, para. 9.
[32] Kavanagh Declaration, para. 9. *See also* Berg Report at 9; Photographs DSC 00179 & 00180 (Yuba Unit L).
[33] Kavanagh Declaration, para. 6. *See also* Berg Report at 9; Photograph DSC 00198 (Yuba Unit C)
[34] Berg Report at 9.
[35] Kavanagh Declaration, para. 10. *See also* Photographs DSC 00112 & 00114 (Yuba Unit R).
[36] *Id.*
[37] Kavanagh Declaration, para. 7 (Yuba). *See also* Berg Report at 9 ("Units D, E, and F are celled units that hold about fifty inmates each."). DSC 00106 (Yuba Unit I, with bolted table against the wall); DSC 00179 (Yuba Unit L, with bolted table and chairs); DSC 00175 (Yuba Unit K); DSC 00105 & 00106 (Yuba Unit I). Knox Declaration, para. 9 (Mesa Verde).
[38] Berg Report at 9.
[39] Stanley Declaration, para. 12-14. *See also* Berg Report at 9 ("S1, S1, S3, S4, S5, and S6 are two-bed cells used for segregation.").

35. Because detainees get in and out of bed, bunk beds that are closer than ten feet from one another will not allow adequate social distancing. Moreover, the risk of disease tramsmission from communal sleeping arrangements is greater than the risk of risk of transmission for otherwise being in the proximity of infected individuals for short periods of time, for instance passing individuals in the street or the grocery store. This is because risk increases in confined spaces as the time increases.

36. I understand that there are few isolation cells, which together would be insufficient for segregating individuals who are confirmed infected.

    a. At Mesa Verde Detention Center, there are believed to be "fewer than five isolation cells," which are typically occupied by those with chronic mental health conditions or subject to disciplinary isolation.[40] There are medical isolation rooms in the medical unit which are sometimes used for "protective custody segregation." There is also a restrictive housing unit (RHU) consisting of three single cells, and used for "protective custody, administrative segregation, and disciplinary segregation."[41]

    b. At Yuba County Jail, there are also six medical isolation cells (M-cells), four holding cells and two safety cells.[42]

37. I understand that there is no capacity for social distancing at mealtimes, recreation, or in the bathrooms at either facility. Multiple declarants even reported that they had only heard of "social distancing" from the news, but not from detention center authorities.[43]

    a. At both facilities, most of the tables used by all detainees are bolted to the ground and with attached chairs or benches which cannot be moved, and where detainees sit only a few feet apart.[44] Detainees report that they can touch the others seated at a table easily – they sit "elbow to elbow," as one detainee described – and no efforts have been made to permit or encourage social distancing at mealtimes. Individuals also often line up to get meals.[45]

    b. In both facilities, there is very limited area for eating and recreation and it is often impossible to use these areas with adequate spacing between people. There is also limited and inadequate ventilation.[46]

    c. There are typically small common areas with common tables where

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[40] Knox Declaration, para. 9 (Mesa Verde).
[41] Mesa Verde PREA Audit at 2.
[42] Stanley Declaration, para. 12-14.
[43] Declaration of Javier Alfaro, para. 20.
[44] Kavanagh Declaration, para. 3 (Yuba); Takei Photographs, Dkt. 197-17, Dkt. 197-15 (Yuba); Takei Mesa Verde Declaration, photographs at 5, 24, 25 (Mesa Verde). *See, e.g.*, Declaration of Brenda Rubi Ruiz Tovar, para. 14; Declaration of Coraima Yaritza Sanchez Nuñez, para. 14.
[45] *See, e.g.*, Declaration of Brenda Rubi Ruiz Tovar, para. 14; Declaration of Lawrence Kuria Mwaura, paras. 12-13; Declaration of Coraima Yaritza Sanchez Nuñez, para. 14.
[46] *See generally* Kavanagh Declaration (Yuba); Knox Declaration, para. 10 (Mesa Verde).

individuals eat and recreate "with very little room to maneuver."[47] Detainees report that the tables and chairs are full at mealtimes, and they have to line up to get food, one after another, without adequate spacing between people.[48]

d. Shower and toilet stalls are not six feet apart. At Mesa Verde, each unit of 100 detainees has a shared bathroom of "two multi-user bathrooms consisting of five showers, five toilets, and seven sinks."[49] At Yuba, toilets and showers are typically "separated only by thin dividers that rise to around shoulder height."[50] Detainees report being "shoulder to shoulder" with other detainees, or within arms reach, if at the sink, in the shower, or at the toilet.[51] Detainees report that there are sometimes lines to use the bathroom, guaranteeing that there is no social distancing either in the bathroom or waiting for the bathroom.

e. Individuals move in and out of small telephone booths, packed closely to each other and close to other people.[52]

38. From current reports from those detained at the facilities, there is inadequate care and attention given to hygiene and sanitation, increasing the risks of infectious spread. I understand that there are limited instructions about hygiene and sanitation provided to detainees, and insufficient supplies given to detainees to enable them to practice proper hygiene and sanitation. Plaintiffs have reported that the common areas, including the bathrooms, are unsanitary.

a. Plaintiffs report that they have learned little about the coronavirus and protective measures from authorities at the detention centers. Multiple people reported that they learned about social distancing from the news, rather than from the authorities, and that there have been no efforts to implement or enforce social distancing within the facilities.[53]

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[47] *See, e.g.*, Kavanagh Declaration, para. 9.
[48] *See, e.g.*, Declaration of Dung Tuan Dang, paras. 17-18.
[49] Mesa Verde PREA Audit at 2; Takei Mesa Verde Declaration, photograph at 14 (Mesa Verde). *See, e.g.*, Declaration of Dung Tuan Dang, paras. 14-15 ("On each side of the dorm there are two urinals and three toilet stalls. In the morning there is a line for the bathrooms. There is no distancing when you are in line. When you stand to go pee at a urinal, and if someone else is peeing at the same time, they are standing right next to you – they could be inches away depending on the size of the person. The closed toilet stalls are separated by wood panels. The panels do not go all the way up to the ceiling. If someone stands in the stall next to you, you can see their head. They are the same distance away as the distance between the urinals. In the restroom area there are five sinks for washing your hands and brushing your teeth. The sinks are in an open area without dividers. The distance between the sinks is about a hand length if you stretch your fingers out wide."); Declaration of Javier Alfaro, para. 22.
[50] Kavanagh Declaration, para. 6. *See, e.g.*, Declaration of Brenda Rubi Ruiz Tovar, para. 15; Declaration of Lawrence Kuria Mwaura, para. 16.
[51] *See, e.g.*, Declaration of Coraima Yaritza Sanchez Nuñez, para. 12.
[52] Kavanagh Declaration, para. 8. *See, e.g.*, Declaration of Brenda Rubi Ruiz Tovar, para. 16.
[53] *See, e.g.*, Declaration of Brenda Rubi Ruiz Tovar, para. 20.

b. Plaintiffs have reported the lack of the most basic supplies—including, for example, soap dispensers in the bathrooms at the women's unit at Mesa Verde, or sufficient soap and personal hygiene items for those at both facilities.[54]

c. Detainees are responsible for cleaning the communal spaces at Mesa Verde, and plaintiffs have reported that they are denied adequate supplies or time in order to do so effectively.[55] At both facilities, detainees reported that some bathrooms were highly unsanitary and often with noticeable excrement.[56]

d. Detainees report that when they are cleaning their own areas in the detention centers, or communal areas, they are not given adequate protective equipment.[57]

39. I also understand that there have been serious complaints voiced about the adequacy of medical care provided to detainees at these facilities independent of the COVID-19 pandemic, which raises concerns about the ability of the facilities to provide adequate medical care in the more challenging context of the current pandemic.[58]

40. I note from the declarations of Plaintiffs, there is not a consistent practice of testing and/or quarantining new entrants to the facilities.[59] There continue to be new entrants, which in and of itself raises concerns about the introduction of COVID-19 into the facilities, and these new arrivals are not placed in quarantine or monitored for 14 days.

41. I understand that there has been no, or virtually no, testing for COVID-19 at either facility. From the declarations of Plaintiffs, I understand that detainees with symptoms, including medically vulnerable detainees, are reporting that they are not being tested.[60] Some but not all detainees, in some but not all units of the two facilities, report more regular temperature checks but these remain inconsistent, and in some instances require detainees to stand in line without adequate social distancing.[61] The lack of testing, and even consistent and safe temperature checks, raises concerns about their care, about the availability of tests, and about ICE's adherence to CDC guidance.

42. There also is evidence that there are not sufficient protections for those who are medically vulnerable; they remain in large dormitory settings without social distancing.[62]

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[54] *See, e.g.*, Declaration of Brenda Rubi Ruiz Tovar, para. 14; Declaration of Lawrence Kuria Mwaura, paras. 30, 34; Declaration of Coraima Yaritza Sanchez Nuñez, para. 11; Declaration of Coraima Yaritza Sanchez Nuñez, para. 18.
[55] *See, e.g.*, Declaration of Dung Tuan Dang, para. 16; Declaration of Javier Alfaro, para. 23; Declaration of Coraima Yaritza Sanchez Nuñez, para. 12.
[56] *See, e.g.*, Declaration of Brenda Rubi Ruiz Tovar, paras. 15, 17; Declaration of Lawrence Kuria Mwaura, para. 15.
[57] *See, e.g.*, Declaration of Brenda Rubi Ruiz Tovar, para. 21.
[58] Kavanagh Declaration, paras. 14-15 (Yuba); Knox Declaration, paras. 4-5 (Mesa Verde). *See, e.g.*, Declaration of Brenda Rubi Ruiz Tovar, paras. 18, 22.
[59] Declaration of Javier Alfaro, para. 30 (new entrants not quarantined at Mesa Verde); Declaration of Lawrence Kuria Mwaura, para. 11 (new entrants not quarantined at Yuba); Declaration of Coraima Yaritza Sanchez Nuñez, para. 16.
[60] *See, e.g.*, Declaration of Brenda Rubi Ruiz Tovar, paras. 7-13.
[61] *See, e.g.*, Declaration of Javier Alfaro, para. 29 (no regular temperature checks at Mesa Verde); Declaration of Lawrence Kuria Mwaura, paras. 18-19 (inconsistent temperature checks at Yuba).
[62] *See, e.g.*, Declaration of Javier Alfaro, para. 19.

43. As noted above, there is a dramatically increased risk of rapid infectious spread at congregate facilities such as ICE detention centers, and there continue to be serious deficiencies in ICE's policy in response to COVID-19. In addition, however, the structure and facilities of the Mesa Verde Detention Center and the Yuba County Jail lead me to conclude that social distancing is impossible at either facility, and there is a serious risk of infection for all of those who are detained. The close proximity of the sleeping arrangements is one problem, but the fact that there is no ability to practice social distancing at mealtimes, recreation, or in using the shower or bathroom amplifies dramatically the risks. The lack of adequate sanitation and hygiene, as reported, further increases the risks to detainees, staff and other personnel, and the broader community.

ICE Has Failed to Adequately Respond to COVID-19 at Immigration Detention Facilities

44. ICE's response to the COVID-19 pandemic, both nationally and at individual facilities including the Mesa Verde and Yuba County ICE detention centers, is deficient, putting detainees, especially those who are high-risk, in imminent danger of serious illness and death.

45. Infection with the virus that causes COVID-19 is widespread across the United States. A disease model devised by University of Texas researchers concludes that, by the time an individual county has just *two* known COVID-19 cases, there is a 70% likelihood that a "sustained, undetected outbreak – an epidemic – is already taking place" in the community, and that probability of an existing epidemic rises to 95% if a county has 10 known COVID-19 cases and 99% if the county has 20 or more cases.[63] [64] As of April 18, 2020, Yuba and Sutter Counties has 40 confirmed cases,[65] and Kern County has 610 confirmed cases of COVID-19.[66] Immediate intervention is necessary to avert preventable deaths at detention facilities located in these or other counties where there is a demonstrated probability of a present epidemic.

46. Based on my training and decades of experience in public health, I conclude that although ICE's April 10 Guidance is a marked improvement over its past COVID guidance documents, ICE's COVID protocols fall short of what is needed to address the threats posed to high-risk immigrant detainees by COVID-19, and are likely very challenging for facilities, especially those with reduced staff, to successfully implement. Further, as elaborated above, even the April 10 Guidance is not being implemented at Mesa Verde and Yuba County Jail.

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[63] Javan, Fox, & Myers. Probability of current COVID-19 Outbreaks in All U.S. Counties, https://cid.utexas.edu/sites/default/files/cid/files/covid-risk-maps_counties_4.3.2020.pdf?m=1585958755, accessed April 16, 2020.

[64] N.Y. Times, *Does My County Have an Epidemic? Estimates Show Hidden Transmission* (Apr. 3, 2020), https://www.nytimes.com/interactive/2020/04/03/us/coronavirus-county-epidemics.html.

[65] "Coronavirus Updates for Yuba County," at https://www.yuba.org/coronavirus/ (accessed Apr. 18, 2020).

[66] Tracking Coronavirus in California," LA Times, at https://www.latimes.com/projects/california-coronavirus-cases-tracking-outbreak/ (accessed Apr. 18, 2020).

47. **Social Distancing**: ICE recognizes social distancing is an important mitigation measure but fails to mandate it in its facilities. Indeed, ICE's April 10 Guidance acknowledges that there are limits to the amount of social distancing that can be accomplished due to the infrastructure of ICE facilities. ICE facilities have fixed architecture and are designed as congregate settings, requiring close proximity in confined spaces. The measures outlined in ICE's April 10 Guidance are impossible to carry out given the limits of the infrastructure.

    a. ICE's April 10 Guidance suggests that facilities should stagger detainee access to recreation, law library, and meals, so that they encounter fewer other people throughout the course of their day, especially people from other housing units. However, even these steps fall well short of what is needed to actually prevent the transmission of COVID-19, especially in light of crowding within housing units.

    b. ICE's April 10 Guidance acknowledges that social distancing may not be possible. It says that beds should be rearranged, but only "if practicable," and that six feet of distance should be maintained, but only "whenever possible." The ICE Website Guidance similarly identifies social distancing reforms at individual facilities as optional. Individuals at immigration detention facilities have described how it is impossible to stay six feet away from someone during congregate meals, in shared bathrooms and recreation spaces, and in cells with bunk beds.

48. **Release:** Most significantly, ICE fails to appreciate the importance of releasing detainees to limit the risk for the individuals released, for those who remain detained, and for the general public. Because of the risks inherent in detention centers, and the unparalleled importance of social distancing, release is the most important means of mitigating the spread of COVID-19 in ICE detention centers. This would be true even if the conditions inside the facility were impeccable.

    a. ICE's April 10 Guidance says that ICE should reduce its facilities to 75% capacity. ICE's Website Guidance uses a goal of 70% capacity. This is an arbitrary number, particularly since facility design and ventilation varies considerably across the country. ICE provides no evidence that 70% or 75% capacity would facilitate effective social distancing within dormitories or cells, which requires that individuals maintain six feet of separation. In fact, from what I know of most of the ICE facilities, the 70% or 75% figures are not just arbitrary but also inadequate; ICE would need to downsize far more significantly in order to limit the risks of coronavirus for those detained, and for the broader community.

    b. Detention centers are extraordinarily high-risk environments for the transmission of infectious diseases. Thus, the "capacity" of a facility is not an appropriate marker for the facility's ability to house people safely during the COVID-19 pandemic. This is because the facility's capacity does not take into account the need for social distancing in mitigating the COVID-19 pandemic. Social distancing of six feet, as recommended by the CDC, will be impossible without significant downsizing.

49. **Identifying High-Risk Individuals:** ICE's April 10 Guidance directs jails and ICE detention facilities to identify all detainees who meet the Center for Disease Control and Prevention's ("CDC") identified criteria for people at especially high risk for serious illness from coronavirus. The April 10 Guidance does not, however, fully account for high-risk factors, or identify or requires steps to be taken to protect those who are at high risk.

    a. The April 10 Guidance does not identify pregnancy, the postpartum period or history of smoking as risk factors. The guidance fails to include hypertension as a risk factor. Even though hypertension has been recognized by the CDC as among the "risk factors for severe illness."[67] The ICE guidance also defines obesity as a BMI of 40 or more, though in an April 8, 2020 CDC Morbidity and Mortality Weekly Report ("MMWR"), obesity (a BMI of 30 or more) was the second most common underlying medical condition amongst hospitalized COVID-19 cases, behind hypertension. 48.3% of hospitalized COVID-19 patients have a BMI over 30, and are therefore obese according to the CDC.[68]

    b. The April 10 guidance provides 65 years of age as the cutoff age for higher-risk individuals despite that the risk of severe COVID-19 begins to increase markedly for individuals earlier, with studies showing significant increased risk of morbidity and mortality for people in their 50s, and risks increasing already for people in their 40s.[69]

    c. ICE's April 10 Guidance does not identify steps that protect high-risk detainees from getting COVID-19. The guidance only requires that ICE identify these individuals, their underlying medical issues, and their location. There are no requirements to release or otherwise protect these individuals. At most, detainees who are vulnerable because they fall into a higher risk category are "cohorted," which means that they are assigned to shared living quarters or quarantined as a group, which actually facilitates transmission among high risk patients in the absence of adequate social distancing and access to proper hygiene. Since there are no heightened protections for high risk individuals, it is unlikely that illness will be detected until it is too late for preventive intervention.

50. **Transfers:** The April 10 Guidance discourages but does not prohibit transfers. It requires only that transfers of the "detained non-ICE populations" be limited "where possible." It does not limit the transfer of ICE detainees at all. The April 10 Guidance does not require

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[67] CDC, "Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease," dated March 30, 2020 https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.
[68] *See* Shikha Garg et al., *Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 — COVID-NET, 14 States, March 1–30, 2020*, CENTERS FOR DISEASE CONTROL & PREVENTION (Apr. 8, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_w#T1_down.
[69] Robert Varity et al., *Estimates of the Severity of Coronavirus Disease 2019: A Model-Based Analysis*, THE LANCET, (Mar. 30, 2020); World Health Organization, "Coronavirus Disease 2019: Situation Report—51," Mar. 11, 2020, at https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200311-sitrep-51-covid-19.pdf?sfvrsn=1ba62e57_10.

the quarantining of new arrivals, but only that "considerable effort" be made to quarantine new entrants. Even where quarantining is considered, the Guidance instructs only "the most effective cohorting methods practicable based on the individual facility characteristics." Transferring individuals between facilities, a common ICE practice, is medically inappropriate during the outbreak.

a. The lack of automatic isolation or quarantining of new arrivals introduces considerable health risks. Nearly every person who newly arrives at the detention facility will have had close contact to someone with COVID-19. Thus, appropriate guidelines would quarantine and monitor all new arrivals. The isolation and quarantine procedures by ICE do not comply with best practice.

51. **Screening New Detainees:** ICE's April 10 Guidance does not address how facilities will account for large numbers of people who have already been exposed to COVID-19, including transfers. Not only do new detainees need to be accounted for, but also staff, vendors, and other people who go in and out of the facility.

a. ICE's April 10 Guidance says that people without symptoms, but who have had contact with someone with COVID-19 or those who meet the epidemiological risk criteria will be quarantined and monitored for 14 days. But this does not recognize the scope of the current crisis. A large share of newly arriving individuals will have had contact with someone with COVID-19 or will have been in areas of community spread, including transfers from other facilities. ICE would need to use this level of individual monitoring for each and every person arriving at the facility. ICE would have to increase its medical resources to provide this level of care to this many people, but has not indicated that it has the capacity to do so.

b. ICE's April 10 Guidance does not account for asymptomatic transmission of COVID-19. "Because persons with asymptomatic and mild disease . . . are likely playing a role in transmission and spread of COVID-19 in the community, social distancing and everyday preventive behaviors are recommended for persons of all ages to slow the spread of the virus, protect the health care system from being overloaded, and protect older adults and persons of any age with serious underlying medical conditions."[70] In fact, half of individuals who tested positive for coronavirus had mild or no symptoms in some studies.[71]

52. **Testing:** Neither ICE's April 10 Guidance nor ICE's Website Guidance address the paucity of testing in their facilities. ICE's Website Guidance only includes a cursory mention that "ICE testing . . . complies with CDC guidance." Much of the ICE COVID Guidance relies on what to do with "confirmed" cases among either detainees or staff. However, without explicit testing criteria and actual testing, ICE will not be able to

[70] *See Coronavirus Disease 2019 in Children — United States, February 12–April 2, 2020*, CENTERS FOR DISEASE CONTROL & PREVENTION (Apr. 20, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6914e4.htm?s_cid=mm6914e4_w.

[71] *See* Pien Huang, *What We Know About The Silent Spreaders Of COVID-19*, NATIONAL PUBLIC RADIO (Apr. 13, 2020), https://www.npr.org/sections/goatsandsoda/2020/04/13/831883560/can-a-coronavirus-patient-who-isnt-showing-symptoms-infect-others.

identify "confirmed" cases within its facilities. To say that there are no "confirmed" cases in a facility in no way implies that the facility is "clean" of the virus when there has been little or no testing.

53. **Staff:** ICE's April 10 Guidance does not provide criteria for when staff should be tested, and does not require the testing of staff who interact with detainees. Staff, vendors and other non-detained personnel are especially important vectors in this outbreak. Since they go back and forth between the outside world, detention centers will be hit by COVID-19 when the rest of the community is, staff and their families included. Despite this, ICE COVID procotols do not provide meaningful guidance for screening and testing these personnel.

    a. The April 10 Guidance provides that staff should "stay home when sick," have their temperature checked, and "inform their workplace" if they test positive. The Guidance provides that staff must not be admitted if they are symptomatic. But there is no recognition of the lack of available testing or the risk of asymptomatic transmission.

    b. Monitoring active symptoms, including fever, is important. To limit the spread of the virus, however, ICE policy must also recognize the significance of the spread of COVID-19 from *asymptomatic* individuals. An individual can present without a fever or respiratory problems and still be infected and infectious. There are many more COVID-19 cases than are confirmed.

    c. The April 10 Guidance also provides no guidance with regard to limiting the risk of exposure from contractors and vendors. This is not enough to guard against staff or vendors introducing COVID-19 into these facilities, particularly as they may be infected but asymptomatic.

54. **Medical Isolation for Confirmed COVID Cases:** The April 10 Guidance recognizes the CDC guidance that confirmed COVID-19 cases should be medically isolated. However, many facilities only have one to four of these rooms available in the facility. Based on the experience of detention and other congregate facilities, and the trajectory of this virus, as soon as there are infections at the detention facility, if there are not already, there will be many more than one to four people with COVID-19 in the detention center at a time. Symptomatic patients should live separately from those who are asymptomatic or at risk but who do not have confirmed cases, but in my experience, the structure of detention centers makes this nearly impossible.

55. **Cohorting:** ICE's April 10 Guidance acknowledges that confirmed cases should not be confined with suspected cases or close contacts. However, it doesn't say how social distancing will occur within cohorts of suspected cases or close contacts. Cohorting necessarily means that people will be in close contact with other individuals who may be infected. The April 10 Guidance concerning cohorting again does not take into account that there is very limited testing available and conducted in immigration detention facilities.

a. The ICE Website Guidance states that "cohorting serves as an alternative to self-monitoring at home." But this is contrary to the guidance of the CDC. The CDC identifies "cohorting" as a suboptimal practice of group quarantining. Where cohorting can be an effective mitigation strategy in the absence of sufficient space for medical isolation, it requires adequate space for appropriate groupings. For instance, confirmed cases should not be in the same cohort as suspected cases or case contacts; those who had contact with an infected person ten days ago should not be in the same cohort as someone who had contact with an infected person two days ago. Any new arrival should be assumed to have had exposure to coronavirus and thus adding any new individual to an existing cohort requires the 14-day monitoring period to begin anew.

b. Appropriate cohorting is likely impossible based upon the staffing and space constraints inherent in ICE detention. The detention facility's medical unit simply cannot handle the volume of patients that would need this level of monitoring. ICE COVID protocols do not mention any way to accommodate such a level.

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

57. Nothing in the April 10 Guidance has changed my conclusion that COVID-19 will likely spread rapidly throughout immigration detention facilities, and specifically at Mesa Verde Detention Center and Yuba County Jail.

Conclusions

58. Given the lack of testing, known periods of infection without symptoms and the likelihood of virus transmission from people who do not have symptoms, every congregate setting should expect infection within the facility. Intramural transmission is highly likely. The facilities, living arrangements, and sanitation and hygiene practices at both Mesa Verde and Yuba lead me to conclude that these facilities have a very high risk of infection, if there is not infection already at the facilities.

59. The facilities fail to meet minimally acceptable standards of social distancing, putting the residents at grave and unacceptable risk of pervasive infections, leading to serious illness and death. The only way to avoid these unacceptable risk is to materially reduce the

population, implement social distancing as described herein, and ensure appropriate hygiene.

60. Releasing individuals, and prioritizing the most vulnerable, reduces the burden on local health care resources, as it reduces the risk of transmission of the disease to a large number of people living in close proximity for an extended period of time. It also reduces the risk of transmission to staff. Even with the best-laid plans to address the spread of COVID-19 in detention facilities, the release of individuals, prioritizing the most medically vulnerable individuals, is a key part of a risk mitigation strategy. In my opinion, as a matter of public health it is imperative to release significant numbers of people from detention at the immigration detention centers at Mesa Verde and Yuba County Jail, prioritizing those who are most vulnerable, 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.

61. Any suggestion that the moment for medically necessary interventions, including release, arrives only when a case of COVID-19 has been confirmed inside an ICE detention facility is wrong, without any basis in medical science, and is dangerous.

62. Based on my experience working on health care in detention facilities and my review of the literature concerning the coronavirus, for the reasons outlined in this declaration, it is my opinion that immigration detention facilities at Mesa Verde and Yuba are not prepared to prevent the spread of COVID-19, treat those who are most medically vulnerable, and contain any outbreak. The risk of transmission of infection at each of these facilities is very high.

63. Immigration detention centers are not equipped to care for those who are severely affected by COVID-19. If individuals are not released, care for those who become sick with COVID-19 will overburden the limited health care resources of the detention center and the broader community.

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

Executed this 19th day in April, 2020 in New York City, New York.

Robert B. Greifinger, M.D.

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

SUMMARY OF EXPERIENCE

MEDICAL MANAGEMENT AND QUALITY IMPROVEMENT SERVICES 1995-Present

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

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

NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES 1989 - 1995

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

Deputy Commissioner/Chief Medical Officer, 1989 - 1995

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

MONTEFIORE MEDICAL CENTER, Bronx, NY 1985 - 1989

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

Vice President, Health Care Systems, 1986 - 1989

Director, Alternative Delivery Systems, 1985 - 1986

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

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

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

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

Vice President and Medical Director

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

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

COMMUNITY HEALTH PLAN OF SUFFOLK, INC. 1977 - 1980

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

Medical Director

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

MONTEFIORE MEDICAL CENTER, Bronx, NY 1976 - 1977

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

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

UNITED STATES PUBLIC HEALTH SERVICE 1972 - 1974

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

ROBERT B. GREIFINGER, M.D.

FACULTY APPOINTMENTS

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

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

NATIONAL COMMITTEE FOR QUALITY ASSURANCE

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

OTHER PROFESSIONAL ACTIVITIES

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

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

EDUCATION

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

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

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

CERTIFICATION

Diplomate, National Board of Medical Examiners, 1971

Diplomate, American Board of Pediatrics, 1976

Fellow, American Academy of Pediatrics, 1977

Fellow, American College of Physician Executives, 1983

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

License: New York, Pennsylvania (inactive)

ROBERT B. GREIFINGER, M.D.

Updated February 2018

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

ANGEL DE JESUS ZEPEDA RIVAS, BRENDA RUIZ TOVAR, LAWRENCE MWAURA, LUCIANO GONZALO MENDOZA JERONIMO, CORAIMA YARITZA SANCHEZ NUÑEZ, JAVIER ALFARO, DUNG TUAN DANG,

Petitioners-Plaintiffs,

v.

DAVID JENNINGS, Acting Director of the San Francisco Field Office of U.S. Immigration and Customs Enforcement; MATTHEW T. ALBENCE, Deputy Director and Senior Official Performing the Duties of the Director of the U.S. Immigration and Customs Enforcement; U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT; GEO GROUP, INC.; NATHAN ALLEN, Warden of Mesa Verde Detention Facility,

Respondents-Defendants.

DECLARATION OF DR. RANIT MISHORI (MD, MHS, FAAFP)

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Declaration of Dr. Ranit Mishori (MD, MHS, FAAFP)

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

I. Background

1. I am Dr. Ranit Mishori. I am a senior medical advisor at Physicians for Human Rights (PHR), and Professor of family medicine at the Georgetown University School of Medicine, where I am the director of the department's Global Health Initiatives, Health Policy fellowship and our practice-based research network. A fellow of the American Academy of Family Physicians and Diplomate of the American Board of Family Medicine, I did my residency training at the Georgetown University/Providence Hospital Family Medicine Residency program. I received my medical degree from Georgetown University School of Medicine and a master's degree in International Health from the Johns Hopkins Bloomberg School of Public Health, in the Disease Control and Prevention Track (focusing on the science of how to halt the spread of infectious disease).

2. I am the faculty leader for Georgetown University School of Medicine's Correctional Health Interest group, where I supervise medical students placed at various area jails, prisons and detention centers. In addition, I am the director of Georgetown University's Asylum program which focuses on the care and medico-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 senior medical advisor at PHR (and prior to that, as a consultant for PHR), I have reviewed and analyzed dozens of cases related to health outcomes of individuals in correctional facilities, and advised the organization and other partners (civil society, legal aid organizations and the media) about issues related to incarceration, including hunger strikes, medical care quality, communicable disease management, violence, and care of pregnant women in such settings.[1]

[1] *See, e.g.*, Ranit Mishori, *Risk Behind Bars: Coronavirus and Immigration Detention*, The Hill (Mar. 17, 2020), https://thehill.com/opinion/immigration/487986-risk-behind-bars-coronavirus-and-immigration-detention; Amanda Holpuch, *Coronavirus Inevitable in Prison-Like US Immigration Centers, Doctors Say*, The Guardian (Mar. 11,

3. As an attending physician at the Georgetown University/Washington Hospital Center Family Medicine Residency Program, I work with urban underserved populations, including the homeless, formerly incarcerated individuals, immigrants and refugees. I routinely come in contact with victims of abuse, trauma and poverty where I regularly assess their medical as well as psycho-social needs in the context of their social-determinants of health (such as housing and incarceration).

4. For four years I was an elected member of the American Academy of Family Physicians' Commission on the Health of the Public and Science, where I chaired the Public Health Issues sub-committee. During that time, I was a one of the lead authors of the Academy's comprehensive position paper on Incarceration and Health.

5. My CV is attached as Exhibit A.

II. COVID-19 in Detention Centers

6. The novel coronavirus, officially known as SARS-CoV-2 (Coronavirus), causes a disease known as COVID-19. The novel coronavirus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but it also survives on surfaces for some period of time. 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 Coronavirus originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. The "contagiousness" of this novel coronavirus—its R0 (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

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through droplets, everyone is at risk of infection because our immune systems have never been exposed to or developed protective responses against this virus.

7. The risk posed by infectious diseases in immigration detention facilities 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.

8. 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. 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.

9. Jails, prisons and detention centers 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.

10. 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). Jails and prisons 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.

11. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community. Congregate settings such as jails and prisons allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When people live

in close, crowded quarters and must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater. Toilets, sinks, and showers are shared, without disinfection between use. Spaces within jails and prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Detainees often have a small number of telephones that they share, and which form their only contact with the outside world—including their family and lawyers. Placing someone in such a setting therefore dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases.

12. Additionally, jails and prisons are often unable to adequately provide the mitigation recommendations recommended by medical and public health experts. During an infectious disease outbreak, people can protect themselves by washing hands. Detention centers, jails and prisons do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. Jails and prisons are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for people detained in these settings. High-touch surfaces (doorknobs, light switches, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but this is often not done in jails and prisons.

13. People incarcerated in detention centers, jails and prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community.[2] This is because people in detention centers, jails, and prisons, for a variety of reasons, have higher rates of chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and suppressed immune systems from HIV or other conditions, than people in the community.

[2] *Active Case Finding For Communicable Diseases in Prisons*, 391 The Lancet 2186 (2018), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31251-0/fulltext.

14. Detention centers, jails and prisons are often poorly equipped to manage infectious disease outbreaks. Some detention centers, jails and prisons lack onsite medical facilities or 24-hour medical care. The medical facilities at detention centers, jails and prisons are almost never sufficiently equipped to handle large outbreaks of infectious diseases. To prevent transmission of droplet-borne infectious diseases, people who are infected and symptomatic need to be isolated in specialized negative pressure rooms. Most detention centers, jails and prisons have few negative pressure rooms if any, and these may be already in use by people with other conditions (including tuberculosis or influenza). ICE has admitted that not all of the detention centers it oversees have even one.[3] In the course of an infectious disease outbreak, resources will become exhausted rapidly and any beds available will soon be at capacity.

15. 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 the staff. This makes both containing the illness and caring for those who have become infected much more difficult.

16. A coronavirus brought into a detention facility can quickly spread among the dense detainee cohort. Soon 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.

[3] Brittny Mejia, *ICE Says No Confirmed Coronavirus Among Detainees After 4 Test Negative*, Los Angeles Times, accessed Mar. 18, 2020, https://www.latimes.com/california/story/2020-03-10/ice-says-no-detainees-have-coronavirus-four-being-tested

17. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities in Maine, resulting in two inmate deaths.[4] Subsequent CDC investigation 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.[5] H1N1 is far less contagious than coronavirus. 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 the coronavirus COVID-19, for which there is currently neither.

18. 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.

19. Additionally, as health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these conditions.

20. We have ample basis to conclude that detention settings are equally unprepared for the rapid spread of coronavirus. Not surprisingly, Chinese prison officials report that over 500 COVID-19 cases in the current outbreak stemmed from the Hubei province prisons. In Israel, an entire prison was quarantined. Recognizing that the release of those incarcerated is the only solution, jails in at least a dozen states in the United States have begun releasing inmates. In Iran, over 80,000 prisoners were released as a means of preventing death in government prisons. In the United Kingdom, the government released 300 immigrants from

[4] *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.
[5] 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/.

detention centers as a result of coronavirus. Major human rights organizations such as Human Rights Watch, Physicians for Human Rights and Amnesty International have issued calls to release those detained in immigration facilities to prevent the spread of coronavirus.

III. Conclusion and Recommendations

21. For the reasons above, it is my professional judgment that individuals placed in ICE's immigration detention centers are at a significantly higher risk of infection with coronavirus 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.

22. 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 centers, jails and prisons 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.

23. Even with the best-laid plans to address the spread of coronavirus in detention facilities, the release of high-risk individuals is a key part of a risk mitigation strategy. In my professional opinion, the only viable public health recommendation is to release people from detention, with highest priority to those at most high risk, 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 carceral settings that can adequately manage the serious risk of harm for high-risk individuals during the COVID-19 pandemic. So long as carceral settings include congregate living spaces, shared bathrooms, and shared and confined spaces for eating and recreating, there is no way to minimize the risks to an acceptable level in these spaces.

24. Immediate release is crucial for individuals who are older, with risks increasing at around 50 years of age, and those with chronic illnesses or other preexisting conditions (*e.g.*, 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).

25. Releasing people from incarceration is the best and safest way to prevent the spread of disease and reduce the threat to the most vulnerable people who are detained, as well as for vulnerable people in the community and for the public health. 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. Once a case of coronavirus is identified in a facility, it will likely be too late to prevent a widespread outbreak.

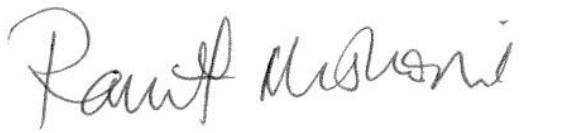
IV. Expert Disclosures

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

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

Executed this 19th day of April, 2020 in Washington, D.C.

Ranit Mishori, M.D, MHS, FAAFP



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Professor of Family Medicine

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EDUCATION

- Residency: Georgetown University/Providence Hospital Family Medicine Residency April 2004-January 2008
- Medical Education: Georgetown University School of Medicine 1998-2002. Doctor of Medicine
- Graduate Education: Johns Hopkins Bloomberg School of Public Health. 1997-1999. Master of Health Sciences (MHS), International Health
- Undergraduate: Columbia University. 1995-1997. Pre-Med Post-Baccalaureate Program Certificate.
- State University of New York. Empire State College. 1994-1996. Bachelor of Science, Communications

PROFESSIONAL EXPERIENCE

Clinical Appointments:

- Family Physician. MedStar Health Center – Family Medicine Spring Valley 08-2011 – present
- Family Physician. Department of Ob-Gyn. Georgetown University Hospital. 3 PHC. 07-2008 – 07-2011
- Family Medicine Attending. Providence Hospital, Washington, DC February 2008 – Aug 2019.

Faculty Appointments and Positions.

- Professor, Department of Family Medicine Medical Educator Track. July 2014- Present
- Associate Professor, Department of Family Medicine. Medical Educator Track. April 2012 – 2014.
- Assistant Professor, Department of Family Medicine. Medical Educator Track. Sept 2008 – April 2012
- Instructor, Department of Family Medicine. Medical Educator Track. February 2008 – September 2008
- Director, Health Policy Fellowship. 2017-Present.
- Director, Health and Media Fellowship. 2013-Present.
- Director, CAPRICORN, Georgetown's Practice-Based Research Network (PBRN), 2013- Present
- Director, Global Health Initiatives and Global Health Residency Track. January 2011 - Present.
- Clerkship Director, Family Medicine Clerkship. 2009-2011.
- Research Network Coordinator, Research Associate. CAPRICORN (Capital Area Practice Based Research Network). Georgetown University Department of Family Medicine. 2003-2004

Additional Work Experience

- Senior Medical Advisor, Physicians for Human Rights. October 2019-Present
- Health Policy Team Member (Co-Lead Women, Sexual and Reproductive Health). Pete Buttigieg Presidential Campaign. April 2019 – Current.
- Consulting Medical Expert. Physicians for Human Rights Program on Sexual Violence in Conflict Zones. 2011-Sept 2019
- Contributing Health Editor. Parade Magazine. 2007-2010.
- Freelance Health Reporter. The Washington Post. 2003-2017.
- Television Producer/Editor. International News. Worldwide Television News (WTN); CBS News; European Broadcasting Union (EBU); Israeli Defense Forces (IDF) Radio. Various Locations Worldwide. 1984-1994

HONORS AND AWARDS

- Member of small team awarded **multiple awards** for MediCapt (mobile app for documentation of Sexual Violence): MediCapt has received multiple awards, including: the Science and Human Rights Innovator Award from the American Association for the Advancement of Science (2019); New England Innovation Award in the nonprofit category for MediCapt; the Sexual Violence Research Initiative and World Bank Group Development Marketplace Award for Innovation in the Prevention and Response to Gender Based Violence (2019); the MIT Solve Award in the Frontlines of Health category (2018); and the USAID-Humanity United Tech Challenge for Atrocity Prevention competition in the Safe Documentation category (2013).
- **Silver Award for Best Commentary,** from the American Society of Healthcare Publication Editors. For editorial, "What Needs to Change to Make Deprescribing Doable" Family Practice Management. April 2019.
- **Award,** Medical/Health Award for Efforts on Behalf of Women with FGM/C. Women PEACE Foundation. Washington, DC October 2018.
- **Dahlgren READ Nominee.** Selected by peers and students to be featured as part of the annual Dahlgren READ campaign, which honors those who best exemplify the school's commitment to cura personalis, "care of the whole person." September 2016.
- **Award,** Leonard Tow Humanism in Medicine, Georgetown University Medical Center 2016
- **Inductee,** Gold Foundation, GUMC 2016
- **Honoree,** invited by the class of 2016 to give the "Past Medical Histories" lecture reflecting on a career in medicine. September 2015.
- **Honoree,** Community Faculty Appreciation Day. Family Medicine. Selected by the Students of the Georgetown University School of Medicine. May 2015.
- **Finalist,** Macy Foundation Scholar Program. April 2015.
- **GUMC Nominee.** Macy Foundation Scholar Program. February 2015.
- **Awarded degree of Fellow** by the American Academy of Family Physicians. October 2014
- **Teaching Excellence Award** (inpatient attending) given by the residents of the Georgetown University/Providence Hospital Family Medicine Residency Program. June 2014
- **Top Doctor,** Washingtonian Magazine Annual Top Doctor Issue. 2014-2018
- **First Prize, USAID-Humanity United Tech Challenge for Atrocity Prevention competition**. Member of Physician for Human Rights team that conceived of and designed a mobile forensic application, *MediCapt*. January 2013
- **The John Eisenberg Career Development Award.** Georgetown Women in Medicine. October 2010
- **Emerging Leader Award.** Society of Teachers of Family Medicine, annual STFM-NE conference/Family Medicine Education Consortium (FMEC). October 2009.
- Featured on the cover of Parade Magazine, as one of "America's Top Doctors", alongside Sanjay Gupta and Francis Collins. September 2009.
- **Teaching Excellence Award** given by the residents of the Georgetown University/Providence Hospital Family Medicine Residency Program. June 2009

- **Finalist**, MORE (Media Orthopedic Reporting Excellence) Awards, The American Academy of Orthopedic Surgeons. "Do You Need This Surgery", Parade Magazine. October 2008
- **Nominee**, Spring Golden Apple Award (class of 2011). May 2008.
- **Nominee,** National Magazine Award (The Truth About Hormones, Parade Magazine). May 2008
- **Natural Medicine Recognition Award.** Georgetown University/Providence Hospital Family Medicine Residency Program. June 2007
- **Nominated and Selected**. Bertelsmann Foundation Young Leaders Fellowship Network. June 2007.
- **3rd Place**, Providence Hospital Resident Research Day. Providence Hospital, Washington, DC. March 2007
- **Gold Triangle Award**, Health Writing, Parade Magazine. American Academy of Dermatology. March 2004
- **International Programs Award**. Georgetown University School of Medicine. May 2002
- **Young Ambassador**. Vienna, Austria. Selected to represent the State of Israel in political, social and cultural dialogues with Austrian students and youth. October-December 1987.

PROFESSIONAL SOCIETY MEMBERSHIP

- American Academy of Family Physicians 2002-present
- American Medical Association 2000-present
- Society of Teachers of Family Medicine 2008-present
- Association of Health Care Journalists 2004-present
- American Public Health Association 2003-Present
- Association Prevention Teaching and Research APTR 2010-2013
- Global Health Council 2003-2012

PUBLIC AND PROFESSIONAL SERVICE

International and National Committees

- **Member,** Steering Committee. US End FGM/C Network. 2018-present.
- **Member.** Health Equity Committee. WONCA (World Organization of Family Doctors). 2018-present.
- **Member.** Istanbul Protocol Supplement Project**.** Working Group: Ethical Codes. 2018-present.
- **Chair and Founder,** US Clinician Network on FGM. 2016-present.
- **Vice-Convenor** WONCA (World Organization of Family Doctors), Executive Committee, Group on Conflict & Catastrophe Medicine 2015-2018.
- **Chair,** Healthcare Working group. First annual US End FGM/C Summit. Washington, DC, July-December 2016.
- **American Academy of Family Physicians (AAFP**) 2014-present.
  - **Representative**, Amgen 2019 Health Equity Summit. April 2019.
  - **Appointed Commissioner**, Health of the Public and Science (CHPS) 2014-2018. Sub-committees: Clinical Practice Guidelines, Public Health.
  - **Chair,** Committee on Public Health Issues (SPHI), American Academy of Family Physicians. 2015-2018.
  - **Chair,** Working Group on Antimicrobial Resistance. AAFP. June 2016-2018.
  - **Liaison,** Global Health MIG liaison to CHPS 2016-2017
  - **Representative** to the National Lupus Foundation Annual Meeting. Indianapolis, IN. June 2016
  - **Board-appointed Liaison** to the US National Breastfeeding Coalition (USBC). 2015-2017.
  - **Board-appointed Liaison** to American College of Obstetrics and Gynecology's (ACOG) Committee on Practice Bulletins on Obstetrics. 2014-2017.
  - **Board-appointed Liaison** to the CDC and National Association of Chronic Disease Directors (NACDD) committee to develop a public health agenda for Lupus 2015
  - **Member,** AAFP selection committee Public Health Physician of the Year. 2013-2014.

- **Delegate (DC)**. DC-Academy of Family Physicians Chapter. Women's Constituency. National Conference of Constituency Leaders (2016, 2014)
- **Member,** International Consortium for Torture Scar Documentation and Photo Atlas. Brussels, Belgium. 2015-2016.
- **Member,** Education and Research committees HEAL Trafficking, an international coalition of health professionals united against human trafficking. 2014-current.
- **Member,** Outcomes & Evaluation Center Advisory Leadership Committee. PCPCC (Patient-Centered Primary Care Collaborative). Current. December 2012-2015
- **Member,** US Masters Swimming Health Network. Sports Medicine & Science Committee, United States Masters Swimming. Authored Report: Transgender Rules in Sports Participation. October 2011-current.
- **Member.** STFM Group On Public Health in Medical School Education. July 2011-2013.
- **Advisory Committee Member.** The SAGE Project: Assessing the **S**ocial **A**ccountability of **G**lobal Health **E**xperiences. Society of Teachers of Family Medicine Group on Global Health. 2011-2013.
- **Medical Education Committee Member.** Center for the Rural Development of Milot (CRUDEM) Foundation. Haiti. 2011-2013
- **Judge,** Family Medicine Physician of the Year 2010, AAFP, 2009.

Board Membership

- **Director,** elected to the Board of Directors of the National Physicians Alliance. 2017-2018. Chair, Communications Committee.
- **Advisory Board Member.** AAFP National Research Network (NRN). 2018-Current.
- **Member**, steering committee Pregnancy Risk Assessment Monitoring System, (PRAMS). DC DOH 2016-Present
- **Member**, Maternal Child Health Advisory Council DC DOH 2016-Present.
- **Advisory Board Member,** AAFP Center for Global Health Initiatives (CGHI). July 2015 – 2018.
- **Elected Board Member.** DC Chapter, American Academy of Family Medicine. 2-year term. 2012-14, 2014-2016, 2017-2019, 2019-2021. Co-chair, Advocacy Committee
- **Board Member,** Community Advisory Board (CAB) of the Georgetown- Howard Universities Center for Clinical and Translational Science (GHUCCTS). 2013-Present
- **Elected Board Member.** Healing Across the Divides (Middle East based NGO). 2010-2018
- **Elected Member, Board of Directors.** CC AHEC – Capital City Area Health Education Center. 2008

International and National Conference Committees/Abstract Reviewer

Abstract Reviewer:

- NAPCRG 2017 annual meeting. Montreal, Canada November 2017.
- 21st WONCA world Conference of Family Doctors. Rio de Janeiro, Brazil. November 2016.
- Stanford Medicine X | Symplur Signals Research Challenge. July 2015.
- WONCA (World Organization of Family Doctors) Annual Meeting. June 2013, Prague.
- 7th Annual AAFP Global Health Workshop. Atlanta, GA, September 2016
- 2012 National Health Promotion Summit. Association for Prevention Teaching and Research (APTR). November 2011.

Conference Planning Committee Member.

- Multi-Sectoral Planning Committee. Healthcare Working group. First annual US End FGM/C Summit. Washington, DC, July-December 2016.
- CUGH (Consortium of Universities for Global Health) Annual Conference's Review Committee November 2012-March 2013.

- Torture Treatment Annual Meeting and Symposium. Co-Sponsored with the Department of Family Medicine. (February 2012). August 2011-February 2012.
- Clinical Preventive Medicine & Lifestyle Track. American College of Preventive Medicine (ACPM) Annual Meeting, Prevention 2012. August 2011-February 2012.
- Global Health Council, 2011 Annual Meeting. January-March 2011. March-May 2012.
- Society of Teachers of Family Medicine (STFM) – NE Regional Conference. May 2008 – October 2008

Journal Editorial Board and Peer Reviewer

- **Associate Editor.** BMC International Health and Human Rights. 2018-current.
- **Editorial Board Member**: Ambulatory Care Management 2013-current;
- **Peer Reviewer**: The BMJ; Annals of Internal Medicine; Journal of Medical Internet Research; Family Medicine; Journal of Immigrant and Minority Health; American Journal of Preventive Medicine; Journal of Family Practice; Journal of the National Cancer Institute; Public Health Reviews;
- **Reviewer** HealthNewsReview.org a web-based source for health reporting quality. 2010-2018.
- **Invited Reviewer.** FGM/C Guidance for Pediatric Professionals. American Academy of Pediatrics. April 2018.
- **Invited Reviewer.** Intimacy, Immigration and Integration. Family Planning and Communication across generations in the Israeli Ethiopian Migrant Community. Grant Review 'Open Door' – Israeli Reproductive Health NGO. October-December 2017.
- **Invited Reviewer.** Reproductive Health Survey for Eritrean Migrants in Israel. Mesila Organization – Israeli NGO Dedicated to programs for African Migrants. February-August 2017.
- **Invited Reviewer.** Choosing an International Elective: A Roadmap for your Decision. https://www.choosinganelective.org/about
- **Invited Reviewer**: American Academy of Otolaryngology, Clinical Practice Guidelines Hoarseness (Dysphonia). March 2016.
- **Invited Reviewer**: AHRQ Psychosocial and Pharmacologic Interventions for Disruptive Behavior in Children and Adolescents. March 2016. (Project ID VBE4400SR)

National Grant Reviewer

- **Invited Grant Reviewer,** USAID's Middle East Regional Cooperation (MERC) Program February 2015
- **Invited Reviewer**. National Center on Minority Health and Health Disparities (NCMHD) at the National Institutes of Health (NIH). NCMHD Special Emphasis Panel (SEP), reviewing applications for Recovery Act Limited Competition: NCMHD Exploratory Centers of Excellence (P20). August 2009

INVITED TALKS: NATIONAL AND INTERNATIONAL.

Invited guest speaker.

- Local Care with a Global Perspective. Human Rights: from Global to Local. Annual meeting TASSC International. Washington College of Law, American University. June 26, 2019. Washington, DC.
- Human Trafficking. What Clinicians Need to Know. Grand Rounds, Franklin Square Family Medicine Residency Program. Baltimore, MD. May 2nd 2019.
- What Child Protective Services Need to Know about FGM/C. 21st National Conference on Child Abuse and Neglect (NCCAN). Washington, DC April 2019.
- Clinicians' Role in Addressing Health Inequities. Amgen Health Equity Summit. Washington, DC. April 2019.
- The Health of Forced Migrants. GlobeMed Capitol Hilltop 2019. George Washington University. April 2019.
- PHR Asylum Training Workshop. Houston, TX. March 2019.
- The US Asylum System: Medical Evaluations. University of Illinois Chicago Medical Center. January 19, 2019.

- "The Political Determinants of Health" Universal Health Care Action Network (UHCAN), National Stakeholder conference. Tuesday, November 13, 2018.
- Physicians Role in Human Rights. A Personal Journey. UNC Department of Family Medicine. September 2018.
- Working with Media to Amplify Your Actions. Affordable Medicine Now National Conference. Washington, DC. June 2018
- Killer Medicine. A Forensic Look at Health Care Policies and Practices During and Since the Holocaust. Washington, DC March 2018.
- Female Genital Mutilation/Cutting: What Medical Service Providers Need to Know. Meeting organized by DOJ, HHS. March 2018. Washington, DC.
- Gun Violence Prevention Media Training Webinar for Physicians. National Physicians' Alliance. March 2018.
- Opening Remarks, PHR National Student Conference, Annual Meeting. November 2017, Washington DC (via skype from Bangladesh)
- The Social Determinants of Health -- a Global Perspective. Workshop for participants of International Center for Journalists (ICFJ) 2017 Global Health Reporting Contest. Washington, DC September 2017
- Asylum Healthcare; FGM/C. The 2nd Annual North Carolina Refugee Health Conference: Challenges & Opportunities. Greensboro, NC. August 2017
- Using a mobile app to document sexual violence in conflict zones. Gender-Based Violence (GBV) Task Force of USAID's Interagency Gender Working Group (IGWG). Washington, DC. June 2017.
- Keynote Speaker. DC Superior District Court, Naturalization Service. April 2017.
- American Family Physician Podcast. Advocacy and Family Medicine. March 23, 2017
- Forced Migration. The Health of Refugees, Asylum Seekers and Unaccompanied Youth. Ranit Mishori. AMSA Annual National Conference. Crystal City, VA. February 2017.
- Media 101. How Physicians should talk to the media. National Physician Alliance (NPA) Health Policy Seminar. February 18, 2017.
- Refugee and Asylee Health. OUWB School of Medicine. Detroit, Michigan. January 2017.
- AMA Journal of Ethics. January 2017. Human Trafficking and Medicine. AMA Journal of Ethics. Podcast. Responding to Trafficked Persons in Health Care Settings: An Interview with Dr. Ranit Mishori. January 2017.
- Zika Webinar, for AAFP. Mishori, R. Zika Virus: an Update for Family Physicians. September 2016.
- Female Genital Mutilation. Round Table. US Department of Justice. June 2016. Baltimore, MD.
- Mishori, R. Brick, M, Alley, A. Fostering Sustainable Lupus Awareness and Education Annual Leadership Institute, Lupus Foundation of America. Indianapolis, Indiana. June 20, 2016
- Refugee Health. SUNY Upstate Medical University MPH Program. Grand Rounds. April 2016.
- Public Health Issues in the US. International Center for Journalists (ICFJ), International Health Reporting Fellowship Program November 2015.
- "Women, Health and the Global Battle for Dignity and Rights" PHR National Student Conference. Columbia University School of Surgeons and Physicians. NYC, November 2015.
- Refugee Health in North America. AAFP Annual Global Health Workshop. October 2014 (San Diego, CA); October 2015 (Denver, CO)
- Covering Maternal and Child Health in the US and Globally. International Center for Journalists ICFJ, International Health Reporting Fellowship. September 2014
- Covering Community health and health disparities. International Center for Journalists ICFJ, Community Health Reporting Fellowship. June 2014
- A mobile app to document sexual violence. Global Summit to End Sexual Violence in Conflict. London, June 2014.
- Media and Health: Research Collaboration and Opportunities. Georgetown University Department of Linguistics Monthly Health Discourse Seminar. September 27, 2013.
- The US Health Care System: Stories, Resources and Databases. International Center for Journalists ICFJ, Global

Health Reporting Fellows. May 2013

- Female Genital Cutting: Clinical and Legal Issues. Georgetown Law Center. March 2012, 2013, 2014. 2016. 2017. 2018.
- Human Rights and Medical Practice. Virginia Commonwealth University/Fairfax Family Medicine Residency Program. April 13 2012
- Being a Patient 101: How to Navigate a Complex Health Care System. Georgetown University Mini-Med School. October 2008
- What is Family Medicine? National Youth Leadership Forum on Medicine. July 2007

Invited Moderator

- Migrant Health In Crisis. An International Symposium. Moderator: Border Health – Focus on the US-Mexico Border. Washington, DC November 2019.
- NEJM Group Open Forum. The Unhealthy Effects of US Health Care of Aggressive Travel Restrictions. March 27-31, 2017.
- Medical & Service Providers. End Violence Against Girls: Summit on FGM/C. December 2, 2016, United States Institute of Peace (USIP)
- Plenary panel on Refugee Health with Dr. Curi Kim, Director for the Division of Refugee Health (DRH) at the Office of Refugee Resettlement (ORR) within the Administration for Children and Families. AAFP Global Health Workshop. Atlanta, Georgia, September 2016.

Invited Panelist

- Overtreatment. Kaiser Family Foundation. September 2018.
- Best Practices and Solutions. End Violence Against Girls: Summit on FGM/C. December 2, 2016, United States Institute of Peace (USIP).
- Panel on the topic of "Communicating Scholarship in the 21st Century and to Generations to Come," a Symposium that is being sponsored by the Scholarly Communication Committee. April 2014
- Women's Health. National Journal "Women 2020 Super Summit: Celebrating Progress: How Women Are Changing the World", July 18, 2013, Washington, D.C.
- Washington Ideas Forum Working Summit- Health, Healthcare and Wellness. The 4th Annual Washington Ideas Forum. The Aspen Institute/The Atlantic. November 2012.
- Avoiding Avoidable Care Leadership summit, organized by the Lown Cardiovascular Research Foundation and the New America Foundation, and co-hosted by the Institute of Medicine. Cambridge, MA April 25-26, 2012.
- The Role of Public/Private Partnerships in Treating Illnesses Plaguing the Developing World. Research!America and The Atlantic. December 6th, 2011.
- The Future of Health Reform. The 3rd Annual Washington Ideas Forum. The Aspen Institute/The Atlantic. October 5, 2011.

Invited Contributor:

- Invited to contribute bi-monthly video commentaries for the Primary Care/Family Medicine online Channel. Medscape Primary Care. 2014-present. https://www.medscape.com/partners/gumc-fm/public/gumc-fm

UNIVERSITY SERVICE

Media appearances on TV, radio, print, on behalf of Georgetown University, via the GUSOM Communications office. Live interviews, taped interviews and quotes on: NPR (ATC), The Today show, CNN, The Diane Rehm Show, Talk of the Nation, The Associated Press, USA Today, CBS News, MSNBC.com, ABCNews, Voice of America, WUSA, abcnews.com, Los Angeles Times, Chicago Tribune, Fox Channel 5, The Guardian, among many others.

Committee Membership

- Georgetown University Medical Center. Diversity Committee (Leadership subcommittee). 2018-present
- Georgetown University, Advisory Committee to the Gender Equity Task Force. 2017-2019
- Georgetown University. Scholarly Communication Committee 2017-2018.
- Georgetown University Medical Center Faculty Senate (elected) 2017- 2019.
- MedStar-Georgetown Population Health Steering Committee. 2017-2018.
- Medical Center's Philanthropy Faculty Advisory Committee. 2016-2019.
- GUMC IRB-C (Social Behavioral). 2016-2017. Alternate member 2018 - present
- GUMC Faculty Development Advisory Board and subcommittee on mentoring. 2014-2016.
- CENTILE Programs Working Group. 2013-2016
- CAB Academic Partnered Research Subcommittee (APRS) 2013-2016.
- Community Advisory Board (CAB) of the Georgetown- Howard Universities Center for Clinical and Translational Science (GHUCCTS). 2013-Present
- Subcommittee on Evaluation and Assessment (SEA), Georgetown University School of Medicine. 2008-2012.
- Institutional Review Board (IRB). Providence Hospital. 2006-2012.
- LCME Sub-committee on Student Affairs. Georgetown University School of Medicine. 2010
- Clerkship Directors Committee. Georgetown University School of Medicine. 2008-2010
- Resident Chair Department Family Medicine Residency Program. Patient Education Committee. 2007-2008
- Steering Committee. CAPRICORN, Primary Care Research Network, Department of Family Medicine, Georgetown University Medical Center. 2003-2004
- Student Medical Education Committee, Georgetown University School of Medicine. 2001-2002

Internal Grant Reviewer

- Medstar Health Research Institute (MHRI). Small Collaborative Grants 2015.
- CENTILE Health Education Research Colloquium 2014, 2015.
- CIRCLE Georgetown Medical Education Grants 2014-2017.
- GHUCCTS Community Engagement and Research Partnership Stimulation Mini Grants. June 2014

Leadership and Stewardship

- **Chair,** Scholarly Activities Committee, Department of Family Medicine. June 2017-current
- **Co-Founder, Faculty Advisor and Leader** Student-run Asylum Program. July 2014-current.
- **Faculty Advisor and Leader**. Student Incarceration Health interest group. 2017 –present.
- **Initiator and Founder** annual GU Student Family Medicine/Primary Care Research Award 2015- present
- **Founder and Co-Leader.** First Annual Institute of Medicine (IOM)/Georgetown University DC Regional Pubic Health Case Competition. 2013-2016.
- **Faculty leader** and organizer. Georgetown team's participation in the Emory Global Health Case Competition. March 2013, 2014.
- **Faculty Advisor**. groups on Global Health and Public Health. 2010-2016
- **Advisory Board Member,** NIH Grant: Experience of Polyvictimization in Latino and Black African Immigrant Youth. (PIs: Edilma Yearwood, Elzbieta Gozdziak, Rosemary Sokas). October 2013-2015.
- **Invited member** of group on Women and Human Development, as part of a University-wide initiative in Global Human Development. 2012.

University Service, Other

- **Faculty Advisor,** GUSOM Population Health Track. 2014-current.
- **Judge** Annual George M. Kober Student Research Day 2013-current
- **Volunteer Physician.** Hoya Clinic, Student-run free clinic. 2009-2010
- OSCE Review and Remediation. Georgetown University School of Medicine. 2008-2010.
- **Interviewer,** Medical School Applicants. Georgetown University School of Medicine. 2008-2009

Invited Speaker (GUMC, Internal):

- Georgetown University Family Medicine Residency Program. Multiple clinical talks. 2008-present
- Invited Speaker. Why Doctors Should Care About Human Rights? Georgetown Health Equity Series. January 2020.
- AMWA student chapter. Women's Careers in Medicine. September 2018.
- FMIG. Family Medicine and Global Health. October 2018.
- GUMC Health Policy Elective. Migrant and Refugee Health. 2016, 2017. 2018, 2019.
- Georgetown Law Center: Trauma in Asylum Seekers, Vicarious Trauma in Asylum Evaluators. January 2018; January 2019.
- Georgetown University School of Medicine. Reflections on Assessing Human Rights Violations of Rohingya Refugees. January 2018.
- Department of Family Medicine Grand Rounds. The Health of Forced Migrants. May 2017.
- Female Genital Mutilation (PHR and OB interest groups). May 2017
- Career in Human Rights. PHR interest Group. May 2017.
- Conducting an Asylum Evaluation. GUSOM-PHR Chapter day-long training workshop. Georgetown University. 2014-2019 (twice yearly).
- Mishori, R. Gender Based Violence in Conflict Zones. Georgetown University Gender Justice Initiative Colloquium. September 2016.
- Antibiotic Resistance: A Global Health Concern. Doctors Speak Out Forum, Georgetown University, Dec 8, 2015
- GUMC Annual Convocation Colloquium, "Antibiotics: Panacea or Problem?" November 3, 2015. panel on Global Health. IHIG. March 2015.
- Global Health and Primary Care. FMIG Primary Care Week. October 2014.
- The Primary Care of Refugees and Immigrants. Primary Care Week. Georgetown University. November 2010.
- Refugee Health Series. Graduate Program in Global Infectious Disease. Georgetown University. November 2010.
- How to Talk to the Media. Georgetown Women in Medicine. November 2008
- Healthcare in Afghanistan Panel. Social Justice Week, Georgetown University School of Medicine. April 2009
- Gateway: Biology of Global Health, Cancer Module. BIOL-194 course, Undergraduate College. Department of Biology.

TEACHING ACTIVITIES

Director:

- Annual Media Workshop for Trainees and Primary Care Clinicians (in collaboration with FMEC). 2016-present.
- Health Policy Fellowship. 2017-present.
- Health and Media Fellowship. 2014-current.
- Residency Global Health Track. 2012-current.
- Health Disparities (Georgetown College) 2012-2014
- Health and Human Rights 2011 - 2017
- Family Medicine Clerkship 2009-2011

- Selectives 2007-2008

Assistant Director:
- Introduction to Health Care 2007-2008.

Curriculum Development:
- Health and Media faculty development Fellowship 2014
- Health and Media elective 2014
- IOM/Georgetown Regional Public Health Case Challenge 2013
- Course on Health Disparities for joint Graduate/Undergraduate Program, Georgetown University. 2012
- Clinician training in Gender-Based Violence identification and reporting. Physicians for Human Rights, The Democratic Republic of Congo 2011-2012.
- Residency Global Health Track. 2012.
- Haiti: Traditional and skilled Birth Attendant Training Curriculum. 2011-current.
- Health and Human Rights Selective 2011 (SOM-I)
- Case Series in Global Health. 2010-2011 (SOM; Residency)
- Conducting Asylum Evaluations. 2011. (Residency)
- Chronic Care Model Workshop 2010 (SOM-III)
- Motivational Interviewing Workshop 2010. (SOM-III)
- Medical Spanish Selective. 2009. (SOM-I)
- The Writings of Atul Gawande. Selective. 2008. (SOM-I)
- Preventive Medicine Workshop. 2009. (SOM-III).

Courses Taught
1st Year: Service Learning; Evidence-Based Medicine I; Selective; Health Policy and Economics; Patient, Physician Communication; Society, Culture and Ethics; Mind-Body Medicine; Physical Diagnosis; Ambulatory Care; Patients, Physicians, Populations.
2nd Year: Evidence-Based Medicine II; Ambulatory Care Preceptor.
3rd Year: Family Medicine Clerkship; Preventive Medicine Lecture; Motivational Interviewing workshop; Evidence-Based Medicine Workshop; Chronic Care Model Workshop.
4th Year: Clinical Pharmacology; Student mentor – Independent Study Project.

Residency Teaching
- Family Medicine Outpatient Service; Clinical Supervisor. Fort Lincoln Family Medicine Residency Program Clinic.
- Family Medicine, Inpatient Service. Providence Hospital. Clinical Supervisor/Attending Physician.
- Advanced Life Support in Obstetrics (ALSO). Faculty Instructor.
- Asylum Evaluations. 2010-current
- Didactic Lectures. 2008-current.

MENTORING

FELLOWS:
- Dr. Brian Antono. Health Policy Fellow 2019-2020.
- Dr. Mara Gordon. Health and Media Fellow 2018-2019
- Dr. Alison Huffstetler. Health Policy Fellow. 2018-2019.
- Dr. Rob Bailleu. Health Policy Fellow. 2017-2018
- Dr. Amber Robins, Health and Media Fellow 2018-2017
- Dr. Hannah Jackson. Health Policy Fellow 2018-2017

- Dr. Anita Ravi. RWJF clinical Scholar fellow. Trafficking authorship; JAMA letter to the editor; Career mentorship; authorship of additional articles at AFP. 2015-2016.
- Dr. Melanie Raffoul. Global Health activities; writing and scholarly activities; Career mentoring 2015-2016.
- Dr. LaTasha Seliby. Health and media, scholarship and writing.
- Dr. John Parks: global health activities and research project. 2013-2014.
- Dr. Sarah Kureshi. Global Health Project; Human Rights curriculum design. Abstract Submission (selected as poster at International Conference). Survey design and analysis. Asylum Work. 2011- 2012.
- Dr. Christy Theranos. Project on International Medical Graduates. Study design; grant writing; funding opportunities. 2012.
- Dr. Matthew Burke. Global Health project: electronic medical records in Haiti. Article/Abstract Submission (presented at international conference). Career mentorship and networking opportunities. 2010-2012.

RESIDENTS:

- Grace Walters; Health Policy Scholar. Research Project. 2018-present.
- Molly Bloom. Global Health Scholar. Research project; global heatlh career. 2019-2020.
- Joanna Choi. Global Health Scholar. Research project and global health career. 2017
- Tracy Cassagnol. Health Writing. Outcomes: one online publication; One Washington Post publications.
- Sadhna Rajamoorthi. Global Health Scholar. Proposal writing, IRB, survey design, project development, scholarly output. 2015-present.
- Isha Chaudary. Global Health Scholar. Proposal writing, IRB, survey design, project development, scholarly output. 2015-present.
- Kathy Stolarz. Global Health Scholar. 2012-present. Proposal writing, IRB, survey design, project development, scholarly output. Presented at AAFP Global Health 2013, 2015.
- Phil Nguyen .Global Health Scholar. 2012-Presnet. Proposal writing, IRB, survey design, project development, scholarly output. Presented at AAFP Global Health 2013. Co-faculty leader P3.
- Andrew Eastman. Global Health Scholar. Project development. Proposal writing. Presentation at AAFP GH Workshop 2015. 2014-present.
- Corey Carson. Scholarly activities. Resulted in two publications (Washington Post and whilte paper).
- Assigned Faculty Advisor. Dr. Jennifer Ah-Kee. Family Medicine Resident. 2011-2013. Manuscript preparation; career planning.
- Megan Barber.MS4-PGY-II. EBM research project/ISP. FPIN/EBM elective, article writing. Publication February 2014.
- Assigned Faculty advisor, Dr. Asha Robinson-Parks. Family Medicine Resident. 2008-2011
- Dr. Sarah Murray. Research project design and IRB application: Medical Student attitudes about Pharma (ongoing). Paul Ambrose Fellowship application (accepted); global health activities: received two scholarships to attend program in Argentina. 2010-current.
- Dr. Brendan Levy. Family Medicine Resident. Asylum Evaluation preparation. Journal Club and PEPID preparation and publication. Social Media study participation. Publication in Family Medcine. 2011-present.
- Dr. Aye Otubu. Family Medicine Resident. Global Health Activities; Journal article writing and accepted publication (Journal of Family Practice); Two abstracts accepted at conferences. Case-study development. 2009-current.
- Dr. Sarah Fellers. Family Medicine Resident. Global Health activities; 2 accepted publications (AAFP International Health Newsletter; PEPID). 2009-2011.
- Aminah Allyn Jones. Family Medicine Resident. Journal article submission and writing (accepted for publication). 2010-2011.
- Dr. Kumo Lartevi. Global Health Activities. Abstract submission (accepted); Essay preparation (accepted AAFP newsletter). 2011.
- Corry Chapman, Family Medicine Resident. Essay Writing (accepted, The Lancet), International Health

Experience. Winner, 2008 Wakely Prize, The Lancet

STUDENTS:

- Anu Murthy. Correctional Health, multiple projects, grant award. 2017-2019.
- Jessica Beer. Asylum – multiple project and research project; 2017-2020.
- Karen Schirm. Human Trafficking curricular proposal, clinical placement, research project. 2018-cirent.
- Stephanie Johng. Social Media and Health Promotion. Research project; poster and writing. 2018-present.
- Zayn Holt. FGM research project execution. 2017-2018.
- Nicholas Stukel. Proposal writing, career mentorship. Article publishing, ISP and research programs 2015-2017
- Nathan Praschan. Proposal writing, career mentorship. Article publishing, ISP and research programs. 2013-2017.
- Diasy Kim. Proposal writing, career mentorship. Asylum Program work. 2013-2017.
- Kevin Diasti. Proposal writing, career mentorship. Asylum Program work. 2013-2017
- Dora Dakhal. ISP research support and mentorship. 2013-2017
- Hennessey, C., Stukel, N. Mishori, R. (ISP) Medical Students' Attitudes Towards Refugees & Asylum Seekers. 2013. 2017
- Katherine Mullins (Population Health track). Summer project design, summary; IRB preparation; Poster preparation. Poster presented at two regional meetings.
- Dori Abel. Global Health ISP research Project – mHealth. Co-presenter at Global mHealth Conference, November 2015.
- Emily Platz. ISP Diabetes community services; presented poster in 2 meetings.
- Elise Park. ISP Health discourse on TED talks
- Elizabeth Edwards. ISP. Critical review of role of Hymen. Manuscript Preparation.
- Lawrence Law. TV and EBM. ISP. Manuscript preparation; won ISP honorable mention .
- Brendan Kiernan. ISP project on violence and sex workers in The Democratic Republic of Congo. Manuscript co-authored and published . ISP presentation .2012-presesnt.
- Vera Hendrix. ISP project on menstrual hygiene in developing countries. 2013. Presentations at two national conferences, Social Justice week and ISP.
- Kelley Coffman. ISP project Cervical Cancer provider KAP in Zambia. 2012-2014. Poster in Health Justice Session March 2014.
- Courtney Quin. ISP project DVT/PE in Elite Athletes. Article in Journal of Family Practice accepted for publication. 2013-2014.
- Alexandra Coughlan (MS1). International Health Activities. ISP Research Study. DRC Project on Gender Based Violence. (Ongoing).
- Liz Oler. AMWA assigned mentor. Global Health activities; Public Policy interest. Cost of Care manuscript. 2013-2014.
- Nicole Boisvert. International Health activities. ISP, research study design and IRB process. Cambodia Child Health Research Project (ongoing). Publication Submission (ongoing). Trinidad HIV program (accepted presentation at AAFP meeting); essay preparation and submission to AAFP Global Health newsletter (published).
- Catherine Matthys. Global Health Research Project (won a scholarship via competitive process). Clean Water Project in Rural Tanzania (ongoing): IRB application, data analysis. 1st Prize and cover Photo of the Year in The Lancet (2012). Acceptance of poster to AAFP Global Health Workshop 2012. Essay preparation and submission to AAFP Global Health newsletter
- Sanna Ronkainen. Public Health career mentorship. Summer Public Health HHS internship (accepted). MPH counseling (accepted to Hopkins). 2010-2013.
- Katherine McCllelan. ISP. Ugandan Maternal Health Education Program. International Health Activities. Independent Study Project (ISP). Publication submissions (accepted AAFP Newsletter Spring 2011). 2010-2011.
- Shoshana Aleinikoff. Conducting an Asylum evaluation and affidavit writing. 2011. Career in Family Medicine

(ongoing).

- Emily Lovallo, Medical Student. Creation of Global Health Education Longitudinal Curriculum. Accepted as poster AAFP Scientific assembly 2008. First Place, AAFP Residency Conference 2008; Accepted, Poster APHA 2008; Accepted, CDC International Fellowship 2008

GRANT ACTIVITIES

Active; Awarded.

- Jarris, Y., Doyle, A., Kureshi, S., **Mishori, R**., Chen, C. A Longitudinal Medical Student Curriculum on Screening for Food Insecurity. CIRCLE Grant. May 2018. ($25,000)
- **Mishori, R**., Ravi, A., Stolarz K, Chambers R. Human Trafficking Education in Family Medicine Residency Programs. CERA – PD Grant. October 2017 $10,000.
- **Mishori, R**. Baillieu, R., Pasderka M, Connors G. Beyond the Exam Room: A Scoping Review of the Benefits and Potential Harms of Screening for the Social Determinants of Health. Gold Foundation "Mapping the Landscape, Journeying Together" initiative . $5,000. July 13, 2017
- Sheth, N. Patel, S., **Mishori, R**., Akil M., Dutton, MA., To Screen or Not to Screen: Exploring and Addressing Controversies in Screening for Trauma Among Refugee and Asylum Seekers. Reflective Engagement Grant. March 2017.
- Seth N, Patel S., **Mishori, R**., Gozdziak E., Global Mental Health in Our Own Backyards: A Collaborative Needs Assessment of Refugee and Asylee Mental Health. Global Health Collaborative Seed Grant Project. March 2017. ($15,000).
- **Ranit Mishori,** Rebecca Reingold, Kevin FitzGerald. Should I Re-infibulate? Should I report? Helping clinicians address complex medical-ethical-legal issues related to Female Genital Mutilation (FGM). Complex Moral Problems, Georgetown University (20,000). April 2016.
- **Ranit Mishori (PI).** Global is Local. The Asylee and Refugee Clinic (ARC) Project. Scholl Foundation. $25,000. November 2015.
- **Ranit Mishori**, Macy Foundation Presidential Grant. Designing a Refugee Health Curriculum. $35,000. September 2015-2016.
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- **Ranit Mishori,** Anne Rosenwald. Advancing Educational Objectives Using Case Competitions. First Annual CENTILE Colloquium, Georgetown University Medical Center. June 2014.
- **Ranit Mishori,** Karen Naimer, Sucharita Varanasi. Hope Ferdowsian. Multi-Sectoral Response to Sexual Violence. Consortium of Universities in Global Health (CUGH) Annual Meeting. Washington, DC May 2014.
- Vera Hendrix, **Ranit Mishori.** Menstruation in the Developing World. Consortium of Universities in Global Health (CUGH) Annual Meeting. Washington, DC May 2014.
- Kelley Coffman, Christian Petrauskis, **Ranit Mishori** Secondary Prevention of Cervical Cancer in Lusaka, Zambia: Perceived Barriers. Health Justice Track Research Day. GUSOM. March 2014.
- **Ranit Mishori**, Vincent WinklerPrins, Stanley Kozakowsi et al. Medical Students And Residents' Attitudes And Knowledge About Appropriateness of Care: A National Survey. 2013 NAPCRG Annual Meeting. November 9-13, 2013 in Ottawa, Ontario.
- **Ranit Mishori**, Jeffrey Weinfeld, Michele Malloy, Joyce Fu. TV And EBM: A Credibility Assessment of Daytime Talk-show Health Information And Advice. 2013 NAPCRG Annual Meeting. November 9-13, 2013 in Ottawa, Ontario
- Jacob Prunuske, **Ranit Mishori**, Linda Chang, Christopher Morley. Evaluation of the Extent and Methods of Public Health Instruction in US Medical Schools. STFM Medical Student Education Annual Meeting. San Antonio, TX. January 2013.
- Christopher Morley, Jacob Prunuske, **Ranit Mishori**, Linda Chang. Evaluation of the Extent and Methods of Public Health Training in US Medical Schools and Family Medicine Training Programs. NAPCRG Annual Meeting. New Orleans, LA. December 2012.
- Vera Hendrix, **Ranit Mishori**. Deal with It. Period. Menstruation in the Developing World. FMEC annual Conference. Philadelphia, PA. November 1-3, 2013

- Catherine Matthys, **Ranit Mishori**. Factors impacting Shared Water Filter Usage Among Tanzanian Women. AAFP Global Health Workshop. Minneapolis MN, September 2012.
- Kate Komis, Joyce Fu, Jeffrey Weinfeld, **Ranit Mishori**. TV and EBM: A Credibility Assessment of Daytime Talk-Show Health Information and Advice. Annual Research Day, Department of Internal Medicine, Georgetown University Hospital. September 2012.
- Megan Barber, **Ranit Mishori**, TV and EBM: A Credibility Assessment of Daytime Talk-Show Health Information and Advice. Georgetown University School of Medicine Research Day. May 2012.
- Nicholas Zimick, **Ranit Mishori**, Jeffrey Weinfeld. Analysis of Advertisements Aired During Daytime Network Medical TV Shows. Georgetown University Research Day, April 2013
- Aye Otubu, **Ranit Mishori**. Skilled Birth Attendant Training in Haiti. Lessons Learned. International Research and Project Workshop, Howard University. December 2011.
- Sarah Kureshi**, Ranit Mishori,** 'Teaching Health and Human Rights in Medical School - a Pilot'. CUGH/CHEC Conference. Montreal. November 2011.
- **Ranit Mishori**, Aye Otubu, Kumo Lartevi. "Training Haitian Skilled Birth Attendants in Pregnancy Support, Emergency Obstetric Care and Neonatal Resuscitation". AAFP Global Health Workshop. San Diego. October 2011.
- Rochelle E. Tractenberg, Jeff Collmann, Joel Selanikio, Amanda Liddle, **Ranit Mishori**, Kevin FitzGerald, Wolfgang Rennert. An integrated medical education (IME) system via SMS mobile technology for use by rural medical/public health providers in Kenya. Poster. Northeast Group on Educational Affairs (NEGEA) Annual Retreat. Washington, DC March, 2011.
- Matthew Burke, Steve Maynard, **Ranit Mishori**, Joe Giere. Sacre Coeur Hospital Records Improvement Project (SCHRIMP). Poster. NAPCRG Annual Meeting, Seattle Washington, November 2010.
- **Ranit Mishori**, Marguerite Duane, Daniel Harris. Beyond Traditional "Medical Spanish": Enhancing Medical Students' Ability to Communicate With Their Spanish-speaking Patients. Poster Presentation. Society of Teachers of Family Medicine, Annual Pre-Doctoral Meeting. Jacksonville, Florida. January 2010.
- Moore, Eileen, **Mishori Ranit**, Meyers David. Clinician and Patient Perceptions of the Burden and Manifestations of Ongoing Terrorism Threats. Poster Presentation. North American Primary Care Research Group (NAPCRG). October 2003

BOOK CHAPTERS

- Developing Global Health Programming: A Guidebook for Medical and Professional Schools, Second Edition. Chapter 7: Teaching and Implementing Advocacy. Editor: **Ranit Mishori**, Lindsey Briggs**.** ISBN 9780578127217. Copyright: Global Health Collaborations Press. Published January 15, 2014.
- Haiti: Clinical Medical Guide. **Ranit Mishori**, Editor: Maternal Care Chapter. Editor: Preventive Health Chapter. Publication. Fall 2012.
- Marguerite Duane, **Ranit Mishori**. Chapter: Preventive Medicine. In Essentials of Family Medicine, 6th Edition. Editors: Sloane et al. Publication Date: May 20, 2011. ISBN/ISSN: 9781608316557

POLICY STATEMENTS

- Co-author, All Health Policies of the Pete Buttigieg presidential campaign. April 2019-current.
- Co-Author, AAFP Position paper on Mental Health in Primary Care. 2018.
- Co-Author, AAFP Position paper on Incarceration and Health. 2016.
- Co-author, AAFP Policy Healthy Nutrition in Health Care Facilities and Other Workplaces 2016
- Co-Author, AAFP Policy Violence as a Public Health Concern 2016
- Co-Author, AAFP Policy on Organ Donation, 2016
- Lead Author, AAFP Position Paper, Mental Health Care Services by Family Physicians 2016
- Lead Author, AAFP Policy, Human Trafficking 2016
- Lead Author**:** AAFP Position paper Youth Violence and Media 2015

- Lead Author: AAFP Policy. Female Genital Cutting 2015
- Co-Author: AAFP Tobacco and Nicotine Product Policy 2015
- Co-author: AAFP position paper PreConception Counseling 2015
- Co-author AAFP position paper: Youth Alcohol Advertising 2015
- Co-Contributor: APHA Policy Proposal: Support for More Training and Research on the Interaction Between Human Trafficking and Healthcare. 2015.
- Lead Reviewer, author: AAFP Resolution. Don't Rape Programs 2014
- Lead Reviewer, author: AAFP Resolution. Sexual Assault Resources. 2014
- Co-Author: AAFP Tobacco and Nicotine Product Policy 2014
- End Violence Against Girls: FGM/C Summit report. Healthcare Sector Recommendations Strategies to Respond to FGM/C in the United States. Published April 2017. http://www.equalitynow.org/sites/default/files/Summit%20-FGM_Recommendations_HEALTHCARE_sector.pdf
- **Mishori, R,** Carson, C. Participation of Transgender Athletes in Sports: A Review (2014 Update). White paper **p**repared for The US Masters Swimming Rules Committee, Subcommittee on Competition after Gender Reassignment. December 2014
- **Mishori, R,** Participation of Transgender Athletes in Sports: A Brief Review. White paper **p**repared for The US Masters Swimming Rules Committee, Subcommittee on Competition after Gender Reassignment. April 2012.

CONFERENCE PRESENTATIONS

- Ottenheimer D, Cassohboy A, **Mishori, R**. "Female Genital Mutilation/Cutting (FGM/C) in the US after the Michigan Ruling. Now What?" APHA Annual Meeting. Phladelphia, PA, 2019
- Haar R, Khin MW, **Mishori, R**. Conflict-Related Public Health Vulnerabilities in Myanmar and Investigation of Human Rights Abuses of *Rohingya* Refugee. APHA Annual Meeting. Philadelphia, PA, Novmber 2019
- McKenzie K. Ferdowsian H. **Mishori, R.** Incorporating Health and Human Rights in Medical Education. North America Refugee Health Conference. Toronto, ON. June 2019.
- Jarris Y, Chen C, Cammack A, Kureshi S, **Mishori R**. A Longitudinal Medical Student Curriculum on Screening for Food Insecurity" CENTILE colloquium /MedStar Research Symposium. Columbia, MD. May 2019.
- Atkinson H, Ottenheimer D, **Mishori, R**. FGM/C US Research Agenda. 3rd International Expert Meeting on FGM/C. Brussels, Belgium. May 20-22, 2019
- Wikholm K, **Mishori R**, Ottenheimer D, Wikholm N, Khortoshevsy V, Reingold R, Hampton K. Analysis of FGM/C Asylum Cases. 3rd International Expert Meeting on FGM/C. Brussels, Belgium. May 20-22, 2019
- **Mishori, R**. Female Genital Mutilation of Girls in the United States: Why Child Protection Officials Should be Concerned. 21st National Conference on Child Abuse and Neglect. April 25th. 2019 Washington, DC
- **Mishori, R**. Rahman Z. The Rohingya Refugee Crisis: a Family Medicine Perspective. WONCA World Conference. Seoul, South Korea. October 2018.
- **Mishori, R**. Global and Domestic Human Trafficking: An overview. AAFP Global Health Summit. Jacksonville, FL. September 2018
- **Mishori, R**. A Conversation We must Have: Safety and Security Protocols in Global Health Programs. AAFP Global Health Summit. Jacksonville, FL. September 2018
- Namak S, Sahhar F., El RAyess F, Kureshi S, **Mishori, R**. International Medical Graduates: Adversity, Loss, and Improved Global Health. AAFP Global Health Summit. Jacksonville, FL. September 2018.
- Sheth N, O'Connor S, Patel S, Mishori, R. Dutton MA, Global Mental Health in our own Backyards: A Collaborative Needs Assessment of Refugee and Asylee Mental Health. North American Refugee Health Conference. Portland, OR, June 2018
- **Mishori, R.** McKenzie K, Stukel N., Thomas, A. Medical Evaluation of Asylum Seekers: Lessons from Two University-Based Models. STFM Annual Meeting. Washington DC. May 2018.
- Nguyen M., Kureshi S., Lin L, **Mishori R.** How to Write an Op-Ed. Washington DC. May 2018

- **Mishori, R.** Carlough, M, Walden J. Migrant Health in the US. Pre-Conference on Refugee Health. AAFP Annual Global Health Workshop. Houston, TX, October 2017.
- **Mishori, R.** Human Trafficking: An overview. Advice for the Family Physician. AAFP Annual Global Health Workshop. Houston, TX, October 2017.
- **Mishori, R.** The ABCs of FGM. AAFP Annual Global Health Workshop. Houston, TX, October 2017.
- **Mishori, R.** Human Rights, Why is it a Doctor's Business. AAFP Annual Global Health Workshop. Houston, TX, October 2017.
- **Mishori, R.** A Conversation We Must Have: Safety and Security in Global Health AAFP Annual Global Health Workshop. Houston, TX, October 2017.
- **Mishori, R.** The Medical Evaluation of Asylum Seekers AAFP Annual Global Health Workshop. Houston, TX, October 2017.
- A Conversation We Must Have: Safety and Security in Global Health
- Valdman O., **Mishori, R**., Waldman J., Carlough M. Building capacity to care for refugees: Nuts and Bolts of setting up refugee health care services in your clinical site. North American Refugee Health Conference. Toronto, Ca. June 2016
- Praschan N, Vaidya P, Hennessey C, Stukel N, **Mishori R**, Improving an Asylum Program: Lessons from GUSOM, March 23, 2017 – Health Justice Week. Georgetown University School of Medicine. Washington, DC.
- Praschan N, Vaidya P, **Mishori, R**. Barriers and Facilitators to Participation for Clinician Volunteers. March 23, 2017 – Health Justice Week. Georgetown University School of Medicine. Washington, DC.
- Wu S, FitzGerald K, **Mishori R,** Reingold, R. Improving FGM/C healthcare and clinical guidelines through community engagement and leadership. Management and Prevention of FGM/c. Geneva, Switzerland. March 2017
- **Mishori R**, FitzGerald K, Wu S, Reingold R. Making an Ethical Decision in the Exam Room: A Brief Review of the Legal, Ethical and Moral aspects of the Clinical Management of FGM/C. Management and Prevention of FGM/c. Geneva, Switzerland. March 2017.
- Reingold R, **Mishori R**, FitzGerald K, Wu S. A Cross-Country Comparison: Trends in the Adoption and Enforcement of FGM/C Laws relating to Reinfibulation and Vacation Cutting. Management and Prevention of FGM/c. Geneva, Switzerland. March 2017.
- Maria van den Muijsenbergh (Holland); Aral Sürmeli (Turkey); Kevin Pottie (Canada); Ana Costa, Guus Busser (Holland); Christos Lionis (Greece): **Ranit Mishori (US)**; Jill Benson (Australia); Refugees in primary care: what are their needs and how can we care best? WONCA World Meeting. Rio de Janeiro, Brazil. November 2016.
- **Mishori R,** Lin K, Teber K, Kamerow D, Bauer L. Media Workshop for Primary Care Physicians. A daylong media workshop covering how to speak to the media, social media, making a pitch, creating a media strategy and more. Georgetown University School of Medicine. September 2016
- **Mishori, R**. Human Trafficking: An Overview"
- AAFP Global Health Workshop. Atlanta, GA, September 2016
- **Mishori, R.** The ABC's of Female Genital Cutting/Mutilation: What Clinicians Need to Know. AAFP Global Health Workshop. Atlanta, GA, September 2016
- **Mishori, R** Human Rights: Why it is a Doctor's Business. AAFP Global Health Workshop. Atlanta, GA, September 2016
- **Mishori, R**. A Student-Run Asylum Program: Service, Capacity Building, and Refugee Health. AAFP Global Health Workshop. Atlanta, GA, September 2016
- **Ranit Mishori**, Nathan Praschan, Kevin Diasti, Nicholas Stukel.
- Creating a Student-Run Asylum Program: Service, Capacity Building, and Refugee Health. North American Refugee Health Conference. Niagara Falls, NY. June 11-14, 2016.
- **Ranit Mishori**, Hope Ferdowsian, Sarah KureshiMed School Goes To War: Using an Online Game to Teach About Survival During Conflict. North American Refugee Health Conference. Niagara Falls, NY. June 11-14, 2016.

- **Ranit Mishori**, Alexa Koenig, Wendy Betts, Betsy Beaumon.
- The Art of Admission: How Mobile Apps Are Documenting Court-Admissible Evidence of Human Rights Violations RightsCon. San Francisco. March 2016.
- **Ranit Mishori,** Sucharita Varanasi, Michael Antasario, Dori Able. Armed with Mobile Technologies: Public Health Emergencies and Fragile Situations. Medicapt: Improving documentation of Sexual Violence. Global mHealth Forum. Annual mHealth Conference. Washington, DC, November 2015.
- **Ranit Mishori,** Susannah Sirkin. Human Rights – Why it is a Doctor's Business. FMEC Annual Northeast Regional Meeting. Boston, MA. October 2015.
- **Ranit Mishori,** Mikhail Varshavsky, Laurence Bauer. Leadership Skills: Media Training. FMEC Annual Northeast Regional Meeting. Boston, MA. October 2015.
- Gretchen Heinrichs, **Ranit Mishori**, Katherine Stolarz. Female Genital Cutting/Mutilation: What clinicians Need to Know. AAFP Annual Global Health Workshop. Denver, CO. October 2015.
- **Ranit Mishori**, Daniel Kortsch. Refugee and Immigrant Health in the US and Canada: Challenges and Opportunities for the Family Physician. AAFP Annual Global Health Workshop. Denver, CO. October 2015.
- Andrew Eastman, **Ranit Mishori**. Violence Towards Health Care Workers in Conflict and Nonconflict Global Health Settings: Current Trends, Operating Environment, and Situational Awareness. AAFP Annual Global Health Workshop. Denver, CO. October 2015.
- **Ranit Mishori**, James Sanders, Shoshana Aleinikoff, Melanie Raffoul. Evaluating Refugees and Asylum Seekers. What you Need to Know. AAFP Annual Global Health Workshop. Denver, CO. October 2015.
- **Ranit Mishori**, MD, MHS, Kelly DiLorenzo (M4) , Nathan Praschan (M2), Nicholas Stukel (M2). Teaching Clinical Human Rights through a Student-Run Asylum Clinic. CENTILE 2nd annual Colloquium. June 2015.
- Jarris, Y. **Mishori, R**., Stoto M., Furlong, M. Preparing Medical Students for Their Roles in a Public Health Emergency. CENTILE 2nd Annual Colloquium. June 2015.
- Christopher Morely, Jacob Prunuske, **Ranit Mishori**, Scott Rosas, William Jordan, Yumi Jarris. Essential Public Health Competencies for Medical Trainees: Establishing a Consensus. Annual STFM Conference on Medical Student Education. February 2015. Atlanta, GA
- Christopher Morely, Jacob Prunuske**, Ranit Mishori**, Scott Rosas, William Jordan, Yumi Jarris. Essential Public Health Competencies for Medical Trainees: Establishing a Consensus. Annual NAPCRG conference. New York City, November 2014.
- **Ranit Mishori**, Larry Bauer. Family Medicine and the Media.
  FMEC Annual NE regional meeting, Washington, DC October 2014

- **R, Mishori,** Praseedha Janakiram, Daniel Kortsch. Refugee & Immigrant Health within the US and Canada. AAFP Annual Global Health Workshop, San Diego, CA September 2014.
- Sam Matheny, Olga Valdman, Paul Hennig, Jeff Hall, Jessica Evert, Will Perez, **Ranit Mishori**, Jeff Markuns, Omar Khan. Family Medicine Place in the Broader Global Health Conversation: A collaborative SWOT analysis. AAFP Annual Global Health Workshop, San Diego, CA September 2014.
- **Ranit Mishori,** Anne Rosenwald, Bridget Kelly. Case Competitions: a New Frontier in Inter-Professional Health Education? AMEE Annual Meeting, Milan, Italy, September 2014.
- **Ranit Mishori**, Karen Naimer, Sucharita Varanasi. Harnessing the Power of Technology to Improve Accountability for Sexual Violence. Global Summit on Sexual Violence in Conflict Zones. London, UK, June 2014.
- **Ranit Mishori**, Anne Rosenwald. Teaching Health Disparities via Case Challenges. CENTILE Colloquium. GUMC. June 2014
- Winston R. Liaw, Andrew Bazemore, **Ranit Mishori**, Philip M. Diller, Inis Jane Bardella, Newton Cheng. The Financial Health of Global Health Programs. STFM Annual Meeting, San Antonio, TX. April 2014.
- Paul R. Larson, Bruce Dahlman, Memoona Hasnain, Joseph J. Brocato, William E. Cayley Jr, Andrea L. Pfeifle, Linda Hogan, Fadya El Rayess, Bich-May Nguyen, Brian M Johnson, Anna Doubeni, **Ranit Mishori**. Strengthening Family Medicine Faculty Development: Needs Assessment to Guide Countries Where The

Specialty Is Emerging. STFM Annual Meeting, San Antonio, TX April 2014.

- Karen Naimer, **Ranit Mishori,** Sucharita Varanasi. Harnessing the Power of Technology to Improve Accountability for Sexual Violence. RightsCon. Silicone Valley, 2014.
- Jacob Prunuske Linda Chang **Ranit Mishori** Dean Seehusen Alison Dobbie Christopher Morley .The Extent And Methods of Public Health Instruction In Family Medicine Undergraduate And Graduate Medical Education. 2013 NAPCRG Annual Meeting. November 9-13, 2013 in Ottawa, Ontario
- Morely CP, Prunuske J, **Mishori, R**, Jordan W, Jarris Y. Essential Public Health Competencies for Medical Trainees: Establishing a Consensus. 2013 NAPCRG Annual Meeting. November 9-13, 2013 in Ottawa, Ontario
- **Ranit Mishori,** Sarah Kureshi. Identification and Management of Victims of Human Trafficking – Advice for the Family Physician. Annual AAFP Global Health Workshop. Baltimore, MD, October 2013.
- Mark Ryan, **Ranit Mishori**. The Shrinking Globe: Social Media and Global Health. Plenary Session. Annual AAFP Global Health Workshop. Baltimore, MD, October 2013.
- **Ranit Mishori**, Gender Based Violence (GBV) in Conflict Zones. Plenary session. Annual AAFP Global Health Workshop. Baltimore, MD, October 2013.
- **Ranit Mishori**, Phillip Nguyen, The Medical Evaluation of Asylum Seekers. Annual AAFP Global Health Workshop. Baltimore, MD, October 2013.
- **Ranit Mishori (moderator),** Scott Loglieger (moderator). From Policy to Practice: Primary Care's Role in Global Health. CUGH Annual Meeting. Washington, DC. March 2013.
- Jacob Prunuske, Yumi Jarris, Willam Jordan, **Ranit Mishori**, Christopher Morley. Optimizing Integration of Public Health and Medical Education: The Role of Family Medicine Residencies. 46th STFM Annual Spring Conference. Baltimore, MD May 2013
- Prunuske, Morley, **R. Mishori**, Chang. The Extent and Methods of Public Health Instruction in US Family Medicine Residency Programs. 46th STFM Annual Spring Conference. Baltimore, MD May 2013
- Ashley Bentley, **Ranit Mishori**. Exposing Students to Family Medicine Through Global Health Research**.** 46th STFM Annual Spring Conference. Baltimore, MD May 2013
- Jacob Prunuske, Yumi Jarris, Willam Jordan, **Ranit Mishori**, Christopher Morley. Optimizing Integration of Public Health and Medical Education: The Role of Family Medicine Educators. STFM-Annual Medical Education Conference. January 2013. San Antonio, TX.
- **Ranit Mishori**. Conducting Asylum Evaluations: A Workshop for Family Physicians. FMEC/NE-STFM Annual Meeting. Cleveland, OH. September 2012.
- Ashley Bieck, **Ranit Mishori**, Stealth Family Medicine: Exposing students to family medicine through global health research. AAFP Global Health Workshop. Minneapolis, MN. September 2012.
- **Ranit Mishori** (moderator). USPSTF in Practice. Preventive Medicine 2012. Annual Meeting of the American College of Preventive Medicine. Orlando, FL. February 2012.
- Yumi Jarris, Alison Bartleman, **Ranit Mishori**, Erica McClaskey. A First Year Medical Student Curriculum on The Patient-Centered Medical Home. Presentation. Society of Teachers of Family Medicine. Annual Medical Education Conference. February, 2012
- Caroline Wellbery, Vince WinklerPrins, Yumi Jarris, **Ranit Mishori**.
- From Motivational Interviewing to System-based Care: A Third-year Clerkship Chronic Care Model Curriculum And OSCE. Presentation. Society of Teachers of Family Medicine. Annual Medical Education Conference. February, 2012.
- Jacob P. Prunuske, Linda Chang, **Ranit Mishori**, Christopher P. Morley. Public Health Training In Medical Education: Developing The Role of Family Medicine. Discussion. Society of Teachers of Family Medicine. Annual Medical Education Conference. February, 2012. THIS PRESENTATION WAS SELECTED AS A 'MODEL PROPOSAL' BY THE STFM.
- **Ranit Mishori**, Nancy Harazduk. Using Mind-body Medicine Skills to Reduce Stress And Enhance Well-being for Medical Students And Faculty. Workshop. Society of Teachers of Family Medicine. Annual Medical Education Conference. February, 2012.
- **Ranit Mishori,** Lawrence Bauer. Global Health Leadership Initiative. Family Medicine Education Consortium

Annual Meeting. Danvers, MA. October 2011.

- Caroline Wellbery, **Ranit Mishori**. Promoting Family Medicine as a Career Choice. Presentation. Society of Teachers of Family Medicine. Annual Meeting. Vancouver, Canada. April, 2010

Reviews or Editorials in Refereed Journals

- **Ranit Mishori,** Jessica Evert. Invited editorial. Global Health – Now More Than Ever. American Family Physician.
- **Ranit Mishori**. Older Americans with Supplemental Insurance – Higher Post-MI Coronary Revascularization Rate and Lower in Hospital Mortality. Journal of the National Medical Association. Vol 96, No. 8 August 2004.
- **Ranit Mishori**. Absence of Pre-Existing Conditions at Time of Diagnosis of Prostate Cancer Associated with Higher Death Rates in Black Men. Journal of the National Medical Association. Vol 96, No. 8 August 2004
- Carotid Endarterectomy in Older Women and Men in the United States: Trends in Ethnic Disparities. Press Release for the National Medical Association. July 2005.
- Awareness and Use of the PSA test among African American Men. Press Release for the National Medical Association. June 2005.
- Asthma Consensus Paper. The National Medical Association. Editor. October 2004
- Ranit Mishori, Humanitarianism Survives, Despite Being Under the Gun. Letter to the Editor. JAMA, *1997;278(19):1569*.

Reviewing and Editing

- Reviewed and edited women's health topics for the website of the National Women's Health Resource Center. www.HealthyWomen.org 2009-2012.
- Reviewed and edited Men's Health topics for the Men's Health Information website of the Department of Health and Human Services. August 2010

Articles in Non Peer-Reviewed Publications

Published **over 200 articles** in the popular press.

- Regular Columnist for Parade Magazine. StayHealthy column (readership 70-million). 2008-2011.
- Other Publications include: Washington Post, The Huffington Post. Angle Journal. AARP - The Magazine, The New York Daily News and others. 2002-Present.

PUBLICATION LIST MAY BE REQUESTED SEPARATELY.

Other Scholarly Contributions

Recent Online Publications:

- Ranit Mishori and Kathryn Hampton. The Worst Immigration Policy You've Never Heard Of. https://thehill.com/opinion/immigration/477329-migrant-protection-protocols-the-worst-immigration-policy-youve-never
- Ranit Mishori and Sondra Crosby. "Not just rapper T.I. : Doctors get requests for sexist, unscientific 'virginity tests'." *USA Today*. 2019
- Kate McKenzie, Kate Sugarman and Ranit Mishori. "Physicians to Trump: Immigration detention centers must close." *The Hill.* 2019
- Ranit Mishori, "We must help asylum-seekers. Here's a key way to do that.," *AAMC.org*, October 18, 2019, https://www.aamc.org/news-insights/insights/we-must-help-asylum-seekers-here-s-key-way-do
- Ranit Mishori. "An ICE detention center wants a doctor who will follow orders. That's unethical.." *The Washington Post*. 2019

- Mishori, R., Naimer K, McHale T., "The little tissue that couldn't – the hymen's role in determining sexual history or assault," *On Health, BMC Blog*, July 31, 2019, https://blogs.biomedcentral.com/on-health/2019/07/25/the-little-tissue-that-couldnt-the-hymens-role-in-determining-sexual-history-or-assault/.
- Phelim Kine, Ranit Mishori, "'Branded": Myanmar Military Mutilations of Rohingya Civilians," *https://phr.org/resources/branded-myanmar-military-mutilations-of-rohingya-civilians/*, June 28, 2019
- Mishori, R, "Can Flexible Training Help Combat Burnout?," *The Medical Care Blog*, May 2, 2019, https://www.themedicalcareblog.com/flexible-training-burnout/.
- Ranit Mishori. Marketing Cigarettes and e-Cigarettes: New Product, Same Tactics. Medscape. February 13, 2019. https://www.medscape.com/viewarticle/908749
- Ranit Mishori. Female Genital Mutilation: Why Are Doctors Silent? - Medscape - Jan 07, 2019. *https://www.medscape.com/viewarticle/907104*
- Ranit Mishori, "The Social Determinants of Health? What about the Political determinants of Health?," *APHA The Medical Blog*, October 04, 2018, https://www.themedicalcareblog.com/political-determinants-of-health/.
- Ranit Mishori, "Why I wore my white doctor's coat to protest family separation and detention," *USAToday*, July 18, 2018, https://www.usatoday.com/story/opinion/2018/07/18/doctors-must-speak-out-separated-immigrant-children-column/786638002/.
- Ranit Mishori, "Let's Not Forget the Injured in Shootings," *AAFP*, March 08, 2018, https://www.aafp.org/news/opinion/20180308guestedinjured.html.
- Ranit Mishori, "Cutting Global Health Funding Puts Americans At Risk," *AAFP*, February 22, 2018, https://www.aafp.org/news/opinion/20180222guestedglobal.html.
- Ranit Mishori, "Pulling back the curtain on 'The Doctors' and 'The Dr. Oz Show:' What our analysis revealed," *Healthnewsreview.org*, February 22, 2018, https://www.healthnewsreview.org/2018/02/pulling-back-the-curtain-on-the-doctors-and-the-dr-oz-show-what-our-analysis-reveals/.
- Ranit Mishori, "From Journalism to Medicine: Not Such a Huge Leap After All," *STFMblog*, November 09, 2017, https://blog.stfm.org/?s=mishori.
- Ranit Mishori, Jeanine Turner, Alisse Hannaford, Matthew Biel, "Latino Kids and Autism. Why Are They Diagnosed So Late?," *Angle Journal*, January 2017, http://anglejournal.com/article/2016-11-latino-kids-and-autism-why-are-they-diagnosed-so-late/.
- Ranit Mishori, "Mishori, R. On Reinfibulation: Part of the Female Genital Mutilation/Cutting Discussion that Rarely Gets Mentioned," *Huffington Post*, 2017, https://www.huffingtonpost.com/entry/on-reinfibulation-part-of-the-female-genital-mutilation_us_59a85813e4b096fd8876c15e.
- Ranit Mishori, Rebecca Reingold, Kevin FitzGerald, Samantha Wu, "The Criminalization of FGM in the United States. Responding to Female Genital Cutting: The Michigan Case and Beyond.," *Berkely Center*, 2017, . https://berkleycenter.georgetown.edu/forum/female-genital-cutting-the-michigan-case-and-beyond/responses/the-criminalization-of-fgm-in-the-united-states.
- Hope Ferdowsian, Karen Naimer, Ranit Mishori, "Prosecuting Sexual Violence in Conflict A medical approach," *Angle Journal*, January 2016, https://anglejournal.com/article/2015-12-clinicians-in-the-prosecution-of-conflict-related-sexual-violence/.
- Ranit MIshori and Hope Ferdowsian, "When It Comes to Rape Myths, The U.S. Is No Better Than Conflict Zones," *Huffington Post*, 2016, https://www.huffingtonpost.com/ranit-mishori-md-mhs/rape-in-conflict-zones-an_b_10707854.html.
- Ranit Mishori. Tanvi Nagpal., "Women and Toilets. A Tale of Two Worlds.," *The Huffington Post*, November 17, 2015, https://www.huffingtonpost.com/ranit-mishori-md-mhs/women-and-toilets-a-tale-_b_8575622.html.
- Ranit Mishori, "No Z-pack for you!," *Huffington Post*, 2015, https://www.huffpost.com/entry/antibiotic-resistance_b_8599678.
- Sexual Violence: From the Exam Room to the Courtroom and the Bumpy Road in Between, "Ranit MIshori," *The Huffington Post*, 2015, https://www.huffingtonpost.com/ranit-mishori-md-mhs/sexual-violence-from-the-_b_8681850.html.
- Ranit Mishori, "Why doctors should study human rights," *The Washington Post*, December 10, 2014,

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- **Ranit Mishori.** American Academy of Family Physicians (AAFP) Global health Guidelines: Practicing Global Health in my backyard. Web-based Publication December 2015.

Non-Fiction, Invited Book Reviewer

- Dissecting American Health Care: Commentaries on Health, Policy, and Politics. Douglas B. Kamerow, MD, MPH. RTI Press. September 2011;
- Pacifiers Anonymous. Sumi Sexton, MD. Publication, May 2010.
- Saving Henry: A Mother's Journey. Laurie Strongin. Hyperion. March 2010

PAID CONSULTANT

Physicians for Human Rights. 2011-present.
Senior Medical Advisor.
Program on Gender Based Violence in Conflict Zones (DRC, Kenya)

- Curriculum design and development; creation of teaching materials.
- Teaching and leading seminars and workshops for cross-sectoral teams
- Writing: research manuscripts, reports, advocacy materials
- Research, M&E activities: study design, survey development, analysis, IRB submissions
- Conference presentations and representation.

Asylum Network:

- Design teaching materials.
- Lead Asylum workshops for clinicians
- Ad-hoc consulting on projects, research.

Policy and Advocacy, Special Projects

- Ad-hoc support with media strategy, advocacy, technical writing, media appearances, policy briefings.
- Field work in Bangladesh (fall 2017).

World Bank. 2012-2015.

- Estonia – Reforming the Primary Care Infrastructure. 2013-2014.
- Western Balkans: Health Network Analysis for Tracer Conditions. Aneesa Arur, Ranit Mishori. Work in Progress. September 2012-September 2013.
- Authored report: Serbia's Health System: Issues and Options for Reform. A World Bank Policy Note. July 2012. Christoph Kurowski (Task Team Leader), Ranit Mishori, Ethan Yeh and Ana Holt

Authored report: Clinical Quality Outcomes for Middle and High Income Countries. White Paper. October 2011 – February 2012

Healthcentral.com (a commercial health information portal).Reviewed and edited content on cardiovascular disease for 2008-2009.

PROFESSIONAL DEVELOPMENT:

- **The Association of Medical Education in Europe (AMEE): Research Essential Skills in Medical Education (RESME).** Pre-Conference Workshop. Milan, Italy August 28-Sept 4, 2014.
- **SIT. Systematic Inventive Thinking Workshop.** Bertelsmann Foundation Young Leaders Annual Network Meeting**.** Potsdam, Germany. October 2010. (By Invitation).
- **AAMC: The Early Career Women Faculty Professional Development Seminar.** Washington, DC. July 2010. (By Competitive Selection Process)
- **Immunity to Change: How to Overcome It and Unlock the Potential in Yourself and Your Organization.** Prof. Robert Kagan/Harvard University; Bertelsmann Young Leaders Network Israel, May 5-9, 2009 (By invitation).
- **Mind-Body Medicine Faculty Workshop.** Belmont, Maryland, July 9-11, 2008 (By selection).
- **Young Leaders Fellowship.** Leadership Development, Bertelsmann Foundation. Berlin, June 5-15, 2007; Israel, October 10-19, 2007. (Nominated. Competitive selection process

GLOBAL HEALTH ACTIVITIES:

Field Work:

- Bangladesh, Rohingya Refugee Camps. Fact Finding Mission. October 2017.
- Sexual Violence Multi-Sectoral Training. DRC, Kenya. 2-3 trips annually. 2012-Current.
- Medical Education missions. Training local health care workers. Curriculum development. Supervising Family Medicine residents. Haiti, May 2011, 2012, 2013.
- Medical Mission. Pinares, Honduras. Medical care; supervising Family Medicine residents and medical students. February 2011
- Fact-finding mission. Concepcion, Honduras. July 2010
- Fact-finding mission. Supervising Family Medicine Resident and Fellow. Milot, Haiti. May 2010
- Service Trip, Dominican Republic; Supervising medical students, Residents. November 2009
- Global Health Elective. PGY-III. Northern Israel. Maternal and Child Health. August 2007.
- Global Health Elective. PGY-II. Israel. Community Genetics. August 2006.
- Global Health Elective. MS-IV.Physicians for Human Rights Clinic. Israel. March 2002.

Master's Thesis. John's Hopkins Bloomberg School of Public Health. The Changing Disease Patterns in Ethiopian Immigrants to Israel. May 1999.

MILITARY SERVICE

Israeli Defence Forces (IDF). Mandatory Military Service. Basic Training. Rank: Staff Sergeant. Served in IDF Radio Station, news division 1984-1986.

I certify that this curriculum vitae is a current and accurate statement of my professional record.

Signature:__ _____ Date: 1/1/2020 _____

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

ANGEL DE JESUS ZEPEDA RIVAS, BRENDA RUIZ TOVAR, LAWRENCE MWAURA, LUCIANO GONZALO MENDOZA JERONIMO, CORAIMA YARITZA SANCHEZ NUÑEZ, JAVIER ALFARO, DUNG TUAN DANG,

Petitioners-Plaintiffs,

v.

DAVID JENNINGS, Acting Director of the San Francisco Field Office of U.S. Immigration and Customs Enforcement; MATTHEW T. ALBENCE, Deputy Director and Senior Official Performing the Duties of the Director of the U.S. Immigration and Customs Enforcement; U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT; GEO GROUP, INC.; NATHAN ALLEN, Warden of Mesa Verde Detention Facility,

Respondents-Defendants.

CASE NO.

DECLARATION OF LISA KNOX REGARDING CONDITIONS OF CONFINEMENT AT THE MESA VERDE ICE PROCESSING FACILITY

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DECLARATION OF LISA KNOX REGARDING CONDITIONS OF CONFINEMENT AT THE MESA VERDE ICE PROCESSING FACILITY

I, Lisa Knox, hereby declare as follows:

1. I am an Immigration Managing Attorney at Centro Legal de la Raza ("Centro Legal"), a non-profit organization in San Francisco, California, that provides comprehensive services to immigrants, including legal services. In that role, I manage and regularly supervise a twice-monthly legal services clinic at the Mesa Verde ICE Processing Center ("Mesa Verde"). In the past year, I have personally attended and supervised seven legal service clinics at the facility.

2. The facts stated in this declaration are true and of my own personal knowledge, except as to any matters stated on information and belief, and as to those matters, I am informed and believe them to be true.

3. Centro Legal has provided legal services at the Mesa Verde facility since its opening in approximately 2015. I have regularly attended these visits since 2016. Centro Legal and its partner organizations currently conduct legal clinics in the facility's second-floor cafeteria area. To enter the cafeteria area, staff pass by two men's dormitories and another cafeteria area that is used for meals. All of these areas are visible through windows as staff pass by.

4. In my experience, the Mesa Verde facility lacks the medical resources to be responsive to even basic medical issues. In June 2019, a case of chicken pox was confirmed at the facility. This year alone, we have become aware of three cases in which ICE provided detainees with the wrong medication. Additionally, we have spoken with several diabetic individuals whose doctor-prescribed diet ICE refused to provide.

5. In my observation, ICE at Mesa Verde is particularly ill-equipped to deal with communicable diseases. Though ICE reported only five detainees had been exposed to chicken pox in June 2019, many detainees believed they had been exposed through sharing dormitory

and public space with the infected individuals. Detainees have consistently reported that the dormitory bathrooms regularly lack basic hygiene supplies, such as toilet paper and soap, needed to prevent the spread of communicable diseases.

6. Our most recent in-person visit to Mesa Verde occurred on Friday, March 13, 2020. Prior to the visit, I requested that staff from my organization who were visiting the facility be allowed to bring hand sanitizer and disinfectant wipes into the facility. I was told that no one was allowed to bring in those items, and that only the cleaning supplies at the facility could be used. There are no cleaning supplies or sink for handwashing available in the room where we conduct visits, which also is one of two rooms where detained people eat their meals.

7. On the March 13, 2020 visit, we did not observe anyone—facility staff, detained people, or anyone else in the facility—wearing masks. No one asked our team of legal workers entering the facility about our health, including whether we were experiencing any symptoms. We did not see any posted signs with information about COVID-19 or Coronavirus.

8. Detained individuals reported that they received information verbally during a group presentation earlier in the week--they were instructed to wash their hands with soap, they were provided with bleach-based cleaning solution for the first time, they were instructed to cough and sneeze into their elbows, and they were told to report any flu-like symptoms right away. Despite the instructions to use soap, at the time of our visit some detainees reported that they had not received free soap. I was concerned that the staff mentioned they were already running out of masks, that detainees reported that new detainees were being mixed in with the general population without any mandatory quarantine period (since we know the virus can remain dormant for many days or even be carried by asymptomatic carriers), and that so many individuals with pre-existing conditions that put them at high risk remain in detention.

9. The Mesa Verde facility is an extremely small space where in my observation detainees are continuously in close contact with staff and one another. The facility has four larger dormitory spaces that each house around 100 detainees. During our visits, I have observed that the detainees sleep in bunkbeds that are spaced only a few feet apart. Detainees have reported that they spend all but a few hours a day in the dorm space. Meals are eaten in a common cafeteria space, where I have observed that detainees sit four to a table on bench seats spaced a few feet apart. In my observation and experience spending time in this room, it would be extremely difficult for a detainee to maintain the recommended six feet of social distancing in these spaces for any amount of time.

An organization which conducts visitation at Mesa Verde provided me with this picture, which shows individuals in Dorm C of the facility.

10. My understanding is that there are fewer than five isolation cells available in the facility. In my experience, these cells are usually filled with individuals with chronic mental health conditions or individuals being isolated for disciplinary reasons.

11. During the March 13, 2020 visit, detainees were seated at tables that seat four people per table, which clearly do not allow for 6 feet of space in between people. Detainees were not instructed to sit farther apart. Detainees reported that they eat meals at the same sized

tables that seat four people per table, which clearly do not allow for 6 feet of space in between people.

12. Detainees have regularly reported unsanitary conditions at the facility. Detainees have consistently reported that there is not sufficient soap or shampoo in the shower stalls. They are forced to pay as much as $10 for a bottle of shampoo in the commissary. As a result, many who cannot afford these exorbitant prices are forced to shower without soap or shampoo. Detainees who clean bathrooms have reported that they regularly run out of disinfectant, and are forced to clean with only water.

13. Detainees have reported that the only regular cleaning that occurs within the dorm consists of sweeping and mopping the floors. Detainees are responsible for cleaning their own bunk bed areas, and to do so, they share the same rag and pass it from detainee to detainee.

14. On March 13, 2020, no sanitation precautions were taken that could be observed by the legal worker team. There was no evidence that surfaces were cleaned between the times that each housing unit was brought into the room for legal services. Neither the detained people nor the legal workers had any access to any materials to sanitize surfaces or hands during the day. The only way that legal workers could wash their hands was to request to return to the restrooms in the lobby. Detained individuals reported they did have access to shared bar soap in the bathroom areas of their housing units for hand washing. It did not appear that the detainees had access to hand washing in the room where the legal services were provided on March 13, 2020.

15. On the March 13 visit, many detainees reported worry about the lack of screening of new arrivals to the detention center, as well as concerns about the cleaning of services. One individual reported that showers were being cleaned with soap.

16. On March 19, one of our clients informed us that the conditions described above had not changed. Detainees still share the same rag to clean and wipe down their sleeping areas. They still are not physically able to keep a 6 foot distance from one another for any significant

period of time. Detention personnel do not wear masks, and only some wear gloves. Our client also informed us that there are not regular checks for fevers.

17. As of March 30, a client informed me that officials instructed those in her dorm to maintain social distancing but that is impossible. She estimates that the beds in her dorm are spaced less than 1 meter (3.28 feet) apart. While she was re-assigned a bed so that two empty beds separate her from others, the majority of the detainees sleep in beds directly next to one another. When she needs to move around the dorm, for example to go to the bathroom, my client stated that she cannot help but pass very close by other detainees. My client believes that it would be impossible to maintain the recommended 1.5 meter distance from other women in her dorm for more than short periods of time.

18. On April 12, an individual in Dormitory C informed us that previous the past 7 days, around 11 new individuals were brought and housed in the dorm. We spoke to one of them, who informed us that he had been transferred from Pleasant Valley State Prison. The individual informed us that he himself has never been tested, and that he was never quarantined before arriving at Mesa Verde. Although his transfer involved being brought from Pleasant Valley State Prison, to an ICE office in Fresno, and then to Mesa Verde, he reported that he was never given a face mask to wear. The individual informed us that his temperature was checked in Fresno, but apart from that, no other precautions were taken before bringing him into Mesa Verde. On April 14, an individual in Dormitory C informed us that there was at least one new transfer into the dorm that morning.

19. As of April 12, detainees reported that some staff in at least one dorm were now wearing face masks. However, the facility continued to refuse masks to the detainees themselves. Several detainees stated that, on or about April 3, they made face masks from their own clothing to comply with CDC guidance. The facility guards told them they could not wear the masks.

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

Executed this 14th day of April 2020 in Oakland, California.

Signed: s/ Lisa Knox____

Declarant

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

ANGEL DE JESUS ZEPEDA RIVAS, BRENDA RUIZ TOVAR, LAWRENCE MWAURA, LUCIANO GONZALO MENDOZA JERONIMO, CORAIMA YARITZA SANCHEZ NUÑEZ, JAVIER ALFARO, DUNG TUAN DANG, .

Petitioners-Plaintiffs,

v.

DAVID JENNINGS, Acting Director of the San Francisco Field Office of U.S. Immigration and Customs Enforcement; MATTHEW T. ALBENCE, Deputy Director and Senior Official Performing the Duties of the Director of the U.S. Immigration and Customs Enforcement; U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT; GEO GROUP, INC.; NATHAN ALLEN, Warden of Mesa Verde Detention Facility,

Respondents-Defendants.

Case No.

DECLARATION OF ATTORNEY KATHLEEN ANNE KAVANAGH REGARDING CONDITIONS OF CONFINEMENT AT YUBA COUNTY JAIL

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DECLARATION OF KATHLEEN ANNE KAVANAGH

I, Kathleen Anne Kavanagh, hereby declare as follows:

1. I am an attorney licensed in the state of New York and authorized to practice before the Executive Office for Immigration Review and the Department of Homeland Security throughout the United States. I am the Lead Rapid Response Attorney for the California Collaborative for Immigrant Justice ("CCIJ"), a coalition of organizations providing coordination, advocacy, and legal services to the immigrant community in California, with a focus on individuals who are in, and who face, detention. As part of my role, I help lead monthly visits to the Yuba County Jail in Marysville, California. Yuba County Jail has a current contract with U.S. Immigration and Customs Enforcement ("ICE") to detain immigrants.
2. The facts stated in this declaration are true and of my own personal knowledge, except as to any matters stated on information and belief, and as to those matters, I am informed and believe them to be true.
3. CCIJ and community partners visit Yuba County Jail on a monthly basis to provide legal information and services to individuals detained by ICE. I have been participating in these visits since approximately September 2018. During these visits, we occasionally visit the law library, but primarily enter the housing units where ICE detainees are held, typically commingled with inmates held by the county for criminal offenses. We meet one-on-one with detained noncitizens in their housing units, at tables with attached benches that are otherwise used by inmates and detainees for meals and recreation, and which are often dirty. Sometimes before we sit down, one of the detainees will take the initiative to wipe down the tables with a spray bottle and rag, but they are not instructed to do so by anyone.
4. We are also often in the pods when food is served and eaten. It is served by other ICE detainees or county inmates. I have not personally observed any instruction from staff to

clean tables or wash hands before food is served or consumed, and I have not observed such practices consistently followed. What cleaning I have seen done in the pods is conducted by the detainees themselves. I have observed dirty buckets of mop water and rags reused for cleaning.

5. The housing units in which ICE detainees are housed in Yuba differ significantly in size and layout. However, based on the number of beds and total space in each housing unit I have visited, I do not believe it would be possible for all detainees to maintain six feet of distance from one another in any of the housing units holding ICE detainees at Yuba County Jail without a meaningful reduction in population from the maximum capacity. In every housing unit I have visited, detainees sleep in bunk beds where the top and bottom bunk are not six feet apart, nor are the bunks separated by more than a few feet.
6. B and C Pod are large open rooms with beds to house approximately 50 people each. C Pod is exclusively ICE detainees, while B Pod holds a mix of ICE detainees and county inmates. In B and C Pods, there are second floor lofts that each contain several tables used both for dining and recreation, as well as a ping pong table and phones. There are windows on the upper level that to not open. All of the sets of bunk beds are located on the lower floor, arranged in a giant grid in the middle of the room, spaced only a few feet apart. Detainees are not six feet apart when they are on their bunks. Both floors have a few shower and toilet stalls, which are separated only by thin dividers that rise to around shoulder height.
7. D, E, and F Pods are each comprised of approximately twenty two-person cells along a lower floor and an upper balcony. There are no windows. Detainees in D, E, and F Pods are allowed out of their cells and into the common area on the lower level, which contains four tables and a television, in shifts. They sleep in bunk beds. Each cell has one set of two beds, a sink, and a toilet. When two detainees are anywhere in their small cells, it would be impossible for them to be six feet apart.
8. Within B, C, D, E and F Pods there are also small telephone booths, usually two per pod.

These booths have doors that can be closed. On our visits, I have witnessed individuals moving in and out of the phone booths without cleaning the receiver or other surfaces. I have never seen anyone sanitize the phones or the booths.

9. There are also smaller housing units, commonly referred to as "tanks," that are essentially large cells along certain corridors of the jail. Examples are G Tank, H Tank, I Tank, and L Tank. These are often referred to as the "old" part of the jail because they have not been updated in decades. The tanks are not enclosed rooms; instead, they are separated from the corridors only by a set of bars, with open spaces between the bars, so air flows freely between the tanks and corridors. Each tank holds approximately two dozen men who sleep in sets of bunk beds that are spaced only a few feet apart. There are common tables in the middle of the tank, where the detainees eat and engage in recreation. The common space is small, with very little room to maneuver around the tables and bunk beds. Each tank is comprised of a mix of ICE detainees and county inmates. In these tanks, it is also impossible for people to be six feet apart from each other.
10. In R Pod, one of the women's housing units, the living, sleeping, and bathing quarters are extremely compact. There are approximately two dozen bunk beds spaced a few feet apart lining one wall, a half wall dividing the room lengthwise, and a row of tightly-spaced tables on the other side of the low wall, along the opposite wall. At the far wall from the entrance, there are approximately three showers with plastic dividers between them. The size and layout of the unit make it hard to navigate without coming very close to or into direct physical contact with others. We usually bump into one another when we sit down at and get up from the tables. The tables are the only space the ICE detainees and county inmates have to use for both dining and recreation.
11. Another women's housing unit, P Pod, holds a dozen women in a room so small that usually only a small number of our volunteers can actually enter the pod, in contrast to the other units that the whole group enters at once with an escort. In P Pod, our escort stands by the open unit door with the rest of the volunteers, as there is simply insufficient

space for all of us to enter and to be able to move around. There is one picnic-style table that seats approximately six in the middle of the room. The only window does not open. P Pod holds a mix of female ICE detainees and county inmates.

12. The "law library" at Yuba County Jail is a basement room with no windows and no ventilation that I can recall. There are only about three tables in the law library and during the last time we used the law library there was so little space that we could only speak with a few detainees at a time.

13. Moving from one housing unit to another within the jail, or to walk to a non-housing part of the facility such as the infirmary, the phone room, or the law library, requires traversing a maze of hallways and riding elevators to get between the floors of the jail. The elevators are small enough that it would be impossible for two people riding at the same time to maintain six feet of separation. I estimate that some of the narrower hallways are six feet wide or less, with low ceilings. Other corridors are wider, perhaps ten to 12 feet across, but are lined on one side by the "tanks." The bars of the tanks line the hallway. In my observations, when a detainee is moving from one area of the jail to another, including in the elevators, they are always closely escorted by a guard.

14. In my and my colleagues' experience, Yuba County Jail regularly fails to provide adequate medical care to ICE detainees suffering from a variety of conditions. For instance, in the past year, my client, a 51-year-old in remission from follicular lymphoma, did not undergo medically-recommended follow-up scans until approximately four months after he was due for them. Moreover, he was only able to have the scans after he had been complaining for months of night sweats and unexpected weight loss of 20 pounds. In another example, an ICE detainee complained of severe pain and difficulty breathing for nearly two weeks after an injury before he saw a doctor and was administered x-rays, despite regular requests for medical attention. In yet another example, during our October 2019 visit, a volunteer was approached by an ICE detainee who told us he had been diagnosed with skin cancer three months prior (while in ICE

detention), but he had not yet received any treatment for his condition despite multiple inquiries. Finally, also in October 2019, my office received multiple phone calls from an ICE detainee over a period of approximately two weeks. He told us he had suffered a head injury, and that he had severe pain and near complete hearing loss in one ear. During the approximately two weeks that he was calling my office regularly, he reported that he was making regular requests for medical attention but had not been assisted.

15. There is a specific space on our intake sheets for "conditions issues" and on every one of our monthly visits, we hear from at least three to five individuals that have specific and serious complaints about medical care, cleanliness, and other basic issues regarding health and safety at Yuba County Jail. Sometimes we are approached by county inmates with similar complaints. The same individuals often return to complain to us month after month about the lack of medical attention they receive despite multiple requests for care. Likewise, the ICE detention hotline maintained by CCIJ receives regular complaints from detainees at Yuba County Jail regarding unanswered requests for medical attention.
16. I swear under penalty of perjury that the foregoing is true and correct. Executed at San Francisco, California, on this 23 of March 2020, by:

Kathleen Anne Kavanagh